Meeting of the Board of Directors

To be held in public

Thursday 29 October 2015 from 1:30pm

Venue: Large Training Room, Learning Centre, Calderdale Royal Hospital, HX3 0PW

AGENDA

1.	**Welcome and introductions:-**	Chairman	
2.	Apologies for Absence:- Anna Basford, Director of Transformation and Partnerships Julie Hull, Director of Workforce & OD Welcome:- Grenville Horsfall, Publicly Elected Membership Councillor David Longstaff, Nominated Stakeholder Membership Councillor Lynn Moore, Publicly Elected Membership Councillor	Chairman	
3.	Declaration of interests	All	**VERBAL**
4.	Minutes of the previous meeting held on 24 September 2015	Chairman	**APP A**
5.	**Action Log and Matters arising:** a. CAIP/Mortality Reviews b. NICE Guidance – Cancer Drugs	Chairman Chairman Executive Director of Nursing/Executive Medical Director	**APP B** **VERBAL** **VERBAL**
6.	**Chairman's Report:-** a. Meeting with local Chair's re Winter Pressures	Chairman	**VERBAL**
7.	**Chief Executive's Report:-** a. CQC Report on the state to health care & adult social care in England 2014-15	Chief Executive	**APP C**
Keeping the base safe			
8.	Risk Register	Executive Director of Nursing & Operations	**APP D**
9.	Director of Infection Prevention and Control Report	Executive Medical Director	**APP E**
10.	Care of the Acutely Ill Patient Report	Executive Medical Director	**APP F**
11.	Review of One Year Plan	Company Secretary	**APP G**

12.	Emergency Preparedness, Resilience And Response (EPRR) Core Standards Assurance	Executive Director of PPEF	**APP H**
13.	Health and Safety Annual Report Update	Executive Director of PPEF	**APP I**
14.	**Integrated Board Report** - Responsive - Caring - Safety - Effectiveness - Well Led - CQUINs - Community - Monitor Indicators - Finance	 Executive Director of PPEF/Associate Director of Community/Operations Executive Director of Nursing Executive Director of Nursing Executive Medical Director Interim Director of Workforce and OD Associate Director of Community/Operations Associate Director of Community/Operations Executive Director of Finance	**APP J**
Financial Sustainability			
15.	Month 6 – September 2015 – Financial Narrative	Executive Director of Finance	**APP K**
Transforming and Improving patient care			
No items			
A Workforce for the future			
16.	Disclosure and Barring Report	Executive Director of Nursing	**APP L**
17.	**Update from sub-committees and receipt of minutes** ▪ Quality Committee (Minutes of 22.9.15 and verbal update from meeting held 27.10.15) ▪ Finance and Performance Committee (Minutes of 15.9.15 and verbal update from meeting held 20.10.15) ▪ Audit and Risk Committee draft summary notes from meeting held 20.10.15		**APP M** **APP N** **APP O**
Date and time of next meeting Thursday 26 November commencing at 1.30 pm Venue: Conference Suite, Todmorden Health Centre, Lower George Street, Todmorden, OL14 5RN			

Resolution

The Board resolves that representatives of the press and public be excluded from the meeting at this point on the grounds that the confidential nature of the business to be transacted means that publicity of the matters being reviewed would be prejudicial to public interest. *(Section 1(2) Public Bodies (Admission to Meetings Act 1960).*

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 29th October 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 24.9.15 - The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 24 September 2015.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 24 September 2015.

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 24 September 2015.

Appendix

Attachment:

DRAFT BOD MINS - PUBLIC BOD MINS - 24 9 15(2).pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Minutes of the Public Board Meeting held on Thursday 24 September 2015 in the Boardroom, Sub Basement, Huddersfield Royal Infirmary

PRESENT

Andrew Haigh	Chairman
Dr David Anderson	Non-Executive Director
Dr David Birkenhead	Executive Medical Director
Julie Dawes	Executive Director of Nursing and Operations/Deputy Chief Executive
Keith Griffiths	Executive Director of Finance
Lesley Hill	Executive Director of Planning, Performance, Estates & Facilities
Philip Oldfield	Non-Executive Director
Dr Linda Patterson	Non Executive Director
Jeremy Pease	Non-Executive Director
Prof Peter Roberts	Non-Executive Director
Owen Williams	Chief Executive
Jan Wilson	Non-Executive Director

IN ATTENDANCE/OBSERVERS

Helen Barker	Associate Director of Community Services and Operations
Anna Basford	Director of Commissioning and Partnerships
Caroline Wright	Communications Manager
Kathy Bray	Board Secretary
David Himelfield	Huddersfield Examiner Reporter
Sarah Clenton	Business Manager – Huddersfield Pharmacy Specials (for part of the meeting)
Peter Middleton	Publicly Elected Membership Councillor
Dianne Hughes	Publicly Elected Membership Councillor
Dawn Stephenson	Nominated Stakeholder Membership Councillor
Rochelle Scargill	Customer Services Manager – Huddersfield Pharmacy Specials (for part of the meeting)

Item

132/15 APOLOGIES FOR ABSENCE AND INTRODUCTIONS

Apologies were received from:

Julie Hull	Executive Director of Workforce and Organisational Development
Victoria Pickles	Company Secretary

The Chairman welcomed everyone to the meeting.

133/15 DECLARATION OF INTERESTS

There were no declarations of interest to note.

134/15 MINUTES OF THE MEETING HELD ON THURSDAY 27 AUGUST 2015

The minutes of the meeting were approved as a true record.

135/15 MATTERS ARISING FROM THE MINUTES

128/15 – Mortality Reviews – The Executive Medical Director reported that Dr Bryan Gill, Medical Director and Professor Mohamed from Bradford University were working within the Trust to review the Trust's data and this would be brought back to the Board at a future date.

ACTION: Future Board Agenda Item – date to be confirmed

136/15 ACTION LOG

Risk Register – Winter Pressures – The Associate Director of Community Services and Operations advised that work had been undertaken within the Divisions and it was scheduled that a plan would be taken to the next Weekly Executive Board. Given the difficulties encountered last year it was agreed that this would be brought to the Board in October.

ACTION: Agenda Item – Board of Directors – October 2015.

There were no other items outstanding on the Action Log.

137/15 STAFF STORY – PHARMACY MANUFACTURING UNIT DEVELOPMENTS

Rochelle Scargill, Customer Services Manager and Sarah Clenton, Business Manager from Huddersfield Pharmacy Specials (HPS) attended the Board to give a staff perspective of the developments within the Pharmacy Manufacturing Unit branded as HPS some 3½ years ago.

Rochelle advised that she had joined the Trust 23 years ago and had progressed through the Pharmacy Department to her current post of Customer Services Manager dealing with customers in the community and countrywide. She outlined the changes that had taken place in the department to ensure a business orientated focus was maintained which had entailed a number of staff changes and also retaining some long serving staff. She was appreciative of the support afforded her by the Trust in her on-going development. She was proud of the Trust and the NHS.

Sarah Clenton, Business Manager advised the Board that she had worked within HPS for 3½ years and outlined the various roles which she had undertaken working within CHFT for the last 17 years. It was noted that the HPS was now a national brand and dealt with Trusts and organisations throughout the country.

Sarah advised that the success of the department had not been without some challenges but its success was down to the hard work of an excellent team who had the right attitude. In her opinion this was evidence that with the help of staff with the right attitude anything was possible.

The Board thanked Rochelle and Sarah for their frank and honest opinions.

138/15 CHAIRMAN'S REPORT

a. Joint Board/Membership Council Healthfair and AGM – 17.9.15

The Chairman reported that the joint Board/Membership Council Healthfair and AGM had been a very successful event. There had been a number of positive questions and comments were received regarding an excellent presentation. It was suggested that at the 2016 AGM the Executive Director of Nursing also be invited to present.

ACTION: Action Log for 2016 AGM

139/15 CHIEF EXECUTIVE'S REPORT

The Chief Executive had no other issues to raise which were not already included on the agenda.

140/15 BOARD ASSURANCE FRAMEWORK

The Executive Director of Nursing and Operations presented the Board Assurance Framework which was linked to the Risk Register and had been drawn up by the Company Secretary. It was noted that due to the number of actions due in

September and October the report would be brought to the November Board Meeting and following this it would be submitted on a quarterly basis.

The Board appreciated the additional information contained within the report and found the identification of gaps in control extremely helpful. Discussion took place regarding any issues arising outside the quarterly report and it was agreed that any hotspots might be brought independently to the Board rather than waiting for the quarterly report.

The Chief Executive suggested that the Board Owner for 'Failure to secure patient and public involvement ' should be amended to read the Director of Nursing rather than Director of PPEF.

ACTION: Company Secretary - Updated report to November Board of Directors Meeting and then quarterly.

141/15 RISK REGISTER

The Executive Director of Nursing and Operations reported the top risks (scored 15+) within the organisation. The **top risks** were:-

- Progression of service reconfiguration impact on quality and safety
- Poor clinical decision making in A&E
- Failure to meet CIP
- Outlier on mortality levels
- Staffing risk, nursing and medical
- Ability to deliver service transformation risk

Risks with increased score:-

- No risks had increased score over the previous month.

Risks with reduced score:-

- No risks had reduced in score over the previous month.

New Risk added:-

- No new risks had been added over the month.

Dawn Stephenson advised on the work being undertaken at SWYPFT on their Risk Register and it was suggested that exchange of learning took place between the two trusts.

Jeremy Pease suggested that risk 2827 "Poor clinical decision-making in A&E" should read '**senior** clinicians'

RESOLVED: The Board received and approved the Risk Register report.

142/15 GOVERNANCE REPORT

On behalf of the Company Secretary the Board Secretary presented the Governance Report which included:-

a. Re-appointment of Non-Executive Directors to specific roles.

Following the annual appraisal process and annual review of Non-Executive Director roles the Chairman recommended that Jan Wilson be re-appointed as Deputy Chair and that Dr David Anderson be re-appointed as the Senior Independent Non-Executive Director. Both appointments would be for a further year.

RESOLVED: The Board approved the recommended re-appointments.

b. Q1 2015-16 Feedback from Monitor

The letter received from Monitor giving feedback on the Q1 2015-16 submission was noted.

c. Nominations and Remuneration Committee – Terms of Reference

It was noted that the Trust currently has in place two Nomination Committees and two Remuneration Committees. In line with FT Good Governance Practice it was recommended that these Committees be brought together to form a Nominations and Remuneration Committee (Board of Directors) and a Nominations and Remuneration Committee (Membership Council).

The Terms of Reference for the Nominations and Remuneration Committee (Board of Directors) had been drafted and the main change was that the Chief Executive would be a member of the Committee along with the Chair of the Audit and Risk Committee (excluding remuneration business).

The Terms of Reference for the Nominations and Remuneration Committee (Membership Council) would go to the next Membership Council Meeting in November for consideration and approval.

RESOLVED:

- **The Board Approved the terms of reference for the Nominations and Remuneration Committee (Board of Directors).**
- **It was noted that the Nominations and Remuneration Committee (Board of Directors) had met earlier that day and it was agreed that the decisions made at that meeting be formally ratified.**
- **A revised terms of reference would be submitted to the Membership Council at its meeting on 4 November 2015.**

d. Well Led Committee

The Board were reminded that at the August meeting the Board of Directors approved the creation of a Well Led Committee as a formal sub-committee. Following that meeting further discussion had taken place and the terms of reference contained within the papers had been drafted for consideration and approval. The key points to note were:-

- The Committee would be a formal sub-committee of the Board with a Non-Executive Chair. This would be reviewed in 12 months.
- The Committee would meet every 2 months with a minimum of 5 meetings per year.
- The Committee would have a sub-structure to focus on particular areas such as colleague engagement

RESOLVED: The Board approved the terms of reference for the Well Led Committee.

e. Board Work Plan

The updated work plan was presented to the Board for review.

RESOLVED: The Board agreed the updated work plan

143/15 DIRECTOR OF INFECTION PREVENTION AND CONTROL REPORT

The Executive Medical Director presented the report and specific discussion took place regarding:-

- **C.Diff** – 3 cases had been reported in month all of which had been unavoidable. (The year to date position was 7 - 2 avoidable and 5 unavoidable). The ceiling was 21 cases for the year to March 2016.
- **MRSA** – no cases had been reported. This reflected the good hygiene work being undertaken in the Trust.

- **ANTT compliance –** Work **was o**n-going to validate the data.

RESOLVED: The Board received the report.

144/15 SECURITY MANAGEMENT ANNUAL REPORT

The content of the Security Management Annual Report was received and noted. The Executive Director of Nursing and Operations reported that the managerial role to oversee this had now been handed over to the Executive Director of PPEF. Plans were in place for the appointment to the role of Local Security Management Specialist (LSMS) and a work plan had been developed.

Peter Middleton, Membership Councillor raised concerns about the rise of verbal and physical abuse against staff. Although this was not acceptable, the Executive Director of Nursing and Operations stated that it was not always intentional and may be due to patients with health issues. It was noted that there was a police presence in the A/E Department and staff were offered 'Conflict Resolution Training'.

145/15 NURSING AND MIDWIFERY STAFFING – HARD TRUTHS REQUIREMENT

The Executive Director of Nursing and Operations presented the Hard Truths Report and reported that there was a national requirement to bring a report to the Board twice a year.

The key points from the report included:-

- Achieving safe staffing levels in nursing and midwifery are essential to providing safe and compassionate care.
- Demonstration of compliance with National Quality Board expectations.
- A further paper is to be presented to Board in November 2015 which will recommend any adjustment to nursing and midwifery workforce models.

The Executive Director of Nursing and Operations advised that there were a number of nursing vacancies and further work was underway to recruit more nurses through weekend recruitment events and recruitment of overseas nurses. Work was also on-going regarding the retention of existing staff and having a robust exit interview process in place.

A red flag system was in place to identify harm to patients due to staff issues. Plans were in place to reduce the agency spend by increases in staff on the in-house bank.

It was noted that a letter had been received from Monitor regarding the cap on agency spend and in line with winter pressures within the Trust over the previous year it had been requested that this be increased to 6%. Confirmation was awaited from Monitor.

The Chairman asked whether the complexities of nursing revalidation may mean some nurses may decide to retire early and therefore have a detrimental effect on retention. It was noted that a number of workshops to help nurses complete the reflective practice required were bring provided.

ACTION: BOD AGENDA ITEM – NOVEMBER 2015.

146/15 QUARTERLY QUALITY REPORT

The Executive Director of Nursing and Operations presented the quarterly quality report which covered contractual, quality account, national and local quality priorities to provide a comprehensive overview of quality performance during the first quarter of 2015-2016 within the Trust.

It was noted that the report would help shape the Annual Quality Report which was published as part of the Annual Report and Accounts.

During quarter 1, 2015/16, all CQUIN, Quality Account and contract requirements were achieved, with the exception of MRSA and SHMI.

The Board noted the contents of the full report which had been discussed in detail at the Quality Committee held on 22 September 2015 and it was agreed that although this was an extremely good report, the Board would find it helpful to have an extended executive summary brought to the Board four times per annum after the CQC visit.

ACTION: Executive Summary to Board of Directors – Quarterly

147/15 UPDATE ON CQC ACTION PLAN – ACTIONS

It was noted that the updated CQC action plan is submitted to the monthly Quality Committee.

Jeremy Pease, Non Executive Director stressed that it was important that the Board has an overview of the Trust's action plan with regard to the CQC pending visit. It was noted that the Trust had undertaken a substantial amount of work with weekly meetings and individual assessment and presentation from services.

It was agreed that this report would be brought to the Board on a quarterly basis.

ACTION: Board of Directors Agenda item – December 2015.

148/15 INTEGRATED BOARD REPORT

The Associate Director of Community Services and Operations introduced the Integrated Board report as at 31 August 2015 and explained that key areas would be presented in detail by the appropriate Executive leads.

Summary

The report on August performance highlighted continued good progress against the Monitor metrics. There was a general deterioration across several contractual metrics that have been and continue to be scrutinised with Division and appropriate improvement plans developed. It was noted that the report continued to develop with the inclusion of new metrics and cancer performance was now being reported by tumour site pathway as required nationally.

The key areas to note were:

Responsiveness

- The Trust delivered the Emergency Care standard with a reduction in the length of waiting time for those patients who had been in the department over 4 hours.
- National cancer standards were met at Trust level but the target of referral to other provides by day 38 had not yet been met.
- Delayed discharge improvement is slow but green cross delays are reducing.
- Cancelled operations performance was achieved in August.
- Elective activity continues to track below plan. An exception report had been discussed at Finance and Performance Committee.
- No Appointment Slot Issues data was available due to issues in the national centre. Action plans were being refined based on local knowledge.

- Arrangements were in hand for Healthwatch Kirklees to visit the Trust and gain an understanding from patients on their experience of emergency care including:

- Why they had come to A/E and not other alternatives;
- their experience of waiting longer than 4 hours in A/E;
- what could be improved on discharge arrangements

Caring

- Complaint performance continues to improve.
- Friends and Family Test remains challenging.

Safety

- Pressure ulcers and falls continue to be a cause for concern. Work was underway to examine examples where the appropriate care bundles have been implemented and reductions achieved as a result.
- Harm free care is running below the contract standard.
- 3 Duty of Candour cases remained open at month end.

Effectiveness

- Slight increase in C Difficile cases in August as reported in the DIPC report
- Excellent performance on MRSA continues.
- Emergency readmissions within 30 days delivered.
- HSMR remains a key area of concern. No change to Standardised Hospital Mortality Indicators.
- # Neck of Femur, time to theatre deteriorated significantly in August as predicted in the July report. Otherwise good performance had been achieved on the other parts of the best practice tariff .

Well led

- Sickness has improved in 5 of the 8 areas reported.
- Staff in post, FTE, remains static.
- Appraisal and mandatory training remains red but significant actions taken in month to ensure improvement. Divisions were setting their own targets from September 2015.
- No reds noted in summary hard truths data however 14 individual shifts in the month were rated red.
- The weekly performance meetings continue with an increasing suite of reports reviewed and proactive actions agreed to improve delivery. The Divisional performance packs were being refined to compliment the IPR and enhance Ward to Board escalation.

RESOLVED: The Board received and approved the contents of the Integrated Performance Report.

149/15 MONTH 5 – AUGUST 2015 FINANCIAL NARRATIVE

The Executive Director of Finance presented the finance month 5 report (including the contents of the Integrated Performance Report). It was noted that this information had been discussed in detail at the Finance and Performance Committee held on the 15 September 2015:-

Summary Year to Date:

- The year to date deficit is £10.56m versus a planned deficit of £9.24m, this includes release of £0.60m contingency reserves.

- The adverse variance of £1.32m from plan is due to clinical activity underperformance and high pay spend.
- Elective and day case activity remain behind planned levels in month. Non-elective Activity is also below plan this month.
- Pay expenditure has not followed the activity downturn, remaining high including agency spend.
- Capital expenditure year to date is £7.77m against a planned £8.92m with slippage on Estates and IT schemes.
- Cash balance is £7.25m against a planned £6,13m. £10m of loan funding for capital
- CIP schemes delivered £5.38m in the year to date against a planned target of £4.45m.
- The Continuity of Service Risk Rating (CoSRR) stands at 1 against a planned level of 1

Summary Forecast:-

- The forecast year end deficit (excluding restructuring costs) is £21.97m against a planned £20.01m, an adverse variance of £1.96m. This position includes full release of remaining contingency reserves and delivery of £16.86m CIP against the original planned £14m.
- At EBITDA level, representing the organisations operational position, the forecast is in line with Month 4. This adverse position is driven by the ongoing impact of the activity, income and pay expenditure pressures seen in the year to date and costs associated with additional bed capacity.
- No further contingency reserves remain to cover other pressures and risks.
- Efforts must therefore be focussed on delivering planned activity by increasing productivity and containing pay spend particularly agency costs.
- The year end cash balance is predicted on external cash support being received at a higher level than previously planned.
- Year end capital expenditure is forecast to be in line with the planned £20.72m. The year end CoSRR is forecast to be at level 1.

RESOLVED: The Board received and approved the financial narrative for August 2015.

150/15 UPDATE FROM SUBCOMMITTEES AND RECEIPT OF MINUTES

The following information was received and noted:-

- **Quality Committee** – The Board received the minutes of the 25.8.15 and a verbal update from Jeremy Pease on the meeting held on 22.9.15. Matters arising from the meeting included:-
  - Presentation from Rob Moisey & Julie Kyaw-Tun re Diabetes collaborative.
  - Stroke Services
  - Incident Reporting and Management of Investigations Policy received. Highlights duty of Candour. Formal launch in organisation agreed.
  - NICE Guidance – gaps in compliance undertaken.

  Prof. Peter Roberts, Non Executive Director declared a personal interest in the removal of certain cancer drugs by NICE. It was suggested that the Quality Committee might be the arena where this could be debated but the Executive Director of Nursing and Executive Medical Director agreed to discuss with the Commissioners the social impact this decision might have on patients within the Trust.

ACTION: Executive Director of Nursing and Executive Medical Director to raise with Commissioners outside the meeting.

- **Finance and Performance Committee** - The Board received the minutes of the 18.8.15 and a verbal update from Phil Oldfield on the meeting held 15.9.15. The

main issue considered by the Committee had been the forecast financial position and particularly the work of the Star Chamber in challenging and exploring deeper the CIP schemes currently identified. In addition the Committee had discussed Service Line Reporting and the Chief Executive reported that the Patient Level Information Costing System (PLICS) team wished to run a pilot, with lead clinical colleagues, to encourage the rollout of the plan.

The Chairman thanked everyone for their attendance and contributions.

151/15 DATE AND TIME OF NEXT MEETING

Thursday 29 October 2015 at 1.30 pm in the Large Training Room, Learning Centre, Calderdale Royal Hospital HX3 0PW.

The Chairman closed the meeting at 3.55 pm.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 29th October 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: ACTION LOG - PUBLIC BOARD OF DIRECTORS - OCTOBER 2015 - The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 1 October 2015	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 1 October 2015

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 1 October 2015

Appendix

Attachment:

DRAFT ACTION LOG - BOD - PUBLIC - As at 1 OCTOBER 2015.pdf

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 October 2015 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting Date	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
30.10.14 140/14	**PATIENT/STAFF STORY** 30.10.14 - 'Carol's Story' extract video. 27.11.14 – 'Mr P' – Drug Error 18.12.14 – Dr Sarah Hoye 29.1.15 – Dr Mary Kiely – Care of the Dying 26.2.15 – Catherine Briggs, Matron – Green Cross Patient 26.3.15 – Diane Catlow – Families Senior Locality Manager 23.4.15 – Dr Mark Davies – Perfect Week 28.5.15 – Stroke Team - Patient Story/FAST Awareness 25.6.15 – No information received 30.7.15 – No information received 27.8.15 – Bethany's Story – Complex Needs Care 24.9.15 – Pharmacy Manufacturing Unit/Huddersfield Pharmacy Specials (HPS)	Executive Director of Nursing	Regular item on BOD Agenda going forward.	Monthly Reports		
25.7.13 113/13	**HSMR/MORTALITY/CARE OF THE ACUTELY ILL PATIENT** Presentation received from BC & HT. Action Plan discussed. Update on actions to be brought to BOD Meetings on a bi-monthly basis.	Executive Medical Director	Regular Updates to be brought back to BoD as plan progresses (bi- monthly). 26.9.13 – Update on worsened position received. Key themes and actions identified. Agreed that an updated plan would be brought back to the October 2013 BoD Meeting. 24.10.13 – Update and Action Plan received and note. Board endorsed plan and supported its implementation. Regular Updates to be brought back to BoD as plan progresses (bi- monthly). 19.12.13 – Update on progress received. Agreed that updated Action Plan would be brought to the Board in February 2014.	29.10.15		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 October 2015 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting Date	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
			27.2.14 – Further work being undertaken by Divisions – roll out of mortality review process from March 2014 24.4.14 – Update received. 26.6.14 – Update received 25.9.14 – Update received 27.11.14 – Update received 29.1.15 – Update received 26.3.15 – Update received 28.5.15 – Update received 27.8.15 – Update received			
30.7.15 109/15	**RISK REGISTER - WINTER PRESSURES** It was noted that the Associate Director of Community Services and Operations was undertaking some work across the system regarding a systems resilience plan. It was agreed that an update would be brought to the Board for discussion in August and more detailed risk worked up for the September Board Meeting.	Assoc. Director of Community/ Operations	Winter Resilience Planning presentation to Private BOD Meeting – 29.10.15			
24.9.14	**MORTALITY REVIEWS** The Executive Medical Director reported that Brian Fill and Professor Mohamed from Bradford University were working within the Trust to review the Trust's data and this would be brought back to the Board at a future date.	Executive Medical Director		TBC		
29.9.15	**NURSING & MIDWIFERY STAFFING – HARD TRUTHS REQUIREMENT – WORKFORCE MODELS** Update received. Agreed a further paper be presented to	Executive Director of Nursing		26.11.15		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 October 2015 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting Date	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
	the Board in November 2015 which will recommend any adjustment to Nursing and Midwifery workforce models.					

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 29th October 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: CHIEF EXECUTIVE'S REPORT - The Board is asked to receive and note the contents of the CQC report on state to health care and adult social care in England 2014-15	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive and note the contents of the CQC report on state to health care and adult social care in England 2014-15.

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

The Board is asked to receive and note the contents of the CQC report on state to health care and adult social care in England 2014-15.

Appendix

Attachment:

combined ce report.pdf

Care Quality Commission

The state of health care and adult social care in England

2014/15

STATE OF CARE

Care Quality Commission

The state of health care and adult social care in England

2014/15

Presented to Parliament pursuant to section 83(4)(a) of the Health and Social Care Act 2008.

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Any enquiries regarding this publication should be sent to us at enquiries@cqc.org.uk

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Contents

Half of re-inspections have resulted in improved ratings **50%**

Only 7% have deteriorated after a re-inspection **7%**

Foreword

This report marks a turning point for the Care Quality Commission. For the first time we are able to draw on a growing body of evidence, across health and social care, that we have created as a result of our new inspection approach. Our inspection reports and ratings give us a unique opportunity to start building a comprehensive picture of the quality of care in England and, importantly, enable us to identify and share key elements of high-quality care in order to encourage improvement.

I am pleased that most services we have inspected have been providing good quality care for the people who rely on them. This is heartening given the challenging circumstances facing all the sectors we regulate, and particularly adult social care. Across the country we have found staff who are doing their best for the people using their services every day and night, going above and beyond to look after everyone who needs their services.

Last year I wrote that financial pressures are real but not unexpected, and they would continue into 2015/16 and beyond. This continues to be a challenge. The *Five Year Forward View* starts to map out how the health sector can respond, but adult social care is not in such a strong position. What is clear is that, across health and social care, innovation and transformation of services will be vital. Incremental cuts and efficiency savings will no longer be sufficient to meet the challenges ahead.

This is an exciting opportunity to reshape services around the people who need health and social care. Evidence suggests that person-centred care is not only better for the individual, but can be more economical for service providers. We can only be successful in achieving this step change if we all work together: people, staff, providers, commissioners, and local and national stakeholders. As the quality regulator we commit to playing our part in enabling change, not being a barrier to it.

We believe the vast majority of people in the sectors we regulate share our aim of ensuring that all people who use services receive high-quality care. However, naturally there are also some providers that are struggling to provide a high-quality service. Important elements for improvement include ensuring leaders effectively engage their staff to build ownership of quality and safety, ensuring the right staff are in place to deliver safe care, and working collaboratively across the system to address cross-sector issues.

I am encouraged by the emerging evidence which suggests that our new regulatory model is having a real impact on the quality of these underperforming services and, where it is not, that our inspectors have the confidence to challenge and take enforcement action if necessary to protect people who use services from harm.

We appreciate all the time and effort that providers have put in to work with us to co-produce an approach to inspection that enables us to paint such a rich picture of how the sectors are performing. We hope you will continue to work with us as we evolve our approach in order to ensure people receive high-quality care, as services change in response to the challenges ahead.

David Behan
Chief Executive, Care Quality Commission

Summary

Delivering quality under pressure
The health and care system in England has come under increasing pressure during 2014/15, driven by changing care needs and financial demands on all public services. Providers and staff are being asked to deliver significant efficiency savings, to meet the more complex needs of an older, changing population, while ensuring that the health and care system remains sustainable for the future. In the NHS the main focus has been on handling increasing pressures at a time when the NHS budget increased at a significantly lower rate than before. In adult social care, services have been asked to deliver more with less, as local authority funding has been reduced.

Many services have responded well, despite the increasing pressures, and managed to improve or maintain quality. We celebrate the many services across the country that are delivering high-quality care to the people they care for. Although we have not yet rated all services, more than 80% of the GP practices we have rated so far were good or outstanding. In adult social care, nearly 60% of services were good or outstanding.

Variation in quality of care
But some people are receiving care that is not acceptable: in inspections to the end of May 2015, we rated 7% of services as inadequate, which means that care is so poor that urgent improvements are needed.

The level of variation in quality that we see is also of great concern. Many people continue to experience large differences in the quality of care they receive – both between different services from the same provider and between different providers.

Just as importantly, people experience poor or variable quality depending on who they are, or what care they need. For example people with mental health needs or long-term conditions, and some minority ethnic groups, are less likely to report positive experiences in health and social care settings. Additionally, our thematic review *Right here, right now* concluded that far too many people in a mental health crisis have poor experiences of care and do not receive basic respect, warmth and compassion. This is unsafe and, when compared with the services available to people with physical health problems, unfair.

Safety is our greatest concern
Safety is a fundamental expectation for people who use services, and it continues to be our biggest concern across all of the services we rate. We have rated over one in 10 hospitals (13%) and a similar proportion of adult social care services (10%) as inadequate for safety. In primary medical services, 6% of those we rated were inadequate for safety. Additionally, there are a substantial number of services that have been rated as requires improvement for safety, because there is more they could do to ensure that they have a good safety culture.

A range of factors affect the safety of services, including a failure to investigate incidents properly and learn from them so they do not happen again, ineffective safety and risk management systems and, in hospitals and adult social care, concerns with the adequacy of staffing numbers and mix, alongside skills, training and support.

The ability to improve
Where we see poor care, we will respond and challenge providers to improve. We have evidence our approach is working. The initial results from our re-inspections so far suggest that half of services have been able to improve their ratings within six months. Our survey of providers also shows that they find our reports useful in identifying what they need to do to improve.

Where necessary we will take enforcement action to protect the people who use these services. We took more enforcement actions last year in relation to the inspections we carried out: in 7% of inspections in 2014/15, compared with 4% in 2013/14.

The environment for health and social care will become even more challenging over the next few years. Tensions will arise for providers about how to balance the pressures to increase efficiency

Summary *continued*

with the need to improve or maintain the quality of their care. Therefore, the effective use of resources will be a vital component of success going forward.

What it takes to be outstanding

Some good and outstanding providers achieve high-quality care under constrained financial conditions by managing their resources well. These providers are not simply relying on more money. In all the sectors we inspect, there are many examples of excellent leadership – leaders who are visible and who engage widely with people who use services and staff, who promote a strong culture of safety, who put in place robust governance systems and processes, and who plan their resources well. We recognise what a hard job it is that they do, and the excellent care they and their staff deliver as a result.

More than nine out of 10 (94%) of the services we have rated as good or outstanding overall were also good or outstanding for their leadership. Similarly, 84% of the services we have rated as inadequate overall were inadequately led. In health care good leadership brings together clinical staff and senior management. In all sectors good leadership prioritises person-centred care and engagement with staff and people who use services in everything it does. In our inspections we see that where leadership is strong, then safe, effective, caring and responsive care tends to follow.

Services are also more resilient when they have a culture that prioritises openness, learning and continuous improvement, supported by governance processes so that organisations and staff learn together. This is particularly true when it comes to delivering safe care.

Staffing is one driver of the ratings our inspectors have given for safety across all sectors, although this is about much more than just having the right numbers. Having the right number and mix of staff, with the right skills, at all times is integral to providing safe, high-quality care. We are conscious that there can be difficulties getting staffing right, and that there are specific challenges in some sectors, such as ensuring sufficient nurses in adult social care, GPs in primary care and consultants in A&E. In addition, there is a leadership challenge to ensure the right staff resources are in place to meet the challenges across the system.

All sector partners need to work together to address the challenges they face, including transforming models of care, and ensure that staff are motivated to be part of this change. The NHS has published the ambitious *Five Year Forward View* which has cross-sector support. In adult social care some organisations including the Association of Directors of Adult Social Services and Care England have set out five-year visions, but these do not yet constitute a strong cross-sector agreement on how to solve these challenges. System leaders nationally and locally need to come together to spell out how they will cope with the pressures ahead and put these plans into action. CQC has a part to play in this by providing an objective picture of the quality of care across all the sectors we regulate.

The importance of data and transparency

To innovate and transform care effectively, it is vital to have the feedback mechanisms to know whether or not changes have been successful. Every provider should have good, benchmarked data for all the services it provides, to assure itself that it is providing safe and effective care and to know where improvements are needed. This is particularly important when looking to share learning effectively at a local and national level. The drive to integrate health and adult social care also cannot succeed without an improved flow of information across traditional organisational boundaries.

Across all sectors therefore, better data needs to continue to be developed that is accessible to, and used by, all stakeholders, particularly for adult social care and community and mental health services. Without this it is difficult to systematically understand the current quality of care beyond our inspections, or assess the impact that changes are having on quality of care.

CQC has an important role in working with national and local partners to support sectors and providers in building the resilience they need in the next few years to maintain their focus on quality. We have already started to promote transparency and, as

a result of our work, conversations about quality are becoming more open and honest across all stakeholders. We are also looking at the way we register and inspect, particularly those services that are new and do not fit within traditional models, and at the quality of the data we and providers collect to help understand the experiences of people who use services better. This work should help us support innovation while ensuring people who use services receive high-quality care.

Looking ahead

The sectors we regulate face significant challenges. Our concerns are amplified by our finding that many services do not yet have the leadership and culture required to deliver safe, high-quality care. To survive and thrive will require resilience, innovation and creativity, supported by great leadership. We therefore encourage services across health and social care, together with their local and national partners, to focus on:

- Building a collaborative culture that reaches out to people who use services and engages with all staff to ensure a shared vision and ownership of the quality of care they deliver.
- Being open and transparent and learning from mistakes, ensuring information and data are to hand to make good decisions and to understand what works (and what doesn't), using opportunities to learn from the best.
- Ensuring that services have the right staff and skill mix in place to ensure that care is always safe.

We are highly supportive of the *Five Year Forward View* and the recognition in many parts of the country that the best care systems are those where health and social care go hand in hand, alongside greater local leadership and improvement across care economies. However, to be truly innovative, it is important to be open to the idea that some changes will not succeed. Experience from other industries suggests that new ways of working need iteration and fine tuning before becoming sustainable. Our challenge to all health and social care services, and the sector overall, is therefore to continue to put quality of care at the centre of change, and not fall into the trap of seeing innovation as only driven by the need to save money.

Alongside this, we encourage all partners in adult social care to come together and set out a common vision and plan for how to address the current fragility and uncertainty in the adult social care market, and ensure they can continue to provide good care.

People deserve high-quality care. It is therefore our duty to the people who use services to be open and transparent about the quality of care that we see, and not lower our expectations of quality in the challenging times ahead.

There are examples of good services sharing their experiences with those who want to improve. We believe this type of collaboration is valuable in improving the quality of care for people who use services. Many services are already achieving high quality, and we are confident from what we have seen that others can too.

94%

More than nine out of 10 of the services we have rated as good or outstanding overall were also good or outstanding for their leadership.

Introduction

This report sets out the Care Quality Commission's (CQC's) assessment of the state of care in England in 2014/15, using our new, rigorous and expert-led inspection approach and ratings system.

Our inspections and ratings
When we inspect, we ask the same five key questions of every provider or service:

- **Is it safe?**
  By safe, we mean that people are protected from abuse and avoidable harm.
- **Is it effective?**
  By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.
- **Is it caring?**
  By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.
- **Is it responsive?**
  By responsive, we mean that services are organised so that they meet people's needs.
- **Is it well-led?**
  By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality, person-centred care, supports learning and innovation, and promotes an open and fair culture.

The answers to these questions help us form a clear understanding of the quality of care of each provider or service. When we rate, we award one of four ratings:

- **Outstanding**
- **Good**
- **Requires improvement**
- **Inadequate**

Ratings mean we can identify and celebrate good and outstanding care, take swift action when we find inadequate care, and encourage improvement across all services.

Following a period of piloting and testing in each sector, we formally implemented our new approach as follows:

- **Adult social care services** – we started inspecting and rating in October 2014.
- **Hospitals (NHS trusts and independent hospitals)** – we started inspecting and rating in April 2014.
- **Mental health services** – we started inspecting in April 2014 and rating in October 2014.
- **Primary medical services (GP practices, GP out-of-hours services, dental care and other primary care services)** – we started inspecting and rating GP practices and GP out-of-hours services in October 2014. We started inspecting dental care services in April 2015, but we do not rate these services. We also inspect a range of other primary care services.

Many providers have worked with us to co-produce an approach to inspection that enables us to paint a rich picture of how the sectors are performing. As services change in response to the challenges ahead, we will continue to work with providers and people who use services to evolve our approach, so that it ensures people receive safe, high-quality care.

Data used in this report
The data on inspections and ratings in this report covers the reporting period 1 April 2014 to 31 May 2015 (to capture the majority of inspections completed in 2014/15).

It is important to note that, up to the end of May 2015, we had inspected only a minority of health and social care services under our new, more comprehensive approach. In the main sectors we regulate, by that date we had inspected and rated:

- 47% of acute hospital trusts
- 17% of adult social care services
- 11% of GP practices and GP out-of-hours services.

Other CQC data relates to the year ended 31 March 2015.

We chose services for early inspection on the basis of levels of risk and what we knew about the service. This means that our findings should not be extended to each sector as a whole. Also, as there is more data available to assess risk in some sectors, this means comparisons between sectors should be treated with caution. As we continue to inspect and rate all services under our new approach, we will build a more comprehensive picture and we will also have a larger sample of re-inspections from which to draw conclusions about changes in the quality of care.

Most of the analysis in this report is generated by CQC, specifically:

- Quantitative analysis of our inspection ratings of more than 5,000 services, drawing on other monitoring information including staff and public surveys, and performance and financial data, to understand which factors are most closely associated with quality.
- Qualitative analysis of a sample of 44 inspection reports that were outstanding, requires improvement and inadequate (21 in adult social care, 10 in primary medical services and 13 NHS trust reports). This sample comprised reports of inspections completed under our new methodology and published between February 2014 and June 2015. The sample was stratified by region to ensure services from the north, central, south and London regions were included and the reports for analysis were then drawn at random.
- Analysis of 13 focus groups with inspectors from our sectors, discussions with inspection managers and heads of inspection, and findings from the CQC adult social care symposium held in July 2015.
- All the findings have been triangulated with expert input from our Chief Inspectors and Deputy Chief Inspectors, to ensure that the report represents what we are seeing in our inspections.

Where we have used other data we reference this in the report.

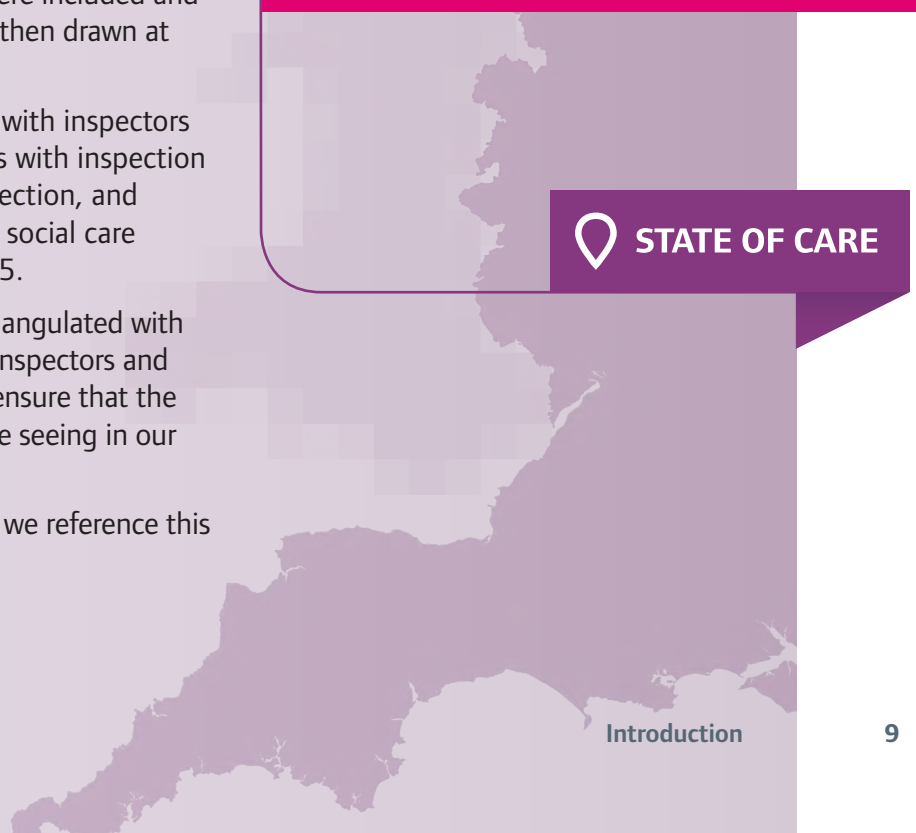
Part 1
THE STATE OF CARE IN ENGLAND

In Part 1, we provide an overview of the sectors we regulate:

- An overview of what we have found about the quality of care in England over the last year.
- The main factors we have seen that contribute to the success of organisations providing good or outstanding care, and the barriers for those organisations requiring further improvement in their care.
- Our perspective on what health and social care organisations will have to do to become more resilient in their ability to improve or maintain the quality of care over the next five years, while they respond to an increasingly challenging health and social care environment through change and innovation.

Part 2
THE SECTORS WE REGULATE

Part 2 gives a more detailed account of the quality of care we have observed in each of the sectors that we regulate, and sets out in greater detail the impact this has had on equality in care for people who use services.



Part 1
THE STATE OF CARE IN ENGLAND

Real-term reduction
NET BUDGETS -31%

400,000

Fewer people receiving publicly funded care services than five years ago

1. The challenges facing health and adult social care

This report outlines the quality of health and adult social care in England in 2014/15, a period in which both the adult social care sector and the NHS have faced significant challenges. Providers have had to become more efficient and they have had to do this at a time when the number of older people is growing faster than ever, and people's needs are more complex.

According to the National Audit Office, local authority budgets have been reduced by 37% in real terms and on a like for like basis over the last five years.[1] Local authorities have worked hard to protect social care budgets from these reductions, and the result is that statutory funding for social care has decreased by £4.6 billion in this period, which is a 31% real-term reduction in net budgets.[2] Local authorities have managed reduced funding partly through greater efficiency and prioritising spending on social care. This now accounts for 35% of their spending, compared with 30% in 2010.[3] At the same time they have made cost savings by reducing fees to providers – contributing to low pay for the care workforce and low skill levels.[4]

Local authorities have also had to prioritise care for those with the most severe need. They have tightened their eligibility criteria, cut back on what is provided in care packages and reduced spending on preventative care.[5] The steepest reductions have been in community services, such as day care and domiciliary care.[6]

The Association of Directors of Adult Social Services estimates that there are at least 400,000 fewer people receiving publicly funded care services than there were in 2009/10.[7] This means that some people who previously might have expected their care to be paid for by the local authority will have had to find alternative ways to support themselves – through self-funding, being cared for by family and friends, or having to make do without support. The UK Homecare Association estimates that there are 1.6 million adults with unmet social care needs.[8]

Although the NHS budget has largely been protected from public sector cuts, the NHS is experiencing unprecedented financial challenges. NHS providers ended 2014/15 with a net deficit of more than £800 million. Almost half of all providers were in deficit, including almost two-thirds of acute hospital trusts. This is despite the Treasury providing extra in-year funding and a transfer from capital to revenue budgets. The deficit included £349 million among foundation trusts – the first time the foundation trust sector has recorded an overspend.[9]

These financial challenges are compounded by England's changing population. It is getting older. In the last 30 years, the number of people aged 90 and over has almost tripled.[10] Health and care needs are changing too: people with multiple long-term conditions are becoming the norm rather than the exception. The number of people in England with two or more conditions at the same time is set to increase from 1.9 million in 2008 to 2.9 million by 2018.[11] This is an opportunity, as well as a challenge, as increasingly people with long-term conditions have the ability to become partners in their care and influence much more directly their health outcomes.

The population is also getting more diverse. The number of people from minority ethnic groups is rising, and in the future more of this population will be British-born.[12] This means that the population's needs from health and social care are likely to be different, and services will have to adapt to meet them.

Of course England is not alone in facing such changing care needs. International comparisons do not provide a comprehensive assessment of the overall quality of a national health service, but they help in establishing a benchmark for quality in specific areas. Two recent reports, by the Commonwealth Fund and Quality Watch, considered the relative merits of different health systems.[13, 14] They present a picture that suggests the NHS is one of the most equitable health services in terms of access. But they also say that more could be done once a person is in the system to make sure they are receiving a service that is effective. For example, the number of people who die following a stroke, or a diagnosis of breast cancer, are both higher in the UK than in comparable countries. We are not aware of any similar reports looking at international comparisons of access and outcomes in adult social care.

2. How health and adult social care is performing

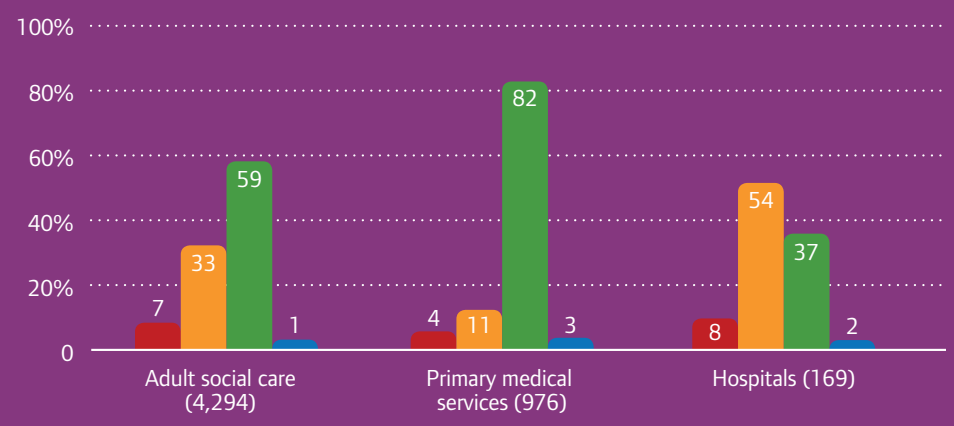
2.1 Our ratings

Overall quality ratings are positive

In our new comprehensive inspection approach, we give a quality rating to most of the providers and services we inspect. We have been rolling out our new approach since early 2014 and we are starting to develop a systematic picture of the quality of care across England.

Our ratings allow us to point to and celebrate examples of excellence and highlight those services that are delivering high-quality care. Up to 31 May 2015, the majority of the 5,439 organisations we have inspected and rated have been good or outstanding, although this differs by sector (figure 1.1). Given the increasingly difficult context in which services have been operating, this is something to be

Figure 1.1 Overall ratings by sector



Note: Data for adult social care and primary medical service sectors is at location level. The hospitals sector ratings are a combination of location level (acute hospitals) and provider level (community health trusts and mental health trusts).
Source: CQC ratings data

Inadequate | Requires improvement | Good | Outstanding

celebrated. The quality of care provided in the primary medical services sector was particularly high. Over four in five (85%) of the GP practices we have rated are good or outstanding.

A substantial proportion of services have received a rating of requires improvement. This rating identifies those services that are not yet of the high standard we expect for people who use services. Our inspection reports give detailed advice on how services can improve. Services that require improvement may provide good care in many areas but they will have a number of specific areas that need attention.

Of intense concern are those services that are inadequate. They account for 7% of the services we have rated overall. We have been surprised at just how very poor some of this inadequate care is, including:

- A&E patients kept on trolleys overnight in a portable unit without proper nursing assessments.
- In a nursing home, an overpowering smell of urine and mould on the walls.
- At a hospital, medicine given without appropriate patient identification.
- Staff at a GP surgery that had not had basic life support training in the last 18 months.
- Medication not administered properly at a care home – some patients had their medicine delayed while others showed overdose symptoms.

Of CQC's key questions, providers were most likely to get an inadequate rating for safety

10%	6%	13%
of adult social care services	of primary medical services	of hospitals

We have increased our enforcement activity to make sure that people using services are protected and that providers are held to account for the poor care. The total number of inspections completed this year was lower than the previous year as we started our new, more comprehensive approach. However, the proportion of enforcement activity we took increased: 7% of inspections in 2014/15 resulted in enforcement action, compared with 4% in 2013/14. As a proportion of our inspection activity, this was a rise of 75%.

In each of the sectors we regulate, our ratings highlight the substantial variation in the quality of care provided to people. Additionally, in larger providers we often see substantial variation between locations or between different services provided in the same location (as highlighted in the ratings example in figure 1.2). This shows the wide range of ratings within a single hospital, across our five key questions and eight core hospital services. There are many examples of good and outstanding care, despite the significant challenges the sectors have been facing. But there are also a small minority where we have significant concerns about inadequate care and who need to do much more to improve.

Safety remains a significant concern

When we give a service an overall rating, we give equal weighting to the five key questions we ask. But people who use services naturally expect the care they receive to be safe, and so do we.

Across all sectors, services were most likely to receive an inadequate rating for safety, compared with the other key questions: 10% of adult social care services, 6% of primary medical services and 13% of hospitals. Similarly, a lower proportion of services were rated good or outstanding for safety. This confirms our early finding last year, outlined in our 2013/14 *State of Care* report, about safety in hospitals and points to similar concerns in the other sectors.

Where a service is rated inadequate in terms of safety, our qualitative analysis shows that this is often due to a range of factors, including:

- A failure to investigate incidents properly and learn from them so they don't happen again.
- Ineffective safety and risk management systems.
- Issues with staffing levels, training and support (in hospitals and adult social care).
- Unsuitable environments and poor or infrequent checks on equipment (in adult social care and to a lesser extent GP practices).

In each sector, there are many services that we have rated as requires improvement for safety (33% of those rated in adult social care; 61% of hospitals; and 25% of GP practices and GP out-of-hours services). Often in these cases, we believe that the providers concerned have the ability and the capacity to improve the safety of the care they provide. It will typically require improvements to systems and processes, such as clinical audit, that will enable the service to ensure they are delivering

Figure 1.2 Example of a ratings grid for an acute hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Requires improvement	Requires improvement	Inadequate	Requires improvement
Medical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Good	Good	Good	Requires improvement	Good	Good
Maternity and gynaecology	Good	Outstanding	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	Good	Good	Good	Good
End of life care	Requires improvement	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Inadequate	Inadequate	Inadequate
Overall	Requires improvement	Good	Good	Requires improvement	Inadequate	Requires improvement

Inadequate Requires improvement Good Outstanding

care safely. In contrast, an inadequate rating is a strong indication that care is unsafe, or that the organisation does not have the capacity without support to sort out its problems.

Encouragingly, where we have re-inspected organisations, there is evidence that they have responded to the concerns identified in our first inspection and made improvements to their rating for safety. But there is much more room for improvement.

Leadership is the key to long-term improvement

Of all the aspects we look at, the quality of leadership most closely correlates with the overall quality of a service. Ninety-four per cent of services that were good or outstanding overall were also good or outstanding for their leadership. Similarly 84% of inadequate services were inadequately led. This suggests that the way in which an organisation is led, and the culture and values that influence it as a result, have a huge and far-reaching impact on the overall quality of care that people receive. Good leadership, at all levels of an organisation, is required to deliver care that is consistently safe, effective, caring and responsive.

In all the sectors we inspect, there are many examples of excellent leadership – leaders who are visible and who engage widely with people who use services and staff, who promote a strong culture of safety, who put in place robust governance systems and processes, and who plan their resources well.

But we also see where leadership is simply not yet good enough. As we believe leadership is the key to long-term improvement, we are concerned by the wide variation in the quality of leadership. While the majority of services were rated good or outstanding on our well-led question (61% in adult social care, 44% in the hospitals sector and 85% in GP practices), a minority were rated inadequate (8%, 8% and 4% respectively). Our qualitative analysis has highlighted common factors among those providers that provide outstanding leadership – these are outlined in section 5.

2.2 What the public say

What people who use services think about the care they receive is of vital importance. We have found that the views of people using services, collected through surveys, can be one of the best predictors of the rating for a GP practice or hospital. The same goes for the views of staff. We set out the evidence for this in section 5.1 below.

When surveyed about their perceptions of the NHS overall, 61% of people thought it was offering good services nationally; 74% agreed that local NHS services in general are good.[15] When asked to rate their personal experience of NHS hospital care, 84% said they were satisfied. Although the results of the survey, if applied to the total patient population, could imply that more than 2 million people are dissatisfied with their care, it does suggest that when people come directly into contact with staff and professionals in the NHS, most are likely to have a positive experience.

In 2013/14 two-thirds (65%) of people in receipt of services funded wholly or in part by social services reported being extremely or very satisfied with the care and support they receive (a similar proportion to those satisfied in 2012/13).[16] The data for 2014/15 will be published by the Health and Social Care Information Centre in October 2015.

These positive results reinforce our own assessments of whether services are caring. For this, we look at people's one-to-one interactions with staff, including whether they are treated with dignity, respect and compassion. The highest ratings in all sectors were achieved for this key question. Eighty-five per cent of services were good or outstanding in adult social care; in the hospitals sector it was 95%; for GP practices it was 97%. However, as outlined in section 2.4, while overall the public say they are satisfied with their care, there are some specific groups of people who report less positive experiences.

CQC has seen some examples of truly outstanding care

An NHS mental health trust with outstanding leadership had good community links and showed innovation in the way it helped people on their recovery journey.

Inspectors were made aware of maths and English tutors who provide individual tutorials to help patients improve literacy and numeracy skills. And there was a 'real work programme' to help people develop skills for their recovery journey – this included a range of roles patients can apply for, such as ward representative, grounds keeper, a ward-based cleaner or shopkeeper.

Patients were involved in the design and delivery of their services and there was a range of ways in which they could have their say. The service also had strong community relationships, and a police liaison officer held sessions on wards to help patients feel safer.

Inspectors at a domiciliary care service saw a service that was not only designed to meet people's individual needs, but also to meet their aspirations – their achievements were celebrated and their views were at the heart of the service.

Staff were taught the principles of person-centred care. They were trained to use individualised care plans and life map tools – and each member of staff had to create their own, so that they fully understood how it worked.

People were treated by compassionate staff and the service worked closely with the community, particularly a local partnership with a deaf academy to help young people in their transition to independent living. People were enabled, with dignity and respect, through positive risk-taking. For example, one person who had never used public transport before was supported to achieve this independently.

An outstanding NHS foundation trust has shown innovative practice to meet the needs of its local population, led by a team that has good relations with its Council of Governors and a range of leadership programmes for staff at different levels.

The trust had a quality improvement strategy with measures for improvement from ward to board – and a quality dashboard was reviewed by the board to help understand variation throughout the hospital. With an open and transparent culture and a real commitment to learn from mistakes, the trust was recognised as outstanding for its leadership.

Staff showed a sense of pride in their work – and in the trust. Strong service planning and delivery meant better outcomes for patients. For example, patients identified as needing end of life care were prioritised – rapid discharge was ensured to their preferred place of care within six hours. A bereavement team worked closely with police to provide support to relatives where sudden deaths were involved.

People at the hospital could use a multi-faith centre that catered to the needs of the local population, including a non-denominational room.

The trust demonstrated good practice in its emergency department with the flow of patients, while the acute medical unit has led the way in embracing the national four-hour target as 'everyone's business' – and not just an issue for the emergency department.

An outstanding general practice had a strong community reputation and this was recognised by inspectors. The practice is in a rural area where regular contact with local schools helped avoid ambulance call-outs or attendance at accident and emergency departments.

GPs understood the needs of their patients and the community and they went out of their way to provide extra support; several examples were seen where people were supported in their own homes or helped on visits to sheltered housing, rather than move into a care home. This was a result of joint working with local carers.

Patients benefitted from integrated person-centred care pathways – arrangements were made for home visits with district nurses and carers. Care was coordinated and patients could see a GP without making an appointment, and GPs tried to treat illnesses and minor injuries themselves rather than refer to a hospital.

Comparing the positive results above with our overall quality ratings reveals the importance of our comprehensive inspection approach. Alongside whether a service is caring, our inspections look at whether services are safe, effective, responsive and well-led. Many of these aspects are not visible to people who use services. For example, people who receive care from a service that has a good culture of safety (one that prioritises openness and learning from mistakes) will probably not experience or see this directly (unless, for example, they receive poor care and make a complaint). This is why our inspections include sector specialists and Experts by Experience (people with personal experience of using, or caring for someone using, the type of service). The inspections bring together a wide array of evidence from national and local data, what we hear from staff and people using services, as well as our own observations

2.3 What we have found

Here, we give an overview of what we have found in each of the main sectors. Our more detailed findings for each sector are set out in Part 2 of this report.

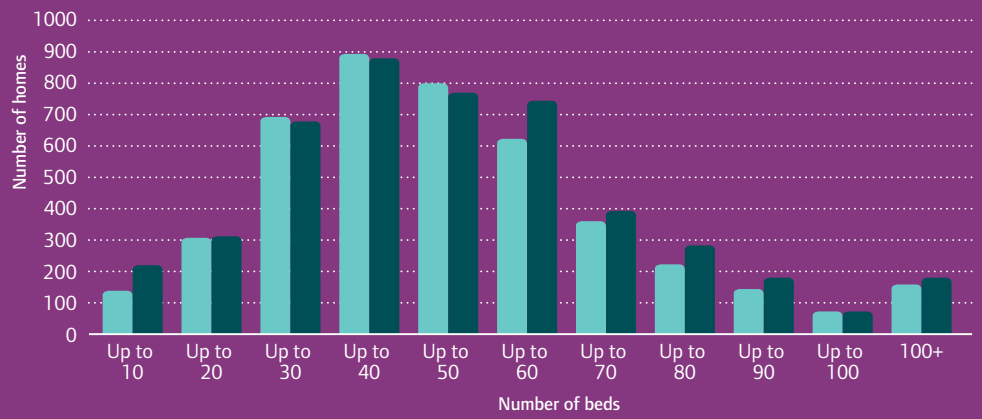
Adult social care

The adult social care market is responding to the challenging environment we described above in a number of ways. For instance, some mid-sized services are closing while new, larger services open. It may be that larger services can achieve economies of scale that are not achievable for smaller services. Our registration data shows a decrease in the number of residential homes in 2014/15.

At the same time, the average number of beds has increased. Figure 1.3 shows our registration data for size of nursing home in 2010 and 2015. There has been an increase in the largest homes and also in those with a very small number of beds (up to 10). Similarly, while overall the number of residential homes is decreasing, the only increase we have seen is in homes with more than 50 residents.

We have also seen an increase in the number of domiciliary care agencies during the same period.

Figure 1.3 Trends in nursing home bed capacity September 2010 and March 2015



Source: CQC ratings data

Up to 31 May 2015, we had inspected and rated almost a fifth (17%) of adult social care services. Almost three in five (59%) of these received a good or outstanding rating overall (figure 1.4). Around a third (33%) of services were rated as requires improvement.

In the majority of cases our inspectors have seen that staff involve and treat people in their care with compassion, kindness, dignity and respect. More than four in five (85%) of services were rated good or outstanding for caring.

Of utmost concern are the 7% of services that we rated inadequate. Where providers fail to meet legal standards, we act quickly to ensure that people are protected and services improve. In 2014/15 overall (including under our old inspection approach) we issued 937 Warning Notices to providers, telling them they needed to make urgent improvements.

