HQIP

Healthcare Quality
Improvement Partnership

HEALTHCARE QUALITY IMPROVEMENT PARTNERSHIP

IN-FOCUS IMPACT REPORT

2024

Measuring and improving our healthcare services

www.hqip.org.uk

Impact of NCISH: system level

- NCISH has collected **in-depth information** on **all suicides** in the **UK** since 1996.
- Our recommendations have **improved patient safety** in mental health settings and **reduced** patient suicide rates, contributing to an **overall reduction** in suicide in the UK.

- Our **"10 ways to improve safety"** are shown to reduce suicide rates.
- These 10 elements have been formulated into a **self-audit toolkit** for specialist mental health services, updated with new evidence.
- The toolkit has been downloaded **~32,000** times, since launch in 2012.

Our evidence is **cited** in the **latest** national **strategies**, **policies**, **clinical guidance** and **regulation** in all UK countries.

Suicide Prevention Strategy, England

"Mental health trusts should continue to review and implement evidence-informed recommendations from the NCISH Annual Report and 10 ways to improve safety"

Suicide Prevention Strategy, NI

"NCISH recommends comprehensive care planning…routine follow-up…in response to missed appointments and addressing adverse life and social circumstances…prior to discharge"

Self-Harm Prevention Strategy, Scotland

"…training for staff working in specific settings, safety planning, implementing NCISH recommendations…will help provide the right support at the earliest opportunity…"

NCISH recommendations underpin NICE guidelines

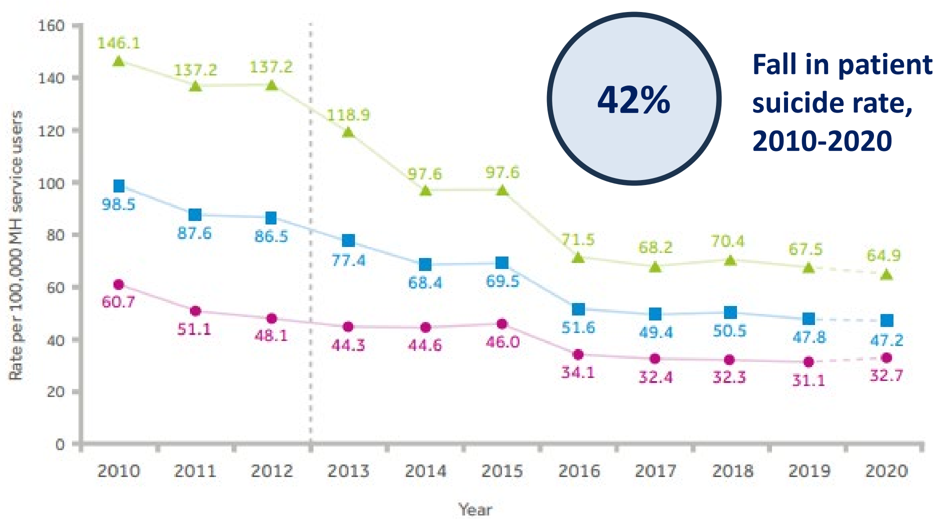
Self-harm: assessment, management and preventing recurrence

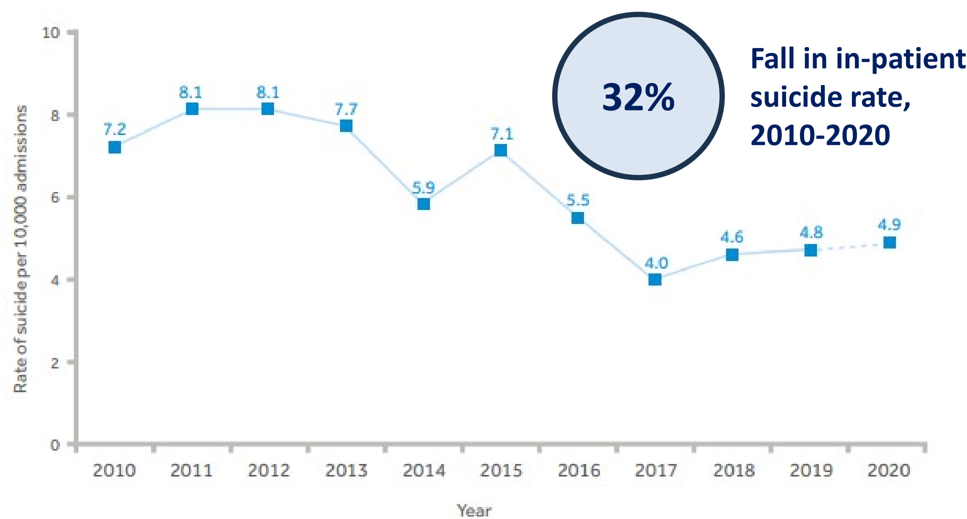
Transition between inpatient mental health settings and community or care home settings

NCISH is cited in the Online Harms White Paper, leading to the Online Safety Bill

Online Harms White Paper

NCISH recommendations have led to a fall in patient, and in-patient suicide rates





Impact examples from July 2004 to Dec 2023. Impact report updated Dec 2023.