Our biggest concerns relate to the safety of services (where 10% were rated inadequate) and to the quality of leadership within services (where 8% of services were rated inadequate for the well-led key question).

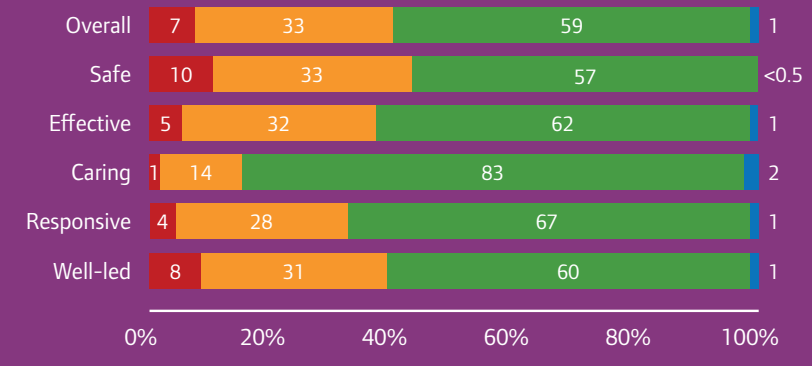
Our ratings show that nursing homes provide a poorer quality of care than other adult social care services (figure 1.5). This confirms our findings in previous years. Just under half (46%) of nursing homes rated up to 31 May 2015 were rated good or outstanding and one in 10 (10%) were rated inadequate. However despite around two-thirds of locations rated so far in domiciliary care, residential homes and community social care (which includes Shared Lives schemes) being good or outstanding (68%, 65% and 68% respectively), there is room for improvement across the whole of the adult social care sector.

While we recognise the pressure that the system is under as it transforms itself to meet the needs of a growing, ageing population at a time of considerable financial strain, it is still vital that the care delivered is of a quality that people have a right to expect.

By May 2015, we had rated a fifth of adult social care providers. Three in five got a good or outstanding rating

59%

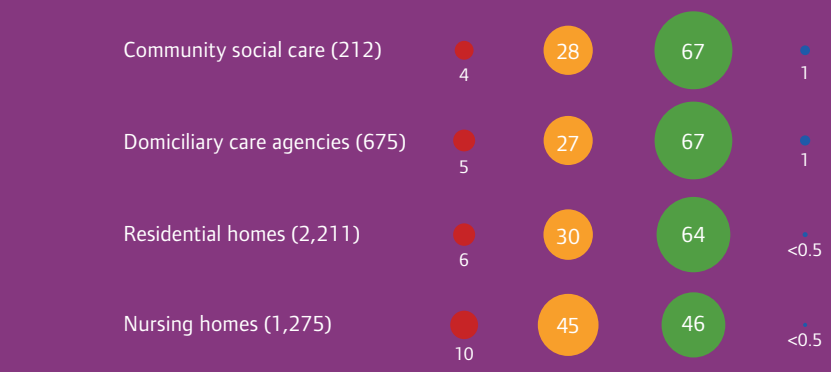
Figure 1.4 Adult social care ratings by key question



Source: CQC ratings data

Inadequate | Requires improvement | Good | Outstanding

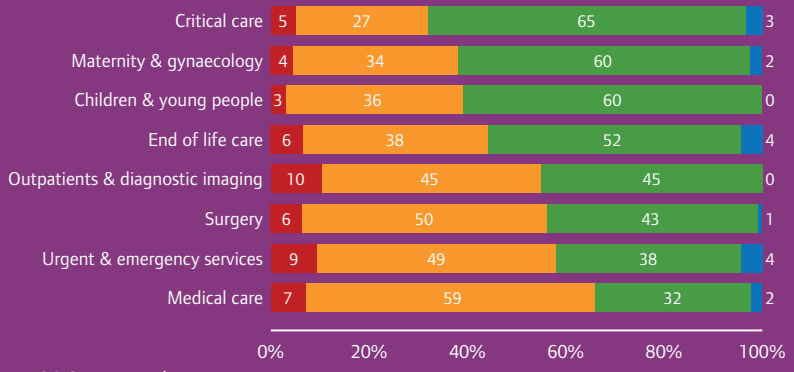
Figure 1.5 Adult social care ratings by service type



Source: CQC ratings data

Percentages

Figure 1.6 Acute hospital overall core service ratings



Source: CQC ratings data
Note: Chart ordered by proportion good/outstanding highest to lowest.

Inadequate | Requires improvement | Good | Outstanding

Hospitals and trusts, including mental health

For this report, the definition of hospitals and trusts includes secondary and tertiary acute health care, mental health care, community health care and ambulance services.

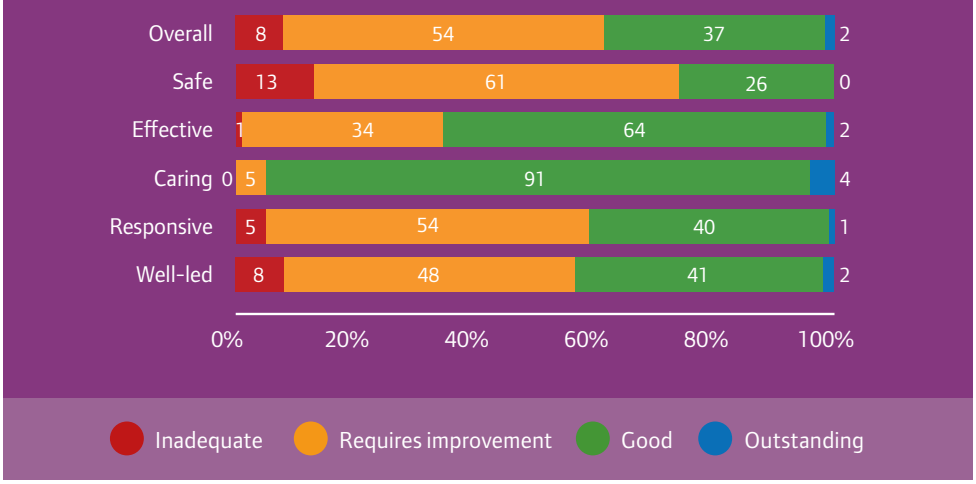
While typically there are fewer changes in the registration of hospitals and trusts than in other sectors, we are seeing signs of this changing as they start to respond to the *Five Year Forward View*. For example, some hospital trusts are registering as providers of care homes. We expect to see increasing diversity in the way hospital care is provided, as more hospitals look to reshape their services with other partners in their area, including through the *Forward View* 'vanguard' areas.

We have rated over half of all acute trusts; this includes 169 hospitals.* The overall ratings in the sector showed a lower proportion of good and outstanding hospital ratings (38%), compared with primary care and adult social care ratings.

However, considering only these aggregated hospital ratings hides significant variation at the

* Hospitals in this context include NHS and independent hospital sites, and mental health and community healthcare providers.

Figure 1.7 Hospitals key question ratings



level of individual core services. In each acute hospital inspection we look at eight core services (where they are provided) and give each a rating which is then aggregated to give the overall hospital level rating. Figure 1.6 shows the wide variation in the quality of different services. There is a 34 percentage point gap between the proportion of critical care services rated good or outstanding compared with the proportion of medical services with those ratings. This suggests, as outlined in section 2.1 above, that experiences for people can vary significantly depending on the care services they need within a hospital, on top of the variation in quality that exists between hospitals.

As in the other sectors we regulate, hospitals achieve the best ratings for the caring key question (95% of those we have rated were good or outstanding for caring), while the safety of care is our biggest concern (13% of those rated were inadequate) (figure 1.7). We explore this in more detail in section 5.

Primary medical services including GP practices

The vast majority (85%) of the 976 primary medical services (including GP practices, out-of-hours and urgent care) we rated in 2014/15 were providing good or outstanding care. At a challenging time for primary care, there are many practices finding innovative ways of meeting the needs of their local population, and this is something that should be celebrated. Fewer than one in eight (11%) of the GP practices we inspected required improvement.

A small proportion (4%) of GP practices were rated inadequate. While this is a relatively small number of those we have rated so far, the quality of care we have observed in some practices has been truly shocking and a significant cause for concern. Where we have rated practices as inadequate, this is often underpinned by a poor safety or leadership rating (figure 1.8) – issues we return to in section 5.

In the primary medical services sector we also inspect a wide range of other services, including dentists, prison health care, remote clinical advice, urgent care services, mobile doctors and independent consulting doctors. Not all of these are rated. However, our inspections to date suggest these services are performing well, with limited need for enforcement action. We see many examples of good practice. We will have more ratings data relating to out-of-hours care and urgent care next year.

Although we are not seeing significant changes in the numbers of registered providers in this sector, we have started

to see new and innovative providers entering the market. For example, we recently registered the first online-only GP service. We are also seeing signs that there are an increasing number of multi-site practices, resulting from some mergers and acquisitions between acute healthcare providers and GP surgeries, and through consolidation or federation of GP practices. A relatively high proportion of the larger practices, with more GPs, have received good ratings, and some small practices have struggled, particularly those where the GPs are professionally isolated and lack local structures that enable them to connect with peers. It will be important to see how the market continues to develop.

2.4 The quality of care people receive

While our findings about the quality of care in different sectors show that many services offer good care, there are some groups of people who are at risk of receiving consistently poorer care because of who they are. This can be seen in access to services, and in people's experience and outcomes.

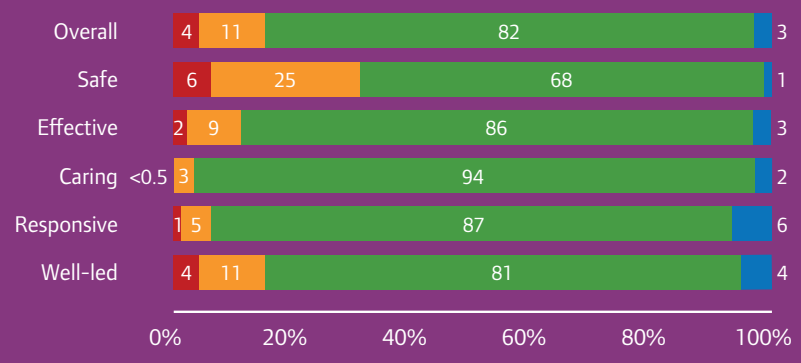
Access

In adult social care, the changing eligibility criteria have had an impact on different groups, and in different parts of the country.

Older people (those aged 65 and over) have been hit harder by reductions in local authority eligibility criteria, compared with other adults. More than 42,300 fewer older people in England received local authority-funded adult social care in 2013/14 compared with the previous year, a 4.7% reduction. The equivalent figure for those aged 18-64 was 12,500, a 2.9% reduction.[17]

Support and ability to navigate the health and social care system, through information and referrals, is also vital for accessing care. Analysing our 2014 NHS inpatient survey, we found that people with long-term conditions – particularly people with mental health conditions – were less likely than others to say they had received information and support to access other services on discharge from hospital. Similarly, people in Black and minority ethnic (BME) groups were less likely to report that they had this help on discharge.

Figure 1.8 Primary medical services ratings by key question



Source: CQC ratings data

Inadequate Requires improvement Good Outstanding

National social care surveys also report that people from BME groups are less likely to say that it is easy to find information about services available to them.[18]

As outlined in section 1, local authorities have chosen to set different levels of eligibility depending on local priorities. However, the Care Act 2014 seeks to reduce some of the variation in eligibility, and this could lead to very different challenges depending on the local authority. Office for National Statistics population data suggests that demographic changes will not impact on each area equally: the projected increase between 2015 and 2025 in the population aged 65 and over varies from 9% (Blackpool) to 44% (Milton Keynes).[19] Similarly the projected increase in people aged 85 and over varies from 6% (Barking and Dagenham) to 69% (Wokingham). It is likely that these areas will face different challenges when seeking to balance budgets while ensuring needs are met.

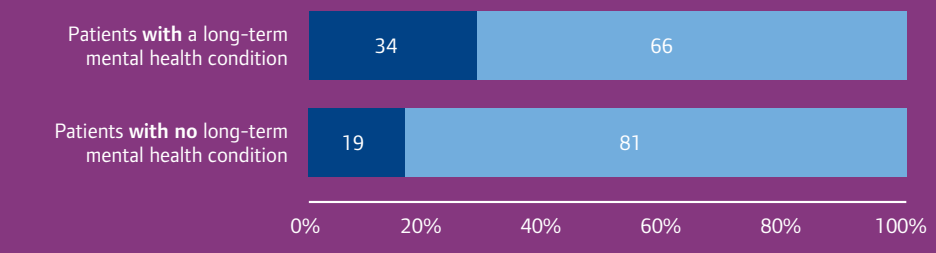
Experience and outcomes

While the public typically say they have positive experiences of care, people with a long-term condition are less likely to report having a good experience of using acute hospital services. This is particularly true for those who have a long-term mental health condition. Figure 1.9 shows the proportion of people who rated their overall experience of attending accident and emergency at least seven out of 10, and those who rated it six out of 10 or less. It highlights a gap of 15 percentage points between those who have a long-term mental health condition and those who do not.

Similarly, we found that all trusts must also do more to ensure that children with a physical disability, a mental health condition or a learning disability are receiving care that meets their specific needs. Through our first national survey of children and young people who received inpatient and day care in hospital, we found:

- Reports of patient experience were poorer for children with a physical disability, a learning disability or a mental health condition across all the survey questions analysed. Children with these long-term conditions were more likely to be negative about the information provided by staff and the quality of their communications with staff. This included questions about whether staff talked with them when they were worried and whether staff always listened to them.

Figure 1.9 2014 A&E survey: patient experiences of A&E based on whether they had or had not self-identified as having a long-standing mental health condition



Source: National survey of patients in A&E 2014

Score up to 6 (poorer experience)

Score 7 and above (better experience)

- 45% of parents and carers of children with a physical disability, and 49% of those with children with a mental health condition or learning disability, said that staff were definitely aware of their child's medical history. This compared with 59% of parents and carers whose children did not have these needs.
- 49% of parents and carers of children with a physical disability, and 48% of those with children with a mental health condition or learning disability, felt that staff definitely knew how to care for their child's individual needs. This compared with 72% of parents and carers whose children did not have these specific needs.

Looking at adult social care, the annual survey of people receiving local authority funding for care also suggests that Asian/Asian British and Black/Black British people using these services are less likely to be satisfied with services. They are also more likely to say that they have a lower quality of life than people in other ethnic groups, and more likely to say that they found it difficult to access information about services that may be helpful to them.

We also found differences in our acute inpatient survey about communication between hospital staff and patients in different equality groups – people with long-term conditions and from some Black and minority ethnic groups were significantly

Mental health crisis care

Alongside inspections of individual health and care services, we carry out in-depth reviews of important issues facing the sectors to build our understanding of quality of care.

In 2014/15 we looked in detail at people's experiences of help, care and support during a mental health crisis. We published our findings in our report *Right here, right now*. There are clear variations in how services in local areas respond to people in crisis. A person's experience depends not only on where they live, but which part of the system they come into contact with. We concluded that services for people with mental health conditions are often unsafe and unfair – a situation that is completely unacceptable.

Two in five (42%) of respondents to our call for evidence told us they felt the care they received failed to provide the right response and didn't help to resolve their crisis. Far too many people said the response they received failed to meet their needs and lacked basic respect, warmth and compassion. Services must recognise that the risks from emotional harm are just as real, and potentially life-threatening, as those from a physical injury. Our findings highlighted that all services involved in mental health have work to do in improving how their staff respond to people in crisis.

Crisis resolution home treatment teams are a vital element of managing mental health crisis events. However, a University College London review, which analysed the work of approximately a third of all crisis teams in England, found that almost a quarter (23%) scored the lowest possible mark for whether they could provide a 24-hour service. There are similar issues in acute hospitals. Local areas must recognise that the nature of a crisis means that services provided between 9am and 5pm will not be sufficient. It is both unsafe and unfair that people with a mental health crisis are often not able to access the services they need when they need them.

We are currently carrying out further thematic reviews to explore people's experiences of end of life care, and the extent to which care is integrated for older people. We are due to publish these in 2016.

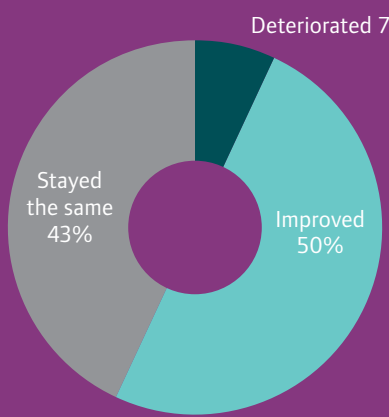
less likely to say that they had been given helpful information on discharge. The survey also showed that people with a mental health condition and people aged 16-35 are significantly less likely to feel treated with dignity and respect while staying in hospital. Some other equality groups are also significantly less likely to report being treated with dignity and respect, although the differences are smaller. There has been little change in these findings about dignity and respect since the last CQC analysis of equality using our NHS Inpatient Survey in 2011.[20]

These findings show that services need to look carefully at whether they are providing equally good care for everyone. Acute hospitals need to engage locally with people from all of these groups to understand the reasons for these survey results and to put in place plans to address the root causes. Our analysis of information returns from adult social care services shows that, while almost all services say they have equality and diversity policies, far fewer – less than 30% – say they have carried out work in the last year to meet the needs of some specific equality groups, such as lesbian, gay, bisexual and transgender people. We would encourage services to consider whether they are offering all people using their services a good experience of care.

In some inspections we have heard that useful data may be collected but there is little to show how it is used to improve service delivery. In other cases staff are not clear what value the data has. Data can be used to identify specific areas where quality can be improved. It should also be part of the process to ensure that the services offered meet the needs of the local population – particularly where people with characteristics protected under the Equality Act 2010 have poorer access to, experiences of, our outcomes from care.

The National Information Governance Committee report to CQC's Board suggests that, in many cases, inspectors are uncovering evidence of both good and poor practice in information governance and making clear links to how this has an impact on the experience of people who use services. It reasserts that services need to engage with different groups within their communities to understand why some equality groups continue to report poorer experiences and outcomes and to take steps to address this. This is particularly important as some of the groups apparently being served less well are likely to increase in future as a proportion of the overall population.

Figure 1.10 Change in ratings on re-inspection



50%

Half of re-inspections have resulted in improved ratings

Source: CQC ratings data

Based on 123 re-inspections (both focused and comprehensive). Improved means at least one key question improved and none deteriorated. Deteriorated means at least one key question deteriorated and none improved.

3. Encouraging improvement

CQC's new expert-led inspections are more robust and comprehensive than previous approaches. They are designed to get a more rigorous, complete picture of the quality of care at a service and the issues, if any, that providers need to tackle. In a survey in January 2015 of people who had had a new approach inspection, 83% agreed that the new inspections helped them to monitor the quality of care they provide. A core part of CQC's purpose is to encourage improvement. Our inspection reports clearly set out what we have found against each of our five key questions, and services should be using them, and the feedback we give during the inspection itself, to focus on what they need to do to improve.

3.1 CQC's inspections are leading to service improvement

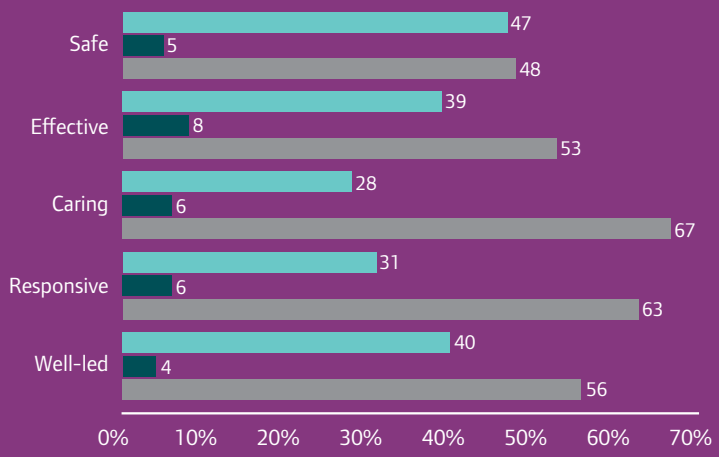
In our annual survey of providers in October/November 2014, almost three-quarters said that our inspection had helped to identify areas of improvement (73%) and that the inspection reports were useful (72%). Just over two-thirds (68%) of providers said they thought that outcomes for people who use services were improved as a result of our inspection activity. This suggests that CQC is playing a central role in encouraging improvement across the system.

Up to 31 May 2015, we had re-inspected 123 rated services, mostly where we were following up concerns about the quality of care in the first inspection. The majority of these related to adult social care, although there were a handful of re-inspections in other sectors (seven NHS acute services, and one GP practice).

Half of the re-inspected services had improved their ratings (figure 1.10). Fewer than one in ten (7%) had deteriorated further. All of these re-inspections will have happened within a year of the original rating, suggesting that improvements can be relatively rapid.

Figure 1.11 shows the areas in which improvements have been made in adult social care re-inspections. Almost half of re-inspections found that the issues relating to safety had improved sufficiently to lead to a

Figure 1.11 What happens to key question ratings on re-inspection in adult social care?



Source: CQC ratings data, based on 115 adult social care re-inspections

higher rating. For well-led, a higher rating was achieved in 40% of re-inspections. This is encouraging given the relatively short period of time in which these improvements were made. The chart shows the change from all initial ratings, some of which will have been 'good', which explains why a number of ratings will not have changed and some may have deteriorated compared with their original rating.

Re-inspections drive improvement

Peterborough and Stamford Hospitals NHS Foundation Trust

Peterborough and Stamford Hospitals NHS Foundation Trust has focused on strong leadership to move from requiring improvement to a good rating in just over a year.

When we visited in March 2014 we found some services that required improvement for being safe, effective and responsive to the needs of patients. We advised the trust to address important issues, including its complaints backlog, support for staff in raising concerns, and the number of admissions to inappropriate wards. We also asked the trust to improve the experiences for people using children's services, A&E and end of life care.

In May 2015 we returned to find a trust with a newly formed senior management team that had worked hard to address our concerns, doing a great job to engage all staff.

The culture at the trust had improved and staff spoke positively of the management team. Senior managers were visible around the wards, and staff members were being given more autonomy and responsibility in their roles.

As a result of this leadership, patient pathways had been re-designed through a new medicines admission unit to improve patient flow and experience. Children and young people had been consulted to see how their services should be improved. And A&E waiting times had been reduced.

Complaints handling had also improved – on the day of inspection there had been no outstanding complaints for the previous 30 days.

3.2 Special measures and enforcement action

Where services are found to be inadequate, we normally apply a process of 'special measures'. This sets out a clear timeframe within which we expect the service to improve, assessed by a re-inspection. We will also take enforcement action where we find that a fundamental standard of care (as set out in legislation) has been breached.

In 2014/15, CQC took 1,179 enforcement actions. This included 63 non-urgent cancellations of registration, and 27 urgent suspensions of registration, or urgent variations or imposition or removal of conditions. These actions were taken because of the risks we felt were posed to those using these services (figure 1.12). Where we cancel registration, this means the provider can no longer run the service – an alternative provider needs to take over the service or an alternative service must be found. We are aware these cancellations, and particularly urgent closures, can have a significant impact on the people using those services – especially where the service is a person's home, such as a care home. We will always take the action necessary to protect people from an unacceptable level of risk of harm, while making sure that together with the service, the commissioner of the service, and other stakeholders – the people who use the service are considered first.

Figure 1.12 CQC enforcement action in 2014/15, 1 April 2014 to 31 March 2015

Enforcement action	Adult Social Care directorate	Hospitals directorate	Primary Medical Services directorate
Special measures total	n/a*	21	10
Warning Notices published	937	33	67
Non-urgent cancellations of registration	53	0	10
Urgent procedure for suspension, variation or conditions of registration**	17	7	3
Non-urgent variation or imposition or removal of conditions	37	0	0
Fixed penalty notices issued	10	0	0
Number of prosecutions	3	0	2
2014/15 overall enforcement actions	1,057	40	82

* Special measures for adult social care only started on 1 April 2015.
** This means urgent suspensions of registration, or urgent variation or imposition or removal of conditions.
Source: CQC enforcement data

3.3 Sharing learning

We also want to make sure that services have access to the information that will help them improve. We gather examples of good practice that we can share across the system. For example, in March 2015 we published *Celebrating good care, championing outstanding care* as a way of sharing what we found on inspection. It provides case study examples that are aligned with our key questions to make it easy for services to read about outstanding practice in areas relevant to them. Similarly, the National Information Governance Committee's report to CQC's Board includes examples of good practice across three sectors.

We understand that the first two trusts we rated as outstanding (Frimley Park and Royal Salford) are now encouraging and receiving visits where other providers come to understand how they have achieved their rating. We hope that increasingly this will happen across sectors.

We have a role to play in encouraging others to improve, and we are committed to making it easier for providers in all sectors to learn about the excellent work that is being carried out across England.

4. Ensuring safe, high-quality care in a period of change

Health and adult social care services are already working in a challenging environment. We have outlined how, despite these challenges, the majority of services deliver a good or outstanding quality of care, even though there is still a lot of room for improvement, particularly with regard to safety.

During the remainder of 2015/16 and beyond, providers will face an even more difficult operating environment. There is a shared understanding that to achieve more with less, without compromising on quality, it will be necessary to bring about radical and innovative changes in how care is provided. If these changes do not happen, tensions are likely to arise between balancing the pressures to increase efficiency with the need to improve or maintain the quality of their care.

The variation in the quality of care we see so far cannot all be explained by the availability of resources. Some services achieve excellent quality of care under constrained financial conditions. This should mean that others can do so too. Services will have to work collaboratively across their local areas, and with their staff and people who use services.

4.1 The scale of the challenge in adult social care

During the last two decades, the challenges facing the adult social care sector have not been exposed to the same public and political debate as health care. There is currently no widely shared vision for how the sector should change and adapt.

Having made significant savings over the last five years, partly through efficiency improvements and partly through restricting access to services by reducing the eligibility for publicly funded social care (figure 1.13), there may now be less room for generating

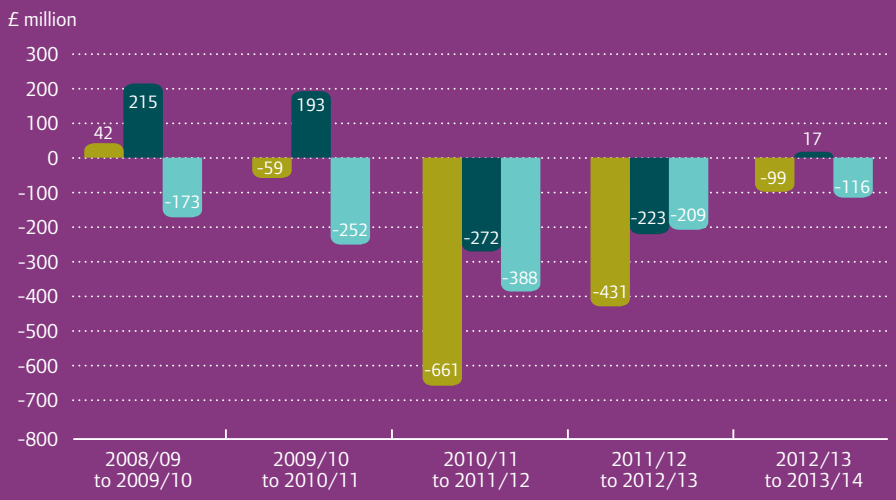
further savings. The new national eligibility criteria for publicly funded care introduced in the Care Act 2014 will also reduce commissioners' ability to limit access in the way some have done so far. This is likely to have significant implications for the ability of services to improve or maintain their quality of care while trying to maintain financial viability.

Commissioners, providers and people who use services are expressing growing anxiety about the 'underfunding' of adult social care and the impact this will have on quality and on the supply of care.

- The UK Homecare Association estimates that the state funded domiciliary care sector ran at a deficit of £514 million in 2013/14. It predicts it will run at a deficit of £753 million over the 2016/17 financial year. It anticipates there will be more providers leaving the market and handing back substantial volumes of state funded packages on the grounds of insufficient fee levels.[22]
- The National Care Forum reports that all providers are concerned about insufficient local authority fee levels and the consequences of underfunding of adult social care.[23]
- According to the Association of Directors of Adult Social Services finance survey, when contemplating the next two years, directors of social services are doubtful that planned savings can be achieved. They are increasingly concerned about the impacts of savings, that fewer people will get access to services and that the size of personal budgets will decrease.[24]

Figure 1.13 Components of total savings in adult social care, 2008/09 to 2013/14

Change in spend (real terms at 2012/13 prices)



Source: National Audit Office [21]

Chart includes spend and activity data for day care, home care, residential care and nursing care for all groups.

Total change in spend | Spend change due to price changes | Spend change due to volume changes

- Carers UK reports that, of 4,500 carers responding to their survey, 55% said they are worried about the impact of cuts to care and support services over the next year.[25]
- The King's Fund have said, "In our view it is not credible to maintain that current standards of care can be sustained (let alone improved) without the funding needed to deliver this."[26]
- The National Audit Office's auditors have increasing concerns about the financial health of single tier and county councils. In 2014/15, they expressed concern about more than half (52%) of authorities and their ability to deliver their medium-term financial strategy.[27]

The organisations attending CQC's adult social care symposium echoed these concerns.

Unpaid, informal care by family, friends or charities has always played an important role in the adult social care sector. However, current data shows that such informal care cannot provide a long-term substitute for publicly or privately funded care. Existing trends imply that the gap between the number of people needing unpaid support, and the number of people available to provide it will be around 15,000 in 2017 and 160,000 by 2032.[28] This is because existing levels of unpaid care given by adults to their parents, covering 20 or more hours a week, are expected to remain steady, while demand for care will continue to rise quite quickly.

The adult social care market is also facing significant pressures that drive up costs for providers. Apart from the likely rises in care costs from the greater complexity of people's needs, staff cost pressures next year will increase further with the introduction of the national living wage. Combined with a likely future increase in the cost of borrowing due to eventual interest rate rises, this potentially puts providers in an increasingly tight financial position during a period where commissioners of services are looking to reduce fees.

4.2 The scale of the challenge in health care

The healthcare sector is also facing an increasingly challenging period, but for different reasons. The NHS *Five Year Forward View*, published by the national NHS organisations including CQC, and backed by the Government, is a common vision for reforming the system over the next five years. It commits to meeting the triple challenge of improving health and improving quality, while achieving efficiencies. It also commits to making progress on specific priorities such as mental health, cancer outcomes and maternity services.

The King's Fund *Quarterly Monitoring Report* for July 2015 states that 66% of provider organisations are forecasting a deficit in 2015/16, with 89% of acute hospital trusts expecting to overspend.[29] Moving forward, Monitor, the NHS Trust Development Authority and NHS England have made it clear that running large deficits is not acceptable, which means that there will be more pressure to achieve financial balance.

The *Forward View* sets out an ambitious programme of developing new models of care through its vanguard programme, which includes bringing together health and housing, and working with greater devolution of how services are managed, as in Greater Manchester. There is a shared understanding that to achieve more with less, without compromising on quality, it will be necessary to bring about radical and innovative changes in how care is provided. Inevitably, such changes are hard to predict, and create uncertainty and variation in how different services respond to these challenges over the next five years.

4.3 The relationship between quality and finance

So far, our analysis to correlate CQC ratings with some financial indicators shows no obvious link between overall quality and more money. For example, our analysis of the potential drivers of quality in adult social care does not show a statistically significant relationship between the local authority hourly rate for domiciliary care and the quality of domiciliary care services in that local authority area (figure 1.14), or between the average local authority funding for every older member of the population and quality of older people's care services in an area.

Figure 1.14 Ratings of domiciliary care agencies by average hourly cost

Source: CQC ratings data; Personal Social Services: Expenditure & Unit Costs, England, 2013/14

Note: We have so far rated only a minority of services. We have produced 95% confidence intervals for the average values by rating, as these values will fluctuate until all services have been inspected. The error bars in each chart show the width of these confidence intervals. If the confidence intervals do not overlap then the differences between the values are statistically significant. In this instance there is not a statistically significant difference.

Inadequate Requires improvement Good/Outstanding

We understand that, beneath the headline figures, the story is likely to be more complex and the data we currently have is limited. For example, local authorities in London and the South East typically pay higher rates to providers of care, but this may be offset by the higher rents and wage costs associated with these regions. Also, the data we have used is the average hourly local authority rate and not necessarily that paid to the particular domiciliary care agency we have rated.

For NHS trusts, an analysis of our ratings showed a weak but significant correlation between better financial performance (defined as having a budget surplus or small deficit) and better quality ratings. The trusts rated outstanding or good had an average deficit of £2 million, which was significantly less than the average deficit of £32 million for trusts that were rated inadequate.[30]

This is in line with the theory that safer, better care does not necessarily cost more, and suggests that in many cases good leadership is able to plan for high-quality care alongside good use of resources. Further evidence comes from the Carter Review commissioned by the Department of Health. This review looked at the potential for making efficiency savings in hospital budgets. This review has identified many opportunities for greater efficiencies that are likely to maintain or improve the quality of care while reducing spending overall. While we recognise some aspects of good care, such as ensuring safe staffing, will have a cost attached, there is a growing body of evidence that higher quality care enables resources to be used more effectively.[31] However, it will be important to continue to monitor closely the relationship between quality and money as budgets become tighter.

An inspector's view

"The directors, the manager and the staff from different levels around the organisation were all working towards the same thing, which was not only making sure people were receiving good care, but everything they did they were able to evidence why they did it, how they did it and how they improved as well. That was really good and it impacted right across the organisation at every level of management, staff and people who use services as well."

5. Building strong leadership, resilience and innovation

In the challenging environment for health and adult social care, financial resources are not the only answer. For health and social care services to be able to ensure the quality and safety of the care they provide, they will need strong leadership and resilience. They will need to find ways to encourage innovation and creativity, while keeping the quality of care for people who use services at the centre of their work.

To understand what lies behind outstanding and inadequate ratings overall – and specifically the key issues of safety and leadership – we carried out further qualitative analysis. This included analysis of more than 50 inspection reports and 13 focus groups with inspectors. These findings were triangulated with discussions with Chief Inspectors and Deputy Chief Inspectors and published literature relating to leadership and safety to corroborate the findings. Therefore, while this section is based on qualitative rather than quantitative data, we can be confident that the findings are robust, and that the areas for improvement are important.

We have identified three key areas of focus for improvement in quality:

- Leaders using engagement to build a shared ownership of quality and safety
- Staff planning that goes beyond simple numbers and includes skill mix, deployment, support and staff development
- Working together to address cross-sector priorities.

All of these can only be achieved by developing a culture where all members of staff take pride in the quality of their work and feel that quality is their responsibility.

5.1 Engaged leaders building a shared ownership of quality and safety

Our analysis shows there are five critical aspects to the good leadership we see:

- Effective engagement and communication with staff and people using services
- The skills, experience and visibility of management
- A strong and positive organisational culture
- Learning when things go wrong
- Governance processes to support openness and transparency.

Effective engagement

We found that engaging with staff and people who use services is a central factor in being well-led across all sectors. Services that prioritise quality and safety have created an environment where staff are encouraged to be involved in recommending new ways of working and suggesting ways to put the organisation's values into practice. In these organisations, an emphasis is put on learning and staff development.

In outstanding services, we see that leaders make sure that staff feel they have a part to play in decision-making and that in large organisations there is multi-disciplinary teamwork. Our hospital inspections also tell us that where we have rated a provider as inadequate for being well-led, there is usually poor alignment between senior clinical staff and senior non-clinical management. In high-quality adult social care services we have seen examples of all staff, including managers and trustees,

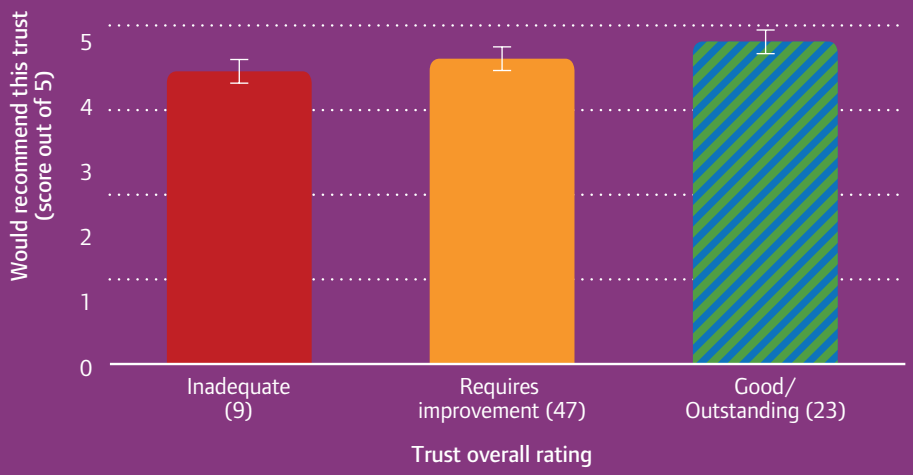
being encouraged to contribute ideas to improve the quality of life for residents.

Services that encourage feedback and are tailored to people's individual needs are more likely to be rated outstanding for well-led. They use creative methods to encourage people to speak up about their care, and any concerns that people raise are addressed. In adult social care services, examples of innovative care methods include individualised care plans, life maps that capture important information about a person's life (such as family, key events and dates) and working with local community groups and agencies. Outstanding GP practices often have strong patient participation groups, genuinely respond to the needs of the local population, and reach out to diverse groups such as people with a learning disability and people who are homeless.

There is a positive correlation between whether staff would recommend the NHS trust they are working for and CQC's quality rating for that trust. Figure 1.15 shows that the average score given by staff of good or outstanding trusts is significantly higher than the score for trusts that are rated requires improvement or inadequate. Similarly, there is a correlation between how staff rate their trust on "good communication between staff and senior management" and our quality rating.

There is also a relationship between our ratings and patient satisfaction, based on findings from our NHS inpatient survey. For the question about inpatients' overall experience of a trust's services, outstanding and good providers received an average score of 8.2 out of 10, compared with trusts requiring improvement and rated inadequate, which scored 7.9 out of 10.

Figure 1.15 NHS acute trust ratings and average scores from the 2014 NHS staff survey: 'Would you recommend this trust?'



Source: CQC ratings data, NHS staff survey 2014
Note: We have so far rated only a minority of services. We have produced 95% confidence intervals for the average values by rating, as these values will fluctuate until all services have been inspected. The error bars in each chart show the width of these confidence intervals. If the confidence intervals do not overlap then the differences between the values are statistically significant.

Inadequate Requires improvement Good/Outstanding

207,000

Complaints received by NHS providers in 2014/15

Handling complaints

One important opportunity to listen to people is when they complain. Our review of complaints handling in health and social care, *Complaints matter* was published in December 2014. This exposed a wide variation in the way complaints are handled and identified, and that much more could be done to encourage an open, transparent culture where staff and managers welcome concerns and learn from them. For example, our inpatient survey shows that only a quarter (26%) of patients either saw or were given information about how to complain to the hospital. While most providers have complaints processes in place, people's experiences of the system are not consistently good.

It is CQC's view that services should encourage and embrace complaints, as they present a valuable opportunity to improve. Our report accepted that a cultural shift will require everyone involved in health and social care to stop seeing complaints as negative, because as long as we do there is an incentive for services to be less open about seeking feedback. Complaints may signal a problem, but this information can help save lives and learning from concerns will help improve the quality of care for other people.

According to data from the Health and Social Care Information Centre (HSCIC), the total number of reported written complaints received by NHS providers in 2014/15 was around 207,000, the equivalent of more than 560 a day.

The total included 121,000 written complaints about hospital and community health services (an increase of just under 6% on the previous year) and an estimated 86,600 relating to family health services (including GP and dental services). Note that for family health services we cannot compare with previous years because there has been a large increase in the number of GPs and dental practices returning data to the HSCIC.[32]

There is no single organisation that collates the number of written complaints received by social care providers in the same way as HSCIC does for NHS providers. However, the Local Government Ombudsman has also reported an increase in complaints received – 16% of around 20,000 complaints received in 2014/15 related to social care, compared with 13% in 2013/14.[33]

We ask about complaints handling as part of our comprehensive inspections. Every inspection report now has a section on how providers manage this type of feedback. We have committed to celebrating good approaches to complaints handling and setting out where improvements need to be made. We are also working hard to make it easier for people to share their experiences with us, and ensuring we can use their information and provide feedback on any action we have taken as a result. These measures, taken together, should help to promote and embed transparency in complaints handling across all sectors.

Skills, experience and visibility of management

Our inspections show that leaders having the right skills, and being visible and accessible to all staff is important. In adult social care, where services are well-led there is usually consistency of leadership with good recruitment and retention of managers. Visibility of managers is also very important – if the manager knows the people receiving care and gets involved with some of the frontline care work, including evening work, staff see this to be very supportive.

In the hospitals sector, alongside good leadership, the competence of managers at all levels and the culture of their teams are very important for driving overall quality. Similarly, in GP practices, the skills and experience of the practice manager make a big difference to the overall leadership of a practice – providing appropriate training and development for the practice manager is therefore integral to ensuring a practice is well-led.

Fit and proper person requirement

In late November 2014 the fit and proper person requirement was introduced for directors of NHS trusts. The duty requires providers to have systems and processes in place to ensure their directors, or equivalent, are fit and proper at the time of recruitment and on an ongoing basis. Since then we have been reporting on how providers meet this requirement in all our trust reports. From April 2015 the fit and proper person requirement has applied to directors of all providers registered with CQC.

The aim of the regulation is for providers to ensure their current directors are fit to manage the quality and safety of the services they are providing. CQC was not asked to investigate individual fitness, maintain a list of those found unfit (in effect, a 'blacklist'), or replace existing employment and legal processes. Historical issues of concern are only considered in so far as they may impact on current fitness.

To date we have not identified a breach of this regulation. There is emerging evidence on the impact the requirement is having, both directly and indirectly, particularly a deterrent effect. The evidence that we have available both from hospital inspections and dialogue with the sector suggests that the requirement is starting to drive culture change. Trusts have reviewed their processes and tightened them where necessary. We believe this may have deterred certain individuals from applying for director posts and it may have deterred trusts from appointing individuals about whom concerns may have been raised. However, it is not yet possible to assess this objectively.

Information about how the fit and proper person requirement is working in other sectors will be included in next year's report, once we have a more comprehensive picture of how services are implementing this requirement.

Duty of candour

In late November 2014 the duty of candour was introduced for NHS trusts, and from April 2015 it is a requirement for all providers registered with CQC. Since November we have been reporting on performance against the duty of candour in all our inspection reports for trusts.

An initial analysis of our hospital inspection reports shows that there is knowledge and awareness of the regulation, especially among senior managers; that specific structures and systems are starting to be put in place to support adherence to duty of candour requirements (including staff training); and that we have seen positive evidence of trusts meeting the regulation, including providing an apology to patients involved in serious incidents.

Information about how the duty of candour is working in other sectors will be included in next year's report, once we have a more comprehensive picture of how services are implementing this duty.

Investigating serious incidents

In our review of the quality of investigations into serious incidents involving patient care in acute hospitals, due to be published later in 2015, we conclude that while investigation of serious incidents is often seen as one of the most important elements of the patient safety process, this can be counterproductive if not done well.

The implementation and roll-out of root cause analysis investigation techniques across the NHS has had the unwanted side-effect, in some cases, of being under pressure to meet timescales at the expense of the quality of the investigation. This suggests, and is supported by the findings of our review, that the categorisation of serious incidents has become inconsistent with the original purpose, which was to identify significant opportunities for learning to reduce or eliminate the risk of the same thing happening again.

Indeed in a third of the investigation reports we reviewed it was not clear from the description of the incident or recommendations of the investigation that the incident met the criteria for a full investigative response. Other approaches to meet the needs of the patient and identify learning may have been more appropriate.

We have observed a high number of investigations that show a lack of skill and expertise in the methodology used; that do not identify the underlying systems issues that led to the incident; or that leave the reader with unanswered questions. There was also limited evidence that patients and families were engaged in the process, or that clinical and other staff were sufficiently involved.

We are encouraged that more attention is being paid to the response to, and learning from, safety incidents now than ever before. We have seen the number of serious incidents reported into the National Reporting and Learning System increase. However, it is important that providers develop expertise and invest in the tools needed to properly investigate, so that the right lessons are learned and shared.

A strong and positive organisational culture

Well-led services have a positive organisational culture that is open and transparent, and a culture where the vision and values are embedded and really understood by staff across the service. In a service where there is pride and enthusiasm among staff, which is echoed by people using the service, this is often indicative of both good leadership and a safe culture. Similarly, the best managers promote an open door policy and they welcome feedback. They are open to challenge and willing to take on suggested changes.

Many services point to their open door policy and their organisational vision and values in our conversations with them. But we have found that this alone is not enough to be well-led. Staff need to see these policies role-modelled by their managers, or they can feel undervalued and disempowered.

A culture of bullying, or staff feeling unable to speak up and report problems or incidents, is often a problem in services rated as inadequate for leadership or safety. Despite the focus on changing NHS culture since the publication of the Sir Robert Francis's Freedom to Speak Up review in 2013, it is still the case that around a quarter of NHS staff (22%) report having experienced harassment, bullying or abuse from their managers or other colleagues (according to the 2014 NHS staff survey). It seems that, although providers may have come some way to improve issues that flow from a poor organisational culture, they have not solved all the problems and need to work harder to do so.

Inclusion is an inspiration

Inclusion Healthcare Social Enterprise in Leicester

Inclusion Healthcare Social Enterprise in Leicester is an inspiring and innovative primary healthcare service that is providing outstanding quality in its services.

Inspectors discovered countless positive stories showing how Inclusion went out of its way to consider the needs of patients, whatever their circumstances. At its heart was strong leadership and there was a positive culture that ensures patient safety is paramount.

Healthcare assistants reminded patients about hospital appointments – and they also offered to go with them. Staff have explained how they support people experiencing a mental health crisis, including monitoring their repeat prescriptions, and the practice has also contributed to funeral costs and memorials for homeless patients.

The kind and compassionate care witnessed was part of the service's patient-centred culture and was also demonstrated in the way staff cared for refugees and people with a learning disability, and their work with hostels, prisons and young offenders institutions.

Learning when things go wrong

Services need to act when things go wrong, capture what happened and what the learning is, and then cascade the learning to prevent it happening again. In last year's *State of Care* report we issued a challenge to providers to make safety a priority in their services. We said there was too much variation when it came to safety and that too many providers had not got to grips with the importance of getting it right. As outlined in section 2, safety remains our biggest area of concern. A priority for improving this is being able to learn from mistakes.

In services rated good and outstanding, we find that staff are encouraged to report incidents. Any subsequent investigations are fair and transparent, focused primarily on learning rather than blame. Risks are identified early, discussed openly in an agreed structure and, in larger organisations, escalated where appropriate.

In these services, staff have clear lines of responsibility and are knowledgeable about their roles. NHS trusts that we have rated outstanding for safety also actively engage their staff in audits of patient outcomes and sharing learning from safety incidents across all teams, not just in the team where an incident occurs. All of this is bolstered by good communication between managers and those delivering care.

Outstanding services train staff on how to respond to near misses and what to do after one to embed learning. They are also able to respond to external information, such as complaints and safety alerts, and use these to identify risks and improve people's safety. This is more common in hospitals, but is important across all sectors.

In services rated inadequate, reporting and investigation of incidents is often delayed from the outset and approached

Deprivation of Liberty Safeguards

As part of our inspections of hospitals and care homes, we monitor the implementation of the Mental Capacity Act 2005, including the Deprivation of Liberty Safeguards (DoLS). In our 2013/14 DoLS annual report, we were concerned that similar themes had repeated over the previous five years. This included persistently low numbers of applications to deprive a person of their liberty, and a continuing lack of understanding and awareness of the Mental Capacity Act. In the report, we also noted the huge increase in applications following the ruling of the Supreme Court in March 2014, which clarified when a person is being deprived of their liberty.

During 2014/15 the number of DoLS applications continued to increase – there has now been a 10-fold increase in applications since 2013/14. This has led to significant pressure on local authorities that are responsible for processing the applications, with a large backlog in applications. As of March 2015, more than 70,000 applications were not yet finalised or had been withdrawn.

The use of DoLS in hospitals and care homes also continues to vary. For example, we have found variation in staff training and understanding of DoLS and providers' policies about DoLS. Overall, while we have found examples of providers meeting requirements, there are also clear examples of poor practice. Full findings from our monitoring activities will be published in our 2014/15 DoLS annual report later this year.

inconsistently. In particular, due to their size, hospitals can have specific challenges, especially where senior managers are not visible and accessible to frontline staff. This can be exacerbated when trusts have no clear escalation protocol or issues have to be raised through certain staff. In these circumstances there is often poor feedback from reporting incidents. In some hospitals rated inadequate, staff have told us they are discouraged from reporting incidents due to fear of repercussions or not wanting to unsettle colleagues.

Governance processes that support openness

Finally, underpinning the success of organisations that provide good or outstanding care are good governance tools and processes to support leadership at all levels. These give organisations the ability to share learning and act on issues and concerns, and they were common to all services rated outstanding for being well-led.

Analysis included in the National Information Governance Committee's report earlier this year showed that there is a common set of important issues across all sectors that all services need to make sure they are managing well – such as completeness of records, protection of personal information, sharing information among teams caring for people, using information to monitor and improve care, and having effective systems to oversee information governance across the organisation.[34] Across all the sectors we regulate, services who were good or outstanding for safety had processes in place to minimise risk and to report incidents when they happen. Staff were able to explain to us how they manage and reassess risk to keep people safe from harm. Similarly, services rated good or outstanding for well-led ensure that systems and processes for good quality care, such as risk management and complaints handling, are consistent and properly audited.

Good governance processes will typically mean that more information is captured. Therefore, on our inspections we do not automatically assume that an increase in reported safety incidents is a cause for concern – often it can indicate a greater openness by staff and management to reporting problems.

In contrast, in services we rated inadequate there were a range of governance issues that undermined the organisation's quality and safety – from poor data quality (such as inaccurate care plans and medication records) or a lack of staff meetings, to little or no responsibility for complaints or mistakes. In some trusts, difficulties with capturing data about patients as a result of their IT systems had an impact on the reliability of information to help staff deliver effective care. Additionally, in some NHS trusts the system used to record risks only captured issues at trust level, rather than by hospital or location. This meant that their executive team were unaware of incidents happening in particular locations, and this made it difficult to identify patterns. In other trusts we found staff using guidance and policies that were out of date because of a lack of appropriate auditing.

Services that are rated inadequate also tend to have ineffective or unaudited systems for managing risk, or no system at all. The statutory requirement to notify CQC of serious incidents is also managed poorly in those services rated inadequate.

5.2 Quality depends on getting staffing right

We have found that staffing is a core factor in our inspectors' assessment of safety across all sectors. Importantly, however, this is not simply about having the right number of staff, but having the right mix of staff, with the right skills, to meet the needs of the people cared for at all times. CQC does not set standards for staffing levels, and we would never reach a judgement on the basis of number or ratios of staff alone. We always look at it in the context of the effectiveness of the provider's systems for determining and ensuring a safe level of suitable staff for the needs of the people using their services, and their approach to mitigation of the risks when staffing is not as planned. This is in line with advice from the National Quality Board, including their 10 expectations around safer staffing, and the guidelines set out by NICE on safe staffing in acute hospitals.

Adult social care staffing

In adult social care, good services had well-planned rotas in place, which ensured sufficient staffing levels and skill mix to allow for safe, high-quality care 24 hours a day. As a result they also relied much less on external agency staff. In contrast, poor performing services had more prominent issues with staffing levels, often due to poor planning. There are examples where at weekends staffing levels worsened in those services rated as inadequate or requires improvement.

The right number of staff and the right mix of staff, with the right skills

Nothing is too much trouble

Elmcroft Care Home in Maldon, Essex

Elmcroft Care Home in Maldon, Essex, is a care provider that has learned from problems and improved its service – its approach to staffing exemplifies this.

Previously the subject of enforcement action by CQC, Elmcroft is now a good care provider. The provider had a process underway to make the permanent manager the registered manager and inspectors saw that staff knew how to keep people safe – they could identify if people are at risk of harm or abuse.

Feedback about staff from people living in the home was positive. Inspectors were told, "Nothing is too much trouble for them." And one relative of a person cared for at the home said, "They're really on the ball in attending to residents' needs."

CQC saw that the number of agency staff had reduced, more permanent staff had been recruited, and there were always qualified nurses on duty. Staff tried to maintain the independence of the people they cared for, while being aware of any individual risks.

2,800

Fewer senior nurses in the NHS than in April 2010

Nurse staffing

The Royal College of Nursing (RCN) reported this year that too often, workforce and safe staffing discussions focus on numbers alone. CQC and the RCN agree that safe staffing is about having the right number of people with the right level of skills to make the right clinical decisions at the right time.

While the NHS has seen an increase in the number of nurses employed (just over 319,000 full-time equivalent nurses, midwives and health visitors in March 2015 compared with just under 314,000 in March 2014, and up from just under 312,000 in March 2010[37]), the loss of senior nurses across the NHS in England (as noted by the RCN) means that the health service is losing skills and experience, ward leadership and those who can mentor and lead the next generation of nurses. This loss of knowledge and experience is a cause for concern, particularly when we consider it in the context of skill mix and safety.

In *The fragile frontline*, the RCN reported workforce band data from the Health and Social Care Information Centre that shows that between April 2010 and October 2014 the more experienced senior nursing posts (bands 7 and 8 which include matrons, nurse consultants and nurse team managers) have decreased disproportionately when compared with other bands (figure 1.17). Although numbers of nurses in senior bands have been increasing again since mid-2013, they remain lower than before. As a result, the NHS has 2,800 fewer senior nurses than it did in April 2010.

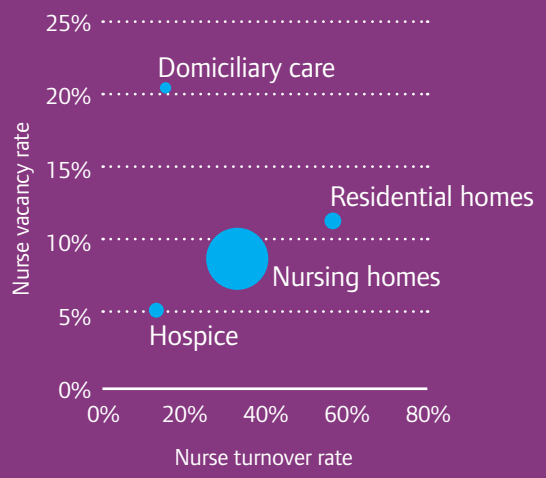
As well as the pressures of maintaining adequate staffing levels, adult social care services are generally struggling to recruit the right staff. The vacancy rate across all positions in the sector is 5%, which is between one and a half and two times the national average. And turnover rate is around 25% a year for adult social care positions, compared with 15% nationally across all sectors.[35] Recruiting and retaining nurses in adult social care is particularly difficult, with vacancy rates as high as 20% in domiciliary care and 11% in residential care.[36] Figure 1.16 shows the high turnover of nurses in nursing homes and residential homes, and high nurse vacancy rates in nursing homes, residential homes, and particularly in domiciliary care.

Staffing in the NHS

In acute trusts, our inspectors found problems with staffing levels in services rated good and outstanding as well as those rated requires improvement or inadequate, although they were more common in services rated inadequate. Our 2014 NHS inpatient survey corroborates this, showing that more than 40% of respondents said that there were sometimes, rarely or never "enough nurses on duty to care for them".

Trusts are working hard to provide seven-day services and to secure safe staffing levels. However, there are significant gaps in some staff groups. For example 8% of organisations surveyed by Health Education England in January 2014 reported between 100 and 250 nurse vacancies, in part due to a limited pool of qualified nurses to recruit from.[39]

Figure 1.16 Nursing vacancy and turnover rates in adult social care, August 2015



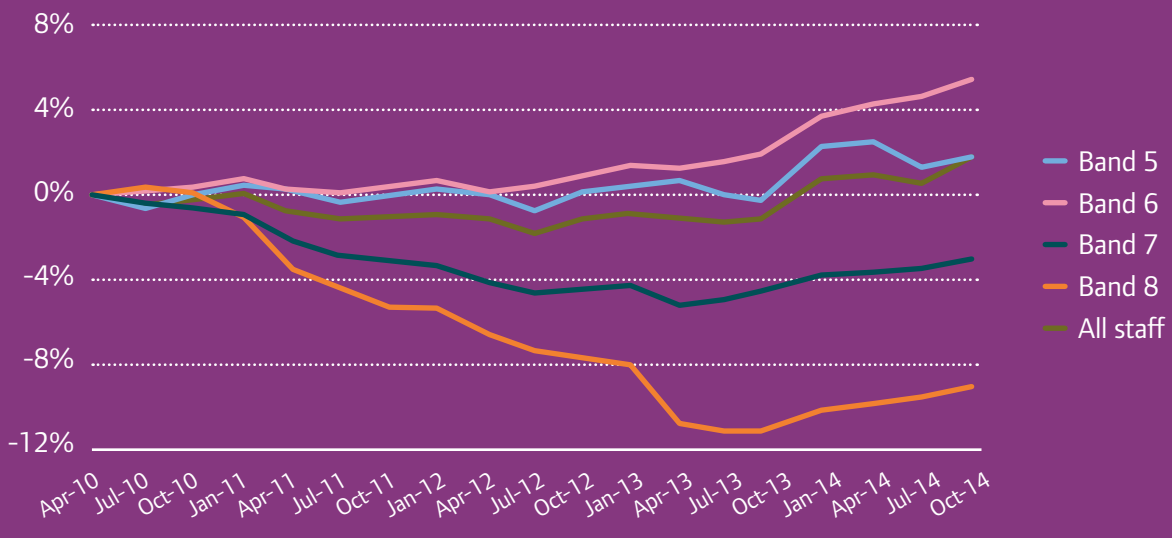
Source: Skills for Care National Minimum Dataset for Social Care

The size of the circles represents the relative size of the nursing workforce in these services. Note that the category of residential homes (that is, mostly 'non-nursing' homes) do sometimes employ nurses.

Trusts continue to use agency and bank staff to fill the gaps. There was a 27% growth in spending on temporary staff between 2012/13 and 2013/14[40], and this trend continued into 2014/15. NHS England, Monitor and the NHS Trust Development Authority have put measures in place to reduce the spend on agency staff in the NHS, but persistent staff shortages will take time to address.

Despite this difficult picture, we found that in trusts we rated good and outstanding, rotas were well planned and there was less reliance on agency nurses. There were still times when staffing levels and skill mix fell below the levels that trusts said they needed to properly care for the number of patients concerned and the severity of their conditions. When this happened, a number of our inspection reports showed that risks to patient safety grew, and there were often more medication incidents, even in trusts we rated good and outstanding. However, these trusts prioritised measures to meet patient demand; for example, developing seven-day support

Figure 1.17 Qualified nursing, midwifery and health visiting staff (full-time equivalent) in NHS hospitals and community services, April 2010 to October 2014



Source: Royal College of Nursing [38]

from consultants, access to out-of-hours consultant-led care and 24-hour availability of diagnostic imaging equipment and operating theatres.

In trusts rated inadequate the number of staff, skill mix and level of experience varied considerably, but generally numbers fell significantly below the levels the trusts said they needed to manage the patients in their care. This was especially the case during the night and at weekends, often due to a lack of medical staff in A&E. There was a tendency to rely on agency and bank staff in trusts rated inadequate, and where suitable staff could not be found departments ran without adequate staff in place.

Mental health trusts are also experiencing staffing challenges. In response to this NHS England issued a safe staffing framework for inpatient mental health wards in June 2015.[41] In producing this guidance NHS England found wide variation in costs and levels of staff recorded in inpatient settings, noting that deficits in qualified staff may be contributing to the variation in money spent. It further found that higher levels of qualified staff were associated with reduced levels of aggression among patients, thereby supporting the link that proper staffing leads to safer patient care.

A culture of developing staff

While staffing levels and skill mix are central to getting safety right, our analysis shows that staff training and staff development are also important. Outstanding adult social care services have training programmes for staff, and a culture that encourages all staff to continuously improve. This is complemented by staff support and development, with regular appraisals and supervision. In contrast, services rated inadequate often have training programmes that are inconsistently delivered or poorly monitored, an overall lack of performance management and periodic supervision for staff.

Staff training and staff engagement also impact on quality in the hospitals sector. The importance of this has been highlighted repeatedly in external research. In February 2015, the Health and Care Professions Council identified it yet again.[42] In outstanding trusts, staff tend to feel well-supported from many different sources – for example, consultants take the extra time to explain a particular situation to junior doctors or nurses, alongside ongoing training, assessment of competencies and feedback on performance.

In trusts that are rated requires improvement or inadequate, although staff generally felt that they were supported by immediate management, there was a lack of direct contact with more senior levels of leadership. Our analysis also suggests that in some departments of trusts rated inadequate there was limited uptake of mandatory training, insufficient performance management and limited priority placed on embedding training into everyday staff activities. This improved slightly with trusts that require improvement, as staff felt generally better supported and engaged.

Outstanding adult social care services have training programmes for staff, and a culture that encourages all staff to continuously improve.

5.3 Working together on cross-sector priorities

This report sets out what we believe health and adult social care services should focus on to ensure they have the resilience to improve and maintain quality while responding to the challenges ahead. However, services doing this on their own is unlikely to be enough. It will require both national and local coordination and collaboration. We believe the most important actions are:

- Working together to ensure the sustainability of health and adult social care.
- Developing all sectors' ability to recognise safeguarding issues, through good staff training and shared learning.
- Ensuring that data is collected to enable a good understanding of what works.

Collaborate to ensure sustainability

The challenges faced by the health and adult social care sectors have renewed efforts from all stakeholders to work together across traditional boundaries.

The NHS *Five Year Forward View* has led to an important step up in the coordination and collaboration of national stakeholders in carrying out their roles to a common vision for the NHS. This is now being replicated in the vanguard areas to develop new models of care across acute, primary, community and social care services. Many local areas – starting with Greater Manchester, and now followed by areas across the country – have also begun to set out how they plan to use the possibility of greater devolution of resources to integrate their approach to health care, adult social care and public health, as well as housing and other services.

These are exciting opportunities for new approaches that offer better quality care while potentially being more efficient. We support and are part of this collaborative approach, while using our independence to provide an objective assessment of the quality of care against which changes are taking place. As part of the *Five Year Forward View*, with NHS England we co-chair the National Quality Board, working together with our national partners to set out a common understanding of quality, how we measure it, and what future priorities should be for quality improvement. We also provide our insights into quality and our perspective as an independent regulator in the other areas of the *Forward View*, such as new care models, efficiency and productivity, workforce and improvement (following the formation of NHS Improvement and the new Independent Patient Safety Investigation Service).

In April 2015 we started to monitor the largest providers of adult social care in England, with the aim of identifying early risks to their financial and business sustainability. We are doing this so that the people using their services are not disadvantaged by unforeseen large provider collapses, as has happened previously (see market oversight box). And from April 2016 we will start to pilot an approach to assessing the use of resources in NHS trusts alongside our inspections on their quality of care.

An inspector's view

"Leadership is the main steer, if there is a good manager in place who knows the service, is passionate about the service, then if they get that right, the rest of it's going to be right. The vision goes throughout service."

Finally, from this year onwards we are exploring ways in which we can assess and comment on the quality of care in a local area, beyond each individual service, to assist the shift towards integration and care models crossing traditional boundaries.

These are positive steps towards greater collaboration across services and sectors. From our inspection findings in adult social care, alongside conversations with providers, commissioners and people who use services and their families and carers, we are concerned that, unlike for the NHS, so far no common, coherent vision has emerged for the future of adult social care. This is inevitably a more complex task, involving more devolved commissioning responsibilities, a significantly mixed private and public market, and large diversity of service types and providers. Some organisations, including the Association of Directors of Adult Social Services and Care England, have set out five-year visions. But this does not yet address the need for a common vision that all stakeholders can jointly work towards, and we believe is needed to provide the current fragility of the adult social care market with a more sustainable, resilient platform for the changes ahead.

We therefore call on all adult social care partners to come together, and set out such a common vision and plan of work, including how services can be encouraged and supported to improve.

Strengthening safeguarding

CQC has a specific role to protect children and adults using services and who are unable to speak up for themselves, as well as a particular responsibility to people who are disenfranchised or who lack the

Market oversight

CQC launched its new market oversight function in April 2015. Its roots are grounded in the events of 2011 when the financial problems faced by Southern Cross, at the time England's largest care provider, exposed the potential risks faced by thousands of people across the UK in the wake of the collapse of a major social care provider.

We have a duty to oversee the financial health of care organisations that local authorities would find difficult to replace if they left the social care market. It empowers us to give an early warning if it seems that they are likely to fail, and that services will be affected. By doing so we will assist local authorities in carrying out their statutory responsibilities to ensure continuity of care.

Those covered by our market oversight scheme are not necessarily at risk of failing, but are recognised as being difficult to replace if they do fail. This may be because they operate a large number of homes, or have a significant regional presence or specialism.

We have published guidance for providers on our market oversight of adult social care: www.cqc.org.uk/content/market-oversight-adult-social-care

mental capacity to protect themselves. This is outlined in our safeguarding statement.[43] Safeguarding is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the person's wellbeing is promoted. However, this is not a substitute for the provider's responsibility to provide safe and high-quality care.

As part of our inspection process we make sure those who lead regulated services fulfil their responsibility to have the right systems and processes in place to offer assurance that people are safe from abuse and neglect.

We receive concerns from the public who are worried about the care that people are receiving. These relate to safeguarding issues or the quality of care received. Some of these concerns come only to us, while the majority are sent to multiple organisations. When concerns are only sent to CQC we share these with partners such as local authorities where necessary, to ensure they are followed up by the organisation best placed to handle them.

Additionally, providers must tell us when they identify that someone in receipt of their service has been abused or neglected, or when an allegation of abuse has been made. Some providers are telling us about incidents that they believe are abuse or neglect through safeguarding reports, but which are more about the quality of care or care management. However, more work is required to improve their understanding of what to report and how.

Safeguarding children

Concerns about safeguarding and the importance of multi-agency working were raised in the review of child protection services carried out by Professor Eileen Munro, whose recommendations form the

How we inspect the safeguarding of children

We recently carried out a review of services in Rotherham, a town that had national focus due to the extensive evidence of child sexual exploitation. CQC's children's services inspection team assessed all health providers in the local authority area for the effectiveness of safeguarding arrangements, along with health services for looked after children. At the same time, CQC's specialist hospital team inspected Rotherham NHS Foundation Trust using our new methodology. CQC took the step of joining these two teams from different inspection programmes together because of the known previous issues in Rotherham.

Both teams found that improvements needed to be made to child safeguarding and that some agencies still did not understand their roles or responsibilities in this area. Partners who provide contraceptive and sexual health services in particular play a potentially critical role in identifying children at risk. We made 24 recommendations and will monitor the local action plan that results from these.

While this was a challenging inspection for Rotherham with a very large team of inspectors on site, the feedback was positive. They appreciated the very thorough and in-depth review of how they safeguard children and felt the findings provided an accurate reflection of their services. In addition, it enabled CQC to trial a methodology of joint inspectorate review that can be refined and implemented in other areas where there may be a greater level of concern.

basis of our multi-agency programmes. Serious case reviews continue to highlight service failures across all agencies in protecting children. Kate Lampard's report on the lessons learned from the Savile inquiries raised the profile of risks to children from people in positions of trust or power. More recently, the widespread risks to children were highlighted by the Alexis Jay inquiry into child sexual exploitation in Rotherham.

The children's inspection team is continuing with its national programme of child safeguarding and looked after children inspections. It has developed a proposed methodology for a five-year joint programme with Ofsted, looking at how local areas are meeting the needs of children with special educational needs and disabilities. A public consultation for this will be launched in the autumn.

Safeguarding adults

We outlined in last year's *State of Care* that the Care Act 2014 statutory requirement for local authorities to have safeguarding adults boards (SABs) would impact on them and the sector. The Act clarifies CQC's role in safeguarding and, although we are not members of SABs, we are partners to their work. Our inspection staff work at a local level with local authority safeguarding teams.

We will work with services to clarify expectations around their responsibilities to safeguard people using services and continue to take timely and robust action where we find that people have been abused or neglected or where there is that potential.

In hospitals we have found a mixed picture in the way safeguarding issues are recognised and reported. Although the statutory guidance to the Care Act (October 2014) does not define adult safeguarding thresholds[44], some local authorities have established thresholds. This is causing confusion among healthcare staff. Staff training levels for safeguarding across trusts was not always at the required level for all staff, especially in A&E and services for children and young people. We found that in trusts rated as good or outstanding, statutory and mandatory training levels were good, with clear plans to address any gaps.

Safeguarding training is also a concern across our primary care inspections. In particular, our inspectors comment that adult safeguarding training is being overlooked in a number of services, with some services solely focused on child safeguarding. A GP practice rated as outstanding for safety worked across sectors on implementing a safeguarding training programme at a residential care home. This was following a major safeguarding concern where a practice had not picked up on injuries sustained by patients at a residential care home. It is apparent that dental practices do not always understand their responsibilities under the Mental Capacity Act, which can lead to safeguarding issues.

Similarly, in adult social care our inspections have highlighted the impact that a lack of robust training can have on people who use these services. Some services tell us they only have enough money to do essential training, with a lot of online or DVD training being undertaken. Poor training results in staff not taking the right action. There is a mixed picture across the sector about the culture of safeguarding and knowledge of when to report. We are concerned about incidents, for example physical assaults by people using dementia services, where the provider has not identified themselves that the incident was a safeguarding issue and needed action.

Understanding effectiveness with better data

Providers and local and national bodies in health and social care need to work together to better collect and exploit data. There is little evidence that this is receiving the same degree of investment as other initiatives to improve care. Every provider should have good, benchmarked data for all the services it provides, and the data to assure itself that it is providing safe and effective care. This is important to get right because our inspectors are making clear links between the experience of people who use services and how well information is handled and used to improve care. Without it:

- Providers of care may not always have a good awareness of the impact that their service is having, which calls into question whether they, and their commissioners, can be assured that the care they provide is safe, compassionate and effective.
- Staff and their leaders will find it difficult to make robust evidence-based decisions, underpinned by high-quality information.
- People who use services cannot access consistently high-quality information about the safety and effectiveness of the services from whom they receive care.

These are some of the reasons why CQC fully supports the work of the National Information Board (NIB) and the vision to bring greater digital maturity to health and social care.

At the moment we are able to collect and publish information to support providers in making better use of available data. We do this through our Intelligent Monitoring, provider information returns and data packs. We also follow key lines of enquiry during inspections under both the effective and well-led key questions. We do this to test how well the provider uses data to underpin good decision making, at both the level of the person using the service and at a corporate level.

From next year we intend to take a provider's compliance against new data quality standards into account in our judgements of NHS services. These standards are being developed jointly by the Health and Social Care Information Centre, Monitor, the NHS Trust Development Authority and CQC, informed by Dame Fiona Caldicott's work as National Data Guardian. They will include improvement in the timeliness, accuracy and completeness with which data is entered into electronic records and made accessible to carers and patients. We will also continue to work with our NIB partners to transform health and care services through data and technology and have a lead role in implementing Personalised Health and Care 2020, the government framework for action in this area.

An inspector's view

"They are keeping on top of it, the management team know what is going on… so they know, they can tell you we have had a problem with staffing numbers we have had a lot of sickness and this is what we are doing about it… they are then making sure they are keeping on top of whatever improvements have been made to make sure they are being sustained."

However, if the quality of data were improved it would lead to improvements across all sectors for providers, commissioners, the public and our partners:

- It would enable professionals and leaders to access higher quality data about safety, the experience of people using services, and the outcomes that matter to people using services.
- It would enable professionals to collaborate on continuous improvement with the confidence that they have the data they need to monitor progress, for instance benchmarking data.
- It would be easier to detect unwarranted variations in the quality, equity and efficiency of health and care services. This insight could in turn be used to spread good practice and tackle underperforming services.

The English health and social care sector is not alone in its need to harness data better, and there are emerging examples from other industries and other countries that we can learn from. Our concern is that if we continue to fail to prioritise this, we are never going to be able to get a fair and accurate picture of the real issues affecting the system at national, local and provider levels. Providers and national bodies need to work together to make this happen. With better data we can encourage continuous improvement, detect and respond to unwarranted variation and explain to the public the impact of the changes we are making.

An inspector's view

"That is the first time I have ever seen that kind of thing in any care home ever, where a manager will see a story about a care home in the news, she'll write a quick précis about it and the staff sit and talk about it and say what we can learn from this one. Now that to me is innovative, creative practice."

6. Conclusions

In this report we have highlighted that, despite the increasingly challenging circumstances they are facing, services across health and social care are mostly delivering high-quality care. The majority of the services we have inspected have been rated good, and a number have been found to be outstanding. Where services are performing well, this is often as a result of good leadership.

There remains, however, significant variation in the quality of care across services, and some people still experience an unacceptable quality of care. We are particularly concerned about whether services are routinely ensuring the safety of people who use their services, and whether they are able to provide a consistent quality of care for the varying needs of different groups of people in their area. Where we see unacceptable care, we are increasingly taking enforcement action to protect people using services. We are encouraged, however, by the evidence that services are able to improve following our inspections, and by the positive feedback from providers about how our reports help them improve. Completing our inspection programme in 2016/17 will give us a baseline of all services from which we will be able to measure progress.

Looking ahead, the sectors we regulate face significant challenges. Specifically, in adult social care our concern is that the market could become increasingly fragile over the next few years, while in the NHS our questions are more concerned with whether providers can address the variation in quality while also reshaping care models to provide a more efficient, joined-up service. These concerns are amplified by the finding that many services do not yet have the leadership and culture required to deliver safe, high-quality care that is resilient to the inevitable changes ahead.

The projected shortfall in NHS and adult social care funding creates a powerful impetus for innovation and change in the ways that care is provided. We are highly supportive of the *Five Year Forward View* and the recognition in many parts of the country that the best care systems are those where health and social care go hand in hand. However, to be truly innovative, it is important to be open to the idea that some changes will not succeed, and experience from other industries suggests that new ways of working need iteration and fine-tuning before becoming a sustainable system. Our challenge to all health and social care services, and the system overall, is therefore to continue to put quality of care at the centre of change, and not fall into the trap of seeing innovation as only driven by the need to save money.

Alongside this, we encourage all partners in adult social care to come together and set out a common vision and plan for how to address the current fragility and uncertainty in the adult social care market, and ensure they can continue to provide good quality care to all people using their services.

Soon after this report is published, we understand the Government's spending review will set out plans for mitigating the impact of the national living wage on the care sector. We know that the sectors we regulate are expected to undergo rapid change, and under these conditions there is a risk that the quality of care could become increasingly variable. We will encourage innovation, and work with providers to ensure that this is done in a way that protects the interests of people who use services. Change is vital, but it should not come at the cost of quality, in the short or long term.

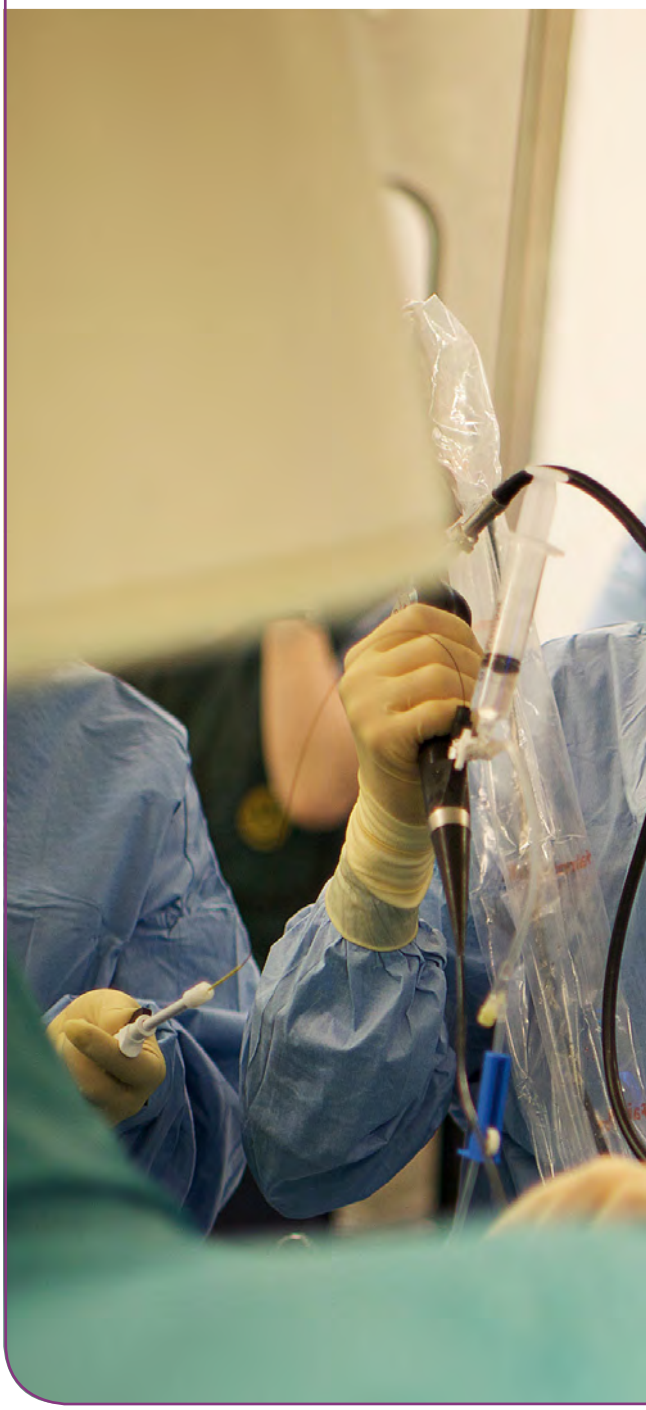
We understand that services are already under significant pressure. To survive and

thrive, sustaining the safe, good quality care that people who use services expect, will require resilience, innovation and great leadership. We therefore encourage services across health and social care, together with their local and national partners, to focus on:

- Building a collaborative culture that reaches out to people who use services and engages with all staff to ensure shared vision and ownership of the quality of care they deliver.
- Being open and transparent and learning from mistakes, ensuring information and data are to hand to make good decisions and to understand what works (and what doesn't), using opportunities to learn from the best.
- Ensuring that services have the right staff and skill mix in place to ensure that care is always safe.

We will continue to enable and encourage all services to improve by providing an honest assessment of the quality of care we see, advocating for better data, and celebrating and sharing learning from outstanding services.

People deserve high-quality services. It is therefore our duty to the people who use services to be open and transparent about the quality of care that we see, and not lower our expectations of quality in the challenging times ahead. There are examples of good services sharing their experiences with those who want to improve. We see this type of collaboration as valuable in improving the quality of care for people who use services. Many services are already achieving high quality and we are confident from what we have seen that others can too.



An inspector's view

"Good managers have a clear action plan, they've identified short, medium and long-term goals and those good managers actually share that with the staff, so that staff buy in to the improvements that are required. It is no good the manager having the action plan in the office and nobody else knows about it."

Part 2
THE SECTORS WE REGULATE

The majority of the organisations inspected and rated are good or outstanding – so far, CQC has rated:

47% of acute hospital trusts

17% of adult social care services

11% of GP practices and GP out-of-hours services

- Adult social care
- Hospitals
- Mental health
- Primary medical services
- Equality in health and social care services

Adult social care

Key points

- The adult social care sector is under pressure and there are issues around the sustainability of provision, due to the increasing complexity of people's care needs, significant cuts to local authority budgets, increasing costs, high vacancy rates, and pressure from local commissioners to keep fees as low as possible.
- Despite this pressure, our inspections to 31 May 2015 showed that almost 60% of services were providing good or outstanding care.
- It is concerning, however, that up to that date 7% of services were rated inadequate. Safety is our biggest concern: of those we inspected, a third required improvement for safety and 10% were rated inadequate for safety. In these services, contributory factors were staffing levels, understanding and reporting safeguarding concerns, and poor medicines management.
- The vast majority of services were caring, with 85% receiving good or outstanding ratings. This is supported by high satisfaction rates of people who use adult social care services.
- Having a consistent registered manager in post has a positive influence on the quality of a service and helps to make sure that people receive care services that are safe, effective, caring and responsive. The outstanding leaders we see are characterised by their passion, excellence and integrity, collaboration with their staff and the provider, and their determination to ensure people's views and wishes are at the centre of their care.

Introduction

Adult social care in England supports people aged 18 or over that have a wide range of care needs. We regulate and inspect:

- More than 17,000 care homes that offer accommodation and personal care for people who may need help to look after themselves. Of these, around 4,700 also provide nursing care.
- More than 8,200 domiciliary care services, which support people with personal care in their own homes.
- Around 2,200 other social care services provided in the community, for example Shared Lives and supported living where people are supported to choose where they live and the particular services they need.
- More than 300 hospices.

The demand for social care is increasing. The numbers of people aged over 85 (the group who are most likely to need care) and older people with a disability are projected to rise sharply in the coming years (figure 2.1).

This rising demand is coming during a time of increased financial strain and concerns around sustainability for the adult social care sector.

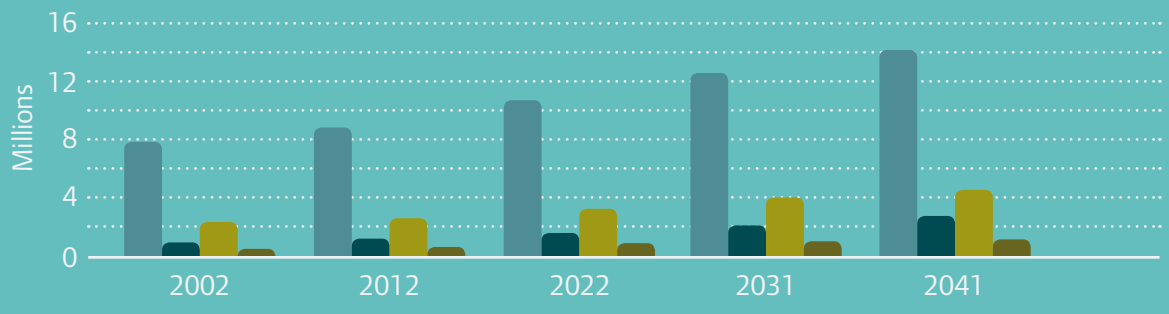
Over the past five years there have been significant cuts to local authority budgets, and as a result the level of public funding available to adult social care has decreased significantly. Figure 2.2 shows the impact of this. Commissioners of adult social care services are under pressure to keep fees as low as possible to enable them to manage increasing demand with reducing budgets.

The national living wage, to be introduced from April 2016, will put further pressure on the budgets of providers and/or commissioners. Analysis for the review that led to the national living wage found that, of all work sectors, social care offers the greatest cause for concern, because wages in the industry already start from a low base and productivity improvements can be difficult to realise.[45]

On top of these pressures, adult social care providers struggle to recruit the staff they need. Vacancies and turnover in the sector are high. For nurses, vacancy rates can be as high as 20% in domiciliary care and 11% in residential care.[46]

Figure 2.3 shows the interaction of high turnover of nurses in nursing and other care homes, and high nurse vacancy rates. It is clear that nursing homes are the most severely affected. Adult social care providers agree that these vacancy and turnover rates are too high, and that there is an urgent need

Figure 2.1 Future projections of numbers of older people



Source: PSSRU Personal Social Services Research Unit 2006: Future Demand for Long-Term Care, 2002 to 2041: Projections of Demand for Long-Term Care for Older People in England

Numbers of older people (65+)
Numbers of older people (85+)
Numbers of older people with some disability
Numbers of older people severely disabled

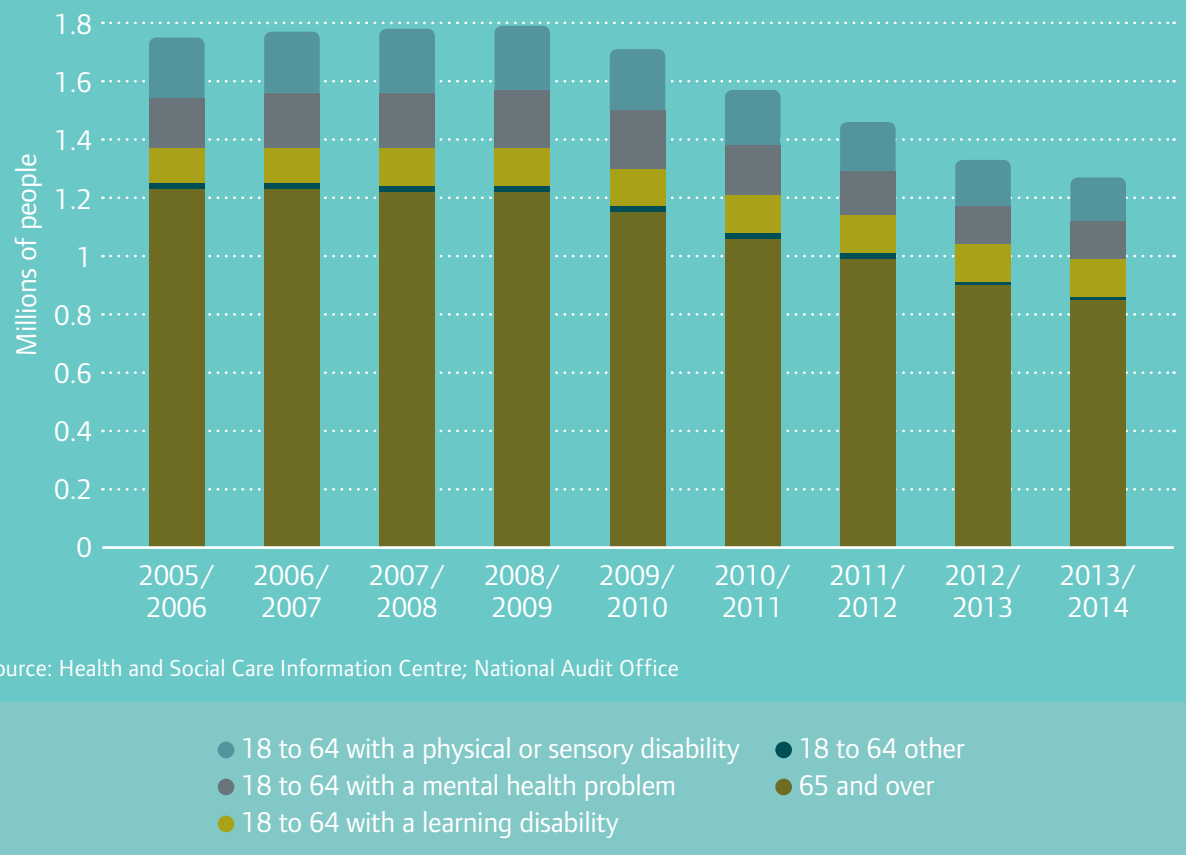
to share and use best recruitment and retention practices throughout the sector. However, provider representatives at CQC's adult social care symposium in July 2015 said that the sector struggled to compete with the NHS in retaining their nursing staff. Our register of providers shows how the social care market is responding to these pressures of demand and resourcing. Over the last five years, there has been a 42% rise in the number of domiciliary care agencies, coupled with a 10% reduction in the number of residential homes (and a 6% reduction in the number of beds) (figure 2.4). We also see a trend of smaller services being replaced by newer, larger ones. Our register shows that the only category of residential homes that has increased between 2010 and 2015 is homes with more than 50 beds. The number of nursing homes with more than 50 beds has also increased over the same period, whereas the number with between 20 and 50 beds has decreased.

Overall quality

By 31 May 2015, we had rated 18% of residential care homes, 27% of nursing homes, 8% of domiciliary care services and 10% of other community services. This gives us an early picture of adult social care, but it is important to note that we have been prioritising those organisations where we already had concerns.

Despite the challenges facing the sector, our ratings so far show that overall most services were providing good or outstanding care. One per cent of these services were outstanding and 59% were good (figure 2.5). The outstanding services that we see have a culture of care that both puts the views and wishes of each person at the centre of their care, and supports staff to deliver that care. Values are embedded in the organisation and demonstrated in practice. Managers make sure their staff receive continuous development and training, and they carry

Figure 2.2 Number of adults receiving local authority-funded social care services

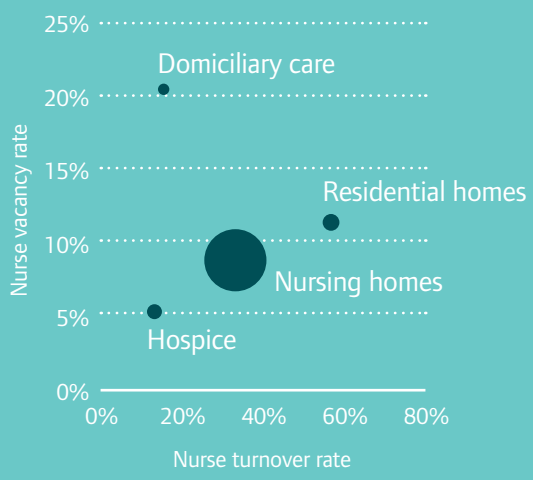


Source: Health and Social Care Information Centre; National Audit Office

out regular audits so that shared learning can prevent future risks to people's safety, health and wellbeing. Staff involve people using the service and their family and carers to develop care plans. They keep plans close at hand and regularly reviewed so that the care being delivered is always reflective of people's needs.

Despite this majority of good care, overall 33% of services required improvement. And there were 320 services that we rated inadequate, which equates to 7% of all those we rated. While we recognise the pressure that the system is under, it is vital that the care delivered is of a quality that people have a right to expect. Where providers are failing to meet legal standards, we act quickly to ensure that people are protected and services improve. In 2014/15 we issued 937 Warning Notices to providers, telling them they needed to make urgent improvements.

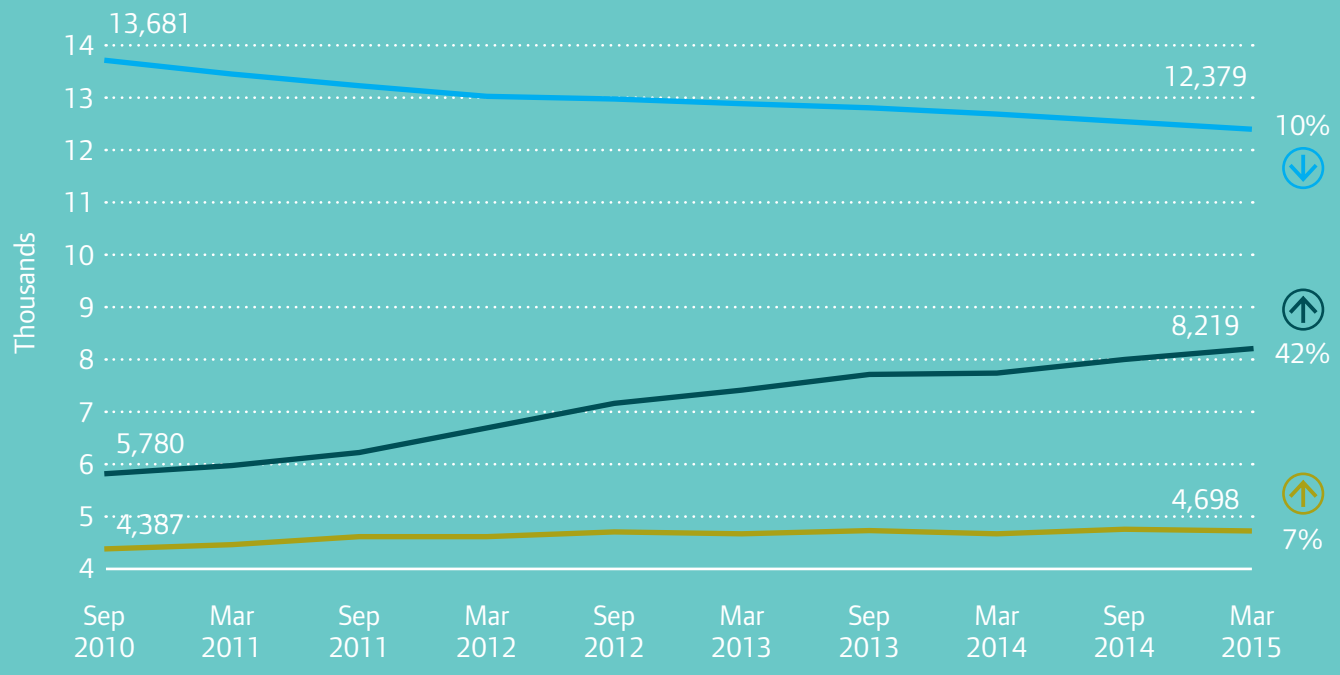
Figure 2.3 Nursing vacancy and turnover rates in adult social care, August 2015



Source: Skills for Care National Minimum Dataset for Social Care

The size of the circles represents the relative size of the nursing workforce in these services. Note that the category of residential homes (that is, mostly 'non-nursing' homes) do sometimes employ nurses.

Figure 2.4 CQC register of adult social care locations by type of service



Source: CQC registration data

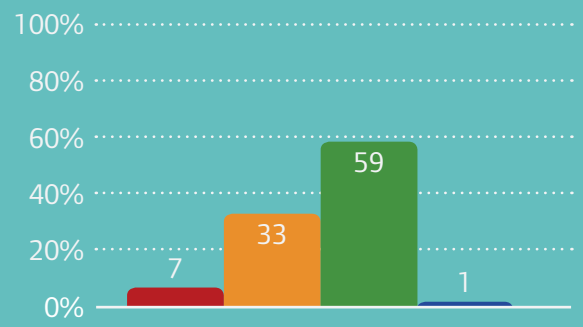
Nursing homes — Residential homes — Domiciliary care agencies

There is evidence that our new inspection regime is already leading to improvement. The re-inspections we have carried out so far have led to 40% of inadequate ratings at service level changing to a higher rating. Twenty-eight per cent of requires improvement ratings at service level have improved on re-inspection

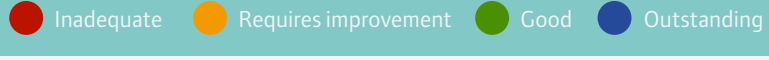
The quality of care in residential care homes, domiciliary care agencies and community services is broadly the same – around two-thirds of services were rated good or outstanding (figure 2.6).

The quality of care in the hospices and Shared Lives locations that we have rated has been good. Up to the end of 31 May 2015, eight out of 27 hospices were rated outstanding, and 17 were good. Of the 14 Shared Lives inspected, 12 were good.

Figure 2.5 Overall ratings for adult social care services



Source: CQC ratings data



An inspector's view

"It was how the people were supported. There were high levels of staff training; the training was just immense really, with staff doing refresher training throughout the year."

More than just a job

Home Instead, West Lancashire and Chorley

Home Instead, West Lancashire and Chorley is an outstanding domiciliary care service where the leadership and culture is a key to its success.

The managers have explained how they try to hold true to the principles (kindness, respect, dignity and compassion) in all that they do. This culture was instilled in the staff too and CQC inspectors saw this for themselves.

Personal touches reflected this. One care worker told a CQC inspector how she ordered books by a particular poet from a library because she was aware that someone in her care told her she loved the writer. Staff were highly motivated and proud of their service, and there were strong links with external organisations and the local community.

A member of staff told the inspector that Home Instead was special because it focused on the little things that matter most, like spending time with people and offering companionship. One person cared for by Home Instead summed up their experience, "I think it's more than just a job to them."

People receive notably poorer care in nursing homes. Only 46% of those we rated were good or outstanding, and 10% of nursing homes were rated inadequate compared with 6% of residential homes that do not provide nursing. Previous editions of our *State of Care* report have identified findings of poorer care in nursing homes, and our new more comprehensive inspections confirm this.

For the homes we have rated, smaller care homes (both nursing and residential) tend to provide a higher quality of care than medium-sized or larger homes (figure 2.7). Again, this corresponds with our findings in previous years, despite the ongoing trend towards larger homes. However, in contrast to the overall picture, we are seeing small nursing homes performing better than small residential homes without nursing. Note, though, that this finding is based only on the inspections conducted so far, and the service profile of smaller homes may differ from larger homes, with for example many more smaller homes providing services for people with a learning disability.

Our very early analysis of domiciliary care services indicates that smaller agencies, that is those providing care to fewer people, tend to achieve higher ratings. However, we need to look at more data before we can say whether there is a correlation.

There are many good adult social care services in every region in England (figure 2.8). However, there are some differences. In the inspections to 31 May 2015, the South East, Yorkshire and Humber, and London contained a higher proportion of services rated inadequate than elsewhere. We will need to carry out further analysis to understand more about these regional differences.

Themes by key question

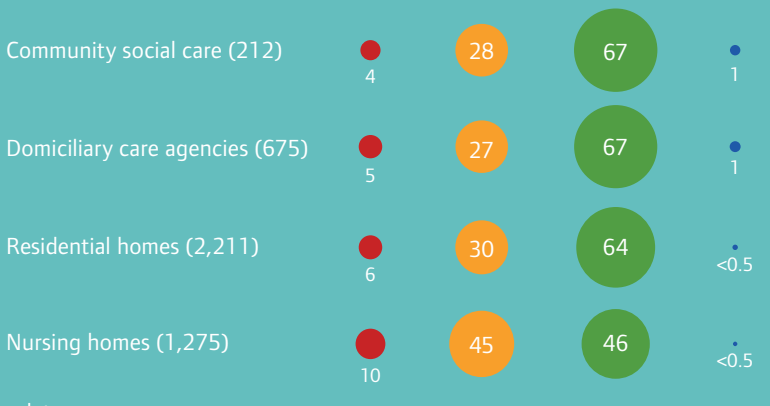
Most adult social care services in England were caring: of those we have rated, 85% were good or outstanding for caring (figure 2.9). Our biggest concerns relate to the safety of services (where 10% were rated inadequate) and to well-led (where 8% of services were rated inadequate).

This profile was similar for all the different types of adult social care. Whether nursing homes, residential homes, domiciliary care or community services, the highest ratings were for caring, and the highest proportion of inadequate ratings were for safe and well-led.

Safe

While 57% of the services we have rated were good or outstanding for safety, there were 33% that required improvement and 10% that were rated inadequate. It is no surprise, therefore, that safety

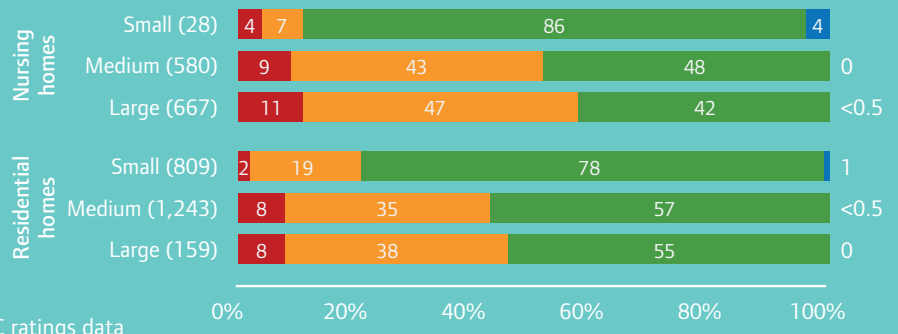
Figure 2.6 Adult social care ratings by service type



Source: CQC ratings data
Note: figures in brackets are numbers of services rated.

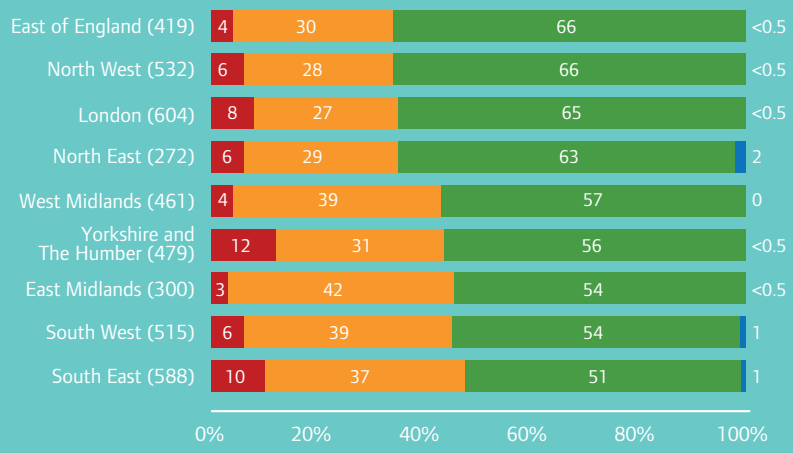
Percentages

Figure 2.7 Overall rating by size of care home



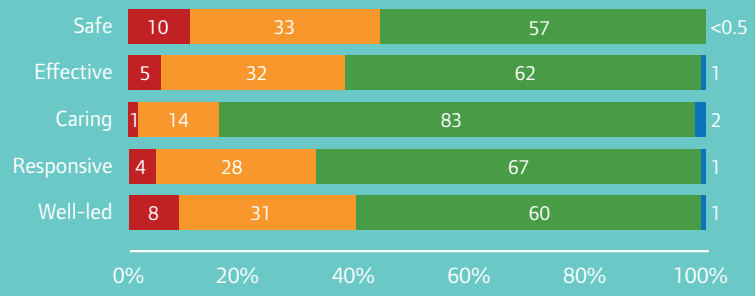
Source: CQC ratings data
Note: figures in brackets are numbers of services rated. Up to 10 beds is categorised as 'small', 11-49 beds is 'medium' and 50+ beds is 'large'.

Figure 2.8 Overall rating by region



Source: CQC ratings data
Note: figures in brackets are numbers of services rated.

Figure 2.9 Ratings for all adult social care services



Source: CQC ratings data

Inadequate Requires improvement Good Outstanding

is the area that we have had to re-inspect the most often. Our inspectors see a number of issues that affect people's safety:

- The number of staff on duty is inappropriate and services cannot show an analysis of people's needs that justifies their staffing.
- Organisations are not appropriately recognising and recording incidents as safeguarding issues; this is sometimes a staff training issue.
- Services rated inadequate and those requiring improvement show weaknesses in follow-up and learning after accidents and incidents.
- There is a lack of knowledge about risk management and reporting of risks.
- Medicines are not administered properly, and some are out of date and not stored correctly.
- Care homes that are rated inadequate or requires improvement are often "smelly" or "dirty" compared with those rated good, which are often "spotlessly clean".
- Essential checks of equipment and the safety of the living environment are either not carried out or acted on, or they are treated as a tick-box exercise.
- A blame culture is associated with poor performance, but a culture of openness and transparency has a high impact on safety – and good performance is associated with management that encourages staff to raise concerns.

Effective

Of the services we rated, 63% were good or outstanding for the effectiveness of the care and support given to people. Thirty-two per cent required improvement and 5% were rated inadequate. Our early findings show that community services achieved the highest ratings for effectiveness, with 72% being good or outstanding compared with only 51% of nursing homes.

As part of our assessment of whether services are effective, we look to see whether staff understand the difference between lawful and unlawful restraint practices. This includes how to get authorisation for a deprivation of liberty. In March 2014, the Cheshire West ruling widened the scope of the Deprivation of Liberty Safeguards (DoLS) and, subsequently, in 2014/15 there were 10 times the number of DoLS applications to the supervisory body compared with the previous year – mainly from care homes to their local authority. This has resulted in a large backlog: by the end of March 2015, more than 56,000 applications received in 2014/15 had not been finalised.[47] Later this year we will publish our separate report on the use in 2014/15 of the Deprivation of Liberty Safeguards.

Caring

In the vast majority of cases, our inspectors see staff who involve and treat people in their care with compassion, kindness, dignity and respect. We rated 85% of the services we inspected as good or outstanding for caring.

These findings are supported by the satisfaction ratings of people using services whose care is funded by a local authority. In 2013/14, 90% of people said they were quite, very or extremely satisfied with their care. Furthermore, over the last four years there has been an increase in people who said they are very or extremely satisfied (from 62% to 65%), and no increase in the small minority saying they were not satisfied (4%).[48]

Responsive

When we ask whether services are responsive, we look at whether services are organised so that they meet people's needs. Despite the pressures that the adult social care sector is under, more than two-thirds (68%) of services were rated good or outstanding for their responsiveness. However, we see that nursing homes struggle more than other services to respond to the needs of the people they care for, with only 58% of good services.

Well-led

Of our five key questions, it was the well-led rating that was most closely aligned to the rating of the service overall.

Sixty-one per cent of adult social care services were rated good or outstanding, and a further 31% required improvement. However, this means that 8% of those we inspected had inadequate leadership.

Our inspectors see a number of common themes underpinning a poor rating for well-led:

- Difficulties in recruiting and retaining managers.
- A lack of capability in some managers, and managers that are not sufficiently visible to staff or the people using the service.
- Poor engagement with staff and people who use services, with managers not aware of, or close to, the day-to-day issues in the service.
- A poor culture in the organisation that does not bring everyone together to share learning and promote improvement.
- Managers that do not proactively support staff development.
- A lack of systems and processes to monitor the quality of care being given to people.
- Financial management that over-emphasises profit to the exclusion of care improvement.

Our findings are starting to show, and the sector also recognises, that a vital aspect of being well-led in adult social care is having a registered manager consistently in post. This has a positive effect on quality: a good manager can inspire staff with the right values, promote a culture of care and compassion, and make a real difference to people's lives. Services that went for six months or more without a registered manager had considerably lower ratings than others. In addition, services with two or more registered managers leaving in a 12-month period had a slight tendency towards lower ratings than those with less managerial turnover.

We have also explored with our inspectors what they see that makes outstanding leadership. Central to successful leadership is putting people at the heart of services and creating an environment where they really matter to the staff and managers who care for them. Our inspectors say that in the services that deliver excellent care, providers and managers:

- Promote an open culture, where any issues can be raised freely by people who use services or staff and are addressed quickly.
- Work well with local care partners and have strong links with the wider community.
- Develop a culture of continuous improvement – seeking to recognise, celebrate and share good practice.

An innovative provider that puts people first

Equal Partnerships, North Tyneside

Equal Partnerships provides personal support to people who have a learning disability and live in their own home in the North Tyneside area.

This is an innovative care service that could demonstrate the ways it puts people first, such as involving them in the recruitment of new staff. And Equal Partnerships runs a flexible staff rota that allows people living at the home to choose what they want to do.

This service provider was dynamic. Rated outstanding by CQC, its staff supported people with a learning disability who live at home to have flexibility in their lives, just like anyone else.

Equal Partnerships had a dedicated staff team for each person it cares for, and they worked out a weekly plan based on what the individual wants to do each day.

The recruitment policy at Equal Partnerships specifies that people using the service should always be involved in the interview process. Inspectors saw that initial interviews and a shortlisting process were always inclusive. One relative explained, "They put people first. When my son needed a new key worker, they let him write his own advertisement and run the interview. They support, but they don't take over."

Being creative with person-centred care

Prince of Wales House, Ipswich

Prince of Wales House in Ipswich is an innovative and creative care services rated outstanding by CQC. It gives personal care for up to 49 older people, including specialist care for people with dementia.

Inspectors described a clear commitment by managers to continually improve and they were impressed by the strong and visible leadership. Described as a 'whole team approach', staff were motivated by a strong culture of inclusivity and work in a vibrant and friendly environment.

The culture at Prince of Wales House was an important factor. Staff told inspectors that the management inspire confidence and that they lead by example.

The care was person-centred with a planning process that considered individuals and their views and preferences. Inspectors saw 'My Story' booklets that give a detailed biography of a person's life so far – these are being developed to include people's current interests and relationships, with the clear message that their lives do not stop when they move into this care service.

Our challenge to the adult social care sector

- Use our inspections and assessments to help your service to improve. We are here to help you take the steps towards improvement.
- Recognise the importance of recruiting strong leaders, and give them and their staff the support, training and professional development they need to carry out their roles.
- Services must have a registered manager consistently in post, as this has a crucial influence on the quality of a service. We take action when services that require a registered manager do not have one.
- The sector is under pressure and there are issues of sustainability, due to increasing demand and costs. There is variation across different types of service and across regions. Sector-led improvement needs to focus on reducing that variation, so that everyone using social care can be confident of receiving safe, compassionate and high-quality care.
- Providers and commissioners should review our findings so far on the quality of different types of care provision, alongside market trends such as larger care homes. It is of utmost importance that responses from local services to financial pressures do not increase the risks to people's health, safety and wellbeing.
- Recruitment and retention of staff, particularly of nurses and care support workers, remain a serious challenge in the adult social care market – one that the whole system, including Health Education England, needs to tackle. We should build on the positive work happening across the country to promote adult social care as a career that makes a difference to people's lives, with a particular focus on reducing the nursing vacancy rate.

Hospitals

Key points

- We have seen some examples of outstanding care despite increased demand for services and challenging efficiency savings. However we have also seen some very poor care. We are concerned that there is too much variation in the standards of care provided within and between trusts.
- The differentiating factors between trusts that are rated outstanding and those rated inadequate are their ability to monitor and act on issues that are identified, sharing the learning from incidents, having a strategy that is communicated and understood by all staff, and promoting a culture of openness.
- We have concerns about the leadership and culture in many trusts. Consistent, good care throughout an organisation can only be achieved by excellent leadership and inclusive staff engagement.
- Of the five key questions we ask of services, safety remains our biggest concern for the sector.
- Staffing levels and skill mix remain an issue in many hospitals.

Introduction and context

Acute healthcare providers in England deliver emergency treatment, medical care, surgical intervention and diagnostic services. Last year, in the NHS alone, there were 22.3 million A&E attendances, a rise of 25% over the last 10 years. There were also 5.5 million emergency admissions to hospital, an increase of 8% since 2011/12. The sector is expected to adapt processes and pathways to better manage the increasing demand, at the same time as achieving ambitious efficiency savings.

We inspect and rate all NHS hospitals and independent hospitals in England. We use a national team of expert hospital inspectors, clinical and other experts (specialist advisors), and people with experience of receiving care (Experts by Experience).

Last year, we prioritised the inspection of NHS acute trusts where our Intelligent Monitoring system showed indications of concern. We began our new approach to inspection in September 2013. By 31 May 2015, we had inspected 47% of acute trusts in England, and inspected several twice due to specific concerns.

We will have inspected all acute trusts by March 2016 and all specialist trusts by June 2016. In autumn 2014, we extended our approach to include independent hospitals as well as NHS trusts. Independent hospitals are now rated in the same way as NHS hospitals, at both hospital and core service level. We have found that our inspection approach works equally well in this sector although – despite some notable developments that are starting in the Private Healthcare Information Network – independent hospitals are still not consistently able to provide robust, comparable data on the quality of care that we can take into account alongside observation, interviews and documentation.

Despite the very real challenges facing acute hospitals and the complexities of how they deliver services, we have seen how outstanding innovation is improving patient care. We have been pleased to give outstanding ratings to two trusts: Salford Royal NHS Foundation Trust and Frimley Park NHS Foundation Trust.

However, we uncovered some very poor care and as a result put a number of NHS trusts into special measures in 2014/15 to ensure they improve.

Fourteen trusts were in special measures at the start of 2014/15, 11 of which had been put into special measures in July 2013 following the Keogh reviews. During 2014/15 a further seven trusts were placed in special measures on the recommendation of the Chief Inspector of Hospitals, following an inadequate rating (figure 2.10).

Five of the initial group of trusts exited special measures following re-inspection by CQC in 2014/15. A further three trusts have subsequently exited – two following re-inspections and one (Heatherwood and Wexham Park) following acquisition by Frimley Park. The outcomes of re-inspections of several more trusts are pending.

Commitment to an open reporting culture

Salford Royal NHS Foundation Trust

Salford Royal NHS Foundation Trust is an integrated provider of hospital, community and primary care services, including the University Teaching Trust. We rated the trust as outstanding.

We found strong leadership, the commitment to be transparent and learn from mistakes, and good staffing to be the foundations of their outstanding rating.

The trust was particularly good at learning from incidents and from patient experiences. A strong, open reporting culture means that incidents were investigated robustly and lessons and action plans are implemented and monitored.

For example, the clinical governance programme, led by the director of nursing, was very strong. Ward clinical standards were assessed through the trust's nursing assessment and accreditation system that measured the quality of care delivered by teams. The score for each ward was then displayed for patients to read. Staff also spoke positively about ensuring that patients received safe, clean and personal care every time.

Quality improvement was a clear focus for the trust through collaboration across all staff groups and a clear vision and strategy. Staff spoke positively about the engagement of the management team, which enhanced a culture of innovation.

Wards were well staffed and staff worked flexibly to ensure any shortages were covered. The trust had some of the best scores in the country on the staff survey, and these views were clear to see during the inspection.

Overall ratings

With almost half of all NHS trusts inspected by 31 May 2015, plus a rapidly increasing number of independent hospitals, we are building up the strongest ever picture of the quality of services in acute settings. Last year we reported that there was too much variation in the standards of care between trusts. This year, our further inspections have confirmed this.

Between the launch of our new approach and 31 May 2015, we have inspected and rated 150 NHS and independent acute hospitals. Of these, two (1%) were rated outstanding, 51 (34%) were good, 85 (57%) required improvement and 12 (8%) were rated inadequate (figure 2.11).

The overall ratings in the sector show a lower proportion of good and outstanding ratings, compared with primary medical services and adult social care. However, the aggregated ratings at trust level mask the substantial variation among individual hospitals, and similarly for the variation of individual core services within a single hospital.

Continuous improvement

Basildon and Thurrock University Hospitals NHS Foundation Trust, Essex

Strong leadership, alongside innovative staff development, continues to help change the culture at Basildon and Thurrock University Hospitals NHS Foundation Trust in Essex.

The trust was placed in special measures in June 2013, but within a year it had improved significantly and was rated good by CQC, with a recommendation to come out of special measures. We then conducted a follow-up inspection in March 2015, and the trust continues to improve.

The trust has a strong, visible and respected leadership team with a vision to have "care and compassion at the heart of everything we do". Many of the staff spoke about the executive team with enthusiasm and respect.

Staff development and support was highlighted in our latest inspection. A new initiative to help develop medical staff in A&E to progress their career to consultant level was seen to be a very innovative response to a national shortage of emergency department medical staff.

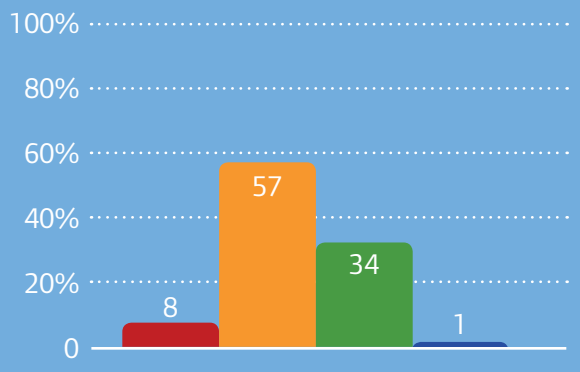
Staff were also very aware of their responsibilities and were engaged with the trust's processes. Those working in the medical care areas were very well prepared for major or emergency incidents.

The trust was committed to continuous improvement, for example increasing skill mix and staffing levels in the critical care unit, in order to build on the achievements demonstrated so far.

Figure 2.10 Trusts in special measures – April 2014 to August 2015

	Entry	Exited April 2014 – March 2015	Exited April 2015 – August 2015
Basildon and Thurrock University Hospitals NHS Foundation Trust	July 2013	●	
George Eliot Hospital NHS Trust	July 2013	●	
Buckinghamshire Healthcare NHS Trust	July 2013	●	
North Lincolnshire and Goole NHS Foundation Trust	July 2013	●	
East Lancashire Hospitals NHS Trust	July 2013	●	
United Lincolnshire Hospitals NHS Trust	July 2013		●
Burton Hospitals NHS Foundation Trust	July 2013		
Tameside Hospital NHS Foundation Trust	July 2013		
North Cumbria University Hospitals NHS Trust	July 2013		
Sherwood Forest Hospitals NHS Foundation Trust	July 2013		
Medway NHS Foundation Trust	July 2013		
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	October 2013		●
Colchester Hospital University NHS Foundation Trust	November 2013		
Barking, Havering and Redbridge University Hospitals NHS Trust	December 2013		
Heatherwood and Wexham Park Hospitals NHS Foundation Trust	May 2014		●
University Hospitals of Morecambe Bay NHS Foundation Trust	June 2014		
East Kent Hospitals University NHS Foundation Trust	August 2014		
Wye Valley NHS Trust	October 2014		
Hinchingbrooke Health Care NHS Trust	January 2015		
Norfolk and Suffolk NHS Foundation Trust	February 2015		
Barts Health NHS Trust	March 2015		

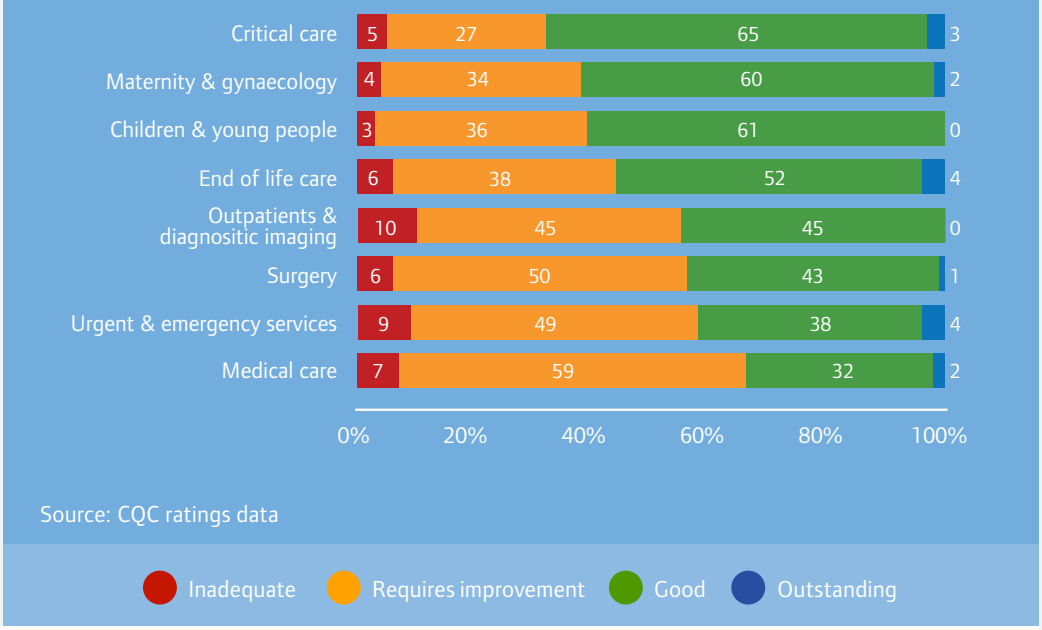
Figure 2.11 Acute hospitals overall ratings



Source: CQC ratings data

Inadequate Requires improvement Good Outstanding

Figure 2.12 Acute hospital overall core service ratings



What we see in trusts that are rated outstanding

- A culture of openness built around embedded values.
- Strong leadership and teamwork at all levels of the organisation and engagement with staff in identifying and implementing improvements.
- A clear vision and long-term plan for the trust and for individual services.
- Joined up working with the public, ensuring patients and carers are always placed at the centre of care, and are actively engaged and consulted on new developments.
- A culture of consistently focusing on patient safety and learning from errors.

What we see in trusts that are rated inadequate

- Failure to carry out basic safety checks and effectively learn from errors.
- Low staffing numbers and poor skill mix, which affect the trust's ability to deliver safe care.
- A culture where frontline staff are unable or unwilling to raise concerns about patient care.
- Poor patient flow, inappropriate admissions and delayed discharges.
- Day-to-day crisis management rather than long-term planning.
- A history of the leadership team taking false assurance from inadequate information.
- Poor leadership and teamwork in clinical teams that is not being addressed effectively.
- Weak relationships with external stakeholders.