USING THE OUTPUTS FROM THE CHILD HEALTH CLINICAL OUTCOME REVIEW PROGRAMME FOR QUALITY IMPROVEMENT.

CHILD HEALTH CLINICAL OUTCOME REVIEW PROGRAMME

Established in 2011

Uses patient/parent/carer focus groups and surveys, clinician questionnaires and a deep dive into the case notes to review the quality of care provided to children, young people and young adults aged 0-25 years.

Published 4 reports to date
- chronic neurodisability
- metal health
- long-term ventilation
- transition

Improving the quality of healthcare
www.ncepod.org.uk

LATEST REPORT - TRANSITION FROM CHILDREN'S TO ADULT HEALTHCARE SERVICES

Published in June 2023

'The Inbetweeners' explored the barriers and facilitators in the process of the transition of children and young people with chronic health conditions into adult health services.

KEY MESSAGES TO IMPROVE TRANSITION

- **Make developmentally appropriate healthcare core business for all healthcare staff**
- **Involve children and young people and their parents/carers in the transition planning**
- **Improve communication and co-ordination of care between all involved in the transfer into adult services**
- **Organise local transition services**
- **Provide Board level and clinical leadership for transition**

149 PATIENTS/ PARENTS/CARERS participated in focus groups/survey were SIGNPOSTED TO SUPPORTIVE TRANSITION TOOLS such as READY STEADY GO

EVENTS ATTENDED TO DISCUSS THE REPORT FINDINGS

- 7th National Annual Transition Conference
- Midlands transition meeting
- NHS England regional leads for children and young people (Children and Young People Transformation Programme)
- WellChild
- National Transition Leads meeting
- NHS England - North East & Yorkshire Region
- Paediatric Neurosciences Operational Delivery Networks
- Barts Health
- British Association for Community Child Health
- Together for Short Lives
- Transition Community of Practice group - Oxford
- East and West Midlands CYP Diabetes Networks
- Hospice UK transition coordinator group
- British Association of Childhood Diseases
- European Symposium for Transition
- Solent NHS Trust and South Thames and Wessex ODN
- East and West Midlands CYP Diabetes Networks
- NHS Derby and Derbyshire Integrated Care Board
- Adolescent Health ODE
- Sheffield Transition conference
- Roald Dahl Nurses conference
- Society of Acute Medicine
- East of England ICB
- Med + 2023
- Nursing Live
- Association of Paediatric Palliative Medicine
- Royal College of Paediatrics and Child Health Board

IMPROVEMENT GOALS

1. **Use each NCEPOD report recommendation checklist to assess local practice & report the status to the Executive Board**
2. **Use the QI tools provided for each report to focus on specific areas for improvement**
3. **Executive Boards need to encourage implementation of NCEPOD recommendations & help share in the learning**

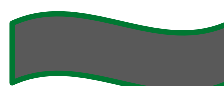
IMPROVEMENT SUPPORT TOOLS

are available on the study webpage including:

1. A recommendation checklist
2. An audit tool
3. Fishbone diagrams
4. Driver diagrams
5. Failure mode and effect analysis templates
6. A commissioner's guide

karina @karina04207419 · 3h
Important reading! #transition @NCEPOD

AYPH charity @AYPHcharity · 51m
New @NCEPOD report explores the barriers & facilitators in the process of transition for children and young people with complex chronic health conditions into adult health services. We were pleased to be involved in the stakeholder meetings for this work.
ncepod.org.uk/2023transition...



Emma @emmabeeden · 1h
Very proud to have been part of the Study Advisory Group for this very important report!

Great to see the experiences of children and young people featured throughout the report sharing what is currently happening & what needs to be improved.