In each acute hospital inspection we look at eight of these core services (where they are provided) and aggregate them to give each separate hospital a rating. The hospital ratings are in turn aggregated to give an overall trust rating. A trust can therefore include many services that are good (or outstanding) but overall be rated, for example, requires improvement because there are enough services with lower ratings to affect the overall rating.

We find significant variation within trusts – for example, we may find good children's services in trusts that are otherwise rated inadequate. Because of this variation in the quality of care across their services, many trusts do not achieve an overall rating of good or outstanding.

Figure 2.12 shows the quality of care in the eight core services. Nationally, critical care offers the highest quality (68% were good or outstanding), while the strongest need for improvement is in medical care (34% were rated good or outstanding).

Urgent and emergency care has the joint highest proportion of outstanding ratings (4%) but also the second highest proportion of inadequate ratings (9%).

The quality of medical care and surgery are the strongest indicator of the quality of the hospital overall, with these services most closely aligned to the hospital rating.

At trust level, there are slight differences between the overall ratings of acute foundation and non-foundation trusts. Of those we inspected up to 31 May 2015, we rated 5% of foundation trusts as outstanding; none of the non-foundation trusts were outstanding. On the other hand, 13% of foundation trusts were rated inadequate overall, compared with 10% of non-foundation trusts.

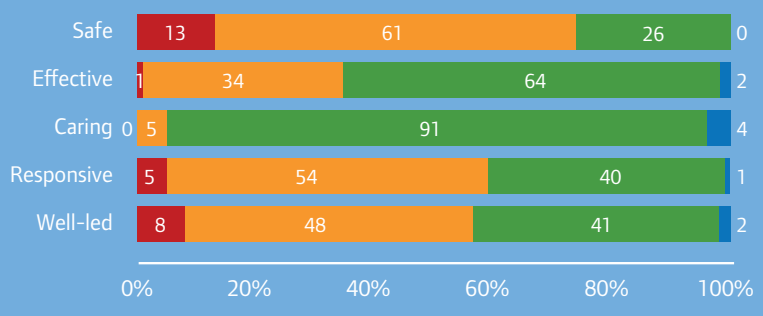
We have also found a relationship between our quality ratings, the level of confidence that patients report in their doctor (from the 2014 NHS inpatient survey), and whether staff would recommend their trust as a place to work or receive treatment (from the 2014 NHS Staff Survey). This shows that the views of staff and patients are good indicators of quality: providers should be taking this feedback very seriously.

Our ratings confirm the wide variation in the quality of care in NHS trusts. We see excellent care that is truly outstanding. But we have been surprised at how truly poor the care can be in those services that we rated inadequate.

Ratings for the five key questions

The safety of services remains our biggest concern. Only 26% of trusts were rated good for safety, and there were no trusts that were rated outstanding (figure 2.13). Sixty-one per cent were rated as requires improvement and 13% as inadequate for safety.

Figure 2.13 Hospitals key question rating



Source: CQC ratings data

Inadequate Requires improvement Good Outstanding

Trusts also need to improve in terms of their responsiveness and leadership. Most worrying is that 8% of trusts were inadequate in terms of being well-led.

Services received high ratings for being caring, with 91% rated as good and 4% outstanding. No trusts have yet been rated inadequate for caring.

Safe

By the very nature of hospital services, patients tend to be at a higher risk than in other sectors. Care is complex and varied, and hospital stays mean additional risk factors must be considered, such as falls, pressure ulcers and hospital-acquired infections.

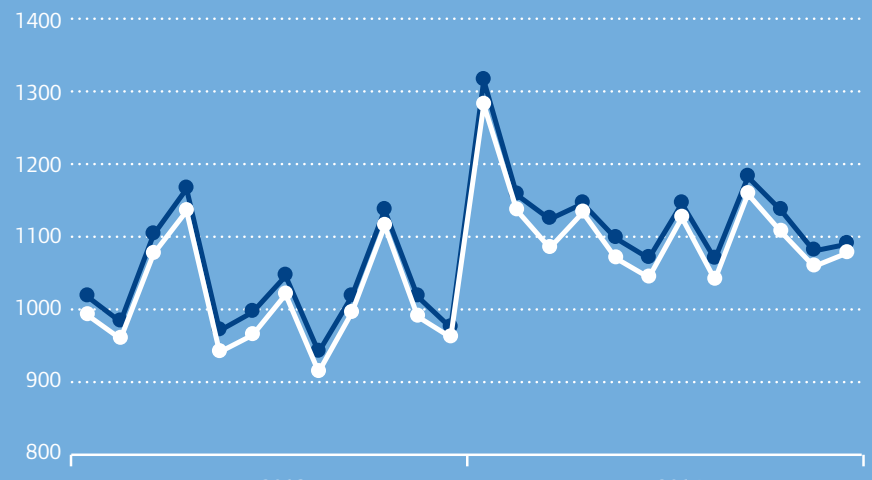
Safety in this environment requires comprehensive processes involving multiple specialisms. However, our inspections have highlighted examples of poor safety cultures, a lack of processes and, in some cases, disregard for patients' safety. In particular we have seen:

- Incomplete safety checks and audits
- Staff not receiving essential training and not undertaking mandatory courses
- Inadequate management of medicines
- Ineffective record keeping.
- Poor management of patients at risk of health complications and ineffective use of the national early warning score (NEWS) system.
- Disregard for infection control practices.
- Unsafe patient streaming processes, for instance non-medically trained staff such as A&E receptionists triaging patients.

The acute sector reported 10% more serious incidents between 2013 and 2014 (figure 2.14). We believe this was primarily a result of the Francis inquiry into Mid Staffordshire NHS Foundation Trust, which made recommendations to include openness, transparency and candour throughout the healthcare system. The rise in reporting is evidence that some hospitals are responding to this need to have a more open, transparent safety culture.

We have found, however, significant inconsistencies in the reporting and investigation of incidents, as well as delays and poor escalation of issues. We have seen poor governance processes where risks were not reported and monitored effectively. In some cases the safety and risk system itself was not fit for purpose as it only looked at trust level and did not reveal local issues. This sometimes left the governing bodies unaware of incidents.

Figure 2.14 Acute hospitals serious incidents 2013 to 2014



Source: STEIS data 2013-14

All serious incidents including never events

Serious incidents without never events

Across the sector, trusts have safety and risk management systems of varying quality, but what differentiates providers is their ability to share the learning, act on the issues and concerns that are identified and seek the input of multi-disciplinary colleagues.

In the outstanding trusts, staff actively participate in audits by monitoring patient outcomes and sharing the learning across the trust. Also, staff are confident in reporting incidents, and investigations are carried out impartially. Risks are identified early and detailed reporting dashboards allow monitoring and review of progress. The whole safety and risk management system is further bolstered by good 'board to ward' and 'ward to board' communication.

In trusts rated inadequate, or those that require improvement, there is limited cross-learning between and within departments, with low awareness of improvements that have taken place. After issues are identified there is often a lack of clear plans or proposals for how and when the issues will be addressed.

A major reason for failings in safety is insufficient numbers of staff and use of temporary staff. This is particularly prevalent in medical care departments, where key safety risks are not always recognised, patient assessments can be poorly carried out and deteriorating patients are not always recognised.

There has been some evidence that the special measures regime for trusts has led to improvement. In February 2015, Dr Foster reported that death rates had fallen across all English hospitals since July 2013 but that the downward trend was more pronounced at the group of 11 trusts that were put into special measures in 2013. The rates had decreased by 9.4% in the trusts in special measures, compared with a 3.3% decrease nationally.

Effective

Our inspections have shown that trusts have increased their participation in external benchmarking of outcomes, such as through national clinical audits. However, the results of these audits are not always reported at board level and there is sometimes not enough focus on addressing poor results. Clinical audit programmes and addressing locally-identified clinical risks are much less consistent and are frequently not monitored or managed effectively. Often there is little evidence that they are being used as part of a quality improvement programme.

Most of the core services we have inspected have good systems in place to ensure that evidence-based clinical guidelines are available for clinical staff. However, they are not always updated in a timely way and there are often no audits in place to make sure they are being implemented.

We have seen variable staff understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). In a number of cases, staff did not understand how they should be applying the requirements of the MCA as a whole, or the DoLS in particular, in their roles. In some cases, there was a lack of adequate training for staff in these areas. There was varied understanding, for example, of when an assessment of capacity needed to be made and how a decision was to be made in a patient's best interests under the MCA, when they did not have capacity to consent to treatment. In some instances, staff could not describe when a DoLS application may be required.

There is a growing call for hospitals to move to a full seven-day working service, and we have seen some initiatives where trusts are adapting their business models. However, it is clear that in order to provide a consistent service over the complete week, considerable investment may be needed in support and diagnostic services and social care services, as well as basic medical or nursing care.

Caring

The one-to-one care in hospitals is almost always caring, with staff treating patients with respect, dignity and compassion. In particular, intensive care, services for children and young people, and outpatients achieve good or outstanding ratings for this key question.

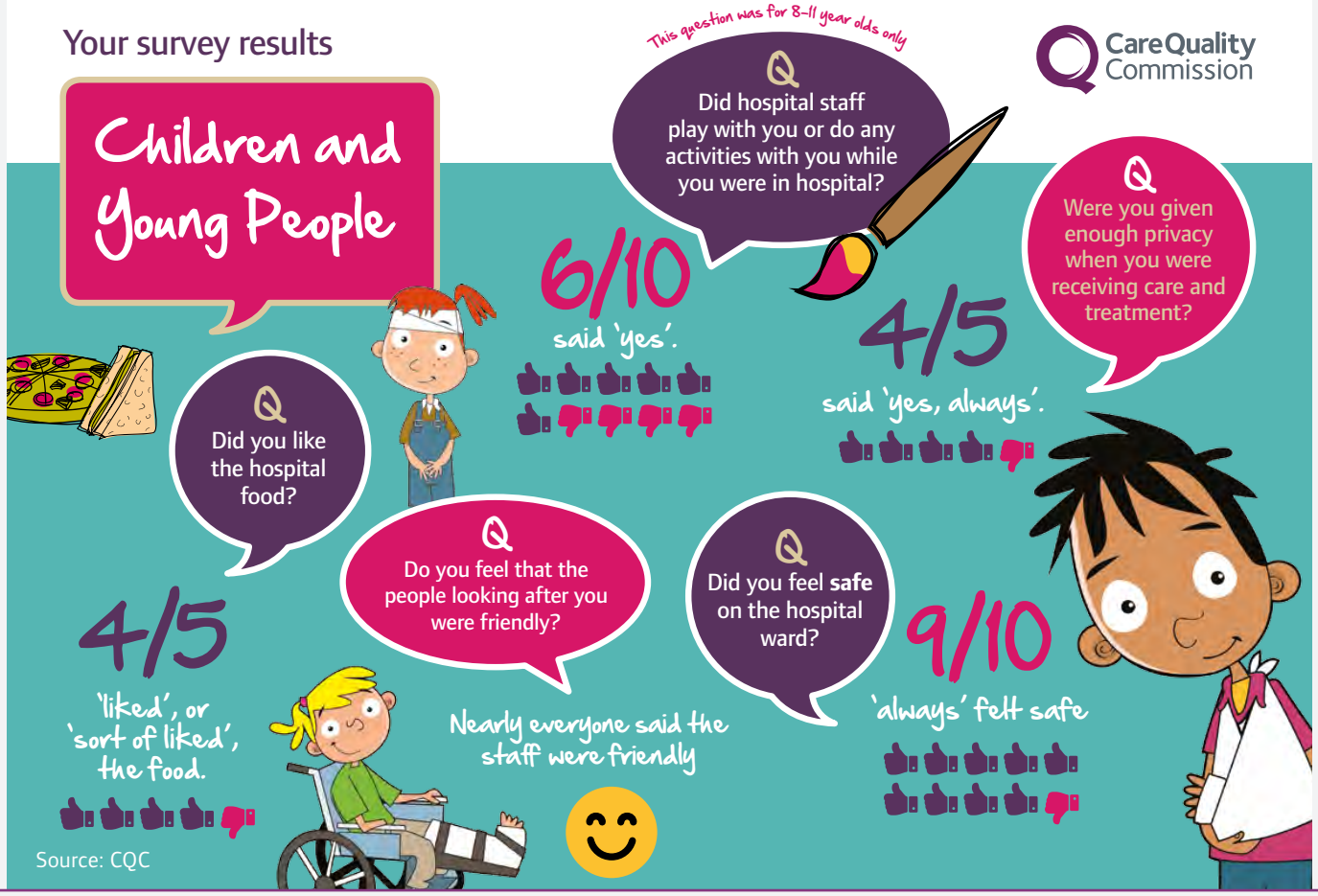
In inspections so far, maternity, surgery and medical care have been the only services to show variation across providers of acute care. Two trusts received a rating of inadequate for being caring in one or more core service.

In August 2014, we carried out the first national survey of children and young people about their hospital experiences (figure 2.15). We received responses from 7,000 children and young people and from more than 12,000 parents and carers.

The results were largely very positive – nearly all of the young people said that staff were friendly, and eight out of 10 children said staff talked to them in a way they could understand. However, we did find that children with a learning or physical disability, or a mental health condition tended to have poorer experiences of care in hospital.

We also uncovered differences by ethnicity when we surveyed the experiences of adult inpatients in 2014. Our findings indicated that White people are significantly more likely to report being treated with dignity and respect than Asian and Asian British people. Similarly, the Cancer Patient Experience Survey 2014 told us that White people are more likely to rate their overall care as excellent or very good (figure 2.16). We explore these issues further in our 'Equality in health and social care services' section.

Figure 2.15 Children and young people's survey of their experiences in hospital, 2014



Responsive

Responsive services are those that are organised so that they meet the needs of their patients.

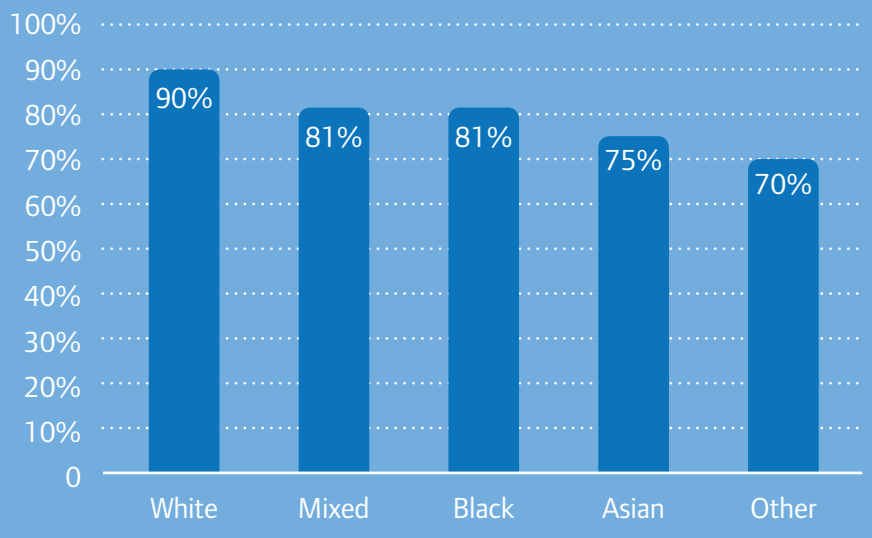
It has been widely documented that, across England, there is a growing increase in the number of A&E attendances and also hospital admissions (an average rise of 3,500 admissions a week in the last year), which has called for a review of patient flow and redesign of care pathways.

Despite the efforts of the majority of trusts, we have continued to see problems with patient admissions and discharges in some cases. High levels of delayed discharges and high bed occupancy rates (consistently above 85%) often lead to patients being cared for on the wrong ward in line with their condition. This, in turn, can lead to missed medical reviews and further delays in discharge.

We saw great variability in the extent to which trusts were actively managing the problem of delayed discharges. Too many regard it as unsolvable.

We also observed capacity issues resulting in long A&E waits and patients being left on trolleys for significant periods. In particular, during the winter of 2014/15, many A&E departments were working under considerable pressure because of an increase in attendances, admissions and acuity of the patients attending. There was, in a number of cases, little evidence that sufficient forward planning had taken place to meet this demand, despite the increase in attendances being generally predictable. Failure to plan ahead led to many hospitals resorting inappropriately to day-to-day crisis management. Some hospitals we inspected had been on the highest level of escalation for weeks. In some organisations we found that the senior management and board members did not put enough focus on the flow of patients through A&E and a degree of acceptance that waiting times would be affected by winter pressures.

Figure 2.16 Cancer patients' reporting of their quality of care by ethnicity



Source: Cancer patient experience survey 2014

Well-led

Good leadership at trust level and clinical team level is essential to provide safe and high-quality patient care. We have found problems at both these levels, often co-existing in the same trust. We find that leaders are frequently unaware of the problems that we find with regard to quality of care, or they are not taking the appropriate action. And there is also a lack of focus on creating the right culture, that emphasises evidence from embedding the values, encouraging transparency and openly apologising when things go wrong.

Where we see good leadership in hospitals, important factors are:

- Strong leadership with a culture of transparency where staff are valued for openly sharing concerns and reporting incidents or near misses.
- Clear lines of accountability and responsibility in all roles.
- Always putting patients first and working with other departments to maximise patient outcomes and experiences.
- Continuous learning, regular appraisals and support to develop specialist and advanced skills.
- Encouragement of all staff to participate in innovative improvements and embed the trust's values.

In our joint report with Monitor and the NHS Trust Development Authority published in August 2014, we reviewed progress in 11 of the first 14 hospital trusts that we put into special measures as a result of the Keogh review into high mortality rates.[49] Of the four factors identified as important in those that had improved, three of them related closely with being well-led: strength of leadership within the trust; acceptance of the scale of the challenges faced by the trust; and alignment or engagement between managers and clinicians.

An inspector's view

"You can often see there is a delay: the trust's very senior staff seven or eight months ahead of the ground staff, they actually think that's been embedded – implementation of policies. But actually when you get down to the ward it's not been implemented, staff don't really know about it. They're disconnected. But where it's good, the work that's gone on is properly translated, embedded and reviewed."

Outstanding multi-disciplinary teamwork

Frimley Park Hospital NHS Foundation Trust, Surrey

When we inspected Frimley Park Hospital NHS Foundation Trust in Surrey, the strength and depth of leadership at both board and ward level was outstanding. One of the most striking aspects was the way that teams worked together across the trust, and with other providers, to make sure that people were getting the best possible treatment and care.

Frimley Park was rated as outstanding in September 2014 – the first acute trust to receive the top rating.

A strong patient-centred culture was evident at all levels. Public engagement was seen as essential in developing services for the communities that the hospital serves. Gaining feedback from patients and their relatives was a priority and the trust used this to improve the care it delivered.

Inspectors saw multiple examples of how services had changed care delivery based on public feedback or working with the local community. The trust had worked hard to support patients whose situations made them vulnerable, such as those living with dementia or a learning disability.

The trust consistently demonstrated a strong safety culture, which was well embedded and a priority for staff at all levels. Learning from events was encouraged, and there were multiple examples where services had been improved as a result.

Staff and patient engagement at the trust were also outstanding. The leadership team were authentic, strong and effective, and at all levels staff reported feeling empowered to develop their own solutions to improve services. There was a strong sense of support and alignment between clinicians, managers and the executive team, who worked well together to deliver outstanding patient care.

Since our rating, the trust has acquired Heatherwood and Wexham Park Hospitals NHS Foundation Trust. They are focusing on clinical leadership to extend their culture of learning with an emphasis on values and support of frontline staff.

In contrast, evidence from trusts rated inadequate included:

- Staff that feel discouraged to report incidents due to a lack of follow-up action or feedback from incidents. Also, staff that are generally reluctant to speak out because they are afraid of repercussions, especially in trusts that are smaller in size.
- A culture of bullying in some cases.
- Low levels of annual appraisals and monitoring of staff needs.
- Frequent changes to management that lead to a lack of engagement and support, making it difficult for staff to develop plans for the future.
- A lack of understanding and following best practice guidelines.
- A lack of vision or long-term planning for the future of clinical services.
- Staff that feel well-supported by immediate line managers, but disconnected from the executive team.
- Inadequate challenge by non-executive directors and, for foundation trusts, governors.

Where we find good services in an otherwise poor trust, this is invariably down to excellent local leadership. What is disappointing is that trusts often do not recognise their own individual successes and share the learning from them among all staff. Leaders in NHS organisations need to demonstrate a commitment to developing a culture that delivers continually improving, high-quality patient care. They must:

- Identify clear objectives in collaboration with staff throughout the organisation.
- Develop multiple avenues for staff engagement and two-way communication.
- Support learning and innovation in all staff.
- Encourage teamworking.

An inspector's view

"There was lots of discussion with all staff involved, sharing learning and allowing staff to openly contribute."

Our challenge to the hospitals sector

- Move your focus from developing individual, short-term quality initiatives to creating the right culture in which staff are able work with autonomy and confidence. Adopt strong values and embed them into your decision-making processes.
- Focus on creating a culture of openness where staff feel empowered to raise issues and make suggestions for improvement, knowing they will be valued
- Patients must be able to complain with the confidence that they will be listened to, and you should actively reassure patients that raising a complaint will not negatively impact on the standard of care they receive.
- Use the findings from your staff surveys to improve morale and encourage continuous two-way communication.

Mental health

Key points

- Across the eight NHS mental health trusts that we rated by 31 May 2015, we rated the individual core services mostly as good (65%) or requires improvement (31%).
- There are some excellent examples of local leadership (for example ward managers), but we found that some boards were unaware of whether their decisions were having any impact on frontline services.
- Our biggest overall concern is the safety of care environments, particularly wards. These are not good enough and are creating risks to patients.
- Our report, *Right here, right now*, highlighted that the attitudes of staff can have a big impact, particularly for those in crisis. All staff, from receptionists to GPs and A&E staff, need to treat people with mental health problems with the kindness, dignity and respect they would provide to people with physical health needs.
- Access to beds, particularly in child and adolescent mental health services, continues to be a problem and leads to people being placed hundreds of miles away from their families.

Introduction and context

Mental illness is the single largest cause of disability in England. It accounts for 23% of the total burden of disease in this country – more than either cancer or heart disease.[50, 51] Despite this, recent estimates are that spending on mental health services forms just 11% of the NHS budget.[52]

As signalled in the NHS *Five Year Forward View*, the Mental Health Taskforce was launched in March 2015 to explore the availability of mental health services across England, look at the outcomes for people using these services, and identify key priorities for improvement. As part of their work, the Taskforce collected the views of 20,000 patients, carers, healthcare professionals and the public on the reshaping of mental health services. The top five calls for change by 2020 were: better access to high-quality services, a wider choice of treatments, more focus on prevention, more funding and less stigma.

The landscape of mental health care in England is complex. We register and inspect mental health NHS trusts, independent mental health hospitals and substance misuse services. These organisations care for people with a wide range of mental health needs in a variety of settings from community and residential care to crisis care services and detention under the Mental Health Act 1983 (MHA).

This landscape is also evolving. Organisations that were once traditionally just mental health services are now also managing, for example, dental surgeries, GP surgeries, community health services, care homes and healthcare services in prisons. In some instances, these are spread across the country, challenging organisations' capability and expertise to manage them.

Within this complex picture, we are continuing our work to better integrate our functions under the MHA and the Health and Social Care Act 2008. As part of this, every CQC comprehensive inspection of a service where there are detained patients includes a Mental Health Act Reviewer. The Reviewer looks at the way the provider discharges its duties under the MHA overall. We have seen pockets of good practice in the way that services use the MHA, but we have had to ask some providers to improve their governance systems and processes to make sure that the care and treatment they provide is in line with the Code of Practice and patients' rights.

In July 2015, with partners we published an update on how we are working together to make sure people with learning disabilities and/or autism, and those with challenging behaviours, get the best care possible in settings that are most appropriate to them.[53] This follows Sir Stephen Bubb's independent review into the future care of people with learning disabilities. We are further developing our work on registration, to make sure that inappropriate models of care do not continue after providers have applied to vary the type of service that they want to offer, and for new applications to only be approved if they reflect an agreed model of care.

Through our inspections we are forming a better picture of the state of mental health care in England. It is important to note, however, that due to the low volume of ratings published to date, we have limited data available so far under our new approach to inspection. As a result, the themes emerging in this report are based on our inspection report findings and evidence from our inspectors.

Overall ratings

Of all 57 NHS mental health trusts, we had inspected 18 (32%) and we had rated eight (14%) by 31 May 2015 (the remainder being part of our piloting phase). Of the eight NHS mental health trusts rated so far, four were good, three required improvement and one was rated inadequate.

We also inspected 14 independent mental health services by 31 May 2015, of which we rated seven. We were pleased in July 2015 to award the first outstanding rating to the North London Clinic.

Under our new approach, there are 11 core services that we will always inspect as part of our comprehensive inspections (figure 2.17).

We rate each of the core services on whether they are safe, effective, caring, responsive and well-led. We then use these ratings to determine how well the trust

is performing overall for each of these key questions.

The number of ratings for core services is too small at present to draw any particular conclusions about their relative performance. Of the 116 core services that we rated across both NHS and independent services, one (1%) was outstanding, 75 (65%) were good, 36 (31%) required improvement and four (3%) were inadequate (figure 2.18). We need to carry out more core service inspections before we are able to highlight any patterns of ratings.

Figure 2.17 Mental health core services inspected by CQC

Mental health wards	Community-based mental health and crisis response services
Acute wards for adults of working age and psychiatric intensive care units	Community-based mental health services for adults of working age
Long stay/rehabilitation mental health wards for working age adults	Mental health crisis services and health-based places of safety
Forensic inpatient/secure wards	Specialist community mental health services for children and young people
Child and adolescent mental health wards	Community-based mental health services for older people
Wards for older people with mental health problems	Community mental health services for people with a learning disability or autism
Wards for people with a learning disability or autism	

Improvement and learning is embedded

The North London Clinic, Edmonton

The North London Clinic in the Edmonton area of London is an independent hospital providing mental health services – forensic and long-stay rehabilitation care – for men. When we inspected we found a solid and committed leadership team driving change across the clinic.

We rated the clinic as outstanding, the first mental health provider to be rated outstanding under our new approach. This is particularly impressive given the challenges of this patient group.

The clinic was very patient-focused and patients were closely involved with the design and delivery of the service, with staff acting on their suggestions. For example 'living together' groups brought patients together to discuss how to improve their environment and clinic experience.

The multi-disciplinary team continuously sought creative ways to improve outcomes for the people in their care. For example, the clinic had introduced a work experience programme and patients received dedicated support to prepare their CVs and apply for roles at the clinic, such as vehicle maintenance assistant or onsite shop manager. The clinic also offered English and maths tutorials to patients.

The service was also committed to reducing restrictions for patients. Additional staff were brought in to accompany patients during their leave (walks around the grounds, day trips) – allowing them freedom, but within safe boundaries.

There was a real sense across the service that continuous improvement and learning were embedded in the culture. The senior leadership team at board and ward level were open and transparent. They were committed to working together, learning from mistakes, and recognising, addressing and improving any shortfalls in the service.

* Note that the inspection report for this inspection was published on 28 July 2015, and is therefore not included in the analysis of inspections for this chapter (which had a cut-off date for published reports of 31 May 2015).

Issues by key question

Looking at the rating for mental health services overall, services perform well in respect of caring. Our biggest concern is around the safety of the care being provided.

Mental Health Act

Each year, we publish a separate statutory report on the use of the MHA and the experiences of patients who receive care under the Act. In our 2013/14 report we expressed our concern that people across England are being detained under the MHA without their legal rights being discussed or explained to them, without being fully assessed for their willingness and ability to consent to their treatment, and without always having easy access to appropriate independent advice. Our findings from 2014/15 will be published in our MHA annual report later this year.

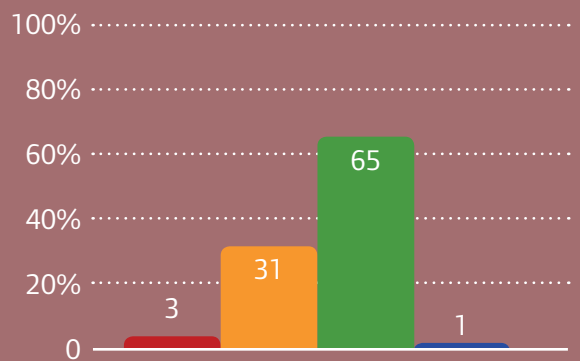
Safe

Our inspections show that safety is an area where trusts are frequently failing and need to make significant improvements.

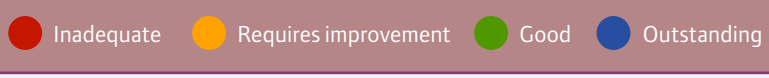
It is not possible to eliminate all risks and sometimes a balance needs to be struck between creating a ward that allows staff to observe patients and one that gives people a degree of dignity and privacy. However, the safety of care environments, particularly wards, is not good enough. Often services have to manage the limitations of old buildings that do not meet modern requirements for design of a mental health facility. This can include managing increased risks for patients, for example the provision of separate accommodation for men and women and the removal of fittings and fixtures that people at risk of suicide might use to harm themselves.

In 2011, the Chief Nursing Officer and Deputy NHS Chief Executive required providers to declare that they would phase out all mixed sex accommodation by April that year. However, in our inspections we are still finding concerns about gender segregation. Many of these are directly linked to the physical design and maintenance of the buildings, with issues such as a lack of female-only lounges, or bathrooms designated for female use being accessible through mixed gender areas.

Figure 2.18 Mental health and community ratings at overall service level



Source: CQC ratings data



An inspector's view

"So the ligature risk assessment has probably been done, but nothing being done to mitigate the risk, that's a common thing – they've found the risks, they know they are there but they aren't doing anything to manage it safely."

Although the number of inpatients who commit suicide is reducing, in 2013, 67 people killed themselves while on a psychiatric ward.[54] Thirteen people killed themselves by hanging or self-strangulation using ligature points. Ligature points are anything that can be used to attach a cord, rope or other material for the purpose of hanging or strangulation. These include shower rails, coat hooks, pipes, radiators, window and door frames and hinges and closures. While we recognise that it is not always possible to get rid of ligature risks, how these risks are managed, prevented and reviewed is important. We have seen good examples where services had used ligature risk assessment tools to review risks and draw up action plans, but some services have not taken structured approaches to managing risk.

We are also concerned that our reports are highlighting problems with wards having the right number of staff. The Francis report in 2013 showed that inadequate staffing leads to poor quality care.[55] We are concerned that from September 2009 to March 2015 there was a 15% fall in the total number of inpatient psychiatric nurses – the equivalent of 4,000 nurses.[56] A report by the King's Fund on workforce planning in the NHS showed that, between 2009 and 2014, there had also been an increase in the use of bank and agency psychiatric nurses.[57] In addition, its analysis of NHS Professionals data found that the number of agency and bank staff hours requested by mental health trusts has increased by around two-thirds since the beginning of 2013/14.

While factors such as the transfer of nurses to voluntary and independent providers will influence these figures, the independent sector would need to be growing very rapidly in order to offset such consistent declines in the NHS workforce.

Effective

When we look at whether a trust is effective, we want to find out whether it is providing people with care, treatment and support that achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

One of the ways we do this is to check whether the organisation has staff with the right skills to deliver the right care, and provides appropriate training to keep these skills up to date. Our reports show that most staff in mental health organisations are appropriately trained and given the opportunity to develop their skills. This is supported by figures from the NHS staff survey, which show that 80% of staff said they received job-relevant training and were given the opportunity to learn and develop. However, of the 87% who said they had received an appraisal in the last 12 months, just under half (42%) felt that their appraisals were well structured (figure 2.19).

Caring

During each of our inspections, the inspection team members speak with hundreds of people who use services. Many of these interviews are conducted by Experts by Experience who themselves have experienced mental health care. On most inspections, the majority of people who use services talk positively about the caring nature of the individual staff members that they come into contact with.

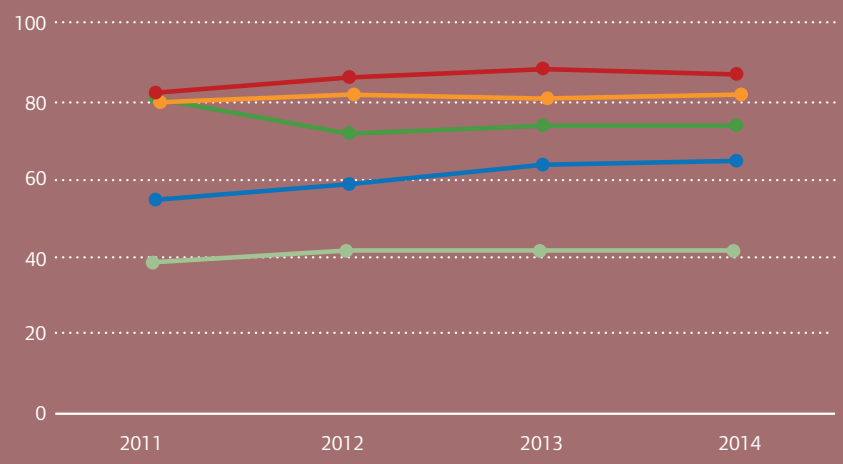
Challenging ward environments

A hospital had particular challenges on some of the ward environments due to the age, design and fabric of the building. However, overall the wards were clean and the provider had a maintenance programme in place to address these issues. For example, on one ward, which was located in the basement of the building, there was damp in one of the bedrooms. On another, there was an old fire escape door that allowed a draught and rain in through the base. The provider had taken action to address these issues by closing off the bedroom until further remedial work was completed and ordering a new fire door.

But we know that this will not be everyone's experience of mental health care. As part of our review of crisis care services for our *Right here, right now* report we held a call for evidence for six weeks in spring 2014. Forty-two per cent of respondents felt that the care they received failed to provide the right response and didn't help to resolve their crisis.

Outside of the voluntary sector, GPs were rated highest (70%) by respondents when asked whether a service made them feel respected when they tried to access it in a crisis. Only 52% of respondents felt that their community-based mental health teams treated them with warmth and compassion, and this dropped to 46% for crisis resolution home treatment teams (figure 2.20). In A&E only a third (34%) of respondents said they received warmth and compassion. Anecdotal stories we received suggested that there are some A&E staff who view people with mental ill-health as a burden that gets in the way of dealing with other patients.[58]

Figure 2.19 Mental health staff appraisals and training 2014



Staff appraised

staff receiving job-related relevant training (learning and development)

Staff receiving health and safety training

Staff having equality and diversity training

Staff having well structured appraisals

Source: NHS staff survey 2014

Well trained staff

In a rehabilitation service at an NHS trust, the training records showed that staff had access to a range of training relevant to their role. Staff told us that they felt well supported by their local manager in relation to training.

Staff received regular clinical supervision and annual appraisals in line with trust policy. The ward had an established, 'Reflective Practice Group' that staff attended to discuss clinical issues. Staff told us they valued these sessions and found them very beneficial.

The Health and Social Care Act 2012 is clear that people who use mental health services should expect to receive the same quality of care as people who use physical health services. However, results from the NHS inpatient survey 2014 also show that people with long-term mental health conditions are less likely to report being treated with respect and dignity in hospital.

The attitudes of staff can have a big impact, particularly for those in crisis. All staff need to treat people with mental health problems with the kindness, dignity and respect they would provide to people with physical health needs.

It is clear that all services have work to do in improving how their staff respond to people in crisis. Every local area in the country has a local Crisis Care Concordat group and a multi-agency action plan in place that sets out how they intend to improve mental health crisis services. Local leaders need to deliver on their commitments.

We have made recommendations that local Crisis Care Concordat groups make sure that all ways into crisis care are focused on providing accessible and available help, care and support for all those who require it at the time they need it. They should also take responsibility for holding commissioners to account for commissioning crisis services that deliver a quality of care based on evidence-based good practice and that is in line with the Concordat's key principles.

LIGATURE POINTS good practice example

In an NHS trust, staff knew and understood the ligature risks in the environment. For example, a bedroom was equipped for women with disabilities but which had known ligature risks. As a result, women were risk assessed before being allocated to the room. One-to-one observations of women were used when the level of risk was judged to be high.

LIGATURE POINTS poor practice example

A long-stay unit at an NHS trust had carried out a ligature audit that had identified some ligature risks but not all. There were still a significant number of ligature risks within the ward environment, both high and low level, including in people's bedrooms and bathrooms. Risks we found included two balcony galleries on the first floor overlooking open communal areas below. People could jump or fall over these balconies. Both also had ligature points that people could access. These balconies exposed people to unnecessary and avoidable risk.

Impact of relying on temporary staffing

At a mental health trust, we saw that there were five staff on duty during the day and four at night. The ward manager told us that for various reasons a number of qualified nurses had left… This meant that there had been a high use of bank and agency staff over the last six months. One person who used the service said that at night there were often agency staff who did not know them, so they did not feel safe at all times.

Figure 2.20 CQC's call for evidence 2014: "I felt" statements

	I was treated with warmth and compassion	
Service	Yes	No
Volunteers or a charity	88%	8%
GP	65%	26%
Telephone helpline	63%	29%
NHS ambulance	63%	23%
Community-based mental health team	52%	39%
Crisis Resolution Home Treatment team	46%	43%
A&E department	34%	53%

Note: Excludes respondents who were "not sure". Table only includes services that were selected by at least 10% of respondents to our call for evidence.
Source: CQC, *Right here right now*, 2015

Impact of staff attitudes

"I had not been taken seriously at triage. I explained how distressed I was feeling as I had been assaulted and how badly I was bleeding. I explained that if I lay down the bleeding was much less severe. The triage nurse was very dismissive and said there were no cubicles free and that I would have a long wait. She told me I would have to lie on the floor of the toilets if I needed to lie down that badly.

They accused me of self-harm while I was in the toilets, which was not the case. I was terrified, humiliated and upset, and could not calm myself down or trust anybody for the rest of my admission, leading to disturbance and distress for other patients.

I felt completely humiliated and was unable to trust the psychiatric staff and home treatment team that attempted to help me afterwards. I was unable to attend outpatient appointments as I felt so humiliated by my experiences and so ashamed."

CQC *Right here, right now*, 2015

Responsive

A responsive service is one that is organised so that it meets people's needs. Our ratings show that the majority (63%) of NHS mental health organisations are performing well in this area.

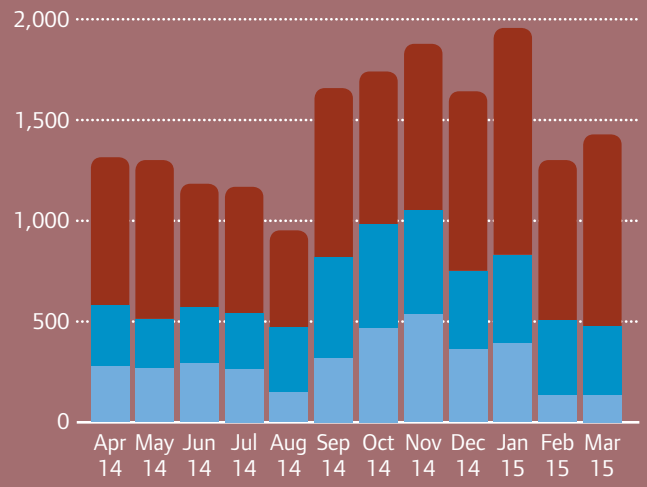
However, we are continuing to find issues, for example with access to beds. The NHS England Bed Availability and Occupancy Data for quarter 4 of 2014/15 shows that 89.6% of mental health beds were occupied overnight.[59] This is concerning as research in the acute sector has shown that bed occupancy levels above 85% can affect the quality of care that people receive.[60]

Accessing beds is a particular problem in child and adolescent mental health services (CAMHS), with children being placed in beds miles away from home or on adult mental health wards when there are no beds available elsewhere. This is inappropriate and unacceptable, and may indicate an issue with the commissioning of inpatient services.

This issue is highlighted in figure 2.21. It shows that, on average, people under 16 spent an average of 300 bed days in adult mental health inpatient settings each month during 2014/15. This equates to at least 10 children under 16 being placed in inappropriate settings every month. The figure is also probably higher than this and could be as many as 300 children, depending on how quickly they are moved off adult wards after they are admitted.

Accessing the right help at the right time is a problem that we are seeing across mental health services, particularly crisis care. Respondents to our call for evidence on crisis care services told us that people are turning to A&E because they do not feel they can access the help they need elsewhere, or because they have been told to go there by another service. For instance, one local group told us: "People are no longer receiving the level of support in the community that they used to. Out-of-hours people often have to resort to presenting at A&E." [61]

Figure 2.21 Number of bed days on adult wards for under 18s each month



Source: MHLDDS/MHMDS by the Health and Social Care Information Centre

17 years old | 16 years old | Under 16

Impact of bed availability

In a mental health trust, all the wards we visited were full and the majority of patients on the wards were detained under the Mental Health Act 1983… as a result of the over-occupancy of wards, beds were not always available for patients on their return from leave. For the first two months of 2015 there were 68 occasions… when a bed was not available to patients… or there were delays to a patient receiving a bed.

Between November 2014 and January 2015 there were a total of 57 occasions where patients did not have a bed to sleep in and slept on the sofa or in the quiet room on a temporary bed. One person… spent 32 hours in the assessment area… when no bed was available… Between November 2014 and January 2015 there were 85 occasions across the acute wards where patients slept on a ward other than the one they were admitted onto… some patients were transferred during the night… Patients told us that when they refused to move they were accommodated on sofas on the wards.

Helping people before they reach crisis point, or preventing a crisis from escalating, helps to reduce delays to treatment, prevents relapses and reduces the long-term impact of the condition. Over the last four years demand for early intervention in psychosis centres has fluctuated, but the number of cases continues to surpass the annual target of 7,500 by 35-40% every year, illustrating the need for these types of services (figure 2.22).

Well-led

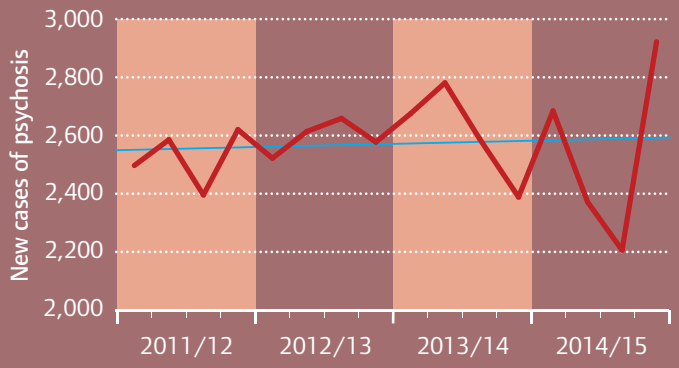
Mental health organisations are often very large, with a number of services spread across a big geographical area, making effective and integrated leadership and engaging with staff very challenging.

We have found issues with board assurance and governance processes, with some boards unaware of whether their decisions were having any impact on frontline services. We also found examples where there were significant gaps or inaccuracies in data that were provided to boards and no clarity on how decisions taken by the board would address performance issues.

Lack of beds for children

In a child and adolescent mental health service, parents told us about the impact of the closing of local inpatient beds. It meant that when children needed inpatient (or Tier 4) beds they were often sent out of the area. One parent told us that their child was "103 miles away, costing £100 to visit". Parents and staff told us of their distress when another child had to be admitted to a unit 126 miles away. We were told that the local children's units were invariably full and that children were being sent anywhere in the country and "being shoved into adult wards".

Figure 2.22 Number of new cases of psychosis served by early intervention teams by quarter



Source: NHS England, Mental Health Community Teams Activity, 2011-2015

What good local leadership looks like

In a forensic service, staff told us they felt confident raising any concerns or ideas to improve the service with their manager and were confident they would be listened to. Staff said they shared their views in a number of ways, including staff meetings, group supervision, away days and governance meetings. Staff told us the senior managers on the ward were visible, approachable and had an open door policy. They told us the managers and teams were open to trying new ways of working to improve the service.

USING FEEDBACK
good practice example

In a perinatal service, women, their partners and other professionals were asked to complete feedback questionnaires in order to develop an understanding of how they experienced the service. Analysis of responses helped to identify where improvements could be made to service delivery.

In addition, some staff did not feel engaged with the trust's visions and values, or involved with the development of the service. This can leave staff feeling demoralised and disconnected from senior management. Not having clear and effective governance structures in place, where staff can feed back to the board and get regular updates, can have a direct impact on the safe delivery of a service.

Good local leadership is equally important. We have seen some great examples, with visible, approachable and supportive managers creating an open culture where staff feel comfortable reporting incidents or putting ideas forward for improvements.

Making sure that local and senior leadership is integrated is very important for ensuring quality and safety. In well-led trusts, there are clear and effective governance structures in place that support the safe delivery of the service. In addition, there is good communication between local and senior management, and effective systems in place for both gathering and using feedback from people to improve their service.

An inspector's view

"There was a real commitment at all levels, from the chief executive to the ward managers, so you could see a kind of movement… they knew where their problems were and they had plans in place."

Our challenge to the mental health sector

- The layout and features of some old buildings that house mental health wards pose a risk to patients. We urge providers to undertake regular assessments of these risks and to take steps to mitigate against them. These steps should ensure that people at risk of suicide are kept safe.
- New build and refurbishment projects should be informed by the best practice standards suggested in building guidance, such as the Department of Health's Health Building Note on adult acute mental health units.[62] Services not covered directly by such guidance should consider and adapt its suggestions as appropriate.
- Staff in the emergency departments of general hospitals must show the same degree of kindness, dignity and respect to people with mental health problems that they would give to people with physical health needs.
- The senior managers of large mental health providers that deliver care from multiple locations must ensure that they have high-quality information about the performance of all of their services. They must also ensure that all of their staff share a common purpose and set of values.
- Local and national commissioners should work with providers to ensure that people who require inpatient care have access to a bed close to their home. This applies particularly to young people.

Primary medical services

Key points

- While most of the GP practices and GP out-of-hours services that we have rated up to 31 May 2015 are providing good care to their patients, we have been shocked at the very poor care provided by the 4% of practices that we have rated inadequate.
- Our inspections have highlighted a strong link between good leadership and good care. Likewise, the practices rated inadequate suffer from poor leadership and a failure to focus on what they need to do to improve.
- There is room for improvement in the safety culture in GP practices. We have seen examples of poor incident reporting and a lack of learning from significant events, as well as evidence of poor medicines management.
- GP practices deliver a better quality of care when sharing learning and providing joined-up care through multi-professional networks. Single handed practices are more likely to work in professional isolation, resulting in a lack of communication and engagement with staff and patients, and an environment that is not open and transparent.
- There is a need for GP practices to review access to medical advice and treatment to ensure they are in line with patients' needs.

Introduction and context

General practice and wider primary care services are under increasing strain. As well as tackling financial challenges, GPs are under pressure to effectively manage the rising demand on their services. An ageing population, more people with multiple health conditions and an increase in people living with long-term conditions (the number of people living with diabetes in the UK has soared by 60% in a decade[63]) are all placing a high demand on GPs across the country.

Pressure is also mounting from a rise in the number of patients registered with a GP and the number of unfilled GP posts. With fewer people entering the profession (in 2014, 12% of GP training posts went unfilled[64]) and 34% of GPs considering retirement in the next five years[65], the sector faces pressure to ensure that existing workforce numbers are sufficient to meet the current demand.

Through our Primary Medical Services and Integrated Care directorate we regulate and inspect a wide range of services:

Figure 2.23 Primary Medical Services and Integrated Care directorate – what we inspect and regulate

GP practices and GP out-of-hours services	By 31 May 2015 we had inspected and rated 976 GP practices and out-of-hours services* (11% of the total we have registered). We aim to have inspected and rated all services by Autumn 2016. Overall there are 8,405 GP service locations on our register. We have started to see new types of provider entering the market that are using Skype, email and web-based methods for consultation. We are also seeing an increasing number of multi-site practices – both through mergers and acquisitions between trusts and GP surgeries and consolidation and federation of GP practices.
Dental care services	There are 10,295 dental care locations on our register. We began our new approach to inspecting and regulating dental services on 1 April 2015 (we will inspect 10% of services a year and we will not rate them). In 2014/15, we continued to inspect services under our old approach.
Health and justice	We inspect, but do not rate, health and social care in prisons and young offender institutions. We also inspect, but do not rate, health care in immigration removal centres, police custody centres, secure training centres and youth offending teams in the community. We conduct this work with HMI Prisons, HMI Probation, HMI Constabulary and Ofsted.
Remote clinical advice	We have started to develop a methodology for regulating providers of remotely-delivered clinical advice.
Urgent care services	We inspect and rate a range of urgent care services such as NHS 111, walk-in centres, minor injury units and urgent care centres as part of our inspection of the primary care provider.
Children's health and children's safeguarding	We inspect, but do not rate, local health service arrangements for safeguarding children and improving the health of looked-after children. Some of this work is conducted with Ofsted, HMI Constabulary and HMI Probation.

* This figure includes two urgent care services and one independent consulting doctor service.

Overall ratings

Despite the challenges faced by the sector, the vast majority (85%) of the GP practices and GP out-of-hours services that we rated up to 31 May 2015 are providing good or outstanding care (figure 2.24). At a challenging time for primary care, there are many practices finding innovative ways of meeting the needs of their local population, and this is something that should be celebrated.

Almost one in nine (11%) of the GP practices we inspected required improvement.

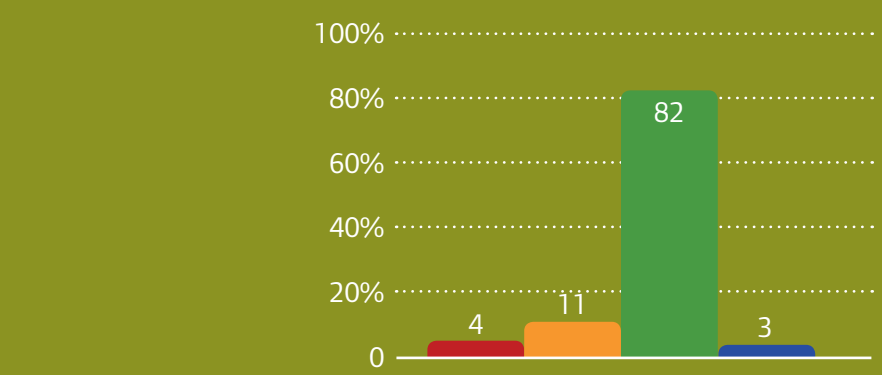
Four per cent of those we inspected were rated inadequate. During 2014/15 we introduced a special measures programme for GP practices. Where we rate a practice as inadequate, the practice is given a defined amount of time to address the issues we have identified, normally six months. The practice is supported in this by NHS England and, in some cases, by the Royal College of General Practitioners. At the end of this period, we inspect again to check whether enough improvement has been made by the practice to bring it out of the regime. If the practice has not made sufficient progress they have another six months to improve before enforcement action is taken against the practice, normally resulting in the cancellation of its registration with CQC.

Up to the end of May 2015 we had placed 30 GP practices that were rated inadequate into special measures. As of 2 September 2015, we had re-inspected two of them, with one now being rated good.

We remain concerned by the very poor care we find in some practices through our inspections. Some of this care is shocking. We have recently cancelled the registration of some practices where we found very poor care, and where there was a real concern about the safety of patients. Where we cancel a registration, it means that the provider cannot legally continue to provide a service, and we work with NHS England to ensure alternative arrangements are made for patients.

For example, following an inspection in June 2015 we cancelled the registration of a GP practice because inspectors had serious concerns about the service and the risks to people using it. During the inspection we identified one locum staff member who had treated patients but could not provide evidence that they were medically qualified to do so. The management of medicines was found to be unsafe and placed patients at serious risk of harm.

Figure 2.24 Overall ratings for GP practices and GP out-of-hours services



Source: CQC ratings data

Medicines were found to be out of date, which rendered them unsafe, and requests for prescriptions had not been processed in a timely manner to ensure patients had access to their medicines. Despite urgent appointments being available on the day they were requested, patients stated that they had to wait a long time for non-urgent appointments and found it very difficult to get through to the practice when phoning to make an appointment.

We also have the ability to temporarily suspend a provider's registration where we have serious concerns but we think that these concerns can be addressed. An example of where we have used this power is with a single-handed GP based in London. CQC had concerns about the performance at the practice since its first inspection in December 2013. Further inspections in 2014 identified serious concerns about risks to patient safety and an urgent notice to suspend the registration of the practice was issued in January 2015. Inspectors found a number of failings that led us to take enforcement action.

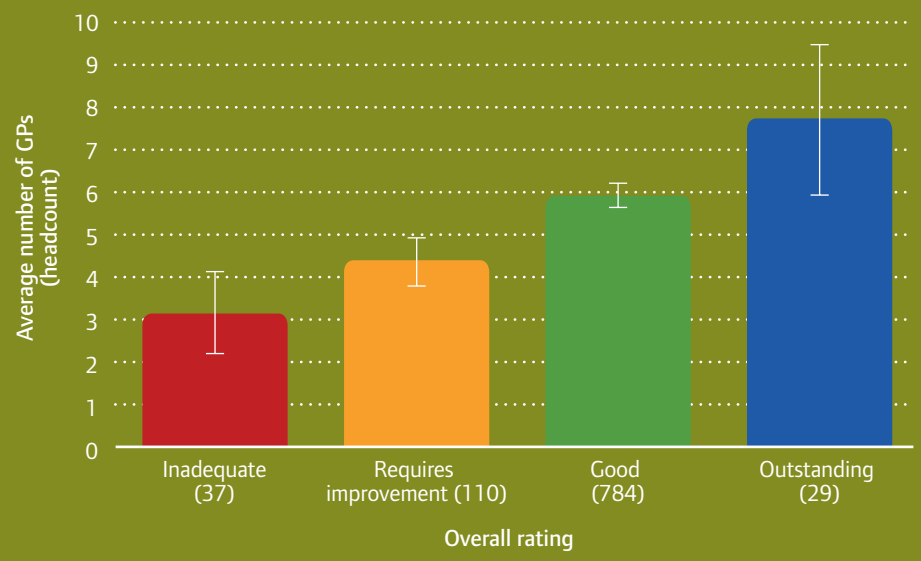
We have analysed GP practice ratings by locality and demographics and by organisational aspects such as staff, numbers of patients and financial data. The factors most strongly associated with a better rating included a higher percentage of patients who would recommend the practice (according to the GP Patient Survey), and a higher number of GPs in the practice (figure 2.25).

Ratings for population groups

Through our ratings, we are starting to look at the quality of services delivered to patient groups. Using six population groups, we want to make sure that our inspections include the quality of care delivered to different types of people, especially those who are particularly vulnerable.

Overall, our inspections show that GP practices typically provide good services to their population groups (figure 2.26). We have not yet carried out

Figure 2.25 GP practice ratings and number of GPs in each practice



Source: CQC ratings; GP Patient Survey 2014
Note: We have so far rated only a minority of services. We have produced 95% confidence intervals for the average values by rating, as these values will fluctuate until all services have been inspected. The error bars in each chart show the width of these confidence intervals. If the confidence intervals do not overlap then the differences between the values are statistically significant.

Inadequate Requires improvement Good Outstanding

Findings from GP practices rated outstanding

The striking feature of outstanding practice is the breadth and diversity of the different examples we observe. We see a wide variety of initiatives that demonstrate:

- Effective leadership, manifested in a strong shared vision among practice staff, effective staff training and support, and a positive patient-centred culture.
- Effective working with multi-professional colleagues, including those from other organisations.
- Extra services that are empowering patients to self-manage long-term conditions and acute minor illnesses.
- Support for patients and carers with their emotional needs (for example, coordinating support groups) and close working with the community to raise awareness of health conditions and contribute to community wellbeing programmes – such as walking groups and social enterprise programmes.

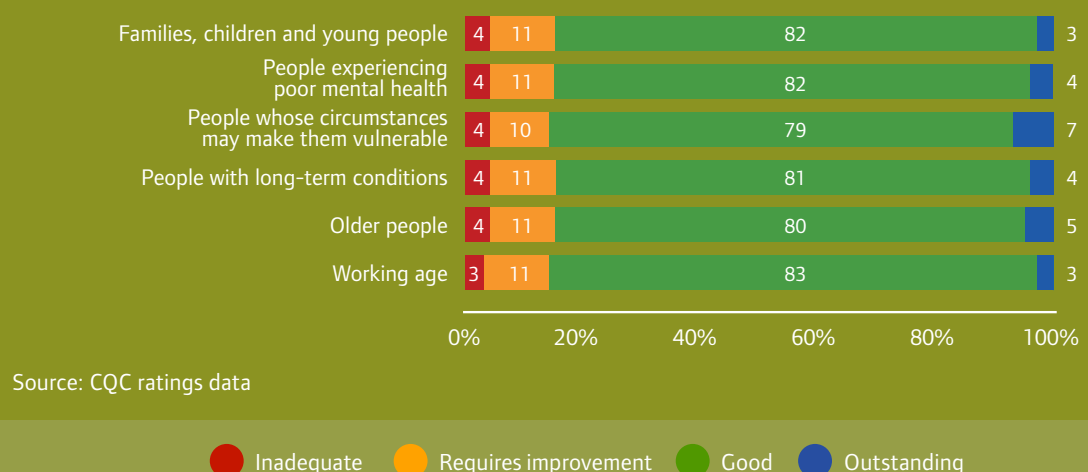
In July 2015, we published our online examples of outstanding care in GP practices. These have been well received (all respondents to an online survey agreed the web tool is useful, with two-thirds reporting it is very useful). We encourage all primary care services to use the tool for learning and improvement opportunities.

Findings from GP practices rated inadequate

From our inspections we find that inadequate practice tends to reflect an absence of important systems or processes and poor outcomes for patients. Practices rated inadequate typically demonstrate:

- Weak leadership and a chaotic and disorganised environment.
- Isolated working – not working closely with other local services to share learning and provide a wider mix of services.
- A lack of vision for the organisation and clarity around individuals' roles and responsibilities.
- A poor culture of safety and learning (for example, a lack of significant event analysis or learning from complaints), poor systems for quality improvement, including quality audit, and limited examples of assurance of the quality of clinical care.
- Disregard for HR processes (for example, Disclosure and Barring Service checks).
- Unsafe medicines management.
- Limited access to advice and treatment.
- Lack of practice nurses or very low number of practice nurse sessions.

Figure 2.26 GP population group ratings



Source: CQC ratings data

enough inspections to determine whether there is any particular variation of ratings between different groups. We did, however, find that in areas where there is a large number of people in one particular population group (for example, older people), some GP practices had done more to adapt their services to the specific needs of those patients.

Between May and July 2015 we surveyed 19 GP practices who have a high density of asylum seekers in their population. We captured the awareness of staff about the needs of asylum seekers, who often have significant physical and mental health needs. Around half of all staff surveyed showed a general lack of awareness of the healthcare needs and rules regarding the care of asylum seekers.

The main barrier to effective care was language differences and access to interpretation services. Clinicians often did not feel confident in the ability of interpreters to accurately convey patient histories and explain diagnoses. They also said they need more guidance and support in referring asylum seekers to specialist services, such as for survivors

Examples of GP services adapted to specific needs

Population group	Example
Working age people	Offering appointments before 8am, after 6.30pm and at weekends. One practice set up a sexual health clinic that ran on Wednesday evenings and Saturday mornings. The service was available to the whole community – not just patients of the practice.
People with long-term conditions	Educating patients to self-manage their long-term conditions more effectively and providing additional services that usually require a hospital visit. For example, managing intravenous lines used for prolonged treatments such as chemotherapy, long-term antibiotics and intravenous feeding.
People whose circumstances may make them vulnerable	Being flexible in their approach to vulnerable people by offering longer appointments, and allowing homeless patients to register at the practice using the practice address as their 'home' address.
Poor mental health	Working collaboratively with local mental health services and improving access to psychological therapies and substance misuse services. Also helping patients with mental illnesses to access high-quality, better coordinated care outside of hospital and therefore improving the number of patients being cared for in the community.
Older people	Managing beds in a care home that led to a reduction in hospital admissions and the number of days many older patients remained in hospital.
Families, children and young people	Offering information in age-appropriate formats for young people and ensuring staff are well-trained on local safeguarding processes. In one practice the nurse practitioner offered a texting service for young insulin-dependent diabetics. Teenagers were able to text their blood test results to the nurse practitioner if they had any concerns about managing their diabetes.

of sexual violence and torture. The complexity of managing this patient group raises concerns that clinicians are struggling to provide appropriate care under the confines of a standard 10-minute consultation.

Ratings for the five key questions

In the vast majority of cases, the services provided by GP practices are caring and responsive to people's needs. Ninety-six per cent of services were rated good or outstanding for caring, and 93% for responsiveness (figure 2.27). This latter figure reflects the fact that services are typically organised to meet the needs of their patients, and they commonly try innovative and effective ways to improve access to services and provide additional support for particular patient groups.

Where we do see inadequate care, this is often driven by poor safety or leadership ratings. Six per cent of the services we rated were inadequate for safety, and 4% were inadequate for well-led.

Safe

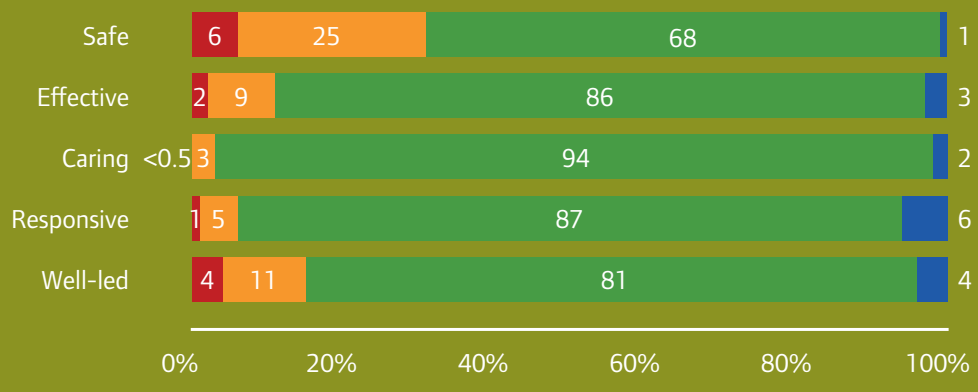
Of the services we rated up to the end of May 2015, 69% of GP practices and GP out-of-hours services were good or outstanding in terms of safe care. The most common theme underpinning safe practice is significant event analysis (SEA). We have seen evidence that most practices discuss and share their learning from SEAs with the multi-disciplinary team and external bodies such as the clinical commissioning group and other local GP practices.

However, we have concerns that incident reporting is not routinely carried out and often lacks the detail required.

In February 2015 a new GP e-form was launched as part of the National Reporting and Learning System. Approximately 100 practices are using it to report patient safety incidents for local and national learning. We encourage all practices to adopt it and we expect, in the near future, to see a significant improvement in the number of incidents being reported.

Although many practices are providing safe care, safety overall remains our main concern. Of the 976 services we rated, 25% required improvement and 6% were inadequate for this key question.

Figure 2.27 Primary medical services ratings by key question



Source: CQC ratings data

We have found a range of safety issues that show a general lack of system and process, meaning risks are not properly monitored or assessed. For example:

- Insufficient evidence of risk management and learning from incidents, including as mentioned above, the completion of incident reports.
- Poor responses to patient complaint letters and a failure to act on the issues raised.
- Lack of effective and timely safeguarding training.
- Poor infection control procedures.
- Poor practice with the condition and storage of emergency equipment and the management of medicines is not satisfactory.
- Fridges at the wrong temperature, insufficient emergency drugs and expired medicines.
- Poor recruitment processes, where services may have had policies in place to ensure that staff were recruited in a safe manner but in reality some services were not properly implementing these. This meant that staff were being recruited without proper checks such as the Disclosure and Barring Service.

Effective

The range of activities provided in general practice is increasing. Eighty-nine per cent of practices and services were good or outstanding for the effectiveness of their care. Our inspections have highlighted multiple examples of good, effective clinical practice, expanded to account for the needs of local populations.

We see practices focusing on good outcomes for patients through quality improvement programmes, coordinated referral processes and joined-up care with other healthcare providers. We also see

Quality and safety are the priorities

Orchard Court Surgery, Darlington

Orchard Court Surgery is an outstanding GP practice that has excellent systems in place to keep people safe.

Inspectors could see that the arrangements for reporting, recording and monitoring significant events were consistently used to improve practice. This included identifying trends and themes and taking action on, for example, medication, clinical assessment and consent, communication and confidentiality.

The whole team contributed to this approach. All safety concerns raised by staff and patients were taken seriously, used as learning and to improve the service provided to patients. Staffing requirements to meet patient needs were clear and staff received the training and support they needed to deliver a good quality service.

Inspectors commented that the practice had a clear vision, which had quality and safety as its top priority. High standards were promoted and owned by all practice staff and there was evidence of team-working across all roles.

evidence of innovative services tailored to the individual needs of specific population groups.

Practices have worked hard over many years to build and maintain strong working relationships with organisations such as schools, universities, and local fire and benefits advisory services. The practices then use these relationships to deliver enhanced services.

Over the last 10 years the number of single-handed GP practices has fallen dramatically. We are now seeing the benefits of larger practices and joined-up models of working. These include offering appointments to patients outside normal working hours by taking shared responsibility for extended accessibility, and providing a wider range of services than most practices are able to deliver on their own.[66]

There are clear improvement opportunities for services rated below good and outstanding – in particular, for smaller isolated practices where collaborative working would be hugely beneficial.

Caring

We see significant examples where practices go the extra mile to involve and treat their patients with compassion, kindness, dignity and respect.

An inspector's view

"They were recording absolutely everything. A RAG (red, amber, green) rating system was in use, and 95% of incidents were green (no patient impact). The learning was clear and obvious."

The practices we rated as outstanding are able to demonstrate specific support for individual population groups, innovative programmes for certain health conditions and flexible access to services.

We rated two practices as inadequate for being caring – a very small number but wholly unacceptable. Our main concerns were based on feedback from patients who found staff to lack compassion and respect. We also observed poor concern for patients' privacy and dignity at the reception desk and waiting area in these surgeries.

Responsive

Typically, practices that are rated as outstanding consider the needs of their population and implement changes to improve the experience for their patients.

As demand for primary care grows, we have seen a sharp increase in the number of GP surgeries offering consultations over the phone and implementing telephone triage. In fact, 63% of GPs now believe that telephone consultations can be an effective replacement for face-to-face appointments.[67]

Innovation in how primary care is provided is developing rapidly. We are increasingly seeing new channels opening up, such as Skype, providing access to a medical consultation through an online video chat facility. Three social enterprises are leading the way in terms of new models of provision to improve the health of vulnerable and excluded groups. They work closely with services across their locality and are generally very responsive to the specific needs of their patients.

Well-led

GP practices are generally well-led, with 85% of practices rated good or outstanding. The typical examples of outstanding leadership we see relate to the culture that practice leaders create, which manifest in excellent staff development and support.

When practices are well-led, their patients are placed right at the centre of their developments. As a result, these practices often have effective patient participation groups that are involved in multiple aspects of the practice's business, including influencing practice development and coordinating services.

Innovative and proactive

St Thomas Medical Group, Devon

St Thomas Health Centre is one of four practices in a group and is rated outstanding overall.

The practice provides primary medical services to approximately 15,500 patients living in Exeter – it is well-led and responds to patient need and feedback, showing innovative and proactive ways to improve patient outcomes.

For example, some patients with leg ulcers no longer have to travel to the other side of the city for treatments, because practice nurses have worked with the dermatology department at the local hospital, and they can now perform more complex dressings. This is over and above what is expected.

Patients also have access to a headache clinic and a vasectomy clinic on Saturday mornings. Patient feedback is consistently positive.

The health centre has nine GP partners plus four additional salaried GPs, 10 registered nurses, four healthcare assistants, a practice manager, and additional administrative and reception staff. They show mutual respect and teamwork is evident – and there are systems in place to monitor and improve quality and identify risk.

Strongly performing healthcare organisations place high importance on staff development. Many of the outstanding practices we inspect demonstrate their effective leadership by implementing special programmes to develop or support staff in their role.

Practices that are rated poorly for well-led tend to lack clarity in the roles and responsibilities for the day-to-day running of the practice. There are also often poor relationships between groups of staff and a lack of visibility of senior staff.

The role and capability of the practice manager appears to play a role in a practice's overall rating. The level of training and support for practice managers is important, as is supervision and good line management. We see examples of poor working relationships between GPs and practice managers and isolated working when trying to make improvements.

In our ratings of GP practices, where well-led was rated inadequate or requires improvement, there was on average a lower proportion of patients who, when surveyed by the 2014 GP Patient Survey, said they would recommend the practice to others (figure 2.28).

Other primary care services

Dental care

We carried out 714 inspections of primary dental care services in 2014/15. Over several years, we have found that, compared with other sectors, dental services present a lower risk to patients' safety. Our stakeholders also agree that the majority of dental services are safe and that the quality of care is good. Therefore, from 1 April 2015 we are carrying out comprehensive inspections at 10% of all practices based on a model of risk and random inspection, as well as inspecting in response to concerns.

Unlike other sectors that we regulate, we will not be rating primary care dental services. It would be unfair and a disadvantage to other providers to rate only the 10% of providers that we inspect. We are working jointly with the General Dental Council, NHS England, NHS Business Services Authority and Healthwatch England on the future model from 2016 onwards.

Figure 2.28 GP practice ratings and whether patients would recommend the practice

Source: CQC ratings; GP Patient Survey 2014
Note: We have so far rated only a minority of services. We have produced 95% confidence intervals for the average values by rating, as these values will fluctuate until all services have been inspected. The error bars in each chart show the width of these confidence intervals. If the confidence intervals do not overlap then the differences between the values are statistically significant.

Inadequate Requires improvement Good Outstanding

Health and justice

People in the criminal justice system have a higher rate of ill health than the general population and are reliant on authorities for their safety, care and wellbeing. In secure settings there is no choice of service provider. This makes monitoring, inspecting and regulating even more important.

We have recently introduced a new approach to inspection alongside HMI Prisons. We published our new inspection handbook in July 2015 after a period of consultation and piloting. Our pilot inspections included three prisons, a youth offending institution and an immigration removal centre. The new approach is now used for all inspections in these settings.

In August 2015, we published new registration guidance for healthcare providers in police custody suites (PCS) and sexual assault referral centres. The guidance helps providers understand when registration is required. The current regulations allow an exemption for services that are commissioned by police authorities. It is expected that, from April 2016, commissioning for PCS will transfer to NHS England and providers will need to register with CQC. We will work with the sector, HMI Probation and HMI Constabulary to develop the approach to inspection for these services.

Pilot inspection of an immigration detention centre

Yarl's Wood Immigration Detention Centre, Bedford

In April 2015 we piloted our inspection method with Yarl's Wood Immigration Detention Centre during an unannounced inspection by HMI Prisons.

Of all the areas in the centre, health care had declined most severely. There were severe staff shortages and women were overwhelmingly negative about access, quality of care and delayed medication.

Our inspection indicated that care planning for women with complex needs was so poor it put patients at risk. Also, the available mental health care did not meet women's needs and this made it particularly unacceptable that a number of women with enduring mental health needs had been detained.

The small enhanced care unit was located in health care and used to isolate women. It was effectively used as an inpatient unit although it was not commissioned, resourced or registered to be so.

Pregnant women had prompt access to community midwives and reasonable antenatal care, but inspectors saw two instances where abdominal pain in early pregnancy was not managed appropriately.

Pharmacy services were chaotic. We issued three requirement notices immediately following this inspection and will be checking that improvements have been implemented.

Source: HMI Prisons and CQC

Children's services

We review how health services keep children safe and contribute to promoting the health and wellbeing of looked-after children and care leavers. In 2014/15 our children's inspection team has done this in three ways:

- Over a two-year period the team has inspected the health service provision in 41 local authority areas. Inspections have been based on the identified risk within the health services in those areas and we have visited at short notice. At the end of each inspection we publish a report that makes recommendation to individual providers of services and the clinical commissioning group. We are reviewing all the reports to draw out the national findings and learning for services.
- During 2015 we have developed joint targeted area inspections with other inspectorates that will examine how well local authorities, health, police and probation services work together in a particular area to safeguard children. The new inspections will include a more in-depth look at elements of practice, with the first six inspections to focus on children at risk of sexual exploitation and those missing from home, school or care.
- The team also works with other parts of CQC to provide advice and expertise in relation to safeguarding children and services to looked-after children. This has included contributing to hospital inspections, responding to concerns at GP inspections and conducting a local area inspection jointly with the hospital team. This year we are extending our work in this area under the banner of Think Child, an initiative to integrate the inspection of children's safeguarding into the wider inspection of health services provided to children.

In 2015/16 the children's team will also be starting a five-year inspection programme with Ofsted looking at how local areas are meeting the needs of children with special educational needs and disabilities.

Continuous improvement

Windsor Surgery, Lancashire

Windsor Surgery in Garstang, Lancashire was rated good overall by CQC and inspectors found evidence of outstanding work in the way the practice meets patients' needs and strives for continuous improvement.

Staff and patients were involved in local forums to drive up standards. Changes in national best practice were shared and agreed between staff and supporting community teams.

In particular, the practice held meetings every week to improve how it delivered services. Many meetings included external professionals – and where appropriate, patients were invited.

Inspectors saw audits on care delivery and outcomes for patients with long-term conditions – the aim is to improve services. The practice nurses worked with community teams to avoid hospital admissions.

For any GPs returning from long-term leave, mentoring is available. This involved a named GP mentor, who provided reviews and consultations around any issues or concerns, and regular meetings to discuss progress and any additional breaks that might be needed.

Our challenge to the primary healthcare sector

- We want primary healthcare services to become the safest, the most effective and the most compassionate in the world. We need clinicians, whether in their own practice or if they work in a leadership position, to speak out and not tolerate care that is unsafe, ineffective or lacking compassion.
- We encourage all healthcare professionals to avoid professional isolation and work with colleagues in and out of their practice.
- We encourage providers to work together across organisational boundaries to reduce variation and improve the quality of care and the provision of more joined-up health and care services. We demand investment in strong, credible leadership at all levels in primary healthcare services.
- At practice level, we need visible leaders, both clinical and managerial, to oversee the running of their practice and develop plans in response to the needs of their local patients. The vision and values of a GP or dental practice are important as they highlight the organisation's strategic objectives. These have a powerful influence on the behaviours of staff at all levels. Leaders within practices must ensure the vision and values are shared by all staff.
- Safety incidents, both within the GP practice and externally, should be reported using the e-form for the National Reporting and Learning System, and a culture of learning embedded among staff.
- Practices should become active learning organisations, encouraging all team members to be engaged in quality improvement activities.
- GP practices should improve patients' access to their services. They should encourage and facilitate self-care, and respond to the needs of their patients by improving appointment systems and looking at different ways to make contact with healthcare practitioners available for different patient groups.

An inspector's view

"One recent practice that was very well-led. One of the reasons for this was staff engagement by setting up task groups – one for patients' services, one for finance, and one for HR and training, each group had one GP, one admin person and one nurse or healthcare assistant. They talked about ideas for the future, feedback from the whole team, and how they could improve in those areas, and they showed how they implemented those ideas."

Equality in health and social care services

Key points

- While international evidence shows that the NHS is one of the most equitable health systems in the world[68], there is still significant variation in access, experience and outcomes for different groups of people using health and care services. This must be addressed, both to ensure good quality services for everyone and because these services need to be ready for changing demographics – for example the growth in the population of older people from Black and minority ethnic (BME) backgrounds.
- Although access issues differ by sector and by equality group, it is a challenge to ensure everyone has the right information in order to access services – we see this in both adult social care and acute hospitals. Also, changes in eligibility for funding in adult social care has had a variable impact on different equality groups.
- Whether people say they are treated with dignity and respect is closely linked to their overall experience of care. In acute hospitals, people in some equality groups are significantly less likely to report being treated with dignity and respect than their peers.
- It is important that providers also ensure equality for their staff. BME staff and women remain less likely to be in management roles than their counterparts, in both health and social care. Additionally, BME staff in NHS trusts report higher levels of discrimination and lower confidence in equality of opportunity. There is evidence that disabled staff and lesbian, gay, bisexual and transgender staff can also experience higher levels of discrimination at work.
- Information from adult social care providers shows that they are not consistently addressing equality. While almost all services say that they have equality policies in place, far fewer say that they have carried out work in the last year on equality – particularly in relation to sexual orientation and gender reassignment.

Introduction and context

This section forms part of our statutory equality information duties under the Equality Act 2010, in particular to report on what we know about equality for groups that are affected by our statutory functions – people using health and social care services and staff working in these services. This builds on our report *Equal measures* in which we concluded that there is still too much variation in access, experience and outcomes for people who use services – and staff working in services – on equality grounds.[69]

In relation to service provision, the Equality Act covers eight protected characteristics: age, disability, gender, gender reassignment, pregnancy and maternity, race, religion and belief, and sexual orientation. One of the challenges – for national reports and for service improvement – is that data is not systematically collected or analysed about the access, experience and outcomes for different equality groups using health and social care. We welcome the work of the NHS Equality and Diversity Council to improve this.[70]

Access to services

Patterns of access

In our *Equal measures* report, we analysed 14.5 million NHS hospital inpatient episodes and 83.5 million outpatient appointments where the age, sex and ethnicity of the patient was known.[71] This showed some differences in patterns of service use. More work is needed to understand if these variations reflect differences in need and behaviours, or in the accessibility or quality of services for these groups.

Equity of access

While the use of primary and secondary health services is increasing, the number of people able to access local authority funded or commissioned adult social care is decreasing, due to budget restrictions and tightening eligibility criteria. The latest figures available, published in December 2014, show a 4.1% overall reduction in the number of adults receiving a social care service, of any type, provided or commissioned by a local authority in 2013/14 compared with 2012/13. The previous year, the reduction was over 9%.[72] This is in the context of an ageing population and therefore potentially an increasing need for social care services. This reduction in access has had different impacts on various equality groups.

Two-thirds of the people receiving local authority funded or commissioned care – more than 850,000 people – are aged 65 and over. There has been a greater reduction in the percentage of older people receiving local authority funded or commissioned care, compared with 18-64 year olds. In turn, this is likely to explain the larger impact on women compared with men and on those with a physical impairment compared with those with a learning disability or mental health need.

People in Asian/Asian British, Black/Black British and mixed ethnic groups only make up 7% of people receiving local authority funded or commissioned care, despite being 13.5% of the population in England.[73] This may in part be a result of the demographic profile of these population groups (typically younger, although now the proportion of older people in these ethnic groups is increasing). The figures suggest an increase in the number of people from these ethnic backgrounds accessing local authority-funded adult social care between 2012/13 and 2013/14, although some of this increase may be explained by better recording of ethnicity. However there was a decrease in the number of people from other minority ethnic backgrounds, which includes for example Chinese and Arab people.

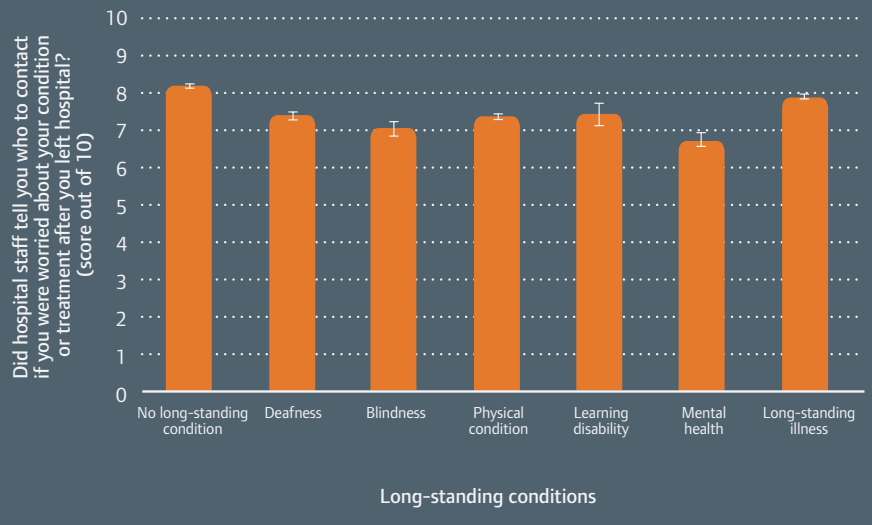
Reductions in local authority funded or commissioned adult social care has had various impacts on different groups of disabled people. This needs to be seen in the context of changing needs, such as the increased number of people with dementia. However, there has been a particular impact on people with a primary need for services due to hearing impairment, with a greater than 10% reduction in the number of people receiving local authority funded adult social care in 2013/14 compared with the year before (figure 2.29).

Figure 2.29 Changes in local authority funded adult social care, 2012/13 to 2013/14, by disability-related needs

	2012/13	2013/14	% change
Physical disability, frailty and/or temporary illness	750,705	704,305	-6.2% ↓
Hearing impairment	18,975	16,990	-10.5% ↓
Visual impairment	27,360	25,595	-6.5% ↓
Dual sensory loss	4,835	4,400	-9.0% ↓
Mental health (excluding dementia)	187,610	174,780	-6.8% ↓
Dementia	80,610	82,760	2.7% ↑
Learning disability	144,830	146,705	1.3% ↑

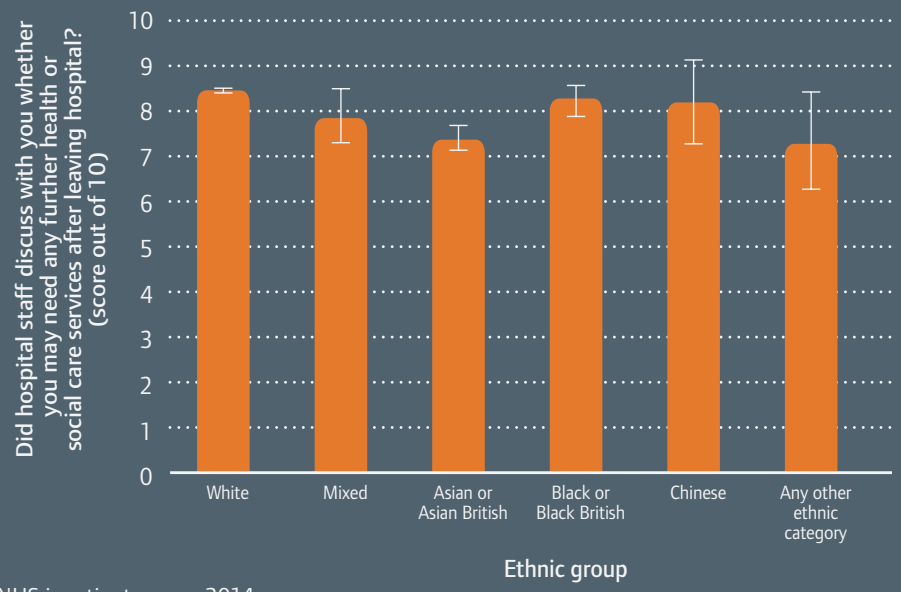
Source: Health and Social Care Information Centre Community Care Statistics 2013/14

Figure 2.30 NHS inpatient survey 2014: who to contact after hospital, by pre-existing health condition or disability



Source: NHS inpatient survey 2014
Note: The chart includes the 95% confidence intervals for the survey results. The sample size varies by demographic group, and the confidence intervals illustrate the level of precision we can attribute to each result.

Figure 2.31 NHS inpatient survey 2014: discussed further services after hospital, by ethnic group



Source: NHS inpatient survey 2014
Note: The chart includes the 95% confidence intervals for the survey results. The sample size varies by demographic group, and the confidence intervals illustrate the level of precision we can attribute to each result.

Specialist support

Dalefield Surgery, Bolton

We rated Dalefield Surgery good for their overall care of patients and outstanding for their treatment of people whose circumstances may make them vulnerable.

Approximately 9% of Dalefield Surgery patients do not speak English as their first language. The reception staff have translation prompts to greet all patients, establish the nature of their visit and help them to book appointments. They also display information and practice leaflets in different languages and offer a translation facility for their website content.

The practice employs support workers to work with non-English speaking families in their homes to help them understand the services available to them and access NHS and social care.

For all non-English speaking patients, extended appointments slots are booked and interpreters are available via a telephone service. For new patients, a referral is made to a support worker to ensure patients are supported to provide voluntary and informed consent to treatment.

Removing barriers

Lack of information can be a major barrier to access to services for some groups. We have analysed some questions in the 2014 NHS inpatient survey to see whether there were differences in how well people were signposted or referred to other services after a stay in hospital.

- People with no longstanding health condition were significantly more likely to say they were told who to contact after they left hospital if they were worried about their condition or treatment, compared with people who had a range of health conditions (figure 2.30). People with a mental health condition were least likely to say that they had been given the name of someone to contact. People with no longstanding health condition were also significantly more likely to report that hospital staff had discussed whether they need equipment or adaptations at home and whether they needed further health or social care services when leaving hospital.
- White people were significantly more likely to report that hospital staff had discussed whether they needed equipment or adaptations at home, compared with Asian, Asian British, Black, Black British or people who viewed themselves as being of mixed race. White people were also significantly more likely to report that hospital staff had discussed whether they needed further health or social care services when leaving hospital compared with Asian and Asian British people (figure 2.31).

There are two possible explanations for these differences. Either hospital staff are not discussing discharge arrangements with people on an equal basis – possibly because of language or communication barriers – or disabled people, people with mental health conditions and people from BME groups are not understanding or remembering the information given. Either way, the communication from hospital staff is less effective for some equality groups and needs to improve. The introduction of the NHS Accessible Information Standard may improve communication with disabled people, including those with a learning disability or mental health condition.[74]

Survey responses from people using adult social care also show a range of differences relating to whether people found it easy to find information about services.[75] In this survey a higher percentage of people with a learning disability found it easy to find information, compared with people with a physical or sensory impairment. A lower percentage of Asian/Asian British and Black/Black British people found it easy to find information, compared with White people, which is similar to the findings from the hospital inpatient survey.

Voluntary and community services can be important in helping people to navigate the health and social care system. There is some evidence that funding reductions have had an impact on voluntary sector advocacy provision for people with a learning disability[76], and on social care and support services for BME older people.[77] In both cases it is difficult to make quantitative assessments about the impact, as relevant data is not regularly collected.

There are other barriers to equality in service access, besides failure to communicate available services – for example physical access to premises and access to interpreting services in primary care.[78] We look in more detail at the issues for asylum seekers in our section above on primary medical services.

Our equality objectives

One of our equality objectives is to improve our regulatory insight and action about the safety and quality of mainstream health services – including acute hospitals – for people with a learning disability or dementia, and those experiencing mental ill-health. This will help us to shine a light on where communication between hospital staff and these patients needs to improve and where there is good practice.

Commissioning

Not all access issues are in the control of providers. Clinical commissioning groups (CCGs) are responsible for commissioning services to meet the needs of the local population. CCGs are required to make use of the NHS Equality Delivery System (EDS2). This is designed to help local NHS organisations, in discussion with local partners including local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010.[79]

One of the 18 system outcomes reported is that services are commissioned, procured, designed and delivered to meet the health needs of local communities.

Figure 2.32 CCG gradings: How well services are commissioned, procured and designed to meet the needs of local communities

EDS2/EDS grading	Description	No of CCGs
Not available		56
Undeveloped	No evidence one way or another for any protected group of how people fare, or evidence shows that the majority of people in only two or less protected groups fare well.	2
Developing	Evidence that the majority of people in three to five protected groups fare well.	28
Achieving	Evidence that the majority of people in six to eight protected groups fare well.	11
Excelling	Evidence that the majority of people in all nine protected groups fare well.	3

Note: Sample was 100 CCGs.

We looked at a sample of 100 CCG websites to see the gradings for this outcome (or the equivalent predecessor outcome if EDS2 gradings were not available yet on the website). Only three CCGs felt they were excelling, and 11 of the 100 felt they were achieving the objective of commissioning, procuring and designing services to meet the needs of local communities (figure 2.32). There is no similar national system in place for adult social care to benchmark and develop commissioning of services to meet the needs of diverse communities.

Unequal experiences

Two of our key questions – whether services are caring and whether they are responsive – relate to people's experience of using health and social care. How people experience care is an aspect of service quality, alongside the outcomes from using care and ease of access. Analysis of the NHS 2014 inpatient survey shows that:

People with no longstanding condition reported a better overall experience than people with a mental health condition.

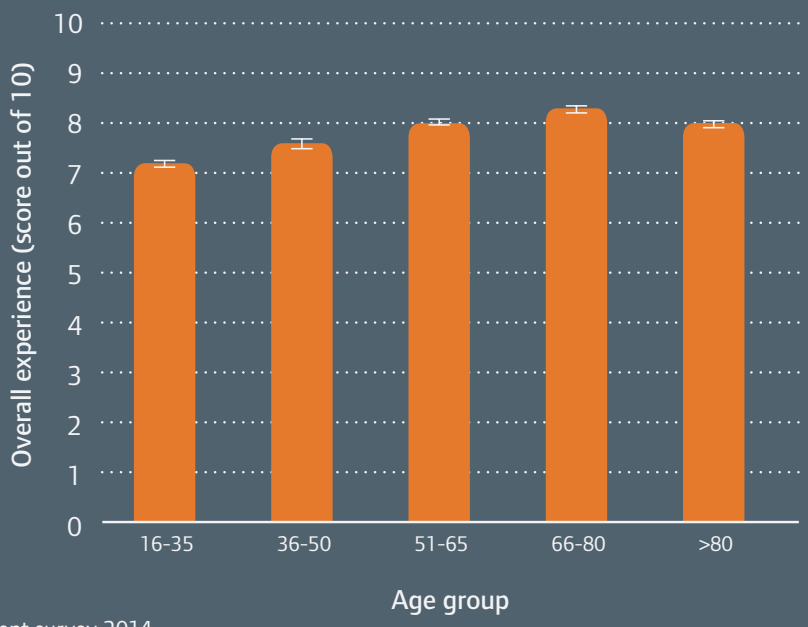
People aged 66-80 report a better overall experience than those aged 16-35 (figure 2.33). This may be due to younger people having higher expectations of health care.

Dignity and respect

There may be several causes of poorer overall experience, such as the communication issues highlighted above. Another factor that can have a bearing on people's overall experience of care is whether people feel that they are treated with dignity and respect during their hospital stay.

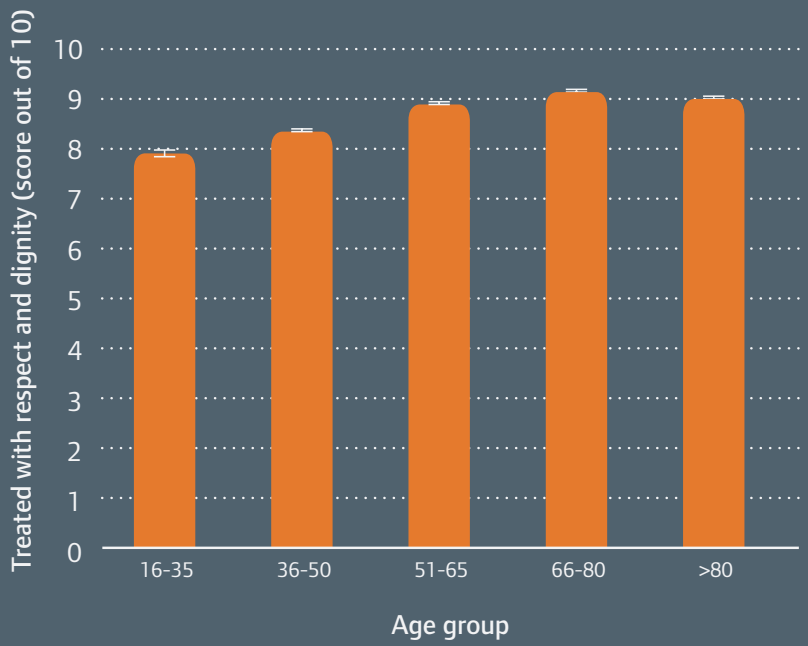
Several equality groups were significantly less likely to say that they were treated with dignity and respect. People aged 16-35 were less likely to say that they were treated with dignity and respect compared with people in older age groups (figure 2.34). People with a mental health condition were less likely to say they were treated with dignity and respect compared with people with no pre-existing health condition (figure 2.35). This supports findings in our mental health crisis care report *Right here, right now*.[80]

Figure 2.33 NHS inpatient survey 2014: overall experience by age



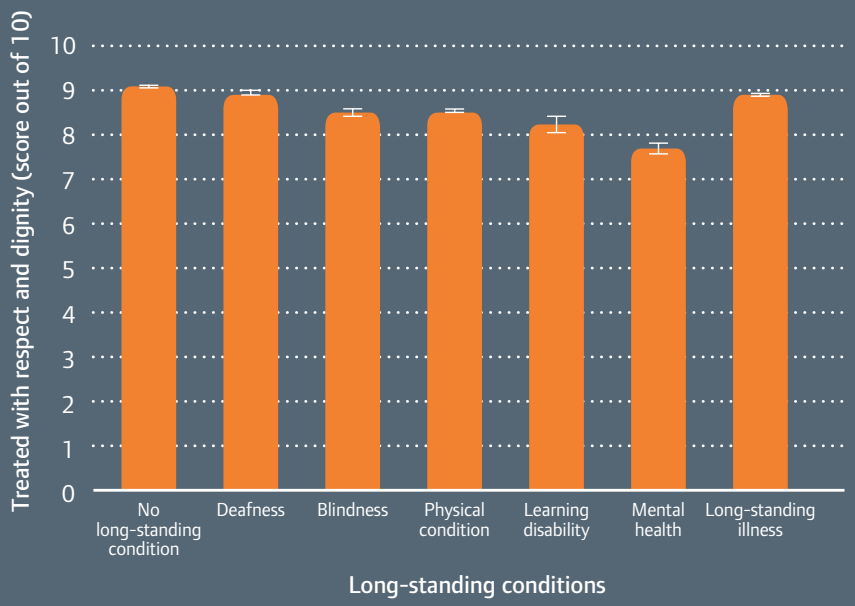
Source: NHS inpatient survey 2014
Note: The chart includes the 95% confidence intervals for the survey results. The sample size varies by demographic group, and the confidence intervals illustrate the level of precision we can attribute to each result.

Figure 2.34 NHS inpatient survey 2014: being treated with dignity and respect, by age group



Source: NHS inpatient survey 2014
Note: The chart includes the 95% confidence intervals for the survey results. The sample size varies by demographic group, and the confidence intervals illustrate the level of precision we can attribute to each result.

Figure 2.35 NHS inpatient survey 2014: being treated with dignity and respect, by pre-existing condition



Source: NHS inpatient survey 2014
Note: The chart includes the 95% confidence intervals for the survey results. The sample size varies by demographic group, and the confidence intervals illustrate the level of precision we can attribute to each result.

Some other equality groups were also significantly less likely to say that they were treated with dignity and respect, although the differences in average scores were smaller than for the groups above. The groups where the average score was at least 0.5 lower than a comparison group included:

- Asian and Asian British people (compared with White people).
- People with a learning disability and blind people, (compared with people with no longstanding conditions).
- Bisexual people (compared with heterosexual people).
- Muslim, Sikh and people with 'other' religions, or those who prefer not to say (compared with Christians).

Other equality groups also had lower ratings, although the difference was less pronounced. These findings are similar to those that we reported in *State of Care 2013/14*, relating to the 2011 inpatient survey.

Meeting people's needs

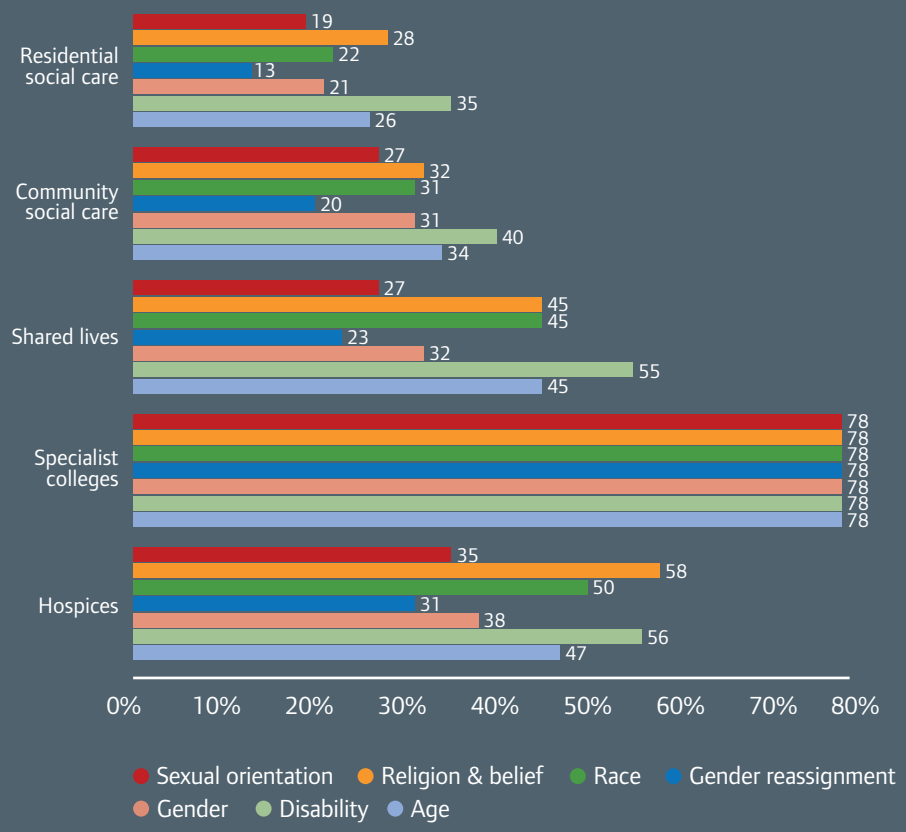
Whether services meet people's needs can also affect your experience. In the inpatient survey, White people were significantly more likely to rate hospital food highly compared with all other groups. They were significantly more likely than all other groups to say that they had been offered a choice of food. This could be due to poor communication with people whose first language is not English, or a smaller range of choice available if people have specific dietary requirements related to religion or culture.

Information from adult social care inspections shows that adult social care services are not consistently addressing equality. Looking at information returned to CQC from more than 7,000 adult social care services between September 2014 and March 2015, 99% of those services have policies covering equality and diversity. However, the percentage of services that said that they had carried out work in the last year to meet the needs of people with particular equality characteristics was much lower, between 13% and 78% depending on the type of service and the characteristic (figure 2.36).

Whether services meet the needs of people related to their equality characteristics is considered under the responsive key question. Residential services (which here include both residential care and nursing homes) have done the least work across all protected characteristics. Our ratings for the responsive key question mirror this data, with residential services having a higher proportion of inadequate and requires improvement ratings compared with other types of social care service.

Across all service types, except specialist colleges, the protected characteristics where least work has been done are gender reassignment and sexual orientation. This mirrors findings in comparable analyses published in 2008 and 2011.[81]

Figure 2.36 Percentage of services reporting that they have undertaken work on equality in the last 12 months – by service type and protected characteristic



Source: CQC provider information returns, Q3/4 2014/15 and Q1/2 2015/16

Unequal outcomes

What do we mean by outcomes?

How we look at outcomes will depend on the type of service. For health services, it is possible to use clinical outcomes as a measure. Our key questions relating to safety and effectiveness are strongly linked with outcomes. There is some evidence of poorer health outcomes for equality groups – for example in relation to higher infant mortality rates among some minority ethnic groups – but the complex factors contributing to the inequality, including the interplay of deprivation, physiological, behavioural, cultural and service access factors are not well understood. There is also a wide body of evidence that some people with a learning disability are dying prematurely, yet there is no agreed data review process in place to see where improvement is needed (though one is proposed as part of the NHS *Five Year Forward View*).[82]

Our equality objectives

One of our equality objectives is to help our inspectors to pursue key lines of enquiry and to make consistent and robust judgements about particular aspects of equality – including whether adult social care services meet the needs of lesbian, gay and bisexual people and people with a sensory impairment.

In adult social care, it is harder to define outcomes, as services have an impact on many aspects of a person's life. The Adult Social Care Outcomes Framework uses a range of indicators arranged into four domains covering quality of life, reducing need for care and support, positive experience of using services and safeguarding.[83] However, the findings from this only relate to people using local authority funded adult social care services. Looking at combined measures in a 'quality of life' outcome score in the latest data, there is little difference on the basis of age or gender. However, the score is higher for people with a learning disability compared with other groups – though this could be affected by expectations – and lower for Asian/Asian British and Black/Black British people compared with people in other ethnic groups.

Satisfaction levels with social care services are also higher for people with a learning disability compared with other groups and higher for White and Chinese people compared with other ethnic groups. Recent research suggests language barriers, knowledge of the "social care system", the need for culturally appropriate services and sometimes experiencing racism are the underlying drivers for the lower satisfaction levels of South Asian people using social care.[84]

Using our ratings

Our ratings of health and social care service providers against five key questions should form a proxy measure of likely outcomes from using a service. If a service is rated good or outstanding, the overall outcomes for people using the service should be higher than those in services rated requires improvement or inadequate.

An analysis of overall ratings for almost 1,000 GP practices rated to date showed no significant correlation between a practice's overall rating and the level of deprivation in the area it served.

Workforce equality

The NHS workforce is very ethnically diverse: 38% of NHS medical staff are from BME groups, compared with 11% in the UK workforce in general. However, in both the NHS and adult social care, a higher percentage of White staff are in management roles than BME staff. In the NHS non-medical workforce, 7% of White staff are in management grades (Band 8a-9) compared with 5% of Asian/Asian British staff and only 3% of Black/Black British staff. In adult social care, BME people make up 20% of the direct care workforce but only 13% of managers or supervisors are from a BME background.[85]

A similar pattern appears by gender: 81% of non-medical staff and 82% of social care staff are women, compared with 46% in the UK workforce in general. However, only 5% of female non-medical staff in the NHS are in management roles, compared with 10% of male staff. Similarly, only 8% of women working in adult social care are in management or supervisory roles, compared with 10% of men.

Comparisons are difficult for other protected characteristics, because the monitoring information is poor due to a mixture of data not being gathered or staff choosing not to disclose.

In April 2015, the NHS Workforce Race Equality Standard (WRES) became mandatory for NHS trusts, following evidence that the number of BME staff at senior and board levels in the NHS is getting worse, that BME staff still experience high levels of discrimination[86] and that there is a link between the treatment of BME staff and patient experience.[87] For the first time, organisations employing almost all of the 1.4 million NHS workforce need to demonstrate progress against a number of indicators of workforce equality.

For acute trusts, we have analysed the four questions from the 2014 NHS staff survey that are included in WRES to look for differences between White staff and BME staff at national level and by trust.

BME staff report significantly more personal experience of discrimination at work than White staff. The highest percentage of White staff to report discrimination by a manager or other staff in any one trust was 12%; the highest percentage for BME staff was 33%. Nearly 60% of trusts showed a difference that is statistically significant between White and BME respondents, with BME groups always showing a higher percentage that say they experience discrimination.

Significantly fewer BME than White staff believe their trust offers equal opportunities for career progression or promotion. Sixty-one per cent of trusts show significant differences between BME and White respondents on this question with BME staff always showing a worse perception of equal opportunities.

An inspector's view

"It's a good sign when the manager actually knows people's names and gets down and does the work beside the staff and gets involved."

Our equality objectives

Another of our equality objectives is to include race equality for staff (through the NHS Workforce Race Equality Standard) as a factor in our judgements about whether hospitals are well-led.

Staff experience
In the analysis of the NHS staff survey for acute trusts:

- BME staff report slightly more harassment, bullying or abuse from patients, relatives or the public than White staff. The highest percentage of White staff to report this in any trust was 40%, whereas the highest percentage for BME staff was 50%.
- BME staff also experienced significantly more harassment, bullying or abuse from other staff than White staff in 13% of trusts. The highest percentage of White staff to report this in any trust was 42%, whereas the highest percentage for BME staff was 55%.

Recent research by the NHS Equality and Diversity Council[88] and Stonewall[89] considers the experience of disabled staff and lesbian, gay, bisexual and transgender staff working in health and social care. These two reports show that staff in these groups can also face discrimination and a poorer workplace experience.

Our challenge to the care sectors on equality

- Everyone has a right to be treated with dignity and respect when using services. Acute hospitals need to engage with local communities to understand why some groups such as Asian and Asian British people and people with mental health conditions are less likely to feel treated with dignity and respect and put plans in place to address the causes.
- Adult social care services need to look at a range of equality issues for people using their service – including giving due to consideration to whether work is required to ensure equality for potentially less 'visible' groups such as lesbian, gay, bisexual and transgender people.
- Providers need to do more to improve communication with all the people that they serve, to ensure that everyone has access to the full range of services that they might need.
- Sectors need to plan services to meet changing demographics – for example the increase in older BME people.
- Sectors need to develop better national and local data on access, experience and outcomes for different equality and inclusion health groups – and make better use of existing data to understand and address service inequalities, including where there is evidence of serious inequalities in outcomes such as higher mortality rates.
- The NHS Workforce Race Equality Standard is a good start to improving workforce race equality and time will tell if it makes an impact. Ways of improving equality for staff on the grounds of other protected characteristics also need development.

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Care Quality Commission

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on the day BRIEFING

the association of foundation trusts and trusts NHS providers

THE STATE OF HEALTH CARE AND ADULT SOCIAL CARE IN ENGLAND 2014/15

This briefing summarises today's publication of the Care Quality Commission's annual *State of Health and Adult Social Care in England 2014/15*, which sets out the key findings from the inspection of almost 5,500 registered organisations in primary, secondary and social care, across both NHS and independent/private providers. This briefing focuses on the content which relates most directly to our members - NHS foundation trusts and trusts - however we have included key themes from across the health and care sector. The findings in the report are derived entirely from the use of CQC's new inspection model for the first time.

Key messages

- **The Care Quality Commission's annual 'State of Care' report provides a valuable update across the health and care sector.** The CQC's acknowledgement of the increasingly difficult financial climate in which NHS providers and their partners are operating is particularly welcome.
- **We note the need for a sustained focus on patient safety which is underpinned by robust governance and a culture of learning and improvement.** Even so, as CQC acknowledges, the funding challenges cannot be ignored if the NHS is to provide sufficient staff to ensure consistently high quality and safe services every day of the week.
- **We look forward to working with CQC and our members to ensure the insights in today's report are reflected in its forthcoming strategy for quality regulation** and to support providers as they strive to improve.
- **In the current climate it is essential that regulation remains risk based and proportionate** and there is a need to balance institutional accountabilities with a view of the wider issues impacting the local health and care economy.
- **The media coverage of the report has on the whole been unhelpful** and does not reflect the fact that not all providers have yet been inspected.

The second annual NHS Providers Regulation Survey has recently completed and we look forward to providing you with the results in the near future.

PART 1: THE STATE OF CARE IN ENGLAND

CQC helpfully recognises the complex and challenging environment in which the majority of services are operating, The report acknowledges the scale of that achievement as the majority of health and social care services have been rated good or outstanding. Overall, across health and social care, CQC found:

- services have responded well to changing care needs and extreme financial constraint and there are many examples of excellent care across the country, and particularly of the compassion and dignity with which frontline staff treat those in their care.
- there is significant variation in the quality of care provided both within and between organisations, and for different groups of patients and service users
- the factors impacting most on the safety of services include safe staffing numbers and skills mix, learning from incidents and errors, creating a culture of transparency and improvement and staff feeling able to raise concerns. The report also highlights the importance appropriate data sharing between services

- Strong leadership and collaboration are emerging as more crucial than ever to delivering good care. 94 per cent of services rated as good or outstanding overall were also rated good or outstanding for leadership. In the future, leadership, resilience and innovation will be key to ensuring that quality is maintained and improved as providers move towards new ways of working to meet the changing health and care needs of their populations.

How health and adult social care is performing

- Safety remains the biggest concern across the health and care sector as a whole, with one in ten providers overall rated inadequate for safety. However, the report acknowledges it will be even more difficult to deliver safe care in the current challenging environment of increasing demand and flat funding.
- 74 per cent of hospital services have been rated 'requires improvement' or 'inadequate' in this domain.
- High quality leadership is identified as crucial to care quality – 94 per cent of services rated good or outstanding also received those ratings for their leadership.

The views of people using services can be one of the best predictors of the rating for a provider:

- Positively, 61 per cent of people thought the NHS offered good services nationally, and 74 per cent said the same of their local services. 84 per cent were satisfied with their own experience of hospital care.
- CQC's findings reflect these views – it awarded the highest ratings in the caring domain, with 95 per cent of services provided by FTs and trusts rated good or outstanding.

There is significant variation in the quality of services provided within and between organisations:

- People with long term conditions, particularly mental health conditions, and those from BME groups were less likely to say they received sufficient information and support to access other services upon discharge.
- People with long term conditions, especially mental health conditions, were less likely to report a positive experience of using acute hospital services.
- Children with specific needs such as physical disability, mental health conditions or learning disabilities, and their parents, were more likely to have a negative experience of care.
- Quality of practice in information governance is linked to the quality of people's experience.

Encouraging improvement

CQC's considers that its new approach to inspections has been effective in driving local improvement in care quality.

- Half of services that were re-inspected after CQC identified concerns improved their ratings on re-inspection.
- CQC is confident that providers have shown they are capable of achieving improvements rapidly when needed.
- The first two trusts to be rated outstanding are now inviting visits from others seeking to understand how they achieved this. CQC encourages providers sharing learning in this way.

Ensuring safe, high quality care in a period of change

CQC recognises that providers across health and social care will need to implement major changes to ensure quality and sustainability in growing operational challenges and complexities.

- Some services achieve excellent care despite financial constraints which leads the report authors to suggest thatothers should be able to do so too.
- Radical change to deliver on *Five year forward view* commitments will inevitably bring some uncertainty and variation in the short term.
- For FTs and trusts, CQC'S analysis showed a "weak but significant" correlation between some financial indicators and better quality ratings. Trusts rated good or outstanding had an average deficit of £2m, compared with £32m average deficit for trusts rated inadequate.

Building strong leadership, resilience and innovation

This section sets out CQC'S view of what is needed for services to improve and provide safe, high quality care which is sustainable in increasingly challenging conditions. Providers can improve quality by focusing on three areas. In each of these areas, well-led trusts are characterised by:

Leadership that builds a shared ownership for quality and safety:

- Engaging with staff and service users. CQC has found a correlation between patient satisfaction and how likely staff are to recommend their trust, and its ratings.
- Open, transparent cultures where staff feel able to raise concerns and report incidents, see complaints as an opportunity rather than a negative, and the focus is on learning rather than blame.
- Alignment of senior clinical and non-clinical staff, and visible and accessible leaders to staff.
- Governance processes that support leaders to act on concerns.
- Since November 2014, NHS providers have put systems in place to support adherence to the fit and proper persons and duty of candour regulations. CQC has not identified any breaches of the duties to date and will report in more depth about the implementation of these measures next year.

Staffing that goes beyond numbers to reflect skill mix, deployment, support and development:

- The right systems to ensure staffing levels meet patients' needs at all times.
- Robust approaches to minimise risks when staffing is not as planned.
- Good management of rotas and reduced reliance on agency nurses, although trusts rated good and outstanding still experienced shortages at times.
- Measures to meet patient demand, such as seven day consultant support, and out of hours consultant-led care.
- A culture of developing staff and strong systems for appraisal and supervision.

Working together to address cross-sector priorities:

- Collaboration to ensure sustainability
- Strong safeguarding process within and between organisations.
- High quality and effective sharing of data about services. Inspectors have found links between the experience of people who use services and how well information is used to improve care.
- From next year CQC will take account of providers' compliance against new data quality standards.

PART 2: SECTOR SUMMARIES

The report uses the term 'hospitals' to encompass providers across acute, specialist, mental health, community based services and some ambulance services. We have therefore structured the information below differently for our members, and we continue to raise with CQC the need to better define, and flex their model to accommodate different types of provision and community based provision in particular. Inspections for ambulance trusts are not included as a dedicated focus within this year's report while CQC continues to roll out the approach to this sector.

Acute care

- By 31 May CQC had inspected 47% of acute trusts, using intelligent monitoring to prioritise those trusts displaying higher levels of risk. They aim to complete all acute and specialist trust inspections by June 2016.
- Of the inspected acute providers (including independent hospitals), two are outstanding, 51 are good, 85 require improvement 12 were rated inadequate.

- However, variability of care quality and safety within services is masked by the aggregated performance ratings.
- Across the eight core services, critical care offers the most consistently high quality (68% good or outstanding), and medical care needs most improvement (34% good or outstanding)
- The overall hospital rating is most closely correlated with service ratings for medical care and surgery, NHS Inpatient Survey scores for patient confidence in their doctor and NHS Staff Survey scores for the trust as a place to work. Of the five inspection domains:
- Caring remains the most consistently high – 95% of providers are good or outstanding.
- Safety: as last year, safety remains of biggest ongoing concern, with 26% trusts rated good and 74% requiring improvement or rated inadequate. Serious incident reporting has grown by 10%, inconsistent quality remains across the sector in reporting, investigation, escalation and shared learning from incidents.
- Effective: trusts are participating more in benchmarking exercises such as national clinical audits, but improvement is not supported consistently enough through reporting the results at board level, performing local clinical audits and risk assessments, monitoring risks and incorporating these in quality improvement plans
- Responsive: Most trusts are actively managing their response to system-level problems that are resulting in delayed discharges and high bed occupancy rates, but inadequate planning means some trusts are resorting to 'day-to-day crisis management'.
- Well-led: care quality is closely correlated with a clear vision and values system that drives a trust culture of openness, transparency, patient-centred focus, visible leadership, investigation and learning from mistakes, multidisciplinary teamwork, clear lines of accountability, regular staff appraisals and development support.
- Improvement in trusts removed from special measures is closely correlated with: strength of trust leadership; acceptance of scale of challenges faced by the trust; and alignment and engagement between managers and clinicians.

Mental health and community services

- Inspections encompassed wards, community-based care, crisis response services and acute settings.
- Of 52 mental health trusts, only 8 have received formal ratings (14%) across 11 core services; 65% of these services were of good standard; CQC considers more inspections are needed to identify any patterns in care.
- Despite the challenges of ageing buildings, more trusts must improve their processes for identifying and managing ligature risks and achieving appropriate gender segregation on wards to ensure safe care.
- Staffing shortages are threatening safety and quality of care on wards, though most of the available staff are appropriately trained and given development opportunities to ensure they continue to provide effective care.
- Most staff are appropriately caring and responsive to service user needs, though emergency department staff require training to show more understanding, compassion and kindness towards people in mental health crisis.
- Commissioners must work with providers to ensure sufficient availability of ward beds and children's services.
- The geographic and service delivery challenges faced by larger providers means that to be well-led, board assurance and governance processes must establish greater connection to the impact of decisions on the frontline, better access to and use of data to understand service challenges and measure improvement, and values based leadership.

Other sectors

- Adult social care is adapting to multiple significant pressures, with growth in domiciliary care providers and residential care providers of 50+ beds, and reductions in small-scale (20-50 bed) residential care. CQC found that 60% of inspected providers (17% of 33,000 registered services) rated good or outstanding; 33% require improvement and 7% are inadequate.

- **Primary medical services** were most proportionately rated as good or outstanding (85% of inspected services); 4% of GP practices were inadequate. Care quality was strongly associated with higher GP Patient Survey scores and higher number of GPs in the practice.
- **Equalities**: different groups report experiencing differing levels dignity and respect, which impacts on their overall experience of care. For acute providers, results suggest there are inconsistent staff communications to patients on discharge arrangements for minority ethnic, mental health and learning disabilities people.

PRESS STATEMENT

NHS Providers welcomes 'State of Care' focus on both challenges and achievements

Miriam Deakin, head of policy at NHS Providers, said:

"The Care Quality Commission's annual 'State of Care' report provides a valuable update across the health and care sector. The fact that 95% of inspected trusts have been rated good or outstanding for 'caring' reflects the commitment and hard work of staff at the frontline and we were pleased to see this reinforced by examples of outstanding practice in the report.

"The CQC's acknowledgement of the increasingly difficult financial climate in which NHS providers and their partners are operating is particularly welcome. The regulator is right to recognise that local leaders need to work collaboratively across their local health economies and to make clear that access to appropriate numbers of staff with the right skills mix is fundamental to safeguard quality of care. This is a timely observation given the recent focus on supporting NHS leadership and on safe and affordable staffing.

"NHS providers take seriously the areas for improvement set out within the report, and we note the need for a sustained focus on patient safety which is underpinned by robust governance and a culture of learning and improvement.

"We look forward to working with CQC and our members to ensure the insights in today's report are reflected in its forthcoming strategy for quality regulation and to support providers as they strive to improve. Our members agree that there is a need to balance institutional accountabilities with a view of the wider issues impacting the local health and care economy. However in the current climate it is essential that regulation remains risk based and proportionate so that provider boards are not held back from demonstrating the leadership qualities put forward in this report and can invest their energies in delivering high quality care for patients."

For further information about this briefing please contact Cassandra Cameron, Policy Advisor.

NHS PROVIDERS
15 OCTOBER 2015

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Andrea McCourt, Head of Governance and Risk
Date: Thursday, 29th October 2015	**Sponsoring Director:** Julie Dawes, Director of Nursing
Title and brief summary: Risk Register - This paper presents to the Board the Corporate Risk Register for the Board's consideration and oversight.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: The Corporate Risk Register has previously been considered at the Risk and Compliance Group on 13 October 2015 and the Quality Committee, 27 October 2015.	
Governance Requirements: Keeping the Base Safe	
Sustainability Implications: None	

Executive Summary

Summary:

This paper presents to the Board the Corporate Risk Register for the Board's consideration and oversight.
The Corporate Risk Register identifies the current significant risks the organisation is facing as at October 2015.

The paper present all risks with a score of 15+ using a risk scoring system and highlights changes to the Corporate Risk Register last seen by the Board in September 2015.

Main Body

Purpose:

The role of the Board is to assure itself that all risks are accurately identified and mitigated adequately. The Corporate Risk Register details the significant risks that the Trust faces

Background/Overview:

The Corporate Risk Register is presented to the Board on a monthly basis to ensure that the Board is aware of the key risks facing the Trust.
The Corporate Risk Register is a key part of the organisation's risk management system, as described in the Risk Management Policy.

On a monthly basis the Risk and Compliance Group considers all risks that potentially may be deemed a corporate risk, i.e. those with a risk score of 15+ or more, on a monthly basis, prior to presenting these to Quality Committee and the Board.

The Issue:

The Corporate Risk Register identifies 16 risks which are detailed in the enclosed report which also includes:

- top risks with the highest scores (20 and 25)
- risks with increased scores
- risks with reduced scores
- new risks
- closed risks.

Next Steps:

The Corporate Risk Register is a dynamic document and will continue to be presented to the Board on a monthly basis to ensure it is aware of all significant risks facing the organisation.

Recommendations:

Board members are requested to:

- consider, challenge and confirm that potential significant risks within the Corporate Risk Register are under control
- consider and approve the current risks on the risk register
- advise on any further risk treatment required.