Elizabeth @hareelizabeth1 · 1h
Such an essential piece of work

NCMD
National Child Mortality Database

HQIP
Healthcare Quality Improvement Partnership

National impact: NCMD in Parliament

The last year has been an important one for the National Child Mortality Database (NCMD) in terms of national influence. Growing recognition of the programme's unique data has contributed to attention not just in the press, but also among politicians and policymakers at the highest levels. Today the NCMD and its work are referenced ten times in Hansard, the record of debates in parliament, and that number continues to grow. This timeline below shows our involvement with three All-Party Parliamentary Groups (APPGs) and a parliamentary discussion through 2022/23.

- **APPG on Baby Loss**
- **APPG on Temporary Accommodation**
- **Sudden Unexplained Death in Childhood**
- **APPG on Drowning and Water Safety**

October 2022

NCMD makes a strong contribution to the APPG on Baby Loss' report Safe Staffing, which looks at the impact of staffing shortages in maternal and neonatal care.

November 2022

NCMD analysis finds that 34 child deaths between 2019 and 2022 involved homelessness. This information is included in the APPG's call for evidence report.

Chancellor Jeremy Hunt acknowledges the APPG report in the Autumn Statement, making commitments to publish a comprehensive workforce plan and recruit 2,000 more midwives.

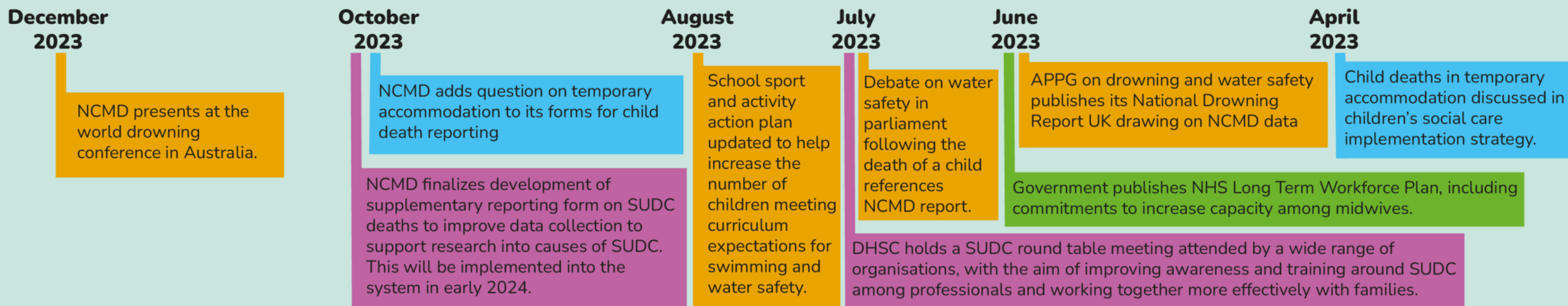
December 2022

NCMD publishes SUDC thematic report.

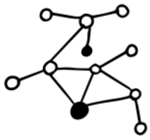
January 2023

Parliament holds first ever debate on sudden and unexpected deaths in childhood.

Temporary accommodation discussed in parliament with NCMD attendance and covered widely in national newspapers.



Supporting regional improvement networks



Integrated Stroke Delivery Networks (ISDNs) are the key vehicle for transforming stroke care across England. SSNAP has been supporting ISDNs and the National Stroke Service Model through data, workshops and reporting changes.

42% (Jan23) → 42% (Feb23) → 43% (Mar23)
admitted to a stroke unit in 4hrs

3.6% (Jan23) → 3.8% (Feb23) → 3.3% (Mar23)
patients receiving thrombectomy

1

Development of monthly dashboard

- Four levels of reporting: national, country, regional, ISDN
- 19 measures reported monthly
- 7 measures reported quarterly
- Refreshed monthly
- Identify and monitor trends in more real-time

2

Regional reporting

- National reports grouped by ISDN
- Compare performance within a region
- All measures reported at ISDN-level
- Monitor and track network performance
- Encourage shared learning between and within networks

80 ISDN-level reports produced each quarter

125 regional attendees

3

Post-acute integrated services

- 7 workshops held to guide and stimulate regional post-acute QI

58.7% (2020/21) → 60.1% (2021/22) → 61.0% (2022/23)
patients discharged to specialist a ESD and/or CRT team

102 combined services
42 standalone CRT
64 standalone ESD

4

Integrated Community Stroke Services

- New team type created to enable reporting of compliance with the ICSS, both baseline and progress
- 227 providers contacted
- 82% increase in providers registered as a combined service

5

Critical Time Standards

- Four key measures identified by NHS England
- Data entered and reported monthly
- Track changes over time nationally and locally

44% routinely admitting teams in England registered

Healthcare Quality Improvement Partnership

communications@hqip.org.uk

www.hqip.org.uk