Appendix

Attachment:

October 2015 Board Summary Corporate Risk register 15+ (2 files merged).pdf

CORPORATE RISK REGISTER REPORT

Risks as at 19 October 2015

TOP RISKS
6131 (25): Progression of service reconfiguration impact on quality and safety 2827 (20): Poor clinical decision making in A&E 4706 (20): Failure to meet cost improvement programmes 4783 (20): Outlier on mortality levels 6345 (20): Staffing risk, nursing and medical 6346 (20): Ability to deliver service transformation risk
RISKS WITH INCREASED SCORE
No risks have increased in score.
RISKS WITH REDUCED SCORE
No risks have reduced in score.
NEW RISKS
Two finance risks have been added relating to: 6150 (15): Cash Flow risk 6027 (15): Suspension of capital programme One risk has been added regarding doctors in training following review by the Risk and Compliance Group. This is deemed a significant risk and appropriate for the Corporate Risk Register. 6094 (12): Medical education: loss of training grade posts
CLOSED RISKS
No risks have been closed.

CORPORATE RISK REGISTER – OCTOBER 2015 Summary of Risks by Risk Type

Risk Ref	Strategic Objective	Risk	Executive Lead (s)	Sept. 2015	Current Risk score and change
		Strategic Risks			
6346	Transforming & Improving Patient Care	Capacity and capability to deliver service reconfiguration	Director of Nursing (JD)	**20**	**20 =**
		Safety and Quality Risks			
6131	Transforming & Improving Patient Care	Progress of reconfiguration, impact on quality and safety	Director of Commissioning and Partnerships (AB)	25	25 =
4783	Transforming & Improving Patient Care	Outlier on mortality levels	Medical Director (DB)	20	20 =
2827	Developing Our workforce	Poor clinical decision-making in A&E	Medical Director (DB)	20	20 =
6299	Keeping the base safe	Failure of high risk medical devices	Director of Estates and Performance (LH)	15	15 =
5806	Keeping the base safe	Urgent estate work not completed	Director of Estates and Performance (LH)	16	16 =
		Financial Risks			
4706	Financial sustainability	Failure to meet cost improvement plans and not adhere to financial governance	Director of Finance (KG)	20	20 =
6230	Transforming & Improving Patient Care	Failure to deliver expected financial benefits of Electronic Patient Record	Director of Finance (KG)	20	20 =
6130	Financial sustainability	Loss of income / service due to commissioner procurement decisions	Director of Commissioning and Partnerships (AB)	15	15=
6150	Financial sustainability	Cash flow risk	Director of Finance (KG)		15 !
6027	Financial sustainability	Suspension of capital programme risk	Director of Finance (KG)		15 !
		Performance and Regulation Risks			
6300	Keeping the base safe	CQC Inspection Outcome	Director of Nursing (JD)	16	16
6078	Keeping the base safe	Insufficient Appointment Slots	Director of Nursing (JD)	16	16 =
2828	Keeping the base safe	Slow patient flow and breach of A&E targets	Director of Nursing (JD)	16	16 =
		People Risks			
6345	Keeping the base safe	Ability to deliver service transformation	Medical Director (DB) , Director of Nursing (JD), HR Director	20	20 =
6094	Keeping The base Safe	Potential loss of training grade posts	Medical Director (DB)		12 !

KEY: = Same score as last period ↓ decreased score since last period
! New risk since last report to Board ↑ increased score since last period

Trust Risk Profile as at 20 October 2015

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Rare (1)					
Unlikely (2)					
Possible (3)				! 6094 Potential loss of training grade posts	= 6230 – Failure to deliver expected benefits of EPR = 6299 – Medical Device failure levels ! 6150 Cash flow risks ! 6027 Suspension of capital risk programme
Likely (4)				= 2828 – Slow patient flow & breach of A&E targets due to bed blockages / transport = 5806 – Urgent estate work not completed = 6078 – AIS, insufficient appointment slots = 6130 = Loss of income/services due to commissioner procurement decisions = 6300 – CQC inspection outcome	= 2827 – Poor clinical decision-making in A&E = 4706 – Failure to meet CIP
Highly Likely (5)				= 4783 – Outlier on morality levels = 6345 – Staffing risk, nursing and medical = 6346 – Ability to deliver service transformation	= 6131 – Progression of service reconfiguration impact on quality and safety

KEY: = Same score as last period ↓ decreased score since last period
! New risk since last period ↑ increased score since last period

Corporate Risk Register
Extreme and Major Risks (15 or over) October 2015

NHS
The Health Informatics Service
Informing Healthcare

	Risk No	Div	Dir	Dep	Opened	Status	Strategic Objective	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initail	Current	Target	Further Actions	Review	Target	RC	Exec Dir	Lead
Extreme	6131	Corporate	Commissioning & Partnerships	Commissioning & Partnerships	Oct-2014	Active	Transforming and Improving Patient Care	There is a risk that the Trust will not be able to quickly progress service reconfiguration due to the requirements of a consultation process initiated by local CCG's resulting in delays to important clinical quality and safety issues e.g: Compliance with A&E National Guidance Compliance with Paediatric Standards Compliance with Critical Care Standards Speciality level review in Medicine Unable to meeting 7 day standards Difficulties in recruiting a medical workforce (increased reliance on Middle Grades and Locums) Increased gaps in Middle Grade Doctors Dual site working is one of the causes of the Trust;s underlying deficit. Delays in being able to reconfigure services will impact on the Trust's financial recovery plan. ***It should be noted that risks 2827 and 4783 should be read in conjunction with this risk.	The continued funding of medical staff on both sites Nurse led service managing Paediatrics Critical care still being managed on both sites High usage of locum doctors Frequent hospital to hospital transfers to ensure access to correct specialties The Trust has developed a contingency plan should it not be able to provide sufficient medical staffing to provide safe A&E services on two sites.	Financial plans of associated reconfiguration not yet completed or agreed with CCG's Estate limitations inhibit the present way of working Consultant rotas cannot always be filled to sustain services on both sites Interim actions to mitigate known clinical risks need to be progressed.	25 5 x 5	25 5 x 5	15 5 x 3	Joint working is in place with Commissioners (through the joint Hospital Board) to revisit the clinical model, activity, workforce and financial modelling of options for hospital reconfiguration. The Trust is required by Monitor to develop a 5 year strategic plan that will improve the Trust's financial and clinical sustainability. This plan will be completed by December 2015 and will include plans for reconfiguration of services across hospital sites. The Trust's five year plan will inform and enable CCG's to make a decision in early January to commence public consultation. The Trust has developed and is discussing with CCGs options for progressing interim actions to mitigate known clinical risks (cardiology and respiratory service configuration, Emergency Pregnancy Assessment configuration).	Sep-2015	Jan-2016	WEB	Anna Basford	Catherine Riley
Major	6346	Trustwide	All Divisions	All Departments/Wards	Jul-2015	Active	Transforming and Improving Patient Care	Capacity and Capability of Delivering Service Transformation Risk of not achieving service transformation due to insufficient capacity and capability across the organisation to deliver the many transformation schemes underway (Electronic Patient Record (EPR), clinical administration review, financial turnaround and cost improvement schemes, CQC preparation, service reconfiguration, i.e. consultation and planning for Outline Business Case, Care Closer to Home Proposal) resulting in impact on delivery of safe clinical care for patients in the right setting and financial imbalance.	Programme Management Office established to managing schemes Strategic and Financial Turnaround Plan, 2015/166 financial plans and cost improvements Integrated Board report details Trust financial position monthly Well Led Governance Review identifies areas to strengthen governance across the Trust CQC Steering Group reviews progress with CQC action plan preparation to identify areas of risk of non-delivery EPR implementation programme	Assurance that the totality of transformation schemes can be delivered	16 4 x 4	20 4 x 5	9 3 x 3	To consider adding the risk to the Board Assurance Framework. July update: Workshop held with Executive team to consider this conflicting priorities. A number of proposals developed to be discussed at next Directors meeting.	Sep-2015	Mar-2016	WEB	Julie Dawes	Director of Nursing, Julie Dawes
Major	2827	Medical	Emergency Network	Accident & Emergency	Apr-2011	Active	Developing our workforce	There is a risk of poor clinical decision making in A/E due to a dependence on locum Middle Grade Doctors at weekends and on nights resulting in possible harm to patients, extended length of stay and increased complaints ***It should be noted that risks 4783 and 6131should be read in conjunction with this risk.	Associated Specialist and Regular locums for continuity appointed Middle Grade Doctors moved within sites to respond to pressures Where necessary other medical staff re-located to ED Consultants act down into middle grade roles to fill gaps temporarily	Difficulty in recruiting Consultants, Middle Grade and longer term locums Relatively high sickness levels amongst locum staff	20 4 x 5	20 5 x 4	12 4 x 3	Expedite Outline Business case for reconfiguration of services across sites to afford better deployment of medical staff Explore use of ANP to fill vacant doctor posts Business Continuity Plan awaiting approval of Urgent care Board covering ability to provide safe services for varying periods of time October 2015 4 Consultant posts advertised in June 15 still vacant as no applications and under consideration for international recruitment	Jan-2016	Oct-2015	WEB	David Birkenhead	Dr Mark Davies/Mrs Bev Walker

Major	4706	Corporate	Finance	Corporate Finance	Jun-2011	Active	Financial sustainability	The Trust is planning to deliver a £20m deficit (excluding restructuring costs) in 2015/16. There is a risk that the Trust fails to achieve it's financial plans for 2015/16 due to failure to deliver cost improvement plans or not adhering to good financial governance, resulting in compromised patient safety and increased external scrutiny.	Standing Financial Instructions set spending limits Turnaround structure in place which has created a more robust Project Management Office and the rigorous administration of cost improvement schemes Implementation of Turnaround Governance procedures (i.e. accurately reporting and projecting financial performance) Divisions can respond to activity targets on a specialty basis (e.g. additional theatre sessions/outsourcing if necessary) Formal Finance Our Future training Board to Budget Holders in place Budget reviews hold budget holders to account Accurate Income and Expenditure forecasting CIP target greater than actual savings required and contingency reserve established by the Director of Finance	The unpredictability of Commissioners tendering process and possible decommissioning of services. Impact of decisions in wider local health and social care system on capacity driven expenditure requirements in Trust.	15 5 x 3	20 4 x 5	10 5 x 2	Plans to be agreed to manage gains or losses following tendering process. October update: The year end forecast continues to be a worsened position from plan, currently forecast £22.2m deficit against planned £22.0m (excluding restructuring costs)	Nov-2015	Mar-2016	FPC	Keith Griffiths	Kirsty Archer
Major	4783	Corporate	All Directorates Corporate	All Departments/Wards Corporate	Aug-2011	Active	Transforming and Improving Patient Care	There is a risk that the Trust falls below national standards for mortality levels due to not delivering appropriate standards of care for acutely ill patients/frail elderly patients and possible incorrect clinical coding resulting in inaccurate reporting of preventable deaths, increased external scrutiny and a possible increase in complaints and claims. ***It should be noted that risks 2827 and 6131 should be read in conjunction with this risk.	Outlier areas are monitored (e.g. Stroke, Sepsis and COPD) Outliers are investigated in depth to identify the cause. Improvement work is implemented via an action plan Mortality dashboard analyses data to specific areas Monitoring key coding indicators and actions in place to track coding issues Written mortality review process agreed to clarify roles and to facilitate a greater number of reviews being completed, process for escalation, linking with other investigation processes e.g. SI panel review. August reviews of July deaths (using new process) compliance 70% - highest since Feb'15 Monthly report of findings to CEAM and COG from Sept 2015 (Aug reviews of July deaths) Revised investigation policy clarifies process for learning from all investigations, including mortality reviews, and monitoring of actions CAIP plan revised Aug 2015 and now focusing on 6 key themes: investigating mortality and learning from findings; reliability; early recognition and response to deterioration; end of life care; frailty; and coding. Care bundles in place	Mortality reviews to assess preventable deaths which is indicating there isn't a problem but not yet performed for long enough or to sufficient depth to determine causes Mortality case notes review may not pick up all factors relating to preventability Coding improvement work not yet complete Improvement to standardized clinical care not yet consistent. To be completed by Dec 15 Care bundles not reliably commenced and completed	20 4 x 5	20 4 x 5	16 4 x 4	- To complete the work in progress - CQUINS to be monitored by the Trust - External review of data and plan to take place - assistance from Prof Mohammed (Bradford) August update: Further information received with increased risks to mortality. Action plan reviewed and presented to WEB. PMO approach to be adopted for reliable implementation of care bundles Sept update: Compliance with mortality reviews for last month significantly increased. October Update: Improvements in coding noticed. Professor Mohammed, mortality expert, has made recommendations which are being progressed. Plan to commission Royal College review into some key services.	Jan-2016	Aug-2016	COB	David Birkenhead	Juliette Cosgrove

Major	6345	Trustwide	All Divisions	All Departments/Wards	Jul-2015	Active	Keeping the Base Safe	Staffing Risk Risk of not being able to deliver safe and effective high quality care and experience for patients due to: - lack of nursing staffing as unable to recruit to substantive posts, i.e. not achieving recommended nurse staffing levels (as per Hard Truths workforce model) - lack of medical staffing as unable to recruit to Consultant / middle grade doctor / junior doctor vacancies across a number of specialties (A&E, Opthalmology, Anaesthetics, Paediatrics, Histopathology, Radiology, Gynaecology/Urology Oncology, Acute Oncology Service) - over-reliance on middle grade doctors meaning less specialist input - dual site working and impact on medical staffing rotas - lack of workforce planning / operational management process and information to manage medical staffing gaps resulting in: - increase in clinical risk to patient safety due to reduced level of service / less specialist input - negative impact on staff morale, motivation,	To ensure safety across 24 hour period: - use of electronic duty roster for nursing staffing, approved by Matrons - risk assessment of nurse staffing levels for each shift and escalation process to Director of Nursing to secure additional staffing - staff redeployment - staff skill mix, eg extend roles of nursing / Allied Health professionals - medical rotas (organised by division) - use of flexible labour where identified staffing shortfalls - bank/ additional hour payments (nursing), internal / agency locum cover - weekly report on usage of agency / bank staff and review of interim resource costs as part of control workstream by Director of HR Active recruitment activity, including international recruitment Retention strategy for nursing Integrated Board Report /Hard Truths report identifies nursing staffing levels below requirements Divisional management:specific staffing gaps identified on Risk Register and reviewed through governance structures, divisional business meetings identify staffing risks and plan to	Lack of: - workforce plan / strategy for medical staff identifying level of workforce required - dedicated resource to develop workforce model for medical staffing - centralised medical staffing roster (currently divisional) / workforce planning for medical staff - system /process to identify, record and manage gaps in planned medical staffing, particularly for junior doctors - measure to quantify how staffing gaps increase clinical risk for patients International recruitment for medical staff yet to take place	16 4 x 4	20 4 x 5	9 3 x 3	Nursing recruitment - investigate the possibility of outsourcing flexible workforce department Continue to recruit to vacant posts / skill mix review, progress international recruitment of medical staff, consider incentive schemes. (Director of Nursing, Medical Director) Secure resource to develop medical staffing workforce planning (Medical Director) Improved operational management of medical staffing workforce (Medical Director) Set up a Task and Finish Group led by Assistant Director of Operations to agree the response to manage the medical workforce risk (September 2015). August update: Medical staffing paper to be presented to August Quality Committee to understand the full extent of the problem and further mitigations to be considered.	Oct-2015	Mar-2016	WLG	David Birkenhead, Julie Dawes & Jackie Green	Jackie Murphy, Jason Eddleston & Juliette Cosgrove

Major	2828	Medical	Emergency Network	Accident & Emergency	Apr-2011	Active	Keeping the Base Safe	There is a risk of slow patient flow and breaches against the ED national standards due to bed blockages across the Trust, resulting in harm to patients through delayed treatment, increased external scrutiny for the Trust and financial penalties against the contract.	Escalation protocol in place which requires ED Co-ordinator to link with Patient Flow/Clinical Site Commander to ensure patients are moved from ED to a bed within national guidelines Site Commander can authorize additional beds by using flexible capacity Level discharges (required discharges at certain points of the day) plan in place. Site Commander to work with Ward Managers at 2 hourly meetings to ensure these happen All patients have a personal plan established by their Ward which includes discharge arrangements Medically stable patients are reviewed daily by the Discharge Team and Local Authority Surge and escalation plan in place to escalate to higher levels of authority (e.g. cancel next day surgery)	Despite the controls, the bed base in still insufficient at certain times The night period is particularly vulnerable. There is a reliance on locum middle grade doctors due to vacancies	20	4 x 5	16	4 x 4	12	4 x 3	Bed modeling review underway as part of the ED Action Plan. To be completed by mid-June 15 Capacity and demand modeling being undertaken (matching resources to peak activity periods). To be complete by mid-June 15 Urgent Care Board is accessible to consider new initiatives and act as an escalation decision making body in the case of very urgent situations. The Board has reserve resources Update: June 2015 - Silver Command put in place and escalation discussions re: whole system specific issues and creating more capacity. - Business case being developed for 10 additional step down beds at Oakmoor. Bed modelling to be presented to Star Chambers in June. August update: Star Chamber held, outputs validated by PMO who supported the suggested cost pressures and change to year end forecast, particularly in relation to bed capacity. Bed modelling paper presented to WEB and on agenda for August Trust Board meeting with recommendations to support bed cost pressures. September update: Beds paper and presentation delivered at BoD - recommendation approved. Operational plan in development and additional beds will be brought on line as per plan. Work underway with SRG to ensure a robust system level response to cope with peak season demand. ED nurse staffing paper in development and will be presented to Medical Division Business Meeting. Senior decision makers on site from 5-8pm 4 days per week due to commence from mid- September. Achieved compliance with . ED 4 hour standard in August	Sep-2015	Dec-2015	CG	Julie Dawes	Sajid Azeb

Major	5806	Estates & Facilities	Estates, Planning & Contracting	Capital Team	May-2015	Active	Keeping the Base Safe	There is a risk that the following urgent Estates schemes cannot be undertaken due to insufficient resources, resulting in a poor patient experience, possible ward closures and harm caused by slips, trips and falls A) Failure to maintain privacy and dignity on the Chemotherapy Unit at HRI B) Poor/unsafe flooring in ICU at HRI C) Environmental/safety standards on Ward 18 at HRI D) Temperature control in winter on Ward 4 at HRI E) Poor environmental conditions on Ward 5 at HRI F) Uneven floor surface on Ward 19 G) Poor fitting windows on Ward 6 at HRI H) Damaged floor on CCU at CRH I) A&E Resus requires more space.	A) Chemo unit- currently still on ward 3 but will be moving to new facilities on ward 7 in September 15 B) ICU- temporary repairs carried out as & when required but decant necessary for full floor replacement. C) Ward 18- Discharge lounge re-located onto Ward 18 which has been decorated & patient entertainment fitted. Ongoing concerns with Ward 18 (Childrens Area). Estates working with AM Henshaw to provide action plan for intermediate repairs (ward upgrade necessary) - ACTION COMPLETE D) Ward 4- heaters were available for cold rooms. Ward 4 has now been connected to existing vent plant The heating system has been set up to enable the BMS system to control BMS valves within the ward to give better heating control within the area. ACTION COMPLETE E) Ward 5- now moved to ward 11 whilst the ward has works done and a minor upgrade. F) Staff aware of issue; decant to be planned to enable re-skimming of floor G) Windows repaired (temporary) & heaters provided H) Cofley aware of CCU Flooring which is being monitored prior to decanting ward to refurb under lifecycle.	A) The privacy & Dignity Issues are being managed by the ward until move onto new Ward. B) Situation monitored by Estates until opportunity to decant ward and fully replace,. E) Issues highlighted for inclusion in the minor upgrade will be addressed prior to the Ward returning to Ward 5. F) Situation monitored by Estates until opportunity to decant ward and fully repair. G) Superficial repair of Ward 6 windows (carried out Site Wide); windows will be monitored by Estates. H) Cofley aware of CCU Flooring at CRH, on lifecycle replacement however monitored prior to decant. I) A&E resus area requires expansion at HRI	16 4 x 4	16 4 x 4	8 4 x 2	A) Chemo Unit to transfer to upgraded area in Sept 15. B) ICU floor to be monitored until decant possible. F) Ward 19 flooring will be monitored until decant possible G) Windows on Ward 6 will be managed by Estates H) CCU Flooring at CRH will be monitored until decant possible. I) ED resus area at HRI. August update: Further work to improve estates on ward 18 has been completed and therefore risk in relation to this specific estates risk has been reduced. Sept Update:- Repairs carried out to Ward 4 Heating; action complete. October Update: Chemo Unit transferred onto new facilities. Action complete	Jan-2016	Mar-2016	RC	Lesley Hill	Paul Gilling
Major	6078	Family & Specialist Services	Appointments & Records	Appointment Services	Aug-2014	Active	Keeping the Base Safe	Appointment Slot Issues – A failure to provide sufficient appointment slots to manage demand. Caused by an increase in referrals to services/reduced available capacity to manage demand. Resulting in: - poor patient experience - inability to access referral letter as e-referrals cannot be accessed until an appointment is allocated - increased administration (reliance on spreadsheets to track capacity requirements) - impact on Trust ability to attract income	Process: Daily spreadsheet to Clinical Divisions highlighting capacity requirements. Regular communications with Specialty capacity leads. Reallocation of cancelled slots to maximise capacity.	- Variations in capacity and demand plans. - Consultant vacancy factor. - Manual process in place to record ASIs extracting information from ERS and PAS. - THIS are working on a live document that clinical and administrative leads can access to eliminate the emailing and filtering of spreadsheets on a daily basis.	16 4 x 4	16 4 x 4	4 4 x 1	- Capacity issues reported at Planned Care Board and Clinical Specialty developed actions plans to reduce ASIs. - Weekly cross-divisional access Meetings established (at ADD level) to monitor performance. - Recruitment of locum / substantive Consultant posts underway. - Review of clinic templates undertaken which is providing increased capacity for new patient slots - Additional Clinics to continue to address shortfall. -- In addition to the call centre actions above an action plan to enhance administration services has been developed which include short notice clinics, reallocation of cancelled slots, conversion of "special slots", removal of named clinician. This will be reviewed in November. October Update: The Action Plan has been reviewed, and narrative added to include the actions by clinical specialties to reduce ASIs. Trajectory for improvement also included.	Nov-2015	Jan-2016	PCB	Julie Dawes	Rob Aitchison / Katharine Fletch

Major	6130	Corporate	Commissioning & Partnerships	Oct-2014	Active	Financial sustainability	There is a risk of loss of income to the Trust due to Greater Huddersfield CCG and Kirklees and Calderdale Councils undertaking competitive procurements. This could have negative impact by increasing the Trust's underlying deficit and on the clinical resilience and stability of retained services.	There is a robust system of horizon scanning in place to identify when services are to be tendered both within and beyond the catchment area to ensure the Trust is able to respond and make decision of whether to submit tenders. New models of care have been developed in response to the requirements of tenders.	Need to anticipate weaknesses and gaps in services through risk assessments prior to tender processes to make service model changes rather than wait for pressure of a tender to force changes Use of Service Line Reporting needs to be strengthened to identify profitability of services and whether to bid against tenders or disinvest. Need to develop appropriate market exit strategies (disinvestment) to eliminate costs where income is lost.	16 4 x 4	16 4 x 4	12 4 x 3	Develop new models of care in advance of Commissioner tendering processes with advance notice of services likely to be tendered in the future. October 2015 Update: Greater Huddersfield CCG has selected Locala Community Partnerships as the preferred provider of Care Closer to Home services in Kirklees. This represents a £5m loss of income to the Trust. The Trust is working with Locala and Commissioners to manage the transfer of services. A number of services transferred to Locala on 1st October. Further services will transfer during November. The Trust is awaiting update from Kirklees Council regarding their review of the procurement of sexual health services.	Jul-2015	Dec-2015	CISC	Anna Basford	Rob Aitchison & Lisa Williams
Major	6300	Trustwide	All Divisions	May-2015	Active	Keeping the Base Safe	Clinical, operational and estates risks in:Children and young people, maternity and family planning, out patients and diagnostic imaging, A&E, Medical care, end of life care, surgery causing increased risks to patients and possible non-regulatory compliance which may result in CHFT not achieving a CQC rating of good or outstanding (e.g. Estates risks; Paediatric Standard compliance; A&E National Standards compliance), which could cause the Trust to have breach of licence.	- System for regular assessment of Divisional and Corporate compliance - Routine policies and procedures - Quality Governance Assurance structure - CQC compliance reported in Quarterly Quality and Divisional Board reports - Weekly strategic CQC meetings	- Full Divisional and Corporate self-assessment still to be completed - Some out of date policies and procedures - Assessments show us to be be in the "requiring improvement" category	16 4 x 4	16 4 x 4	8 4 x 2	- CQC compliance Steering Group - Implementation CQC Compliance action plan - CQC Operational Group - Further embedding of CQC assurance into the Divisions and Corporate Governance structures October Update: External support for assurance on key areas. Date of inspection confirmed. CQC handbook to all staff (October 2015) and focus groups being held with staff	Jan-2016	Feb-2016	WEB	Julie Dawes	Juliette Cosgrove
Major	6027	Corporate	Finance	Corporate Finance	May-2014	Active	Financial sustainability	There is an operational risk that the Trust will have to suspend its capital programme for 2015/16 due to having insufficient cash to meet on-going commitments resulting in a failure to develop infrastructure in support of a sustainable future for the organisation.	• Agreed loan from Independent Trust Financing Facility (ITFF) received in April 15 to support capital programme, specifically Electronic Patient Record (EPR). • Capital programme has been risk assessed and reduced based on this risk assessed process. • Capital programme managed by Capital Planning Group and overseen by the Commercial, Investment and Strategy Group, including forecasting and cash payment profiling. • Discussed and planned for distressed funding cash support from Monitor. • Agreed re-profiling of cash payments of clinical contract income with commissioners to support treasury management in the short term. • Cash Committee established	Distressed cash support through 'Revenue Support Loan' not yet approved by Monitor.	16 4 x 4	15 5 x 3	5 5 x 1	Working Capital Facility from the Independent Trust Financing Facility (ITFF) approved in September 2015 to secure cash in advance of approval for Revenue Support Loan being sponsored by Monitor to ITFF.	Nov-2015	Mar-2016	WEB	Keith Griffiths	Kirsty Archer

Major	6150	Corporate	Finance	Trustwide	Nov-2014	Active	Financial sustainability	There is a risk that the Trust will not be able to pay suppliers, staff and PDC loans due to cash flow timing or an overall shortfall of cash resulting in external scrutiny, significant reputational damage and possible inability to function as a going concern	• Agreed capital loan from Independent Trust Financing Facility received in April 15 • Agreement with main Commissioners to maintain their matching cash flow payments prior to agreement of contracts for 2015/16 • Capital Programme restricted by risk assessing and prioritising schemes • Cash forecasting processes enhanced through 13 week rolling forecasts • Discussed and planned for Distress Funding cash support from Monitor • Trust's Standards Operating Procedures for Treasury Management and Accounts Payable give authority to withhold payments to suppliers • Agreed re-profiling of cash payments of clinical contract income with commissioners to support treasury management in the short term. • Cash management committee being initiated to review and implement actions to aid treasury management.	Distressed cash support through 'Revenue Support Loan' not yet formally approved by Monitor.	15	5 x 3	15	5 x 3	5	5 x 1	Working Capital Facility from the Independent Trust Financing Facility (ITFF) approved in September to secure cash in advance of approval for Revenue Support Loan being sponsored by Monitor to ITFF.	Nov-2015	Sep-2015	FPC	Keith Griffiths	Kirsty Archer
Major	6230	Corporate	Finance	Corporate Finance	Feb-2015	Active	Transforming and Improving Patient Care	There is a risk that the Trust will not be able to deliver the expected financial benefits of the Electronic Patient Record (EPR) system due to the implementation being impeded by financial and operational constraints (eg additional costs incurred due to time delays or lack of appropriate resource being made available) resulting in a failure to demonstrate return on investment or value for money. There are two elements to this risk: Implementation of tactical solutions (e.g. e-rostering; nerve centre; maternity; voice recognition; EDMS); and Project management delays, changes to specification and lack of capacity; clinical engagement and complexities with working jointly with Bradford Teaching Hospitals.	• Agreed loan from Independent Trust Financing Facility (ITFF) received in April 15 to support capital programme, specifically Electronic Patient Record (EPR). • Financial appraisal and selection of preferred supplier that included full benefits realisation and implementation plan. • Modernisation Programme Management and Governance structure to manage the implementation and roll-out of the EPR system within the Trust-wide IT Modernisation Programme. • Transformation Board meets on a monthly basis chaired at CEO level. • Creation of an Assurance Board that includes Non-Executive directors. • A detailed project plan and timelines has been agreed with Cerner (EPR Provider) and Bradford for the roll-out of the EPR.	The full gap analysis of EPR processes against current working practices to be completed with the requirement to develop an associated change management programme.	15	5 x 3	15	5 x 3	5	5 x 1	Regular updates from EPR Benefits Realisation now regular agenda item at the Trust Finance and Performance Committee.	Nov-2015	Apr-2016	FC	Keith Griffiths	Kirsty Archer

Major	6299	Trustwide	All Divisions	All Departments/Wards	May-2015	Active	Keeping the Base Safe	Patient Safety Risk Risk of failure of high risk medical devices (patient monitoring infusion devices, incubators, phototherapy equipment) due to lack of routine maintenance, staffing capacity and systems in Medical Engineering, resulting in potential patient harm and inability to meet CQC requirements for medical devices.	* Health and Safety Committee monitors medical devices action plan to address recruitment issues, database, risk analysis of devices. * Close management of service contracts to ensure planned maintenance activity has been performed *Categorisation / risk analysis of medical devices (high, medium, low) to prioritise maintenance * Development of Planned Preventive Maintenance (PPM) Programme * Recruitment of administrator and 1 Medical Engineer * Audit of medical devices by independent assessor to identify any further actions needed	1. PPM Programme not yet complete 2. Medical Device database needs to be reviewed to ensure accurate information on medical devices needing maintenance. 3. Lack of information on what proportion of equipment has accurate recording of location on medical devices database 4. Medical Devices Assessor final report and action plan not yet received, meaning further actions required not yet known 5. Newly recruited Medical Engineer not yet in post.	15 5 x 3	15 5 x 3	5 5 x 1	1. PPM Programme to be competed by end October 2015 by V. Wotherspoon 2/3. Medical devices database audit by V. Wotherspoon, completion August 2016 to ensure accurate picture of devices needing maintenance and location of devices.. 4. Review final report and actions of independent assessor (due September 2015) and amend plans accordingly. 5. Newly recruited Medical Engineer to start September 2015 6. Medical Engineering team to move to Estates from end of September 2016 to ensure systems and processes for medical devices are closely monitored.	Jan-2016	Aug-2016	DB	Lesley Hill	V Wotherspoon
Moderate	6094	Corporate	Medical & Nursing Directors Office	Medical Education - Post & Under Grad	Jun-2014	Active	Keeping the Base Safe	Potential loss of training grade posts due to national reductions in numbers or 'gap allocation' and the impact this may have on direct service delivery and service stability.	"Regular dialogue with the Deanery to maintain awareness of which posts may be under threat and as a consequence look at alternative ways of delivering the service. Monitoring closely the results of the GMC and Deanery placement surveys and acting upon any areas identified in need of improvement to minimise the risk of posts being removed."	this risk may now increase due to current issues with junior doctor contract negotiations. if junior doctors choose to work overseas then this will further exacerbate the problem.	12 4 x 3	12 4 x 3	0 0 x 0	Action planning following GMC/HEYH Surveys	Jan-2016		NA	David Birkenhead, Medical Director	Dr Andy Lockey

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Jean Robinson, Lead Infection Prevention and Control Nurse
Date: Thursday, 29th October 2015	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: MONTHLY DIPC REPORT - The Board is asked to receive the report on the position of healthcare associated infections	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Executive Board	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive the report on the position of healthcare associated infections

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to receive the report on the position of healthcare associated infections

Appendix

Attachment:

Monthly DIPC Report October 20151.pdf

Report from the Director of Infection Prevention and Control to the Weekly Executive Board October 2015

Performance targets

Indicator	Month agreed target	Current month (September)	YTD agreed target	YTD performance	Actions/Comments
MRSA bacteraemia (trust assigned)	0	**1**	0	**3**	
C.difficile (trust assigned)	3	**3**	21	**10**	3 avoidable 7 unavoidable
MSSA bacteraemia (post admission)	1	**0**	12	**5**	
E.coli bacteraemia (post admission)	3	**0**	29	**15**	
MRSA screening (electives)	95%	**95.29%**	95%	**95.06%**	August validated data
Central line associated blood stream infections (Rate per 1000 cvc days)	1.5	**1.43**	1.5	**0.77**	
ANTT Competency assessments (doctors)			95%	**62.%**	Work is on-going to validate the data
ANTT Competency assessments (nursing and AHP)			95%	**69.9%**	
Hand hygiene	95%	**99.51%**	95%	**99.66%**	

Quality Indicators

Indicator	Current month (September)	YTD performance	Comments
MRSA screening (emergency)	**90.33%**	**90.80%**	August validated data
Isolation breaches	**27**	**149**	
Cleanliness	**97.28%**	**97.3%**	

HCAIs/Areas of Concern/Outbreaks

- **Isolation breaches** recorded by the Infection Control Team during September were 27 , compared to 38 in August.
    - All 27 of the breaches occurred in the medical division
        - 6 at HRI
        - 21 at CRH

- **Analysis of the isolation breaches** - The IPCN's identify the isolation breaches and follow up daily until the patient is isolated and also assist the ward staff by risk assessing the available side rooms and ensuring control measures are in place
    - Of the 21 breaches at CRH, 17 were patients with previous MRSA, 4 were other MDRO. On 13 occasions the staff had not acknowledged the infection alert and were prompted by the IPCT to isolate the patient. On 14 occasions there was no side room available and on 11 occasions the patient was risk assessed against other patients in the side rooms and deemed the lower risk. Isolation breaches ranged from 1 to 5 days.
    - Of the 6 breaches at HRI, all were patients with previous MRSA. On one occasions the staff had not acknowledged the infection alert and were prompted by the IPCT to isolate the patient. On 5 occasions there was no side room available and on 3 occasions the patients were risk assessed against other patients in the side rooms and deemed the lower risk. Isolation breaches range from 1 to 4 days.
    - The IPCT will continue to monitor isolation breaches and actions to reduce breaches to be included in the HCAI annual action plan

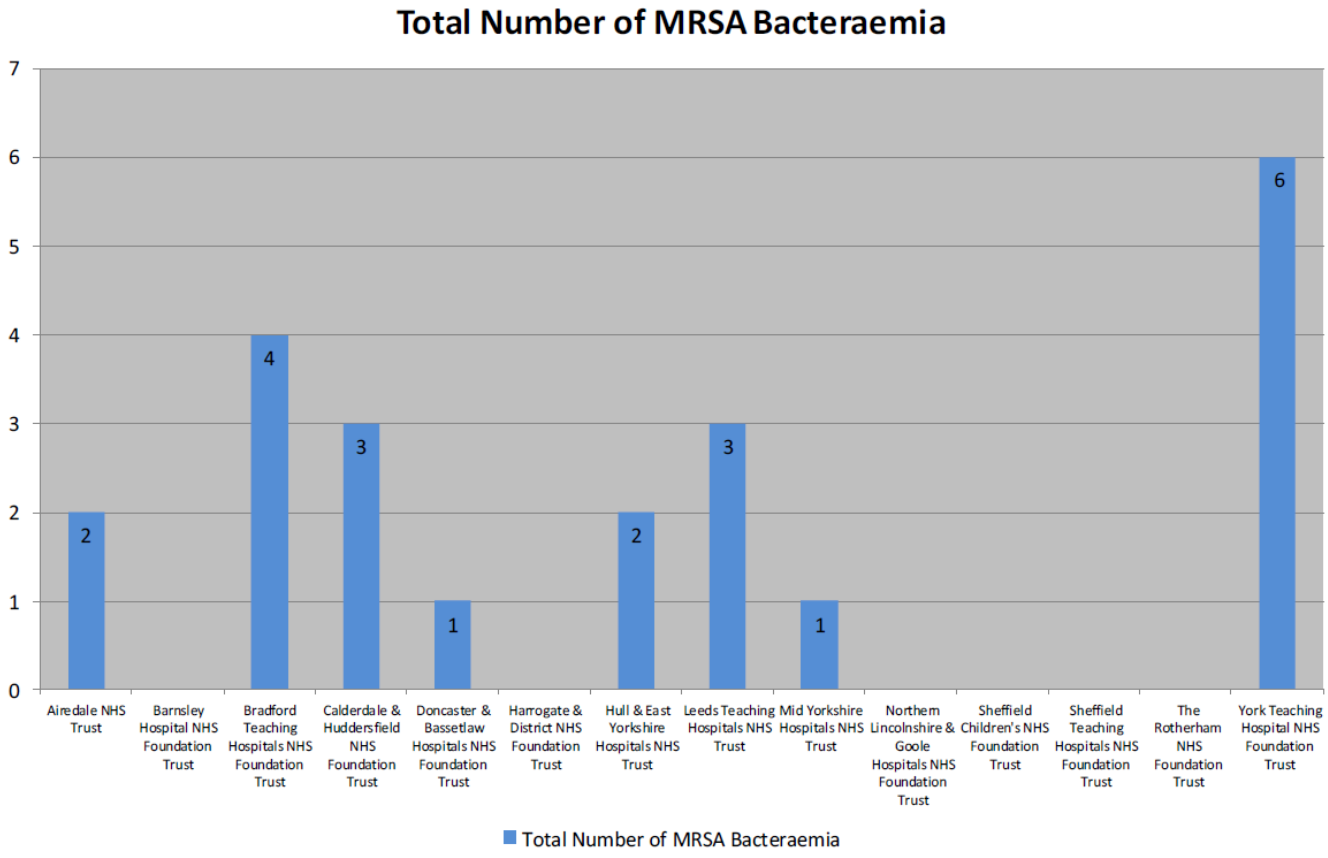
- **Central line Infections -** There have been four central line infections in September; all four have occurred in patients with long term lines. One was an oncology patient, one was a haematology patient and two were gastroenterology patients. Two patients have added risks of stomas. None of the cases are related and are different organisms. RCA investigations have resulted in 2 patients being trained to manage their own lines. There has been a review of the use of chlorhexidine dressings, antiseptic protector caps and antimicrobial line locks for high risk patients. MSSA screening has commenced for patients with CVAD.

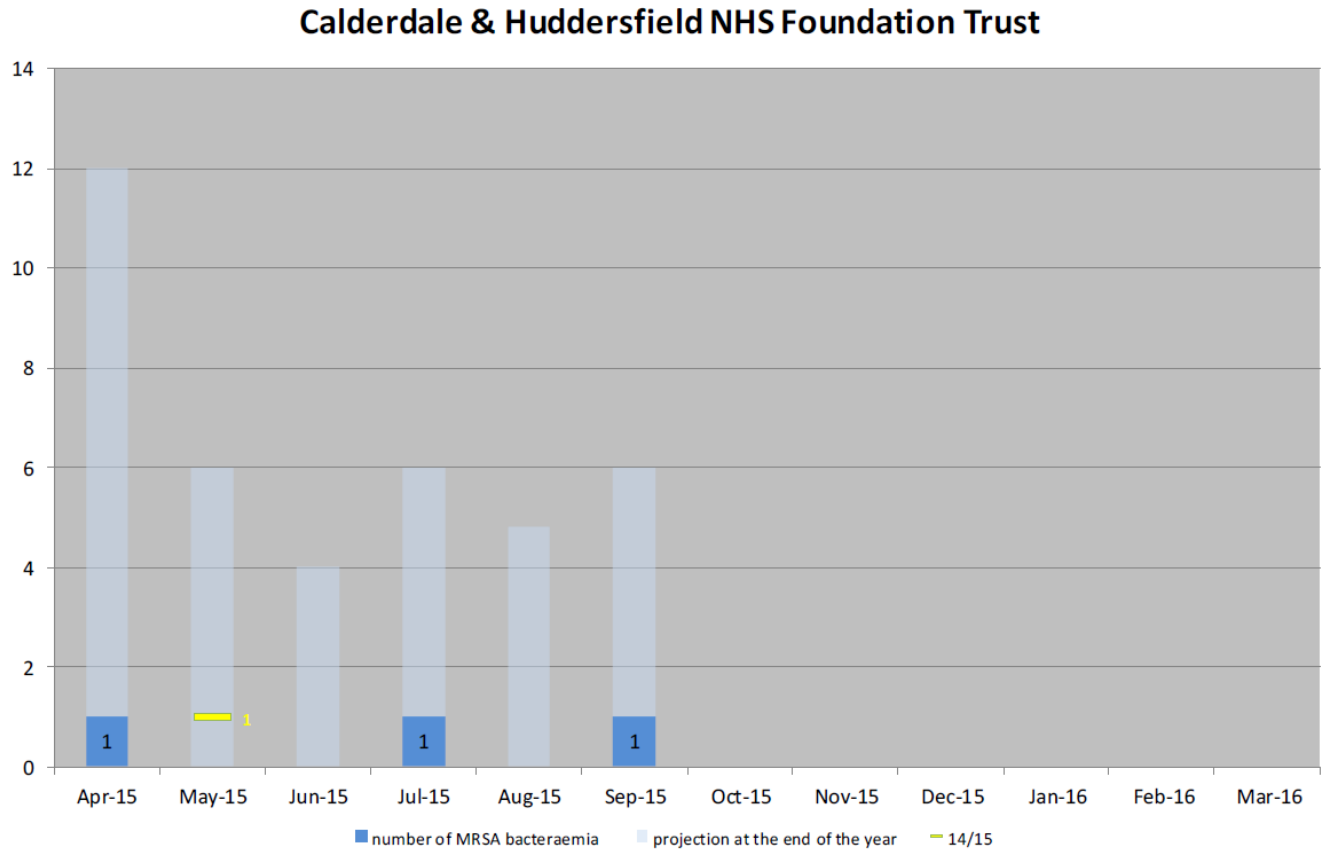
- **MRSA acquisition** – there were **2 cases** of hospital acquired MRSA identified in September; ward 15 and ward 6 HRI. There have been 10 cases in total since April.
- **MRSA bacteraemia** – there was 2 cases in September. One pre attributed to Bradford and one post 48 hour case attributed to the Trust and deemed avoidable following the PIR investigation. See table 1 for summary.

Table 1

Case details	Summary of case	Key issues from PIR
14.09.15 **H6** MESS 436184 Datix 20412	Patient admitted with pneumonia following a collapse. Had been unwell for 2 days with productive cough and shortness of breath. Patient with known COPD and oesophageal carcinoma, completed radiotherapy one month ago. Patient initially treated with Amoxicillin.	• Agreed as an avoidable case. • Lapse in ANTT practice.

The graphs below show the monthly MRSA data from Yorkshire and Humber PHE.


Total Number of MRSA Bacteraemia
7
6
5
4
3
2
1
0
2
4
3
1
2
3
1
6
Airedale NHS Trust
Barnsley Hospital NHS Foundation Trust
Bradford Teaching Hospitals NHS Foundation Trust
Calderdale & Huddersfield NHS Foundation Trust
Doncaster & Bassetlaw Hospitals NHS Foundation Trust
Harrogate & District NHS Foundation Trust
Hull & East Yorkshire Hospitals NHS Trust
Leeds Teaching Hospitals NHS Trust
Mid Yorkshire Hospitals NHS Trust
Northern Lincolnshire & Goole Hospitals NHS Foundation Trust
Sheffield Children's NHS Foundation Trust
Sheffield Teaching Hospitals NHS Foundation Trust
The Rotherham NHS Foundation Trust
York Teaching Hospital NHS Foundation Trust
Total Number of MRSA Bacteraemia

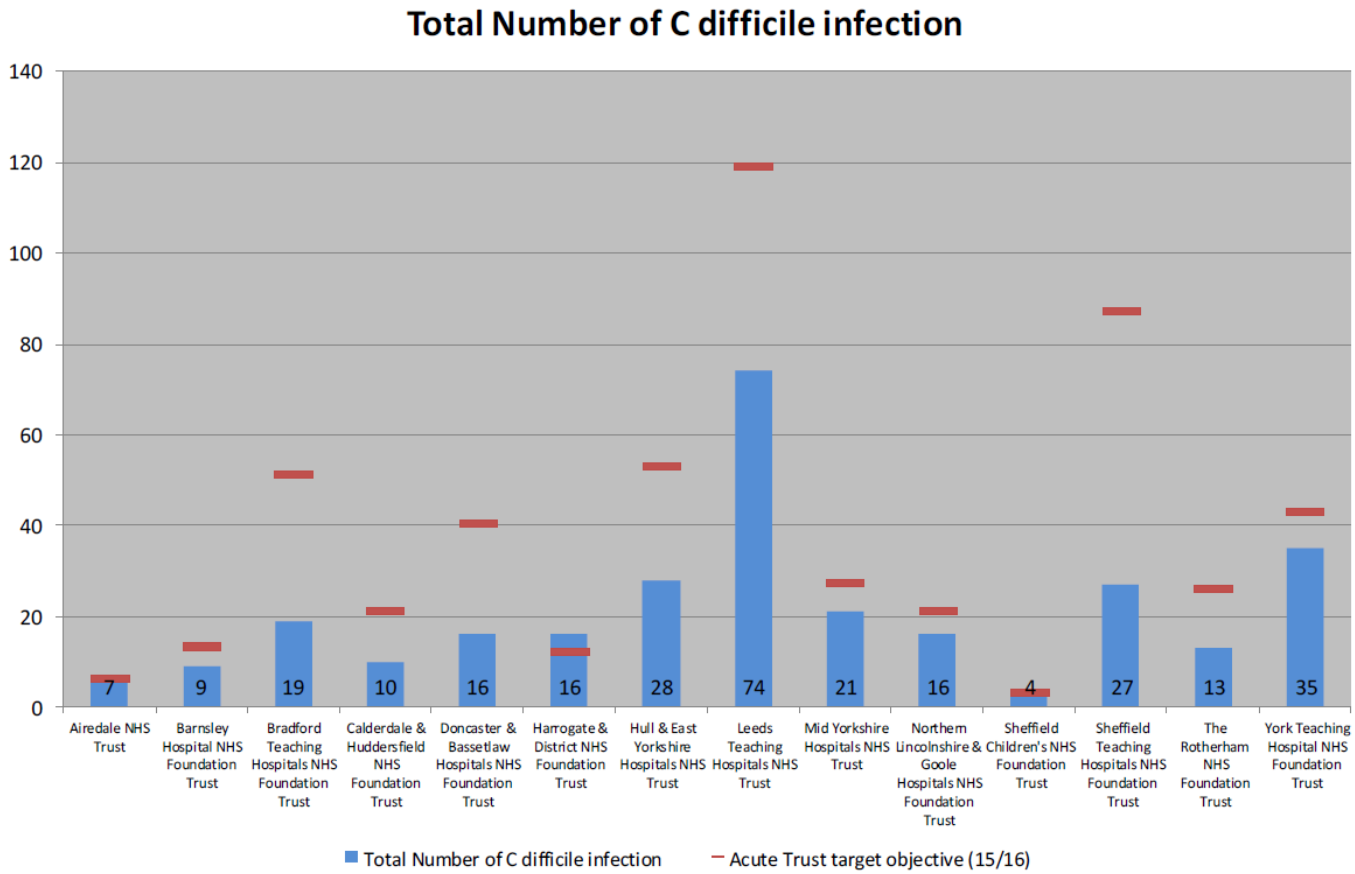

Calderdale & Huddersfield NHS Foundation Trust
14
12
10
8
6
4
2
0
1
1
1
1
1
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
number of MRSA bacteraemia
projection at the end of the year
14/15

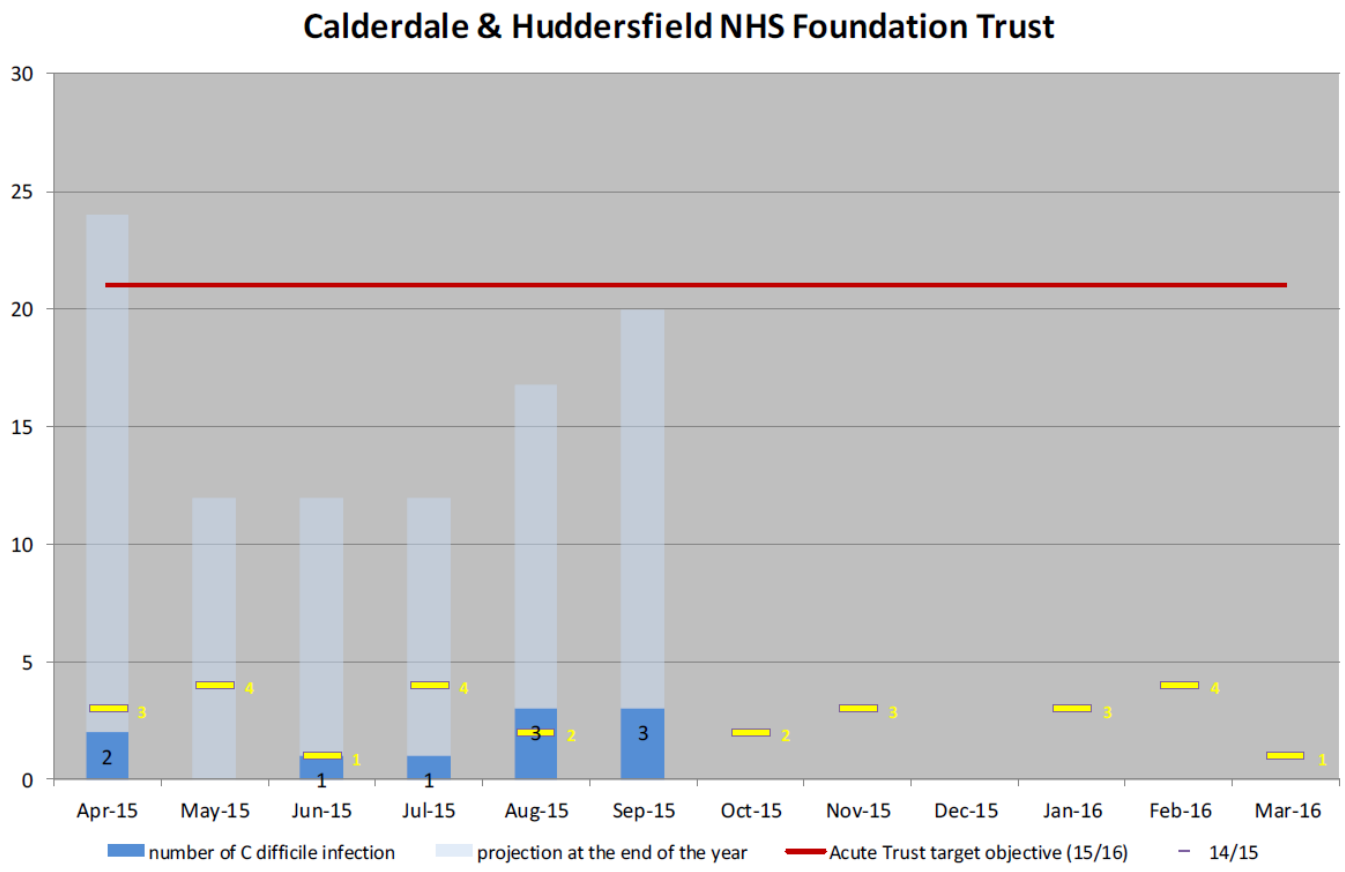
- **C.difficile** – there were three cases in September and are summarised in the table 2 below

Table 2

Case details	Summary of C.difficile case	Key issues identified from RCA
24.09.15 **H19** MESS 437400 Datix 123451	Patient admitted on the 13th September with a fractured neck of femur.	• Agreed as an unavoidable case • To ensure specimens are taken in a timely • Isolate as early as possible • Ensure treatment is commence promptly
25.09.15 **H11** MESS 437485 Datix 20649	Patient admitted on the 10th September, commenced with loose stools on the 20th September results show c-diff gene detected, further sample sent on 24th September resulted in c-diff toxin positive.	• Agreed as an avoidable case • Timely reviews of patients following the discontinuation of End of Life pathway • Education of staff re gene detected patients • No evidence of Abx review dates. • Improve communication within the ward team.
29.09.15 **ward 5A CRH** MESS 438063 Datix 20783	Patient admitted on 24th September (previously discharged on 21.09.15 following fracture to wrist) with reduced mobility and dehydration and diarrhoea for last 3 days. Family and carers unable to cope. Commenced on Trimethoprim by GP for UTI.	• Agreed as an unavoidable case • Delay in obtaining a stool specimen • Antibiotic prescribing by GP • To ensure Bristol stool chart is commenced on all admissions.

The graphs below show the monthly C-difficile data from Yorkshire and Humber PHE.





Quality Improvement Audits

Four Quality Improvement Audits were performed in September

- Ward 5B CRH – 88%
  - Some bedpans and commodes found to be stained.
  - Damage to doors and floors.
  - Staff not aware of single use symbol
  - Some floors in need of scrubbing off

- Ward 7BC CRH – 95% green
  - Temporary closure not used on sharps bins
  - Some high level dust

- Theatres HRI – 79% amber
  - Some clutter in storage rooms
  - Some stained and missing ceiling tiles
  - Hand gel was not available at all bays in recovery
  - Skirting's dusty and vents needs cleaning
- 1st floor Acre Mill – 80% Amber
  - Some high and low level dust throughout the floor
  - One Sharps bin not assembled correctly
  - A notes trolley was being kept in the dirty utility

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Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Katharine Thorley, Lead for Safety and Risk - Quality Directorate
Date: Thursday, 29th October 2015	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Care of the Acutely Ill Patient programme: progress report - This paper provides the Board with an update on the Care of the Acutely Ill Patient programme which is aiming to reduce avoidable mortality for our patients.	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Some of the information was included in the Clinical Outcomes group report to the Quality Committee; September 2015. This has been updated where new information is available.	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

SHMI remains broadly unchanged, at approximately 109.
There was an improvement in completion of mortality reviews during August, but unfortunately this dropped again in September (though remains above average for the year). regular reports of findings are now established. Mortality data is under constant scrutiny and focused reviews are commissioned where concerns are identified.
Care bundles work is now being managed by a PMO approach, all are being reviewed, with the related audit tool, for implementation in January 2016.
Nervecentre is now in place throughout the trust, except for paediatric areas for which some amendments are required.
An improvement in DNACPR compliance is noted, and positive feedback to a pilot of "DNACPR stickers" has led to a plan to use them Trust-wide.
Work is progressing on the frailty work-stream to implement a rapid assessment screening tool.
Work continues within the coding team to recruit qualified coders, for which there is a national shortage, and to improve clinical documentation to facilitate coding.

Main Body

Purpose:

To provide the Board of Directors with an update on the revised Care of the Acutely Ill Patient plan

Background/Overview:

The CAIP programme, commenced in August 2014 with an overarching aim to reduce SHMI to 100 within a year, was reviewed in August 2015 as the SHMI release in July was 109 – the same as when the programme commenced. Progress in each of the eight themes of the original programme had been variable.

The revised CAIP has six clinical outcomes-related themes that will contribute to the reduction of mortality within the Trust: investigating mortality and learning from findings; reliability; early recognition and treatment of deteriorating patients; end of life care; frailty; and coding.

The Issue:

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Next Steps:

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Recommendations:

The Board is asked to note the paper, the progress made, and the next steps planned.

Appendix

Attachment:

CAIP programme summary for BoD_Oct 2015.2.pdf

Care of the Acutely Ill Patient programme

Progress Report for Board of Directors; October 2015

1. Introduction

The Care of the Acutely Ill Patient (CAIP) programme commenced in September 2013, and was revised in August 2014. Although some progress was made with some of the elements of the plan, there was no reduction in the Trust's mortality: the SHMI in August 2015 was essentially unchanged at 109.

The plan was therefore reviewed and refreshed in August 2015, when some of the original eight themes were merged and some removed (as the actions had been incorporated into other work-streams). The revised plan has the overarching aim "to contribute to the reduction of mortality rates within the Trust" in acknowledgement that reduction in the Trust's mortality rates is dependent upon delivery of other actions and work-streams, e.g. leadership and operational improvements.

The revised plan is simplified into six themes:

1) Investigating mortality and learning from findings
2) Reliability
3) Early recognition and treatment of deteriorating patients.
4) End of life care
5) Frailty
6) Coding

This is a working document and is reviewed with updates monthly by the COG.

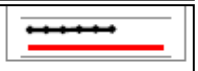
2. Current Mortality Position

2.1 HSMR – The most recent rolling 12 months data for HSMR, June'14 to July'15, indicates a score of 113.80, which is a further increase from the previous release.

Mortality Indicator	June14 - Jul 15		Jan 14 - Dec 14		
TRUST HSMR	100	113.80	100	110.03	

There were 120 deaths in Aug, giving a crude rate 1.18%(compared to 117 / 1.22% in 2014) and 121 deaths in Sept, crude rate 1.22%, (compared to 112 / 1.08% in 2014).

2.2 SHMI – There has been no further release from SHMI since the last report: still showing 109.26 for the12 month period Jan-Dec 2014. This had increased slightly from 109 for the 12 months ending September 2014. The next update is scheduled for 28th October: the preview data released on 18th October indicated that the SMHI would remain at 109.

Mortality Indicator	June14 - Jul 15		Jan 14 - Dec 14		
TRUST SHMI	100	n/a	100	109.3	

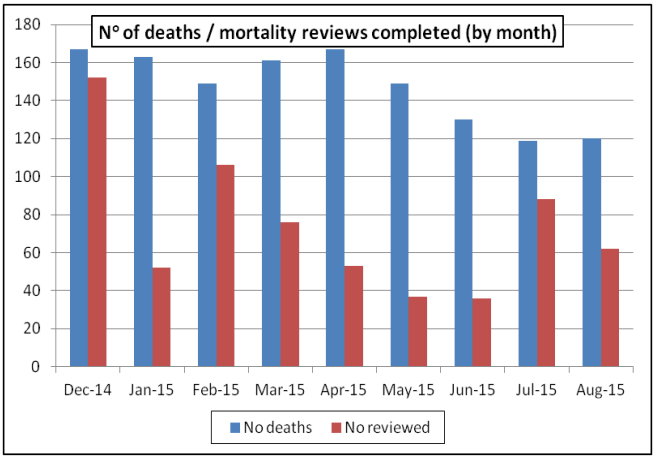
3. Investigating Mortality and Learning from Findings

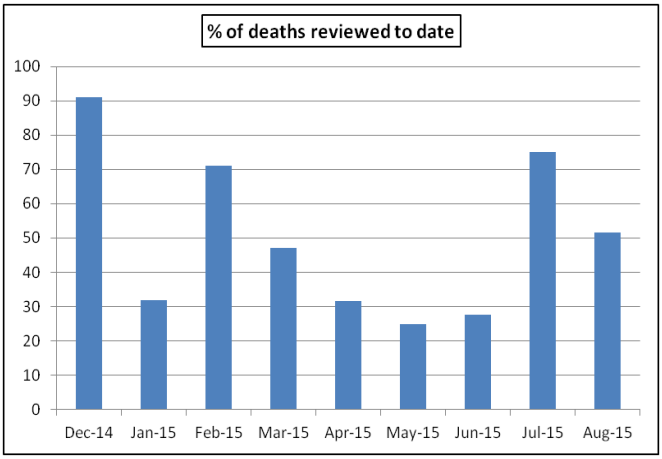
3.1 Current position

3.1.1 Routine reviews

In order to identify key problem areas to focus improvements, the Trust is committed to reviewing 100% of its mortality cases. However, it has proved consistently difficult to achieve this target with significant monthly fluctuations and the average reviews to July being only 46%. A new process for mortality reviews was commenced in August (July's deaths) which resulted in 75% of reviews being completed. A further improvement was expected in September (August's deaths) as initial difficulties had been resolved, but unfortunately this was not the case and to date is only 51.66%. However, the final figure is still to be confirmed, and may rise slightly, though not approaching 75%. The reasons for this are being identified by the Governance team.

The charts below show the current position.





A "Deep Dive into Mortality" presentation was given to WEB in August by the Lead for Patient Safety and Risk, with the Associate Medical Director. The presentation focused on the current mortality position, the developments in and findings from investigations, and the revised CAIP plan. The presentation was well-received and generated some good discussion and positive reaction; it is hoped that this will translate into increased engagement with the review and learning process.

The new mortality review protocol that was approved in July and commenced in August changed the criteria for those cases requiring a second review: this would no longer be done if the initial Hogan score was 2 (slight evidence of preventability) unless there were any other concerns or the case was associated with a complaint, inquest or claim.

In August, 10/88 cases were assessed as Hogan score 2 (slight evidence of preventability). The main issues identified by reviewers were:

- delay in antibiotics (two cases of sepsis and one not stated) - 3 patients
- delayed investigations (chest xay) - 1 patient
- patient under the care of wrong speciality - 1 patient
- delayed insertion of nasogastric tube - 1 patient
- poor nutrition - 1 patient
- delayed discharge and then developed pneumonia - 1 patient
- lack of senior review - 1 patient

3/88 cases were judged as Hogan score 3 and therefore subject to a second review, together with a further case where no Hogan score had been assigned. These reviews are currently in progress and will be reported in the next monthly mortality review report: this is now scheduled each month to present to CEAM and COG with a summary of the review compliance, findings, learning and actions.

3.1.2 Special reviews

A review of all March 2015 deaths in HRI was commissioned in response to a sharp rise in HSMR that was identified at that time. This review was to include, where possible, an audit of the coding accuracy. It was expected that this would be completed and reported by the end of September but this has been delayed due to capacity issues.

Approximately 75% of these cases have been reviewed to date, and the review has also looked at locum and agency usage during the period. This is still underway, although Professor Mohammed's analysis (see below) is now casting doubt on there being anything exceptional about March results.

3.2 Next steps

Professor Mohammed Mohammed of Bradford University, who now has an honorary CHFT contract and access to our data streams, is supporting the Trust with analysis. He is looking for patterns in the data that allow the formulation of hypotheses to be tested. Regular meetings are being established.

Five additional staff have been recruited to the mortality review team, and the new process is being tightly managed by the Governance team. If the increase in reviews that was seen in August is not sustained, then the process will be reviewed again. Additionally, a job description for consultant mortality reviewers has been completed by the Associate Medical Director, to recruit consultants for an additional PA. It is expected that these appointments will be made in the next few weeks. Additionally, a simple training programme for all reviewers, to facilitate consistency, is being developed.

A discussion has taken place to make the review tool / data collection process electronic, similar to the CRAS tool. This should be available from 1st December for November reviews. It is intended to develop the second-level reviews to include additional information, not just case notes e.g. duty rotas etc, which will facilitate a more in-depth review.

A group to review data derived from mortality reviews has been convened with Mr Martin DeBono as chair. It will include clinical representatives from all Divisions, and report to COG as necessary.

4. Reliability

In the revised CAIP plan a new overall “reliability” work-stream was created comprising care bundle compliance, and investigation into SHMI alerting conditions and any concerns relating to site differences. .

4.1 Current Position

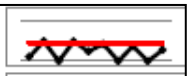
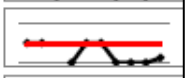
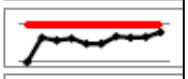
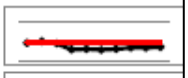
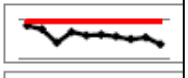
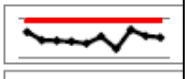
4.1.1 Care Bundles

The care bundles work has adopted the PMO approach, overseen by the newly-formed Clinical Standardisation group, which first met on 1st September. Clinical leads have been identified for each of the bundles and currently they are reviewing the bundles to standardise them to ensure they are simple, clear and do the right thing first time.

Compliance with appropriate commencement of bundles is currently audited by the presence of the "stickers" in the notes for

- Asthma
- Acute Kidney Injury
- Sepsis
- COPD
- Community Acquired Pneumonia

Where bundles have been commenced, completion is also assessed. Compliance is variable, as can be seen from the September 2015 CAIP dashboard shown below:

Indicator	Month Agreed Target	Current Month Performance	Target/YTD	YTD Performance	Performance Trends
Asthma - Bundle Started	95%	57%	95%	63%	
Asthma - Bundle Completed	95%	25%	95%	60%	
AKI - Bundle Started	95%	76%	95%	62%	
AKI - Bundle Completed	95%	32%	95%	39%	
Sepsis - Bundle Started	95%	70%	95%	61%	
Sepsis - Bundle Completed	95%	38%	95%	56%	
COPD - Bundle Started	95%	63%	95%	59%	
COPD - Bundle Completed	95%	53%	95%	54%	
Pneumonia - Bundle Started	95%	100%	95%	68%	
Pneumonia - Bundle Completed	95%	100%	95%	92%	
Heart Failure	Design Phase				

The trends are from Dec 2014.

Bundle	N° of patients	N° commenced	N° completed
Asthma	7	4	1
AKI	33	25	8
Sepsis	64	45	17
COPD	27	17	9
Pneumonia	1	1	1

Chart shows figures from Sept 2015 audit

The heart failure "bundle" has proved difficult to develop and standardisation of care for this group of patients is still under consideration, to incorporate within the clinical documentation.

4.1.2 Conditions currently alerting

Alerts at 95% level:

Condition	SHMI release Sep'15 (Jun'14 to May'15)			HSMR release Aug'15 (Jul 14 to Jun 15)		
	Ratio	Obs	Exp	Ratio	Obs	Exp
Abdominal pain	**204.03**	12	5.9	**352.91**	11	3.1
Cancer of ovary				**379.84**	6	1.6
Cancer of breast	**209.18**	15	7.2	**239.17**	12	5
Urinary tract infections	**142.14**	113	79.5	**149.65**	72	48.1
Acute cerebrovascular disease	**129.83**	143	110.1	**127.19**	133	104.6
Pneumonia (except that caused by tuberculosis or STDs)				**115.76**	323	279
Gastrointestinal haemorrhage				**145.26**	34	23.4
Inflammatory diseases of female pelvic organs	**1539.99**	4	0.3			
Diseases of mouth; excluding dental	**660.76**	5	0.8			
Other and unspecified benign neoplasm	**621.46**	5	0.8			
Other and ill-defined cerebrovascular disease	**1264.49**	2	0.2			
Nausea and vomiting	**255.34**	10	3.9			
Chronic renal failure	**242.66**	10	4.1			
Occlusion or stenosis of precerebral arteries	**937.66**	2	0.2			
Chronic obstructive pulmonary disease and bronchiectasis	**128.38**	92	71.7			

	First Time Alerted
	Review Completed

An investigation is requested when concerns are raised, either locally or by the benchmarking software alerting the Trust that a condition appears to be outlying with a higher rate than expected. However, because of time limitations, many are not completed / reported. A standard reporting template for findings of these reviews has been produced alongside the Mortality Review Process to try to facilitate and simplify the generation of the report of findings.

Previously, formal reviews have been requested by the Associate Medical Director for:

- Complication of device; implant or graft
- Cancer of colon
- Contusion
- Skin ulcers
- Urinary tract infections
- Chronic obstructive pulmonary disease and bronchiectasis
- Pneumonia (except that caused by tuberculosis or sepsis)

Some of these are no longer alerting, and therein lies another difficulty; that of prioritising condition-specific reviews within the limited resource available, when the condition may only trigger transiently.

A review into Diseases of the Mouth (five patients) has been completed by the Associate Medical Director and reported to COG in October. It found no failures and all case note reviews resulted in a Hogan score of 1 – no evidence of preventability. One patient's records were identified as potentially mis-coded: this was investigated by the coding team and found to have been a human error.

4.1.3 Site Differences

Where site differences are identified, these will be investigated to identify the causes. No specific concerns relating to site differences have emerged since the last report.

4.2 Next steps

The PMO workstream is redesigning the Sepsis, AKI, COPD and CAP care bundles, reviewing the process for measurement of reliability of delivery, and planning their integration with routine clerking-in documentation. The aim is for a go live date of the first week in January 2016. A clinical champion has been identified to encourage compliance with the bundles.

Audit tools for bundles are to be reviewed and redesigned to capture compliance with the individual elements of the bundles in order to identify any specific difficulties, and focus areas of improvement.

The recruitment of consultants with an allocated PA for undertaking reviews will facilitate the completion of both routine and special reviews. If the Trust is able to achieve and sustain 100% routine reviews, the response to alerting conditions will be much easier as preliminary information will be readily available.

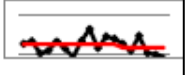
The Trust will commission a Royal College review of Complex Care and Respiratory Medicine to provide independent assurance on the quality of care provided and recommend areas for improvement.

5. Early Recognition and Treatment of Deteriorating Patients

5.1 Current Position

Implementation of 'Nervecentre,' the electronic observation and handover tool to improve accuracy of NEWS and standardisation of escalation, is now complete across the Trust except for paediatric areas. Nervecentre needs to be adjusted to take account of the different early warning score that applies in paediatrics.

The outcome measures for this theme are reduction in cardiac arrests and ICU admissions. The chart below (Sept 2015) shows a reduction in cardiac arrests, though the year-to-date remains above trajectory. Unplanned ICU admissions are above target.

Indicator	Month Agreed Target	Current Month Performance	Target/YTD	YTD Performance		Performance Trends
Number of Cardiac Arrests per 1000 bed days	-	9	-	81		
Number of Cardiac Arrests per 1000 bed days (Rate)	0.68	0.45	0.68	0.71		
Unplanned Admission to ICU	-	49	213	277		

All cardiac arrests are now reported as incidents to facilitate review of the cases and identification of cases of failure to escalate

5.2 Next steps

It is expected that the ongoing implementation nerve centre handover module will improve handover communication and procedures, within all professional groups. A business case has been developed for consideration of the implementation of the H@N Task Management module in Nervecentre. A decision is expected in November 2015.

There is a plan for the night sisters to receive outreach escalations overnight through nervecentre.

The Resuscitation committee is still considering developing a Medical Emergency Team, rather than Cardiac Arrest Team, and team drills / response to simulated crash calls as a training tool to improve communication and teamwork are to commence in October.

6. End of Life Care

6.1 Current Position

A new theme, end of life care, has been added to the revised CAIP plan incorporating DNACPR (appropriate ceiling of care decisions) and also aims to reduce unnecessary admissions for patients who are expected to die within 48 hours, who could have been managed in an alternative location.

The chart below is from the September 2015 dashboard.

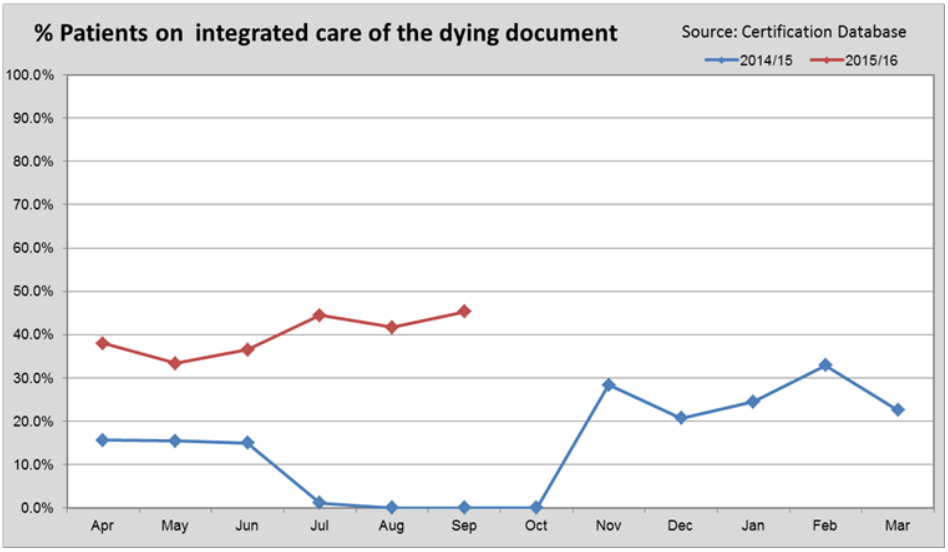
Indicator	Month Agreed Target	Current Month Performance	Target/YTD	YTD Performance		Performance Trends
DNACPR % Discussion completion	95%	82.8%	95%	85.5%		
DNACPR Review date completion %	95%	68.1%	95%	71.2%		

An improvement in compliance with DNACPR discussions, either with the patient or with their family, has been seen over the last three months. There is also some improvement in DNACPR reviews. DNACPR stickers, as a means of a prompt to consider DNACPR, have been tested on one surgical and three medical wards: feedback has been very positive.

A regional training DVD on DNACPR decisions was produced earlier this year and is now available on the intranet.

A second focus of work is the roll out of the Individualised Care of the Dying Document (ICODD) within the community. It is a care plan that guides clinical staff caring for patients who are in the last hours or days of their lives, and was implemented in the trust in November 2014. The ‘Integrated Care of the Dying Document’ (ICODD) is currently in place in the hospitals and hospices, and there is a plan for it to be implemented in the community.

The chart below shows the percentages of patients who are supported by an end of life care plan who then go onto die, since November 2014.



6.2 Next Steps

To drive further improvement in the use of the ICODD through training and education.

Further improvement in review of decisions for DNACPR through training and education and the data received from monthly audits.

DNACPR stickers to be rolled out Trustwide – These are currently on order with the printers. The stickers are used as a prompt to medical staff to complete a DNACPR form. The feedback received from the pilot wards has been very positive.

Duplicated DNACPR forms printed with a red border are currently on order with the printers. This will ensure that a copy remains on the patients' records when the original copy is discharged with the patient. The new forms will be distributed by the resuscitation officers and incorporated in the Basic Life Support training.

7. Frailty

7.1 Current Position

Currently the only measure of frailty on the CAIP dashboard is as shown below: % of deaths where the patient is aged 80+, with 3 or more com-morbidities and three or more previous admissions. A seasonal variation is noted.

Indicator	Month Agreed Target	Current Month Performance	Target/YTD	YTD Performance	Performance Trends
% frailty Deaths (as a proportion of all deaths)	-	9.2%	-	11.9%	

Overall, this work-stream has been slow to progress since August 2014. A task and finish group was set up to define how this group of patients is identified, and there were discussions with Sheffield Teaching Hospitals regarding their use of a "Frail-safe" bundle.

However, work is now progressing to test and implement a rapid assessment frailty screening tool, as has been done at Bradford. Other work areas include:

- discharge planning, with implementation of a generic care plan for discharge supported by a discharge matron post.
- nutritional screening: an acute dysphasia pathway has been approved and all patients are weighed on admission. To improve reliability of nutritional assessment, a business case for a nutritional support nurse has been drafted.
- end of life care is part of the frailty action plan

7.2 Next Steps

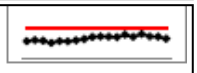
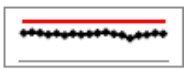
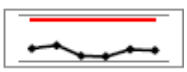
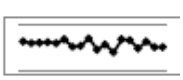
Detailed actions for the CAIP to be agreed and appropriate metrics established.

8. Coding

In relation to the CAIP aim of reducing SHMI and HSMR at the Trust, clinical coding is a key theme as it has a direct impact on the information which is collected in relation to patients who have died. Accurate coding of patients' co-morbidities is particularly important as it directly affects their assessed "likelihood of dying" and therefore the Trust's ratio of actual to expected deaths. Application of the specialist palliative care code, where applicable, is also really important.

8.1 Current Position

The metrics from the September 2015 dashboard below show a slight drop in the average Charlson score (calculated from co-morbidities) and a slight increase in coding of "signs and symptoms" (where a diagnosis isn't clear in the notes).

Indicator	Month Agreed Target	Current Month Performance	Target/YTD	YTD Performance	Performance Trends
Average Charlson Score	4	3.26	4	3.47	
% Sign and Symptom	9.5%	10.6%	9.5%	9.8%	
Average Diagnosis	5	4.06	5	3.98	
Co-morbidity capture	90%	24%	90%	24%	
% Coded with Specialist Pall Care	-	0.50%	-	0.60%	

Changes to coding rules at the start of April 2015 meant that patients admitted for blood transfusions, drug infusions, terminations, pain injections, eye injections codes could not have these codes applied to their stay. This has resulted in a drop in the average diagnosis which remains under trajectory.

A short session on documentation and clinical coding, and its importance, has been included on the FY1 and new doctors' induction programmes. This focused on the importance of accurate documentation and the role of the doctor, to help improve clinical engagement to ensure clinical documentation is 'fit for purpose' for coding. A presentation was also given to new registrars in October.

Clarification on the new “specialist palliative care” code was requested from the HSCIC in April when it was introduced. No additional guidance has been received and the Trust is aware of varied interpretations of when to apply the code across the region. A meeting of the Specialist Palliative Care Lead Consultant, with the coding team, has agreed the criteria, and a local policy has been implemented.

8.2 Next Steps

Work continues to improve existing clinical documentation to improve the quality and content of information used for clinical coding eg pre-operative assessment, medical and surgical clerking in proformas. A pilot is to commence shortly with clinical coders attending ward rounds alongside three upper GI consultants. The aim is to improve the documentation required by clinical coders and hopefully improve the coding process.

A visit to York is planned in early November to understand how their EPR assists in the capture of co-morbidities and complexities.

Another key challenge for coding is in relation to recruitment and retention of qualified coders, of which there is a national shortage. The recruitment process continues and whilst a trainee and two ACC qualified coders will start work with the Trust in the next month there remains a gap of 5-6 WTEs. A coding contractor has been recruited to bridge the gap but the situation remains critical.

9. The Board of Directors is asked to note the following:

- HSMR and SHMI remain higher than target, with no reduction expected in the near future.
- Implementation of the new mortality review process resulted in 75% of reviews being undertaken in August: disappointingly this fell 51.7% in September.
- Lack of capacity is cited as an obstacle in undertaking condition-specific reviews, but additional reviewers have been recruited from the new registrar intake, and three consultants will be given an additional PA specifically for reviews.
- A regular monthly report of findings is in place, scheduled for CEAM and COG. There will be a focus on learning from the review findings, and implementing targeted actions to make improvements
- Compliance with care bundles still requires improvement: this is now being managed in a PMO approach.
- Nervecentre observation / escalation module is now in place across the Trust, with the exception of the paediatric areas.
- The business case for the introduction of Hospital@night module is being progressed.
- DNACPR compliance has improved slightly, and there has been positive feedback from the areas that have trialled the stickers.
- Some progress has been made in relation to frailty which focuses on introduction of an electronic screening tool.
- The agreement of a local process for application of the specialist palliative care code.

Kath Thorley | Lead for Patient Safety and Risk | 16 Oct 2015

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 29th October 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: REVIEW OF PROGRESS AGAINST ONE YEAR PLAN - The Board is asked to receive and note the progress against the delivery of the 2015/16 one year plan.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive and note the progress with the one year plan.

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

The Board is asked to receive and note the progress with the one year plan.

Appendix

Attachment:

1 year plan progress Report October.pdf

Calderdale and Huddersfield NHS Foundation Trust
1 Year Plan - Progress Report October 2015

Introduction

The Trust's vision is:

Together we will deliver outstanding compassionate care to the communities we serve

In May 2015, the Board of Directors agreed the 1 year plan and quality priorities for 2015/16. The plan describes the four goals of the Trust:

- Transforming and improving patient care
- Keeping the base safe
- A workforce fit for the future
- Financial sustainability

These goals are underpinned by the four behaviours:

- We put the patient first
- We go see
- We work together to get results
- We do the must dos

The plan sets out the key areas of delivery to support the achievement of each of the goals described in the table below. The risks of not delivering our goals have been assessed and are included in the Board Assurance Framework. The risks associated with each area of delivery have also been assessed and are included in the corporate risk register. The identified risks are reviewed and escalated as appropriate in line with the Trust's risk management arrangements.

Our Vision	*Together we will deliver outstanding compassionate care to the communities we serve*			
Our behaviours	We put the patient first / We go see / We do the must dos / We work together to get results			
Our goals (The result)	Transforming and improving patient care	Keeping the base safe	A workforce for the future	Financial sustainability
Our response	Design and implement the community division while continuing to work on CC2H	Implement the local quality priorities (see separate page)	Plan and implement workforce change to ensure that our people and resources actively support the reconfiguration of integrated hospital and community services.	Deliver a robust financial plan including CIP for 2015/16 and 2016/17
	Develop and roll out the first wave of 7 day working standards	Ensure readiness to achieve CQC rating of good	Design an innovative Trust-wide internal communications strategy and implementation plan.	Refresh the Commercial Strategy
	Roll out of the first year of programmes to support implementation of EPR	Strengthen our performance framework at corporate and divisional level	Secure safe staffing levels and have clear mitigation plans ready to be deployed if required.	Strengthen our financial control procedures
	Continue the implementation of the Care of the Acutely Ill Patient action plan	Ensure robust plans are in place to monitor and deliver A&E and C Diff	Launch a campaign to actively support improvements in health and well-being and reduce absence	Develop the 5 year turnaround plan with agreement across the local and regional health economy
	Work with commissioners and providers locally and across WY to develop plans for the future configuration of integrated services	Respond to Monitor in relation to breach of licence and undertake Well Led Governance Review	Design a strategic framework to articulate and govern a value driven people focussed approach using work together to get results	
	Develop and implement a Public and Patient Involvement Plan	Implement the health and safety action plan	Create a Trust-wide, multi-disciplinary approach to Learning delivered via a fully integrated education and training function	

Purpose of Report

The purpose of this report is to provide an update for Trust Board members of the progress made against the four goals described in the Trust's 1 year plan 2015/16.

Structure of Report

The report is structured to provide an overview assessment of progress against key deliverables responses and this is rated using the following categories:

1. On track – delivered (green)
2. On track - not yet delivered (amber / green)
3. Off track – with plan (amber / red)
4. Off track – no plan in place

For each area of delivery there is also a summary narrative of the progress and details of where the Board will receive further assurance.

Summary

This report highlights that of the 22 deliverables:

- None are rated red i.e. off track with no plan in place.
- Six are rated amber / red i.e. off track with a plan in place.
- 16 are rated amber / green i.e. on track but not yet delivered.
- None have yet been fully delivered or rated green.

Recommendation

Trust Board Members are requested to:

- Note the assessment of progress against the 2015/16 goals.
- Discuss and agree the future action and assurance that may be required

Goal: Transforming and improving patient care			
Deliverable	Progress rating	Progress summary	Assurance route
Design and implement the community division while continuing to work on CC2H	On track but not yet delivered (amber / green)	Recruitment process for ADD for Community division in progress. Community performance metrics developed and further work being done to refine these. Continuing to work with partners in Calderdale to develop and deliver the community vanguard. First staff transferred to Locala as part of the Kirklees CC2H service. Ongoing discussions with both Locala and Commissioners to clarify the services within scope.	Separate CC2H update provided to Private Board 29/10/2015
Develop and roll out the first wave of 7 day working standards	Off track with plan in place (amber/red)	Report made to WEB on 7DS and completed the audit information requested by Monitor. This has redirected efforts towards those standards considered to have the greatest impact on weekend mortality. Work ongoing to introduce Hospital at Night and Weekend subject to business case approval. Work ongoing within the Divisions to assess the additional requirements to develop services but implementation will be subject to either business plans or increased efficiencies identified through the medical workforce modelling ongoing and supported by Foureyes and EY.	Reported to Weekly Executive Board and Quality Committee.
Roll out of the first year of programmes to support implementation of EPR	On track but not yet delivered (amber/green)	Future State Review completed, designs and future state workflows being designed. Leadership Alignment completed. The communications plan now complete and in communication in progress. Road shows complete on all sites including Bradford Teaching Hospitals. Benefits realisation strategy complete.	Reported monthly to Finance & Performance Committee. Will now come to Board.
Continue the implementation of the Care of the Acutely Ill Patient action plan	On track but not yet delivered (amber/green)	Plan is being refreshed following the increase in HSMR. Independent external support to the analysis of the data. Mortality reviews are ongoing and improving. Care bundles now being managed within a PMO approach. All aspect of the plan being actively monitored within the Clinical Outcomes Board	Bi-monthly report to Board. Board workshop planned for November.
Work with commissioners and providers locally and across WY to develop plans for the future configuration of integrated services	On track but not yet delivered (amber/green)	The West Yorkshire Association of Acute Trusts (WYAAT) is an alliance of the 6 Acute Providers (including Harrogate). The ambition is to draw on West	Chief Executive report to Board on WYAAT. Board to boards with SWYPFT and MYHT

		Yorkshire's track record on technology innovation and use this as a platform to deliver a radical change in the way clinical resource and expertise is delivered to patients in acute services across the West Yorkshire population. Although the Vanguard bid was not selected this work is still progressing.	
Develop and implement a Public and Patient Involvement Plan	Off track with plan in place (amber/red)	Significant patient and public engagement undertaken in partnership with CCGs via the Right Care Right Time Right Place programme and reports due to be finalised and shared this month. Service specific engagement taken place in relation to Emergency Gynaecology and Early Pregnancy Assessment services. Report due to go to Overview and Scrutiny in Kirklees in November. Plans in development for engagement in relation cardiology and respiratory services. Discussion also taking place to formalise PPI responsibilities and reporting arrangements with the CCG.	PPI section now included in quarterly Quality Report.
Goal: Keeping the base safe			
Deliverable	Progress rating	Progress summary	Assurance route
Implement the local quality priorities	On track but not yet delivered (amber / green)	Making good progress against local quality priorities. Detailed quarterly report demonstrating progress and any areas of concern now presented to Quality Committee and Board.	Integrated Board Report Quarterly Quality Report Quality Committee minutes.
Ensure readiness to achieve CQC rating of good	On track but not yet delivered (amber / green)	Inspection date now confirmed. Plans for readiness progressing well. Whole self-assessment completed and all divisions have 90 day plans in place monitored through weekly CQC Executive meeting. Regular reporting to Quality Committee and Board. Intensive communications and engagement plan being rolled out with launch of CQC handbook this week.	Monitored through Quality Committee
Strengthen our performance framework at corporate and divisional level	On track but not yet delivered (amber/green)	The Integrated Board Report is progressing well with the document produced for Board now providing a greater level of assurance with exception reports in place for red performance; this is supplemented by a weekly performance meeting and an associated report The Performance Management Framework has been	Integrated Board Report

		completed in draft and comments received, learning from other Trusts has been undertaken to complete this and the associated accountability framework. The intention is to conclude this and the structures by the end of October	
Ensure robust plans are in place to monitor and deliver A&E and C Diff	On track but not yet delivered (amber/green)	Robust processes for managing cases of C. diff with each case undergoing a detailed root cause analysis, followed by discussion at a multi-professional/multi-agency group. Currently delivering against the A&E 4 hour wait target and this is being closely managed. Work being done with those patients that wait longer than 8 hours to look at both the root cause and the patient experience.	Integrated Board Report Director of Infection Prevention Control monthly report
Respond to Monitor in relation to breach of licence and undertake Well Led Governance Review	On track but not yet delivered (amber/green)	Final prioritised recommendations received from PWC this month. Progress is being made against all of them. Notably a review of the leadership capacity at both a management and clinical level has been undertaken and actions in place to address the gaps. A full update on progress against the recommendations will be presented to the Board in November.	Update to Board due November. Monitored through Workforce Committee
Implement the health and safety action plan	On track but not yet delivered (amber / green)	As requested by the Board the Health and Safety Action Plan is being audited by external specialists to ensure it complies with Health and Safety at Work Act and supporting guidance. Health and Safety training compliance remains a concern and is being closely monitored following revisions to the training course as a result of feedback. There has been work to use risk assessment methodology and DATIX in relation to health and safety incidents and risks as well as awareness raising around RIDDOR.	Quality Committee from Health and Safety Group.
Goal: A workforce fit for the future			
Deliverable	Progress rating	Progress summary	Assurance route
Plan and implement workforce change to ensure that our people and resources actively support the reconfiguration of integrated hospital and community services.	On track but not yet delivered (amber / green)	Steps have been taken to ensure accurate workforce information as the basis for informed decision making by improving the interface between the financial ledger and the Electronic Staff Record (ESR). HR resource has been deployed to support projects with	To be monitored through Workforce Committee

		workforce impact. The establishment of a Workforce Committee, with a sub group infrastructure, reporting to the Board of Directors has been scoped and agreed. Need to develop both a workforce strategy and a recruitment and retention strategy.	
Design an innovative Trust-wide internal communications strategy and implementation plan.	On track but not yet delivered (amber / green)	Colleague engagement and communication plan agreed at WEB in September. New communication channels implemented including monthly team brief (Big Brief); CHFT Weekly; Ask Owen button on the intranet; Meet the Chair sessions. Brand launched across the Trust and work continues to ensure this is appropriately used and represented. Divisional colleague engagement plans being finalised.	Report taken to WEB. Will be monitored through Workforce Committee
Secure safe staffing levels and have clear mitigation plans ready to be deployed if required.	Off track with plan in place (amber/red)	Nurse recruitment and retention being delivered as per plan. Overseas recruitment for nurses complete. Significant number of newly qualified nurses joined the Trust in September and will be fully inducted and on the wards be the end of October. Keep in touch scheme in place. Currently negotiating with NHS Professionals in relation to the staff bank. External support sought from the lead nurse from Portsmouth hospital on ward based staffing review.	Hard Truths report to Board. Workforce Committee / Quality Committee
Launch a campaign to actively support improvements in health and well-being and reduce absence	On track but not yet delivered (amber / green)	• Board and Executive Board presentation on profile and cost of absence • Board support and decision to fund a new approach and dedicated team to address sickness absence position and support sustainable improvements. • Deep dive in Medical Division to support local focus on absence reduction. • Establish attendance management team – team leader already in place and recruitment plan in place and actioned. • 'Go see' activity planned with Leeds Teaching Hospitals NHS Trust in October 2015 • Revised Attendance management policy agreed with non-medical staff side representatives	To be monitored through Workforce Committee

		• Workshops to involve internal stakeholders in colleague health and wellbeing strategy scheduled for November 2015 • Stress management training programmes established for managers and colleagues on managing stress • Mental health first aid 2 day training programme created and delivered • Health and wellbeing champions recruited from within the Trust • 2015 calendar of health and wellbeing activities delivered	
Design a strategic framework to articulate and govern a value driven people focussed approach using work together to get results	Off track with plan in place (amber/red)	Work is progressing on delivering individual elements of the strategy – a colleague engagement and communications strategy has been agreed and is being operationalised, the development of a leadership and management development programme is being progressed as part of the work to redesign clinical management structures and the drive to improve colleague health and wellbeing and reduce sickness absence has been commissioned and is underway .	To be monitored through Workforce Committee
Create a Trust-wide, multi-disciplinary approach to Learning delivered via a fully integrated education and training function	Off track with plan in place (amber/red)	A paper setting out a direction of travel to integrate education and training activity in the Trust has been agreed by the Executive Board. Further work is now required to progress discussions to identify and agree the operational steps to reorganise activities and seek approval for establishing the organisational structure through which education and training activity will be delivered	Reported to WEB.
Goal: Financial sustainability			
Deliverable	Progress rating	Progress summary	Assurance route
Deliver a robust financial plan including CIP for 2015/16 and 2016/17	Off track with plan in place (amber/red)	Detailed CIP report monitored weekly at Turnaround Executive. Currently forecasting delivery of £16.9m of CIP for 2015/16. £13.5m CIP identified for 2016/17 against a target of £14m. This is included in the work with EY to develop the 5 Year Strategic Plan.	Weekly progress monitored through Turnaround Executive. Reported to Finance & Performance Committee
Refresh the Commercial Strategy	On track but not yet delivered	The Trust Board approved a Commercial Strategy and	Part of 5 Year Strategic Plan

	(amber / green)	action plan in 2014. The purpose of the strategy at that time was to: Improve the financial viability of existing services to eliminate or reduce the value of service line deficit; Identify if there are service reconfigurations that could improve the clinical quality and safety of service provision; Retain the Trust's market share of services that generate profit through successful responses to competitive procurement processes. During FY14/15, Monitor determined the Trust was in breach of its licence and the Trust agreed a number of undertakings with Monitor. One of the undertakings agreed with Monitor was that the Trust would commission external support to enable development of a longer term strategic turnaround and sustainability plan. The 5 Year strategic turnaround plan will provide the new refreshed commercial strategy for the Trust	reporting to Board
Strengthen our financial control procedures	On track but not yet delivered (amber / green)	• Cash Committee now up and running with detailed action plan. • Reduction in off-contract spend. • Nurse bank and agency authorisations tightened. • Sickness/absence controls centralised. • Non-contracted activity fast-tracked to invoice. • Legal support for contracts (non-patient) being shared across WY Acute Trusts. • Authorisation levels reviewed. • 200 Trust staff completed face to face Finance Training.	Finance & Performance Committee
Develop the 5 year turnaround plan with agreement across the local and regional health economy	On track but not yet delivered (amber / green)	The Five Year Strategic Plan will: 1. Return the Trust to a sustainable surplus (current underlying deficit of £20 million net of £14m CIP). 2. Improve clinical quality and safety of services provided. 3. Redesign services so that the Trust is operationally viable in a way that meets the needs of the local	There is a timetable of regular Board meetings to monitor progress of the 5 Year Strategic Plan through to sign off at the end of December. An update is on the agenda of the private Board 29/10.

		health economy. This will build on the work already undertaken for the redesign of services delivered across the two sites and will also consider opportunities for working with other providers. This will inform and enable Commissioners' to commence public consultation on the future configuration of services across the two sites. In recognition of the urgency in respect of the need to have a robust Five Year Strategic and Financial Turnaround Plan by 31st December 2015 an ambitious timeline has been agreed and discussed with the Board at its workshop on 14 October.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** HEATHER KIRK, Emergency Planning Officer
Date: Thursday, 29th October 2015	**Sponsoring Director:** Lesley Hill, Director of Planning, Performance, Estates and Facilities
Title and brief summary: EPRR ssurance - The trust must submit a statement of compliance against the EPRR (Emergency Preparedness, Resilience and Response to NHS England. This must be agreed by the BoD before submission to NHS England via the LHRP (Local Health Resilience Partnership). The paper is a summary of trust's compliance against the standards and associated improvement plan.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Health and Safety Committee (20th October 2015), Quality Board (27th October 2015), Executive Board (29th October 2015)	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The trust must submit a statement of compliance against the EPRR (Emergency Preparedness, Resilience and Response) core standards to NHS England. This must be agreed by the BoD before submission to NHS England via the LHRP (Local Health Resilience Partnership). The paper is a summary of trust's compliance against the standards and associated improvement plan.

Main Body

Purpose:

The trust must submit a statement of compliance against the EPRR (Emergency Preparedness, Resilience and Response) core standards to NHS England. This must be agreed by the BoD before submission to NHS England via the LHRP (Local Health Resilience Partnership). The paper is a summary of trust's compliance against the standards and associated improvement plan.

Background/Overview:

The EPRR (Emergency Preparedness, Resilience and Response) Core standards set by NHS England in 2013 are reviewed annually and NHS funded organisations are required to provide a statement of compliance to NHS England via the LHRP (Local Health Resilience Partnership). The statement of compliance is signed on behalf of the trust by the AEO (Accountable Emergency Officer). CHFT's AEO is Lesley Hill. The assurance paper should be agreed by the Executive Board and the Board of Directors before being signed by the AEO.

The Issue:

To provide assurance to NHS England of the trust's compliance against the EPRR Core Standards.

Next Steps:

After approval by the BoD the assurance paper is required to be submitted to the LHRP by 6th November 2015.

Recommendations:

The board is asked to approve the submission of the Trust statement of assurance, to be signed by the Trust Accountable Emergency Officer, as “Full Compliance – That the plans and work programme in place appropriately address all the core standards that the organisation is expected to achieve”

Appendix

Attachment:

BoD paper for EPRR Assurance 2015.pdf

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) CORE STANDARDS ASSURANCE SEPTEMBER 2015

Background

The Civil Contingencies Act, and accompanying non-legislative measures, delivers a single framework for civil protection in the UK. The Act is separated into 2 substantive parts: local arrangements for civil protection (Part 1); and emergency powers (Part 2).

Part 1 of the Act and supporting Regulations and statutory guidance 'Emergency preparedness' establish a clear set of roles and responsibilities for those involved in emergency preparation and response at the local level. The Act divides local responders into 2 categories, imposing a different set of duties on each.

For Acute Trusts these standards clarify the existing and ongoing EPRR requirements, they are not additional. It is expected that the level of preparedness will be proportionate to the role of each organisation as well as the range of services they provide;

- These are the minimum standards that Calderdale & Huddersfield Foundation Trust CHFT) **must** meet.
- The Accountable Emergency Officer is responsible for ensuring that these standards are met.
- All future NHS England framework guidance will be linked to these standards and CHFT will be expected to provide assurance (including evidence) that these standards are being met.

The main aim is to clearly set out the minimum EPRR standards expected of each NHS organisation and provider of NHS funded care.

However, the standards will also -

- Enable agencies across the country to share a purpose and to coordinate activities.
- Provide a consistent framework for self-assessment, peer-review and more formal control processes carried out by NHS England and regulatory bodies.

NHS Trusts which are designated as Category 1 Responders under the Civil Contingencies Act (2004) are required to undertake a self-assessment against the core standards culminating in a statement of compliance and to provide an improvement plan for any arrangements not currently in place (whether scheduled or non-compliant).

The EPRR Organisational Assurance Process ensures that providers of NHS funded care are working towards meeting the requirements for EPRR, particularly as set out in the NHS England Core Standards Matrix, the

NHS England planning framework, Everyone Counts: Planning for Patients 2013/14, and the 2013/14 NHS standard contract (Service Condition 30, page 25).

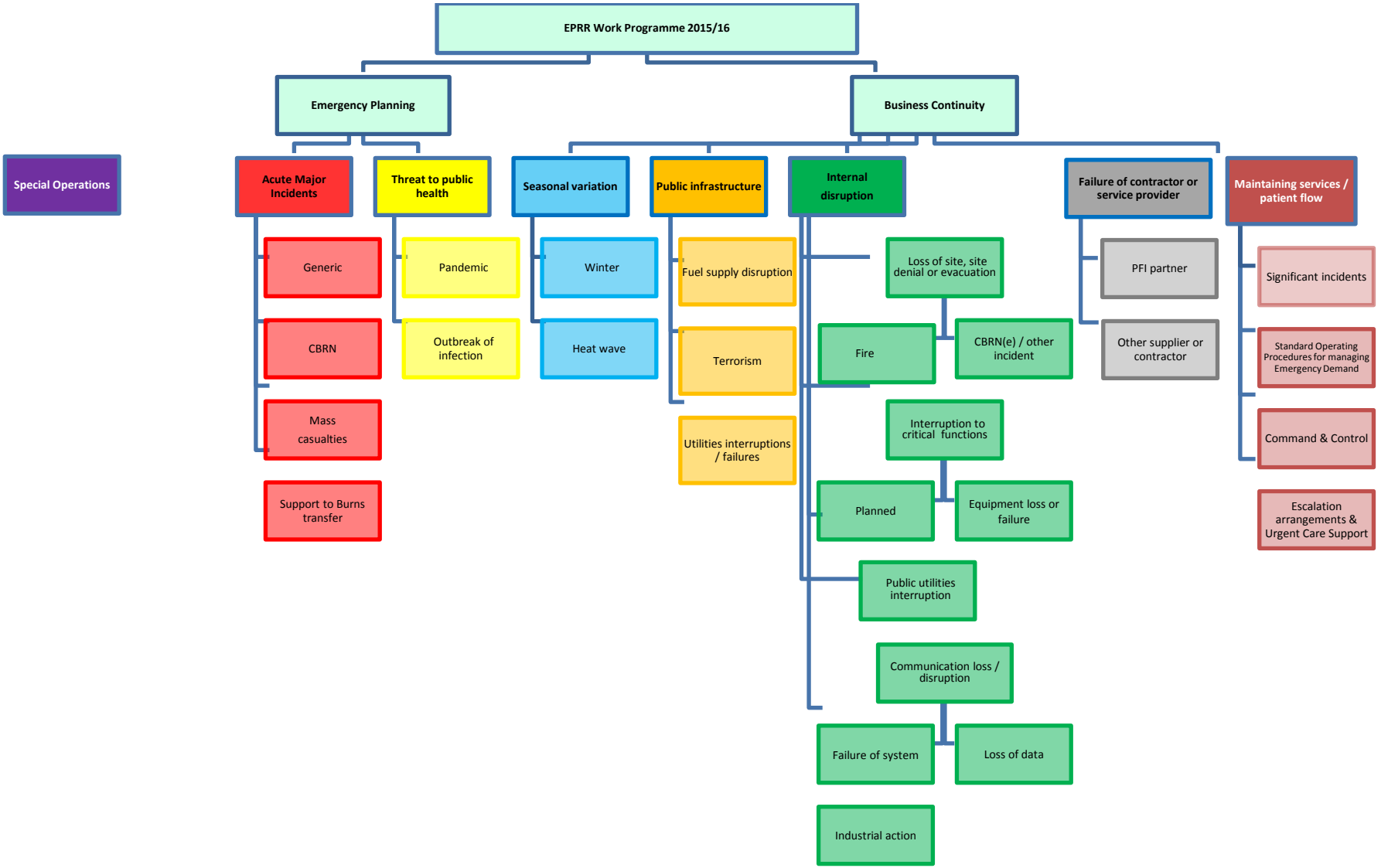
The Statement of compliance and improvement plans form part of the assurance to the NHS England Board and the Department of Health that robust and resilient EPRR arrangements are established and are maintained within NHS Organisations.

Its compliance with Legal and Regulatory standards directly related to EPRR is as follows –

Legal / Regulatory Implications / NHS Constitution
Civil Contingencies Act 2004 and associated guidelines
Health & Social Care Act 2012- Section 46
ISO 22301 and associated PAS2015 guidance
NHS Commissioning Board EPRR Core Standards
ISO 22301 and PAS 2015 guidance

Care Quality Commission Regulations (which apply)
Outcomes 4B, 6D, 10E, 10H, 11C AND 14A.

The compliance with these statutory duties form part of the Trusts resilience programme for each year. This broadly covers the following areas –



compassionate care

EPRR Assurance Process

There are 92 standards assigned to the revised EPRR assurance process divided for 2015/16 into four main work areas applicable to Acute Hospitals –

- EPRR Core Standards
- Pandemic Influenza
- Hazardous Materials (and CBRN) Standards
- Hazardous Material and CBRN Equipment

The NHS England Core Standards for Emergency Preparedness, Resilience and Response 2015-16 and the self-assessed level of compliance for each standard can be found in Appendix B.

The associated improvement plan can be found in Appendix A.

EPRR Core Standards

The core standards section comprises assurance in relation to the legislative duties of the Trust in relation to its Civil Contingencies Act 2004 Duties.

There are 46 core standard, on submitting the statement of compliance for 2015/16 there are 8 standards flagged as amber with associated improvement plans which are timetabled for completion by February 2016.

Pandemic Influenza Deep Dive

There are 4 pandemic influenza standards, on submitting the statement of compliance for 2015/16 there is one standard flagged as amber with associated improvement plan which is timetabled for completion by November 2015 and a duplication of aforementioned EPRR core standard.

Hazmat/CBRN Standards

The Hazmat/CBRN section relates directly to the Trusts preparedness to manage specific incidents again in relation to its Civil Contingencies Act Duties. Preparedness must be undertaken to respond to Chemical, Biological, Radiological and Nuclear incidents – with hazmat being the term used for non-malicious incidents e.g. Industrial accidents, and CBRN being the term used for a deliberate release of an agent.

There are 14 Hazmat/CBRN standards – on submitting the statement of compliance for 2015/16 the Trust has confirmed compliance with all standards.

Hazmat/CBRN equipment Standards

The Hazmat/CBRN equipment section relates directly to the resources needed to facilitate the response to an incident. These are also new additions to the assurance process.

There are 32 standards of which must be replicated across the Trusts 2 Emergency Departments. On submitting the statement of compliance for 2015/16 the Trust has confirmed compliance with all equipment requirements.

Next Steps

The Trust submission has been discussed at the Health and Safety Committee, the Quality Committee and the Trust Executive Board. Following approval from the Trust Executive Board and Board of Directors the Trust Accountable Emergency Officer will sign the Statement of Compliance on the behalf of the Board before submission to NHS England.

Following submission it is likely that there will be a review of all submissions via the Local Health Resilience Partnership attended by the Accountable Emergency Officer.

Recommendations

To approve the submission of the Trust statement of assurance, to be signed by the Trust Accountable Emergency Officer, as “Full Compliance – That the plans and work programme in place appropriately address all the core standards that the organisation is expected to achieve”

Appendix A West Yorkshire EPRR core standards improvement plan September 2015 Trust: Calderdale and Huddersfield Foundation Trust

Core standard reference	Core standard description	Improvement required to achieve compliance	Action to deliver improvement	Deadline
3	Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response.	Overarching EPRR framework to be developed	Preparing for Emergencies Policy and Emergency Management Arrangements have now been incorporated into the Major Incident Plan, Business Continuity Plan and the EPRR Policy which is in draft awaiting ratification.	Completion, sign off and publication of EPRR Policy by the end of November 2015
8.5	Pandemic Influenza	Plan to be updated	Working group containing representatives from areas affected to meet and review the policy.	November 2015
8.6	Mass Countermeasures	To be included in pandemic influenza plan	To be included in Pandemic Influenza plan	November 2015
8.11	Evacuation	Plan to be updated	Evacuation work remains ongoing with partners, planning for localised testing in Winter 2015	December 2015
8.12	Lockdown	Trust Lockdown Plan to be developed	Awaiting appointment of new LSMS prior to review of existing arrangements	February 2016
34	Arrangements include a training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	Revision of previous training arrangements ongoing at present	Formal training needs identified with surrounding West Yorkshire Acute Trusts. Training Strategy to be updated and signed off by Trust prior to implementation.	December 2015
35	Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.			
37	Preparedness ensures all incident commanders (on call directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.			
DD1	Organisation have updated their pandemic influenza arrangements to reflect changes to the NHS and partner organisations, as well as lessons identified from the 2009/10 pandemic including through local debriefing	Plan to be updated	Working group containing representatives from areas affected to meet and review the policy.	November 2015

Appendix B EPRR Core Standards

	Core standard	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Governance					
1	Organisations have a director level accountable emergency officer who is responsible for EPRR (including business continuity management)				
2	Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response.				
3	Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response.		**EPRR policy in draft and awaiting ratification by governance structures**	**Heather Kirk**	Nov-15
4	The accountable emergency officer will ensure that the Board and/or Governing Body will receive as appropriate reports, no less frequently than annually, regarding EPRR, including reports on exercises undertaken by the organisation, significant incidents, and that adequate resources are made available to enable the organisation to meet the requirements of these core standards.				
Duty to assess risk					
5	Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver it's functions.				
6	There is a process to ensure that the risk assessment(s) is in line with the organisational, Local Health Resilience Partnership, other relevant parties, community (Local Resilience Forum/ Borough Resilience Forum), and national risk registers.				
7	There is a process to ensure that the risk assessment(s) is informed by, and consulted and shared with your organisation and relevant partners.				

	Core standard	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Duty to maintain plans – emergency plans and business continuity plans					
8	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity. Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive):				
			Revisions to plan being undertaken currently	Heather Kirk	Nov-15
			Included in pandemic flu plan for revision as above	Heather Kirk	Nov-15
			Evacuation work remains ongoing with partners, planning for localised testing in Winter 2015	Heather Kirk	Dec-15
			Awaiting new LSMS into post prior to revision of existing arrangements	Heather Kirk	Feb-15
		N/A			
		N/A			
9	Ensure that plans are prepared in line with current guidance and good practice which includes:				
10	Arrangements include a procedure for determining whether an emergency or business continuity incident has occurred. And if an emergency or business continuity incident has occurred, whether this requires changing the deployment of resources or acquiring additional resources.				
11	Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.				

	Core standard	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
12	Arrangements explain how VIP and/or high profile patients will be managed.				

	Core standard	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
13	Preparedness is undertaken with the full engagement and co-operation of interested parties and key stakeholders (internal and external) who have a role in the plan and securing agreement to its content				
14	Arrangements include a debrief process so as to identify learning and inform future arrangements				
Command and Control (C2)					
15	Arrangements demonstrate that there is a resilient single point of contact within the organisation, capable of receiving notification at all times of an emergency or business continuity incident; and with an ability to respond or escalate this notification to strategic and/or executive level, as necessary.				
16	Those on-call must meet identified competencies and key knowledge and skills for staff.				
17	Documents identify where and how the emergency or business continuity incident will be managed from, ie the Incident Co-ordination Centre (ICC), how the ICC will operate (including information management) and the key roles required within it, including the role of the loggist .				
18	Arrangements ensure that decisions are recorded and meetings are minuted during an emergency or business continuity incident.				
19	Arrangements detail the process for completing, authorising and submitting situation reports (SITREPs) and/or commonly recognised information pictures (CRIP) / common operating picture (COP) during the emergency or business continuity incident response.				
20	Arrangements to have access to 24-hour specialist adviser available for incidents involving firearms or chemical, biological, radiological, nuclear, explosive or hazardous materials, and support strategic/gold and tactical/silver command in managing these events.				
21	Arrangements to have access to 24-hour radiation protection supervisor available in line with local and national mutual aid arrangements;				
Duty to communicate with the public					
22	Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents.				
23	Arrangements ensure the ability to communicate internally and externally during communication equipment failures				
Information Sharing – mandatory requirements					

	Core standard	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
24	Arrangements contain information sharing protocols to ensure appropriate communication with partners.				
Co-operation					
25	Organisations actively participate in or are represented at the Local Resilience Forum (or Borough Resilience Forum in London if appropriate)				
26	Demonstrate active engagement and co-operation with other category 1 and 2 responders in accordance with the CCA				
27	Arrangements include how mutual aid agreements will be requested, co-ordinated and maintained.				
28	Arrangements outline the procedure for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.	N/A			
29	Arrangements outline the procedure for responding to incidents which affect two or more regions.	N/A			
30	Arrangements demonstrate how organisations support NHS England locally in discharging its EPRR functions and duties				
31	Plans define how links will be made between NHS England, the Department of Health and PHE, including how information relating to national emergencies will be co-ordinated and shared	N/A			
32	Arrangements are in place to ensure an Local Health Resilience Partnership (LHRP) (and/or Patch LHRP for the London region) meets at least once every 6 months	N/A			
33	Arrangements are in place to ensure attendance at all Local Health Resilience Partnership meetings at a director level				
Training And Exercising					
34	Arrangements include a training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents		Formal training needs identified with surrounding West Yorkshire Acutes, Preparing for Emergencies Training Strategy to be updated and signed off by Trust prior to implementation.	Heather Kirk	Dec-15
35	Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.		As above	Heather Kirk	Dec-15
36	Demonstrate organisation wide (including oncall personnel) appropriate participation in multi-agency exercises				
37	Preparedness ensures all incident commanders (oncall directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.		As 34	Heather Kirk	Dec-15

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Community services providers	Mental healthcare providers	NHS England local teams	NHS England Regional & national	CCGs	GPSIs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
2015 Deep Dive																		
DD1	Organisation have updated their pandemic influenza arrangements to reflect changes to the NHS and partner organisations, as well as lessons identified from the 2009/10 pandemic including through local debriefing	• changes since April 2013 are reflected in local plans including formation of NHS England, CCGs and PHE, as well as the move of the previous PCT public health function into local authorities • key changes to the national pandemic influenza strategy (such as de-coupling from WHO, development of DATER phases, and removal of UK alert levels) as well as relevant local learning is reflected	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	• updated planning arrangements reflect changes and learning • version control indicates changes made and timeliness		Revisions to plan being undertaken currently	Heather Kirk	Nov-15
DD2	Organisations have developed and reviewed their plans with LHRP and LRF partners	• relevant local partners (particularly other NHS providers/ commissioners, PHE and local authority public health and social care teams where appropriate) have been engaged in the development of local plans - at a minimum through an opportunity to comment on draft versions	Y	Y	Y	Y	Y	Y		Y			Y	• indication of the process used to develop updated arrangements, including identification of organisations involved in contributing or commenting on drafts • agendas/ minutes illustrating where the updated arrangements have been discussed				
DD3	Organisations have undertaken a pandemic influenza exercise or have one planned in the next six months	• local organisations have held an internal exercise or participated in a multi-organisation exercise since updating their local arrangements to reflect changes and learning described in DD1 • if this has not taken place, there is a clear plan to deliver an exercise in the next six months	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	• documentation related to exercise since the 2013 publication, including lessons identified OR • invitation letters/ documentation related to exercise scheduled to take place in next six months, including an indication of how lessons identified will be addressed				
DD4	Organisations have taken their plans to Boards / Governing bodies for sign off	• updated arrangements that reflect changes and learning described in DD1 have been taken to Boards or Governing Bodies, and even if they have not yet have been signed off by such bodies, the process towards this has been started	Y	Y	Y	Y	Y	Y	Y	Y			Y	• Board/ Governing Body agenda or meeting papers indicating updated pandemic influenza arrangements have been discussed and/ or signed off				

Hazardous materials (HAZMAT) and chemical, biological, radiological and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)			Acute healthcare provider	Specialist services	Ambulance service provider	Community service provider	Mental health care provider		Self assessment RAG: Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = Fully compliant with core standard.	Action to be taken	Lead	Timescale
C	Core standard	Clarifying information						Evidence of assurance				
	Preparedness											
38	There is an organisation specific HAZMAT/ CBRN plan (or dedicated annex)	Arrangements include: - command and control interfaces - tried and tested process for activating the staff and equipment (inc. Step 1-2-3 Plus) - pre-determined decontamination locations and access to facilities - management and decontamination processes for contaminated patients and fatalities in line with the latest guidance - communications planning for public and other agencies - interoperability with other relevant agencies - access to national reserves / Pods - plan to maintain a cordon / access control - emergency / contingency arrangements for staff contamination - plans for the management of hazardous waste - stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes - contact details of key personnel and relevant partner agencies	Y	Y	Y	Y	Y	- Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving arrangements - Version control				
39	Staff are able to access the organisation HAZMAT/ CBRN management plans.	Decontamination trained staff can access the plan	Y	Y	Y	Y	Y	- Site inspection - IT system screen dump				
40	HAZMAT/ CBRN decontamination risk assessments are in place which are appropriate to the organisation.	- Documented systems of work - List of required competencies - Impact assessment of CBRN decontamination on other key facilities - Arrangements for the management of hazardous waste	Y	Y	Y	Y	Y	- Appropriate HAZMAT/ CBRN risk assessments are incorporated into EPRR risk assessments (see core standards 5-7)				
41	Rotas are planned to ensure that there is adequate and appropriate decontamination capability available 24/7.		Y		Y			- Resource provision / % staff trained and available - Rota / rostering arrangements				
42	Staff on-duty know who to contact to obtain specialist advice in relation to a HAZMAT/ CBRN incident and this specialist advice is available 24/7.	- For example PHE, emergency services.	Y	Y	Y	Y	Y	- Provision documented in plan / procedures - Staff awareness				
	Decontamination Equipment											
43	There is an accurate inventory of equipment required for decontaminating patients in place and the organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff.	- Acute and Ambulance service providers - see Equipment checklist overleaf on separate tab - Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londoncn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf) - Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-doftraining/	Y	Y	Y	Y	Y	- completed inventory list (see overleaf) or Response Box (see Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities (NHS London, 2011))				
44	The organisation has the expected number of PRPS suits (tested and in date) available for immediate deployment should they be required. (NHS England published guidance (May 2014) or subsequent later guidance when applicable)	There is a plan and finance in place to revalidate (extend) or replace suits that are reaching the end of shelf life until full capability of the current model is reached in 2017	Y		Y							
45	There are routine checks carried out on the decontamination equipment including: A) Suits B) Tents C) Pump D) RAM GRNE (radiation monitor) E) Other decontamination equipment	There is a named role responsible for ensuring these checks take place	Y		Y							
46	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date Decontamination equipment for: A) Suits B) Tents C) Pump D) RAM GRNE (radiation monitor) E) Other equipment		Y		Y							
47	There are effective disposal arrangements in place for PPE no longer required.	(NHS England published guidance (May 2014) or subsequent later guidance when applicable)	Y		Y							
	Training											
48	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training		Y		Y							
49	Internal training is based upon current good practice and uses material that has been supplied as appropriate.	- Documented training programme - Primary Care HAZMAT/ CBRN guidance - Lead identified for training - Established system for refresher training so that staff that are HAZMAT/ CBRN decontamination trained receive refresher training within a reasonable time frame (annually). - A range of staff roles are trained in decontamination techniques - Include HAZMAT/ CBRN command and control training - Include ongoing fit testing programme in place for FFP3 masks to provide a 24/7 capacity and capability when caring for patients with a suspected or confirmed infectious respiratory virus - Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-doftraining/	Y	Y	Y	Y	Y	- Show evidence that achievement records are kept of staff trained and refresher training attended - Incorporation of HAZMAT/ CBRN issues into exercising programme				
50	The organisation has sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.		Y		Y							
51	Staff that are most likely to come into first contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	- Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-doftraining/ - Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londoncn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf)	Y	Y	Y	Y	Y					

HAZMAT CBRN equipment list - for use by Acute and Ambulance service providers in relation to Core Standard 43.				
No	Equipment	Equipment model/ generation/ details etc.	Self assessment RAG Red = Not in place and not in the EPRR work plan to be in place within the next 12 months. Amber = Not in place and in the EPRR work plan to be in place within the next 12 months. Green = In place.	Self assessment RAG Red = Not in place and not in the EPRR work plan to be in place within the next 12 months. Amber = Not in place and in the EPRR work plan to be in place within the next 12 months. Green = In place.
	EITHER: Inflatable mobile structure		Calderdale	Huddersfield
E1	Inflatable frame		N/A	N/A
E1.1	Liner		N/A	N/A
E1.2	Air inflator pump		N/A	N/A
E1.3	Repair kit		N/A	N/A
E1.2	Tethering equipment		N/A	N/A
	OR: Rigid/ cantilever structure			
E2	Tent shell	PPS Versar Rapid Pro 2 Line 7		
	OR: Built structure			
E3	Decontamination unit or room			
	AND:			
E4	Lights (or way of illuminating decontamination area if dark)			
E5	Shower heads			
E6	Hose connectors and shower heads			
E7	Flooring appropriate to tent in use (with decontamination basin if needed)			
E8	Waste water pump and pipe			
E9	Waste water bladder			
	PPE for chemical, and biological incidents			
E10	The organisation (acute and ambulance providers only) has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required. (NHS England published guidance (May 2014) or subsequent later guidance when applicable).			
E11	Providers to ensure that they hold enough training suits in order to facilitate their local training programme			
	Ancillary			
E12	A facility to provide privacy and dignity to patients			
E13	Buckets, sponges, cloths and blue roll			
E14	Decontamination liquid (COSHH compliant)			
E15	Entry control board (including clock)			
E16	A means to prevent contamination of the water supply			
E17	Poly boom (if required by local Fire and Rescue Service)		N/A	N/A
E18	Minimum of 20 x Disrobe packs or suitable equivalent (combination of sizes)			
E19	Minimum of 20 x re-robe packs or suitable alternative (combination of sizes - to match disrobe packs)			
E20	Waste bins			
	Disposable gloves			
E21	Scissors - for removing patient clothes but of sufficient calibre to execute an emergency PRPS suit disrobe			
E22	FFP3 masks			
E23	Cordon tape			
E24	Loud Hailer			
E25	Signage			
E26	Tabbards identifying members of the decontamination team			
E27	Chemical Exposure Assessment Kits (ChEAKs) (via PHE) or should an acute service provider be required to support PHE in the collection of samples for assisting in the public health risk assessment and response phase of an incident, PHE will contact the acute service provider to agree appropriate arrangements. A Standard Operating Procedure will be issued at the time to explain what is expected from the acute service provider staff. Acute service providers need to be in a position to provide this support.			
	Radiation			
E28	RAM GENE monitors (x 2 per Emergency Department and/or HART team)			
E29	Hooded paper suits			
E30	Goggles			
E31	FFP3 Masks - for HART personnel only		N/A	N/A
E32	Overshoes & Gloves			

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Alison Wilson, Head of Estates Operations and Compliance
Date: Thursday, 29th October 2015	**Sponsoring Director:** Lesley Hill, Director of Planning, Performance, Estates and Facilities
Title and brief summary: Health & Safety - Health and Safety mid year report	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Health & Safety Committee	
Governance Requirements: Health & Safety requirements; keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The report is a mid year assessment of progress made in relation to HEalth and Safety.

Main Body

Purpose:

Annual health and safety reports are provided to Trust Baord; the attached is a mid year report on progress made against the action plan.

Background/Overview:

Provide assurnace on progress made in relation to Health & Safety.

The Issue:

Provide assurance on progress made in relation to health and safety.

Next Steps:

The next report will be 2015/16 annual health and safety report. An assessment of progress made against the action plan will be provided in the report.

Recommendations:

The Board are requested to approve the progress made to date on the health and safety action plan.

Appendix

Attachment:

HEALTH SAFETY ACTION PLAN MID YEAR UPDATE Sept 2015 FINAL.pdf

HEALTH & SAFETY UPDATE
SEPTEMBER 2015

At the request of Trust Board the Health and Safety Action Plan is being audited by external specialists to ensure it complies with Health and Safety at Work Act and supporting guidance. During this period the Trust are continuing to make progress in against the 2015/16 action plan which is attached at appendix 1.

The Trust has made

Action No 1 - RISK ASSESSMENT METHODOLOGY

Risk assessment terminology is not new to CHFT and is already embedded within the Trust working practices with risk assessments for specific risks in place (i.e. manual handling, VTE, sharps etc).

Risk Assessment methodology forms part of the health and safety training for Managers and Supervisors and provides simple examples of when and how to use risk assessments. Attendees are asked as part of the course to identify areas of risk, they then develop the assessments based on those observations using a generic assessment form at present. NHS Property Services repeatedly stress the importance of the assessments in relation to good management practices, legal requirements and of course the reactive requirements of accident investigation, HSE and CQC.

Further work is required to provide the simple tools and techniques to all staff within the Trust.

Action No 2 – REPORTABLE INJURIES AND DANGEROUS OCCURRENCES REGS (RIDDOR)

RIDDOR is the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013. These Regulations require employers, the self-employed and those in control of premises to report specified workplace incidents which include injuries, illnesses and dangerous occurrences.

An explanation of RIDDOR incidents is included in the healthcare specific health and safety training and has also been included in Incident reporting policy. The HSE information sheet guidance “RIDDORs in health and social care” will be cascaded via the Health and Safety Committee in October 2015.

Action No 3 – HEALTHCARE SPECIFIC HEALTH & SAFETY TRAINING

CHFT have engaged with an external provider for health and safety training which was initially provided over 4 days. Following feedback from attendees this has now been condensed into 2 days and focusses on the healthcare setting. The training is being developed further to be approved by the Institute of Occupation Safety and Health (IOSH) and become the first IOSH healthcare health and safety training package.

However, there remain concerns about attendance at training which is illustrated in table 1 below. Whilst there are another 5 training sessions available during October, November and December with a number of staff booked to attend there is likely to be at least 50% of Managers and Supervisors requiring training. A sufficient number of events were planned during 2015 however, due to work pressures, candidates withdraw resulting in events running with reduced numbers.

Table 1 illustrates attendance at the training as at Sept 2015.

	Staff Eligible	Compliant	Non-Compliant	Percentage Compliance	Comments
DATS	20	6	14	30%	*6 staff booked in Oct, November*
CWF	32	20	12	63%	*8 staff booked in Oct & November*
MEDICINE	116	21	95	18%	*25 staff booked in Oct & November*
SURGICAL	60	17	43	28%	*4 staff booked in Oct & November*
ESTATES & FACS	21	13	8	62%	*2 staff booked in November*
CORPORATE	26	9	17	35%	*No staff booked on Event*
THIS	42	0	42	0%	*THIS Event planned for December 15.*
TOTAL	317	86	231	27%	

Action No 4 – GENERIC HEALTH AND SAFETY AWARENESS TRAINING

Health and Safety awareness training has been incorporated in the mandatory training package and is now being measured for compliance against other mandatory training modules.

Action No 5 – HEALTH AND SAFETY MONITORING VIA FRONT LINE OWNERSHIP (FLO)

A number of health and safety related questions are included in the FLO audit which is now captured electronically. Reporting will be explored via the electronic database.

Action No 6 – PROMOTE THE USE OF DATIX

Risk Management are in the process of reviewing its on line Datix system with a view to streamlining the database and simplifying. All Divisions have “super users” who are able to provide regular reports and support to those staff in the Departments who require training / advice and guidance.

Action No 7 – IMPROVE ATTENDANCE AT MANUAL HANDLING TRAINING

Moving and handling continues to be a concern in terms of staff attending training events; this has been captured on the Trust Risk Register. A working group from the health and safety committee are working with Divisions to review how future training may be delivered.

Action No 8 – IMPLEMENT COSHH FRAMEWORK

COSHH training completed for COSHH Strategy Group and COSHH assessors. Work is underway to incorporate COSHH into the Health and Safety training.

Action No 9 – IMPROVE DIVISONAL REPRESENTATION ATTENDANCE AT H&S COMMITTEE

All Divisions have now appointed divisional reps to attend health and safety committee meetings and attendance will continue to be monitored throughout the year.

Action No 10 – IMPROVE STAFF SIDE REPRESENTIVE ATTENDANCE AT H&S COMMITTEE

Staff side have identified Jean Wilkinson as the Trust Health and Safety Representative who represents staff side.

A J Wilson
Estates and Facilities

Appendix 1

	WHAT	WHO	WHEN
1.	Incorporate Risk Assessment methodology into health & safety training.	A Wilson	July 15
2.	Carry out analysis of RIDDOR incidents.	A Wilson / Risk Management	July 15
3.	Provide healthcare specific health & safety training for Managers / Supervisors.	A Wilson / Training Provider	Aug 15
1.	Provide generic health & safety awareness training via Workforce Organisation and Development.	A Wilson / B France	July 15
5	Include health & safety monitoring within FLO Audit.	A Wilson / J Robinson	May 15
6	Support Risk Management to promote the use of Datix (Incident Reporting System)	Risk Management Dept / A Wilson	Sept 15
7	Improve attendance at Manual Handling Training	Risk Management Dept & Divisions	Sept 15
8.	Implement COSHH Framework	M Culshaw	June 15
9.	Improve divisional representation at Health & Safety Committee	L Hill / Exec Directors	June 15
10.	Improve staff side representation at Health & Safety Committee	L Hill / J Eddleston	June 15

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 29th October 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: INTEGRATED BOARD REPORT - The Board is asked to receive and note the Integrated Board Report	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Quality Committee, Weekly Executive Board	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive and note the Integrated Board Report

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

The Board is asked to receive and note the Integrated Board Report

Appendix

Attachment:

IBR Report Sept 15.pdf

Board of Directors Integrated Performance Report

Calderdale and Huddersfield NHS
NHS Foundation Trust

compassionate care

Contents

Report For: September 2015

Board of Directors

Integrated Performance Report

Executive Summary Commentary

The report on September performance remains good for the Monitor indicators and is showing more indicators improving on the previous month. The key areas to note are:

Responsiveness
The Trust delivered the Emergency Care Standard for the month and quarter
National cancer standards were met at Trust level and Day 38 performance is improving
Delayed transfer of care significantly improved in September
Diagnostics performance dipped with a fail for the month
Cancelled operations performance deteriorated with some high volume cancellations in Ophthalmology related to equipment failure
Elective activity continues to track below plan
Slight improvement of ASIs in month but sustainable improvement not yet in place.

Caring
Complaint acknowledged within 3 days remains at 100%
Friends and Family Test percentage was achieved in Maternity for September

Safety
Falls and Pressure ulcers remain a concern and are the focus of specific in depth reviews
Percentage of SI investigations completed within timescales has significantly improved
Maternity indicators show continued good performance

Effectiveness
A further MRSA reported in September
HSMR remains a key area of concern
Stillbirth rate was above tolerance for the month, all incidents related to known risk factors
Neck of Femur performance still not at required standard

Well led
Sickness has improved in 5 of the 7 service areas reported and 5 out of 8 staff categories with overall % sickness at its lowest point in current service year with a downward trend
Staff in post and fte is static
Over 85% of colleagues have now started their mandatory training programme.
Appraisal activity plans are in place with divisions now RAG rated against these plans.

A Performance Management and Accountability Framework is currently in production that will further increase the scrutiny, structure and delivery of effective performance across the Trust.

Table of Risk

Monitor		Contract		Contract		NHSE		Quality		Quality		Other Internal	
Outcome	Indicator	Outcome	Indicator	Outcome	Indicator	Outcome	Indicator	Outcome	Indicator	Outcome	Indicator	Outcome	Indicator
↑	A and E 4 hour target	↑	% Stroke patients spending 90% of their stay on a stroke unit	→	28 Day Standard for all Last Minute Cancellations	↓	Friends & Family Test (IP Survey) - % would recommend the Service	n/a	End of Life Care Plan in place	↓	Unavoidable Number of Clostridium Difficile Cases	↓	% Elective Variance against Plan
↓	62 Day Gp Referral to Treatment		% Stroke patients scanned within 1 hour of hospital arrival (where indicated)	→	No of Urgent Operations cancelled for a second time	↑	Friends and Family Test A & E Survey - % would recommend the Service	→	Local SHMI - Relative Risk (1yr Rolling Data Jan14- Dec 14)	↓	MRSA Screening - Percentage of Inpatients Matched	↓	% Day Case Variance against Plan
→	62 Day Referral From Screening to Treatment	#N/A	% Stroke patients Thrombolysed within 1 hour	↑	% Harm Free Care	↑	Friends & Family Test (Maternity) - % would recommend the Service	→	Hospital Standardised Mortality Rate (1 yr Rolling Data Jul 14 - Jun 15)	↓	Number of E.Coli - Post 48 Hours	↑	% Non-elective Variance against Plan
→	31 Day Subsequent Surgery Treatment	↓	Percentage of Completed VTE Risk Assessments	↓	62 Day Aggregated Gp Urgent Referral To Treatment And Screening Referral To Treatment	↑	Friends and Family Test Community Survey - % would recommend the Service	↑	Crude Mortality Rate (Latest Month Sep 15)	↓	% Hand Hygiene Compliance	↑	% Outpatient Variance against Plan
→	31 day wait for second or subsequent treatment drug treatments	→	Completion of NHS numbers within acute commissioning datasets submitted via SUS	→	Number of Mixed Sex Accommodation Breaches	↓	Friends & Family Test (IP Survey) - Response Rate	↓	Mortality Reviews – August Deaths	↑	Avoidable number of Clostridium Difficile Cases	↑	Theatre Utilisation (TT) - Main Theatre - CRH
→	31 Days From Diagnosis to First Treatment	↓	Completion of NHS numbers within A&E commissioning datasets submitted via SUS	↑	Stillbirths Rate (including intrapartum & Other)	↑	Friends and Family Test A & E Survey - Response Rate	↑	Average Diagnosis per Coded Episode	↓	Number of MSSA Bacteraemias - Post 48 Hours	↑	Theatre Utilisation (TT) - Main Theatre -HRI
↑	Two Week Wait From Referral to Date First Seen	↑	Number of MRSA Bacteraemias – Trust assigned	→	Never Events	→	Percentage of Stage 1 RCAs completed for all Hospital Acquired Thrombosis	↓	Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours	↓	% Complaints closed within target timeframe	↑	Theatre Utilisation (TT) - HRI DSU
↓	Two Week Wait From Referral to Date First Seen: Breast Symptoms	↑	A&E Ambulance Handovers 30-60 mins (Validated)	↓	Percentage of SI's investigations where reports submitted within timescale (45 days unless extension agreed)	n/a	Percentage of non-elective inpatients 75+ screened for dementia	↓	Left without being seen	n/a	Total Complaints received in the month	↓	Theatre Utilisation (TT) - HRI SPU
→	Community care - referral to treatment information completeness	↓	Delayed Transfers of Care	→	A&E Trolley Waits	n/a	Acute Kidney Injury (Reported quarterly)	↑	Time to Initial Assessment (95th Percentile)	n/a	Total Concerns in the month	↓	World Health Organisation Check List
↓	Community care - referral information completeness	→	Percentage of Non-Compliant Duty of Candour informed within 10 days	↑	Perinatal Deaths (0-7 days)	n/a	Sepsis Screening (Reported quarterly)	↑	Time to Treatment (Median)	↑	Complaints acknowledged within 3 working days	↓	% Daily Discharges - Pre 11am
→	Community care - activity information completeness	↑	Total Duty of Candour informed within 10 days	↓	Neonatal Deaths (8-28 days)	n/a	Sepsis Antibiotic Administration (Reported Quarterly)	↓	Unplanned Re-Attendance	→	Percentage of SI's reported externally within timescale (2 days)	↑	Green Cross Patients (Snapshot at month end)
→	Total Number of Clostridium Difficile Cases - Trust assigned	n/a	Respiratory Care Bundle - Improving management of patients attending A&E with pneumonia (Reported quarterly)	n/a	Nutrition and Hydration - Reducing Hospital Food Waste (reported quarterly)			↑	Inpatient Falls with Serious Harm (10% reduction on 14/15)	n/a	Number of Patient Incidents	↓	Number of Outliers (Bed Days)

Table of Risk

Monitor		Contract		Contract		NHSE		Quality		Quality		Other Internal	
Outcome	Indicator	Outcome	Indicator	Outcome	Indicator	Outcome	Indicator	Outcome	Indicator	Outcome	Indicator	Outcome	Indicator
↑	7 Day Referral to First Seen	n/a	Respiratory Care Bundle - Improving management of patients presenting with Asthma in ED (Reported quarterly)	n/a	Nutrition and Hydration - Patient Satisfaction (Reported quarterly)			n/a	All Falls	n/a	Number of Incidents with Harm	↓	First DNA Rate
↑	38 Day Referral to Tertiary	↑	% Non-admitted Closed Pathways under 18 weeks	n/a	Improving Medicines Safety – Reconciliation (Effective Transfer of Medicines)			→	Missed Doses (Reported quarterly)	n/a	Number of SI's	→	% Hospital Initiated Outpatient Cancellations
↑	54 Referral to Treatment	↓	% Admitted Closed Pathways Under 18 Weeks	n/a	Improving Medicines Safety Discharge Accuracy Checks			n/a	% of diabetic patients supported to self-care	↑	Number of Trust Pressure Ulcers Acquired at CHFT	↓	CHFT Research Recruitment Target
		↑	% Incomplete Pathways <18 Weeks	→	% Diagnostic Waiting List Within 6 Weeks			n/a	Safeguarding Alerts made by the Trust	↑	Number of Category 2 Pressure Ulcers Acquired at CHFT	n/a	Total Number of Spells
		↓	Community - 18 Week RTT Activity	↓	18 weeks Pathways >=26 weeks open			n/a	Safeguarding Alerts made against the Trust	↑	Number of Category 3 Pressure Ulcers Acquired at CHFT	n/a	No of Spells with > 2 Ward Movements
			Appointment Slot Issues on Choose & Book	↓	18 weeks Pathways >=40 weeks open					↑	Number of Category 4 Pressure Ulcers Acquired at CHFT	↑	% of Spells with > 2 ward movements (2% Target)
		↑	% Last Minute Cancellations to Elective Surgery	→	RTT Waits over 52 weeks Threshold > zero					↑	Number of Category 3 & 4 Pressure Ulcers Acquired at CHFT	n/a	No of Spells with > 5 Ward Movements
												n/a	% of spells with > 5 ward movements (No Target)

↑ Improvement on last month ↓ deterioration on last month → No change on last month

RAG rating = GREEN Achieving Target / AMBER = missing target by a small margin / RED = Currently not Achieving Target

Achieving and Improving	Achieving No Change	Achieving but Deteriorating	Not Achieving No Change	Not achieving but improving	Not Achieving and Deteriorating
11	18	17	4	27	16

n/a - New indicators currently no trend /No RAG rating **24**

Overall Rating: Red reflecting enforcement action in place.

CQC status – Formal announced inspection date confirmed as commencing on the 8th March 2016

		Threshold	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Access and Outcome Metrics	% Admitted Closed Pathways Under 18 Weeks	>=90%	91.65%	92.41%	92.67%	92.79%	92.03%	91.64%							92.21%
	% Non-admitted closed Pathways under 18 weeks	>=95%	98.35%	98.89%	98.63%	98.23%	98.55%	98.67%							98.55%
	% Incomplete Pathways <18 Weeks	>=92%	95.02%	95.85%	95.44%	95.55%	95.44%	96.07%							96.07%
	A and E 4 hour target	>=95%	95.01%	94.80%	95.44%	95.44%	95.36%	95.37%							95.23%
	Total Number of Clostridium Difficile Cases - Trust assigned	21	2	0	1	1	3	3							10
	62 Day Gp Referral to Treatment	>=86%	89.38%	92.31%	90.00%	88.95%	93.94%	88.24%							90.09%
	62 Day Referral From Screening to Treatment	>=90%	85.71%	100.00%	100.00%	100.00%	100.00%	100.00%							98.48%
	31 Day Subsequent Surgery Treatment	>=94%	95.45%	100.00%	100.00%	100.00%	100.00%	100.00%							99.08%
	31 day wait for second or subsequent treatment drug treatments	>=98%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%							100.00%
	31 Days From Diagnosis to First Treatment	>=93%	100.00%	100.00%	99.24%	100.00%	100.00%	100.00%							99.86%
	Two Week Wait From Referral to Date First Seen	>=93%	96.45%	98.43%	96.55%	95.64%	93.78%	97.82%							96.43%
	Two Week Wait From Referral to Date First Seen: Breast Symptoms	>=93%	93.33%	93.75%	94.92%	94.87%	98.60%	98.47%							95.80%
	Community care - referral to treatment information completeness	>=50%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%							100.00%
	Community care - referral information completeness	>=50%	98.10%	98.10%	97.94%	97.54%	98.06%	97.56%							97.89%
	Community care - activity information completeness	>=50%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%							100.00%

Third Party Reports	Lung Cancer Peer review completed, awaiting written report. 1 Immediate concern relating to Pathology input to MDT which has been resolved. 1 serious concern relating to lack of Psychology provision but reviewers noted the Trust attempts to resolve and the commissioning decision in relation to this. The team were commended for their preparation, documentation and overall team dynamics reflecting a higher number of areas of good practice than many Trusts.
Quality Governance Indicators	**Patient Metrics -Narrative on Friends and Family included within Exception reports.**
	Staff Metrics : Reported quarterly – no further update from previous report

Finance	Financial Sustainability Risk Rating	2	2
	Operational Performance (Capital Service Cover)	1	1
	Cash & Balance Sheet Performance (Liquidity)	1	1
	Income & Expenditure Margin	1	1
	Income & Expenditure Margin - Variance from Plan	3	3
	Use of Capital	£12.66m	£9.62m
	Income and Expenditure (excluding Restructuring)	(£10.71m)	(£12.14m)
	Cost Improvement Programme (CIP)	£5.64m	£6.93m

	Report For: September 2015	Indicator Source	Target	Trust	Year To Date: Surgical	Medical	Families and Specialist Services	Community	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Trend (Rolling 12 Month)	Directon of travel (past 4 months)	Financial Penalities/Non Financial Impact	Year End Forecast	Data Quality
Activity	% Elective Variance against Plan	Local	0.00%	-6.77%	-8.96%	-0.60%	-0.81%	-	0.00%	-3.56%	-4.86%	-7.94%	6.48%	-		↓			
	% Day Case Variance against Plan	Local	0.00%	-8.67%	-8.25%	-9.46%	-10.26%	-	0.00%	-4.78%	-4.85%	-6.15%	2.53%	-		↑			
	% Non-elective Variance against Plan	Local	0.00%	6.68%	0.11%	6.99%	10.54%	-	0.00%	2.95%	-2.53%	4.37%	3.98%	-		↑			
	% Outpatient Variance against Plan	Local	0.00%	-3.30%	-3.75%	-2.13%	-4.00%	-	0.00%	-2.76%	-2.81%	-3.84%	-0.55%	-		↓			
RESPONSIVE - Theatre Utilisation	Theatre Utilisation (TT) - Main Theatre - CRH	Local	92.50%	89.70%	88.82%	-	96.42%	-	92.50%	87.27%	85.80%	-	97.95%	-		↑			
	Theatre Utilisation (TT) - Main Theatre -HRI	Local	92.50%	93.13%	93.13%	-	-	-	92.50%	94.44%	94.44%	-	-	-		↓			
	Theatre Utilisation (TT) - HRI DSU	Local	92.50%	79.83%	78.48%	-	89.56%	-	92.50%	76.85%	75.52%	-	87.38%	-		↑			
	Theatre Utilisation (TT) - HRI SPU	Local	92.50%	81.97%	81.97%	-	-	-	92.50%	83.23%	83.23%	-	-	-		↓			
Exception Report - Patient Flow	% Daily Discharges - Pre 11am	Local	28.00%	9.84%	12.57%	7.57%	10.19%	-	28.00%	10.43%	13.44%	8.50%	10.22%	-		↓			
	Delayed Transfers of Care	Local	5.00%	5.30%	-	-	-	-	5.00%	6.60%	-	-	-	-		↓			
	Green Cross Patients (Snapshot at month end)	Local	40	71	-	71	-	-	40	71	-	71	-	-		↓			
	Number of Outliers (Bed Days)	Local	267	598	40	558	0	-	1782	3735	362	3373	0	-		↓			
	No of Spells with > 2 Ward Movements	Local	-	129	24	80	25	-	-	823	131	523	169	-		→			
	% of Spells with > 2 ward movements (2% Target)	Local	2.00%	2.37%	1.60%	4.56%	1.14%	-	2.00%	2.28%	1.41%	4.96%	1.04%	-		↑			
	No of Spells with > 5 Ward Movements	Local	-	5	0	5	0	-	-	22	1	21	0	-		↑			
	% of spells with > 5 ward movements (No Target)	Local	-	0.09%	0.00%	0.28%	0.00%	-	-	0.06%	0.01%	0.28%	0.00%	-		↑			
	Total Number of Spells	Local	-	5444	1501	1756	2187	-	-	36040	9309	10540	16191	-		↓			

Calderdale and Huddersfield NHS
NHS Foundation Trust

Responsive Executive Summary - Helen Barker Associate Director of Operations

compassionate care

Report For: September 2015

Year To Date

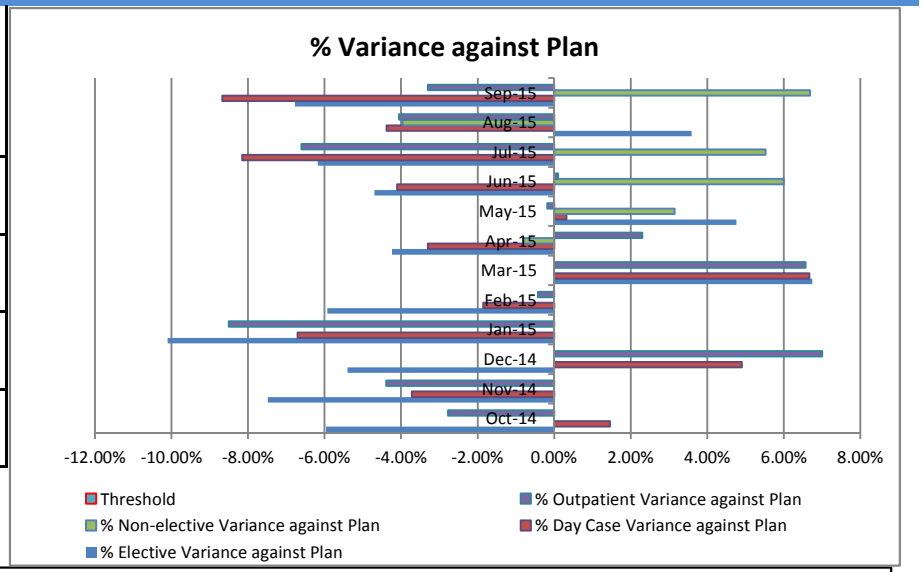
		Indicator Source	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Trend (Rolling 12 Month)	Direction of travel (past 4 months)	Financial Penalities /Non Financial	Year End Forecast	Data Quality
Exception Report - Patient Flow 2	A and E 4 hour target	National & Contract	95.00%	95.37%	-	95.37%	-	-	95.00%	95.23%	-	95.23%	-	-		↓			
	Time to Initial Assessment (95th Percentile)	National	00:15:00	00:19:00	-	00:19:00	-	-	00:15:00	00:20:00	-	00:20:00	-	-		↑			
	Time to Treatment (Median)	National	01:00:00	01:00:00	-	01:00:00	-	-	01:00:00	00:58:00	-	00:58:00	-	-		↑			
	Unplanned Re-Attendance	National	5.00%	4.73%	-	4.73%	-	-	5.00%	5.04%	-	5.04%	-	-		↓			
	Left without being seen	National	5.00%	3.21%	-	3.21%	-	-	5.00%	3.29%	-	3.29%	-	-		↓			
	A&E Ambulance Handovers 30-60 mins (Validated)	National	0	3	-	3	-	-	0	44	-	44	-	-		→			
	A&E Trolley Waits	National	0	0	-	0	-	-	0	0	-	0	-	-		→			
Exception Report - Elective Access	First DNA Rate	Local	7.00%	6.07%	6.17%	6.56%	5.18%	4.10%	7.00%	6.72%	6.72%	6.63%	6.81%	3.80%		↓			
	% Hospital Initiated Outpatient Cancellations	Local	17.6%	13.40%	13.50%	15.30%	10.10%	-	17.6%	14.20%	14.60%	15.10%	11.80%	-		↓			
	Appointment Slot Issues on Choose & Book	Local	-	-	-	-	-	-	5.00%	15.00%	12.25%	8.33%	7.38%	-					
	CHFT Research Recruitment Target	Local	92	68	-	-	-	-	552	315	-	-	-	-		↑			
Exception Report - Elective Access 2	% Non-admitted Closed Pathways under 18 weeks	National & Contract	95.00%	98.67%	98.56%	98.79%	98.86%	-	95.00%	98.55%	98.55%	98.42%	98.86%	-		↑			
	% Admitted Closed Pathways Under 18 Weeks	National & Contract	90.00%	91.64%	90.90%	100.00%	94.50%	-	90.00%	92.21%	91.51%	100.00%	94.92%	-		↓			
	% Incomplete Pathways <18 Weeks	National	92.00%	96.07%	94.78%	99.16%	98.78%	-	92.00%	96.07%	94.78%	99.16%	98.78%	-		↑			
	18 weeks Pathways >=26 weeks open	Local	0	137	130	6	1	-	0	137	130	6	1	-		↓			
	18 weeks Pathways >=40 weeks open	National	0	1	1	0	0	-	0	1	1	0	0	-		↓			
	RTT Waits over 52 weeks Threshold > zero	National & Contract	0	0	0	0	0	0	0	0	0	0	0	0					
	% Diagnostic Waiting List Within 6 Weeks	National & Contract	99.00%	98.56%	100.00%	100.00%	98.13%	-	99.00%	99.56%	99.89%	100.00%	99.41%	-		↓			
	Community - 18 Week RTT Activity	National	95.00%	92.70%	-	-	-	92.70%	95.00%	96.70%	-	-	-	96.70%		→			
	% Last Minute Cancellations to Elective Surgery	National & Contract	0.60%	0.76%	1.15%	0.00%	0.76%	-	0.60%	0.64%	0.92%	0.03%	1.04%	-		↑			
	28 Day Standard for all Last Minute Cancellations	National & Contract	0	0	0	0	0	-	0	0	0	0	0	-		→			
	No of Urgent Operations cancelled for a second time	National & Contract	0	0	0	0	0	-	0	0	0	0	0	-		→			

Responsive Executive Summary - Helen Barker Associate Director of Operations

Year To Date

	Report For: September 2015	Indicator Source	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Trend (Rolling 12 Month)	Direction of travel (past 4 months)	Financial Penalities/ Non Financial Impact	Year End Forecast	Data Quality
Exception Report - Access Stroke	% Stroke patients spending 90% of their stay on a stroke unit	National	83.20%	74.60%	-	74.60%	-	-	83.20%	78.60%	-	78.60%	-	-		↓			
	% Stroke patients Thrombolysed within 1 hour	National & Contract	56.10%	-	-	-	-	-	56.10%	-	-	-	-	-					
	% Stroke patients scanned within 1 hour of hospital arrival (where indicated)	National & Contract	80.00%	-	-	-	-	-	80.00%	-	-	-	-	-					
Exception Report - Elective Access 3	62 Day Gp Referral to Treatment	National & Contract	85.00%	88.24%	90.32%	89.09%	86.67%	-	85.00%	90.09%	91.09%	89.09%	93.67%	-		↓			
	62 Day Referral From Screening to Treatment	National & Contract	90.00%	100.00%	100.00%	-	-	-	90.00%	98.48%	98.44%	-	100.00%	-		→			
	31 Day Subsequent Surgery Treatment	National & Contract	94.00%	100.00%	100.00%	100.00%	-	-	94.00%	99.08%	100.00%	96.67%	-	-		→			
	31 day wait for second or subsequent treatment drug treatments	National & Contract	98.00%	100.00%	100.00%	100.00%	-	-	98.00%	100.00%	100.00%	100.00%	100.00%	-		→			
	62 Day Aggregated Gp Urgent Referral To Treatment And Screening Referral To Treatment	National & Contract	86.00%	89.09%	91.43%	89.09%	86.67%	-	86.00%	90.73%	91.85%	89.09%	94.44%	-		↓			
	31 Days From Diagnosis to First Treatment	National & Contract	96.00%	100.00%	100.00%	100.00%	100.00%	-	96.00%	99.86%	99.78%	100.00%	100.00%	-		↑			
	Two Week Wait From Referral to Date First Seen	National & Contract	93.00%	97.82%	98.40%	96.38%	97.70%	-	93.00%	96.43%	97.92%	92.50%	96.95%	-		↑			
	Two Week Wait From Referral to Date First Seen: Breast Symptoms	National & Contract	93.00%	98.47%	98.47%	-	-	-	93.00%	95.80%	95.80%	-	-	-		↑			
	7 Day Referral to First Seen	National & Contract	50.00%	33.45%	30.30%	35.75%	47.13%	-	50.00%	36.70%	39.57%	29.26%	37.20%	-		↑			
	38 Day Referral to Tertiary	National & Contract	85.00%	60.87%	75.00%	16.67%	-	-	85.00%	51.11%	51.85%	51.16%	44.44%	-		↑			
	54 Referral to Treatment	National & Contract	85.00%	77.48%	79.57%	77.36%	50.00%	-	85.00%	73.73%	76.33%	70.33%	70.73%	-		↑			
Exception Report - Maternity	Antenatal Assessments < 13 weeks		90.00%	90.40%	-	-	90.40%	-	90.00%	92.00%	-	-	92.00%	-		↓			
	Maternal smoking at delivery		11.90%	9.80%	-	-	9.80%	-	11.90%	10.90%	-	-	10.90%	-		↓			

Report For: September 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
% Elective Variance against Plan	0.00%	-6.77%	-8.96%	-0.60%	-0.81%	-
% Day Case Variance against Plan	0.00%	-8.67%	-8.25%	-9.46%	-10.26%	-
% Non-elective Variance against Plan	0.00%	6.68%	0.11%	6.99%	10.54%	-
% Outpatient Variance against Plan	0.00%	-3.30%	-3.75%	-2.13%	-4.00%	-



% Variance against Plan

The main specialties leading to the under-performance against the elective and day case plan are Trauma and Orthopaedics (T&O), Ophthalmology, General Surgery and Rheumatology. The majority of the under-performance is within Day Case.

Why off Plan:

- The 2015-16 T&O plan includes a productivity CIP through the FourEyes work which continues to be under-delivered. The consultant body also has 1 less member since 2014-15 and there has been a reduction in the surgeons providing Waiting List Initiative (WLI) activity. Month 6 has seen a reduction in Spinal work.
- Ophthalmology WETMAC is behind plan due to capacity constraints in September in relation to the OCT (Optical Coherence Tomography) machines. The service also continues to have consultant vacancies.
- General Surgery has consultant and middle-grade vacancies with a consultant replacement starting mid-month. A reduction in casemix has also been seen in September.
- Rheumatology has seen a shift of day case subcutaneous injections now delivered within the community setting leading to activity below plan.

Actions to get back on plan:

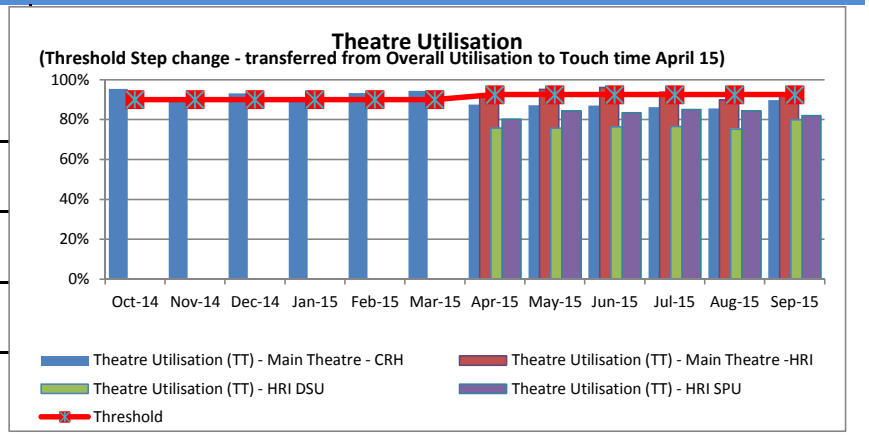
- The T&O recovery includes the appointment of an Upper Limb consultant from January onwards, the use of CHOP and ad-hoc lists where appropriate and changes made to the theatre timetable to improve allocation of Trauma lists. The recovery plans do not however bring activity back to plan levels and further work continues to consider other options.
- Ophthalmology WETMAC recovery includes the new OCT machine becoming available in October plus the recent recruitment of additional nursing posts. Ophthalmology day case activity recovery is due to recruitment to vacant consultant posts with interim locum capacity where available.
- The General Surgery recovery plan includes the recruitment of the 3rd Colorectal Surgeon post and Vascular Post.
- There is no plan to recover the Rheumatology activity as this will now continue to be delivered within the Community.

When will we be back on track

The current forecast reflects a level of recovery but does not anticipate that day case and elective activity will recover back to planned levels.

Accountable : Surgical and Medical Divisional teams

Report For: September 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Theatre Utilisation (TT) - Main Theatre - CRH	92.50%	89.70%	88.82%	-	96.42%	-
Theatre Utilisation (TT) - HRI DSU	92.50%	79.83%	78.48%	-	89.56%	-
Theatre Utilisation (TT) - HRI SPU	92.50%	81.97%	81.97%	-	-	-



Theatre Utilisation:

Why off plan:

We know from our Theatre action week that there are a number of causes for our performance on theatre utilisation:
We have lists that start late due to staffing, on call commitments, patients being available, and last minute changes to lists
Theatre cancellations cause a reduction in utilisation and are due to clinical reasons, patient requests or operational issues
The higher volume of patients on our day cases lists means there is inevitably more down time on the list associated with turning the theatre round between cases.
Stock and equipment availability
Communication errors, including consent forms, Bluespeir data entry, handover, case notes or electronic notes not being complete / available
Staffing levels within our admissions processes to get patients ready for theatre and there on time

Actions to get back to plan:

We have identified recommendations following the theatre action week that will improve the following factors:

- List start time
- Communication
- Upstream processes (e.g. admissions, pre-op etc.)
- Scheduling processes

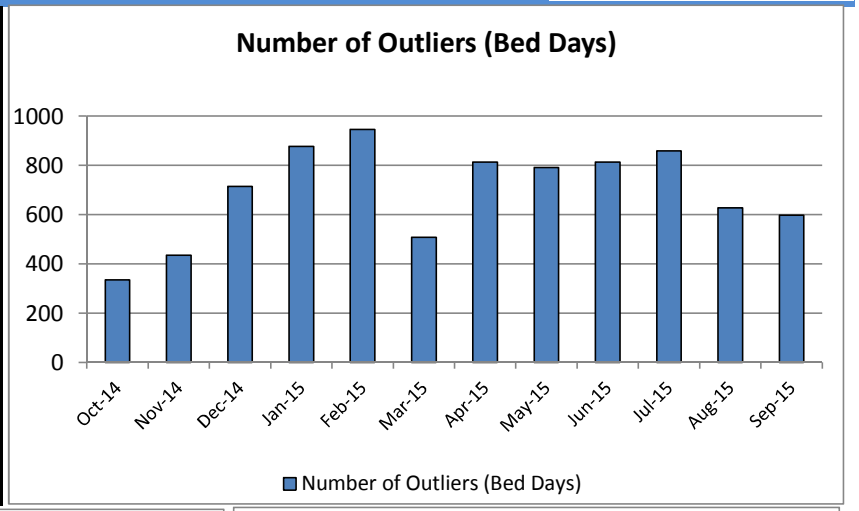
We are assessing the target utilisation against the four eyes data, and other evidence sources for DSU and SPU where high patient turnaround is a feature of the list.
We have assessed our workforce requirements for the admissions process and are implementing a revised workforce model to address this

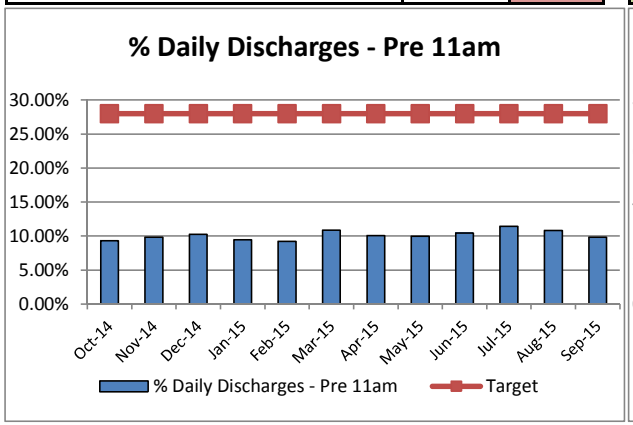
When will we be back on track?

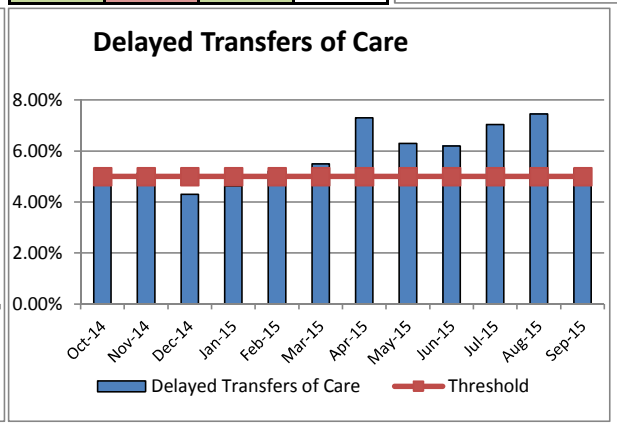
Due to the multifaceted nature of this problem it is difficult to assess when we will be back on track. However we would anticipate a month on month improvement as we implement the actions above in the coming months.

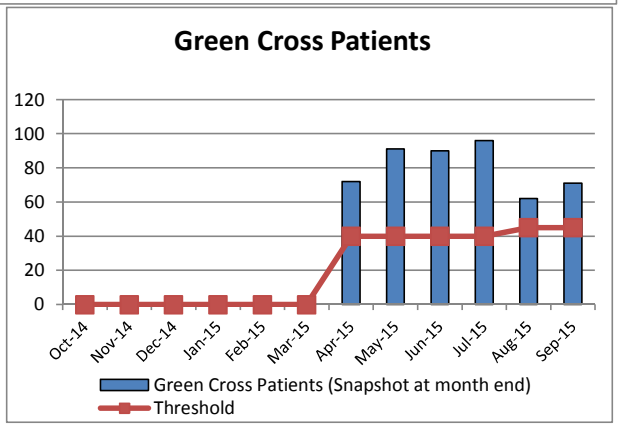
If colleagues wish to know more about the detail of our findings and our proposed actions please contact the Surgical Division for our detailed theatre action week report.

Report For: September 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
% Daily Discharges - Pre 11am	28.00%	9.84%	12.57%	7.57%	10.19%	-
Delayed Transfers of Care	5.00%	5.30%	-	-	-	-
Green Cross Patients (Snapshot at month end)	45	71	-	71	-	-
Number of Outliers (Bed Days)	267	598	40	558	0	-
% of Spells with > 2 ward movements (2% Target)	2.00%	2.37%	1.60%	4.56%	1.14%	-









Why off Plan:
A number of the patient flow metrics remain below target levels. Outlier bed days of 558 represents an average of 18 patients outlying across both our sites. Ward 14 (extra capacity) is currently open accommodating 14 surgical patients (due to location) to then free capacity in surgery to allow for the medical patients to outlie in a planned manner. Number of patients > than 2 moves has increased in month as patients are transferred to create capacity and is partly due to increasing non-elective admissions which were 7% above planned levels during September and 4.4% YTD.

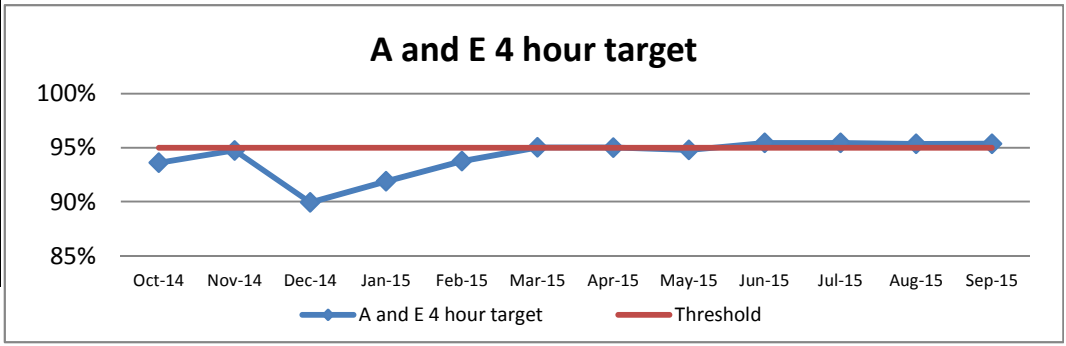
Actions to get back to plan:
Ward 5 at HRI (flex ward) will be handed back by estates on the 15th October allowing this area to come on line for medicine. Antenatal and post natal , C- Section ward have now relocated back to base wards therefore freeing up ward 4D to be used as extra capacity area. Clinical realignment of bed base taking place within Medicine during October to help minimise the number of non-clinical moves for patients. This action should help minimise disruption to patients and ensure improved compliance with other key standards such as stroke 90% stay. Four eyes continue to work on 3 test wards with a key expected output of improving morning discharges. The SRG have been working on a winter plan to ensure improved resilience. They have been asked to consider re-establishing the 12 beds at Oakmoor which were in place and managed by Locala during winter 14/15.

When will we be back on track:

When back on track:
Its expected the above actions will have taken place within the next 6 weeks and therefore should demonstrate improvements against a number of metrics.

Accountable : Helen Barker and Sajid Azeb

Report For: September 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Time to Initial Assessment (95th Percentile)	00:15:00	00:19:00	-	00:19:00	-	-
A&E Ambulance Handovers 30-60 mins (Validated)	0	3	-	3	-	-



Emergency care standard Time to initial assessment

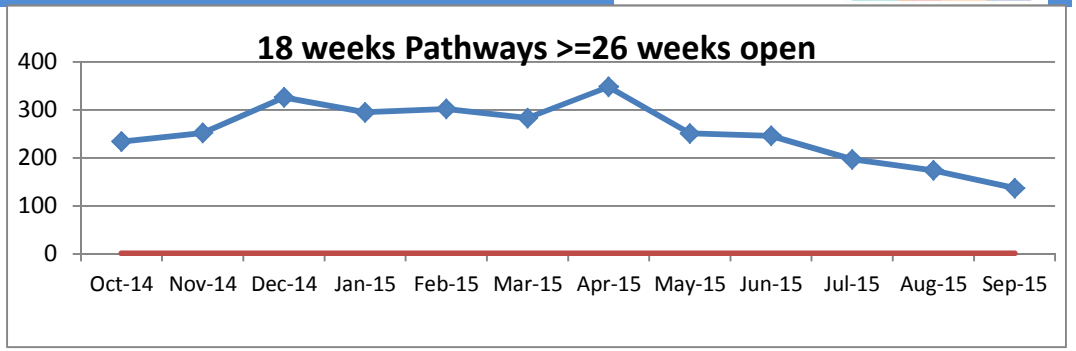
Why off Plan: The lack of cubicle capacity and exit block are the key reasons. A & E turnaround action plan in place. No standardised operational policy for co-ordination within the Emergency Department. Specific days analysis ongoing by Matron and GM where demand is high and performance down to explore further.

A**ctions to get back on plan:** Daily monitoring put in place which has identified specific days when there has been high demand and exit block a particular problem. New SOP for co-ordinator. Ongoing discussions with estates re department capacity fit for purpose whilst exit block an issue.

When will we be back on track: December 2015

Accountable : Bev Walker

Report For: September 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
% Last Minute Cancellations to Elective Surgery	0.60%	0.76%	1.15%	0.00%	0.76%	-
% Diagnostic Waiting List Within 6 Weeks	99.00%	98.56%	100.00%	100.00%	98.13%	-



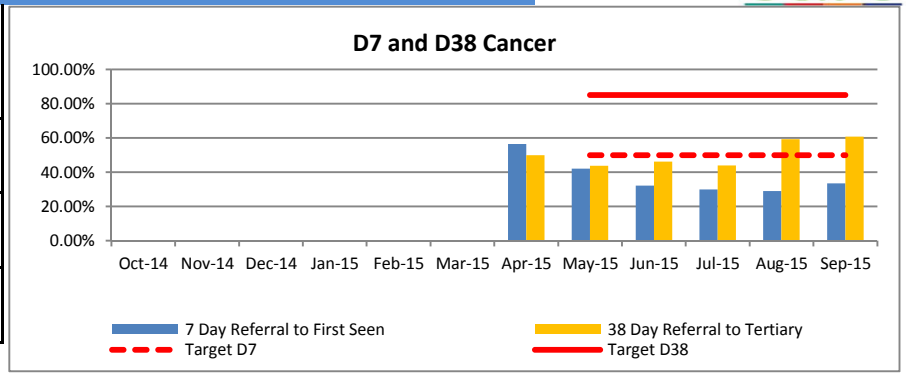
Diagnostics

Why off track : The Trust has failed the 6week diagnostic target in September with the breach volumes in Radiology – MRI & Ultrasound (90 patients)
This is a Symptom of increasing demand via Direct access however ultimately due to process error in booking patients. The increased demand and requirement for additional capacity had not been escalated with patients booked into capacity outside of the 6 week window.

What are we doing to get back on track A Root Cause Analysis is being undertaken in parallel to the immediate implementation of corrective actions which include a revised booking protocol and additional Capacity.
Work had already commenced on the introduction of performance reports for radiology that look forward at booking pressures and referral trends. This work has being expedited with some manual reports and an automated solution is progressing. This is now included in the weekly Performance review meeting
The corrective actions have ensured all breach patients have received their diagnostic and there are no known risks for October
Longer term the 3rd MRI scanner will provide additional physical scanning capacity

Accountable officer: CD via GM in Radiology

Report For: September 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
7 Day Referral to First Seen	50.00%	33.45%	30.30%	35.75%	47.13%	-
38 Day Referral to Tertiary	85.00%	60.87%	75.00%	16.67%	-	-
54 Referral to Treatment	85.00%	77.48%	79.57%	77.36%	50.00%	-



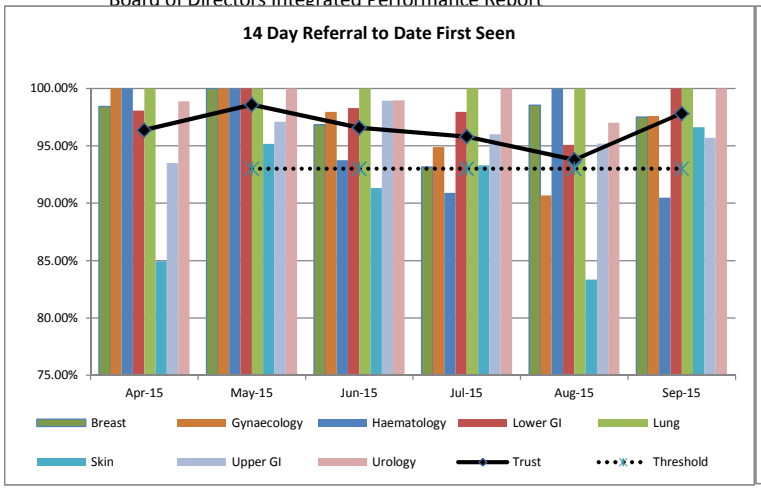
Cancer D7, D38 :

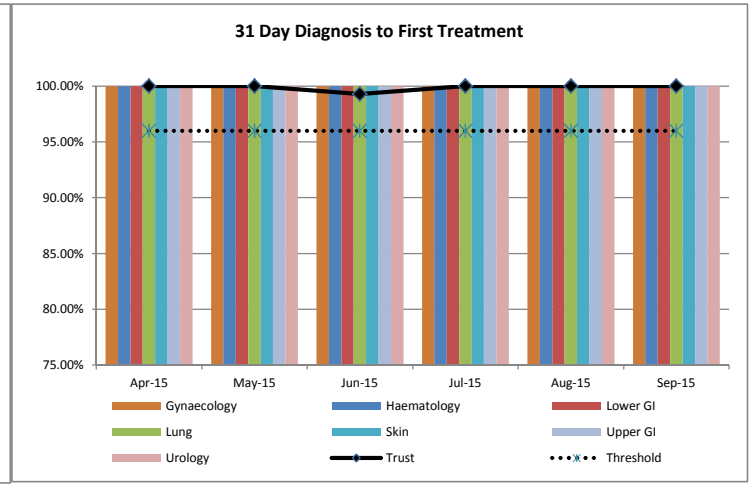
Why off Plan: Day 7 – During September 35.7% of all fast track referrals were seen within 7 days, 96.4% were seen within 14 days of referral. The specialities below the 50% target for 7 days in the Medical division are Skin, Lung and Haematology. The skin cancer performance is variable and is largely due to a significant increase in referrals from GPs and availability of locum consultants. The lung pathway has been changed, however it has come to light that the initial contact that has been made with the patients have not been recorded on PPM which has caused the 7 day breaches. The Haematology service has seen a 56% increase in fast track referral from 11/12 – 15/16 as well as a growth in general new patient referrals of 14% over the same time period. Clinics are often overbooked to try and accommodate patients within target time.

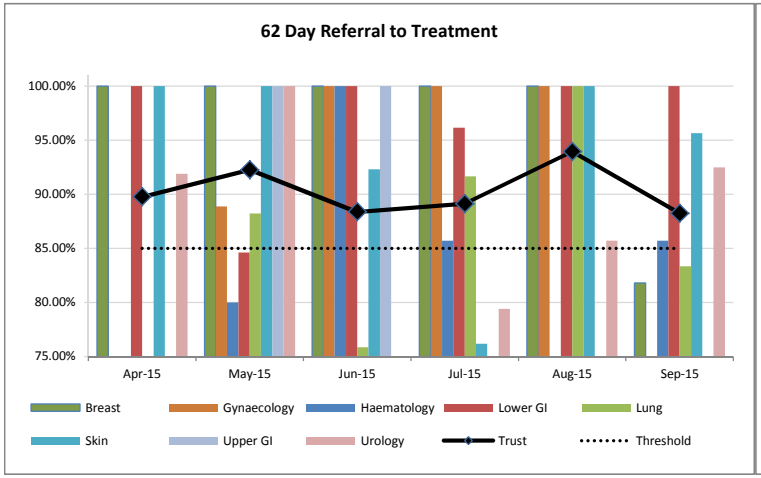
Day 38 – The division had 5 breaches in month against the 38 day standard. All were within the Lung cancer pathway and an analysis of the individual patient pathways has found that this is of the due to diagnostics not being undertaken within 7 days (as per trust agreement), which then leads to a delay in the management plan being formulated.

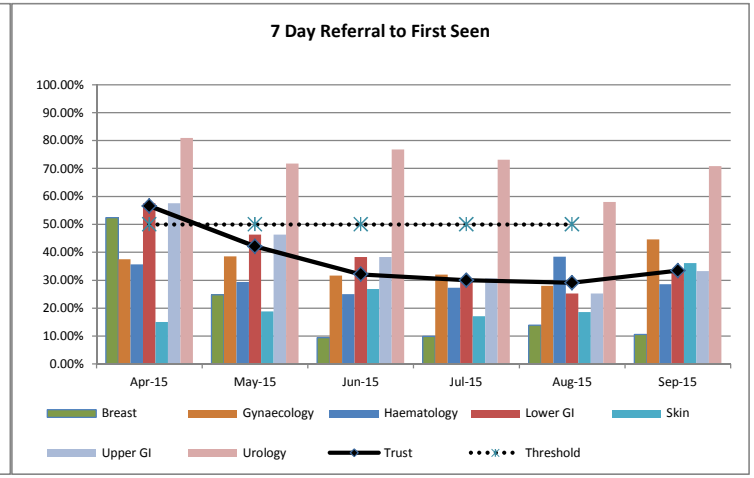
Actions to get back to plan: Day 7 – A number of actions have been taken in order to get back to plan these include:
Respiratory consultants have been asked to ensure all patient interactions are accurately reflected on to the PPM system.
Dermatology remains vulnerable due to its reliance upon locum workforce we have however contacted GP practice to offer specific training and guidance to high referring practices. In addition Locala have been asked to establish a community lesion clinic which should help to reduce the number of fast track referrals we receive within the trust (Locala have struggled with capacity to set this up)
Haematology – a business case for a 5th consultant for the service has been written and presented at the last Divisional Business meeting this is currently with the other divisions for approval of support.

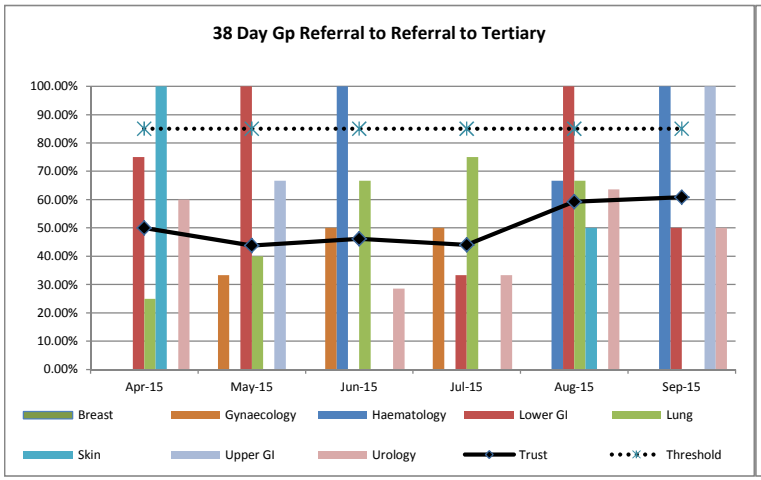
Day 38
Operational policy for 7 day diagnostics being written by Maureen Overton and will be sent through for ratification.
Lung pathway tracker to escalate any pathway delays to GM
Performance monitored on a weekly basis

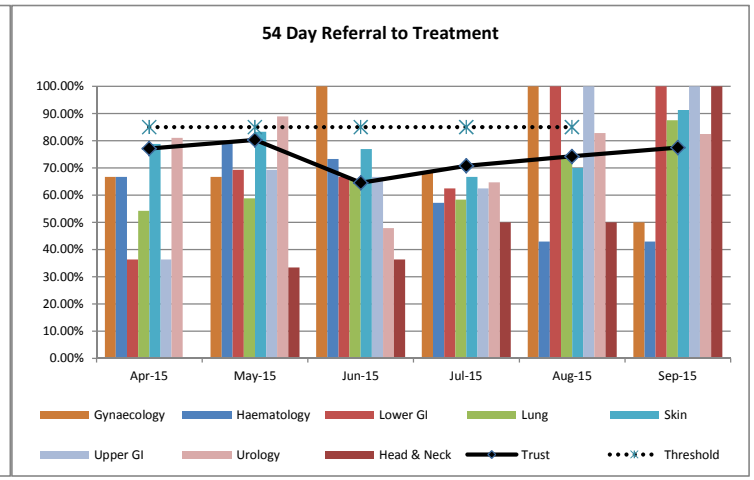

14 Day Referral to Date First Seen
100.00%
95.00%
90.00%
85.00%
80.00%
75.00%
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Breast
Gynaecology
Haematology
Lower GI
Lung
Skin
Upper GI
Urology
Trust
Threshold


31 Day Diagnosis to First Treatment
100.00%
95.00%
90.00%
85.00%
80.00%
75.00%
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Gynaecology
Haematology
Lower GI
Lung
Skin
Upper GI
Urology
Trust
Threshold

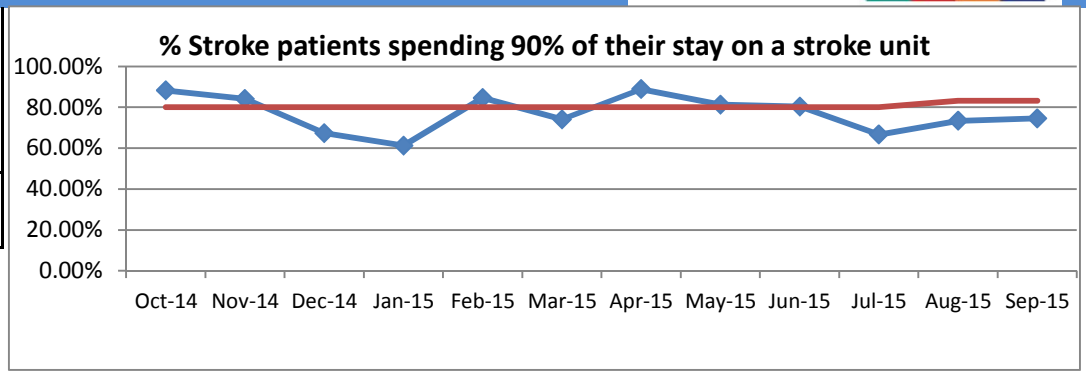

62 Day Referral to Treatment
100.00%
95.00%
90.00%
85.00%
80.00%
75.00%
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Breast
Gynaecology
Haematology
Lower GI
Lung
Skin
Upper GI
Urology
Trust
Threshold


7 Day Referral to First Seen
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Breast
Gynaecology
Haematology
Lower GI
Skin
Upper GI
Urology
Trust
Threshold


38 Day Gp Referral to Referral to Tertiary
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Breast
Gynaecology
Haematology
Lower GI
Lung
Skin
Upper GI
Urology
Trust
Threshold


54 Day Referral to Treatment
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Gynaecology
Haematology
Lower GI
Lung
Skin
Upper GI
Urology
Head & Neck
Trust
Threshold

Report For: September 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
% Stroke patients spending 90% of their stay on a stroke unit	83.20%	74.60%	-	74.60%	-	-



Stroke Activity:

Why off Plan: In month, there were 15 patients who breached this target, with 7 of these due to bed pressures - 4 were initially admitted elsewhere and 3 were moved off the stroke unit to create room for new admissions pending discharge arrangements e.g. POC and patient moved to step down unit. 5 patients were appropriately managed on other clinical wards due to other medical reasons. There were 4 patients who had a delayed diagnosis of stroke and therefore also breached this target.
Actions to get back on plan: Medical revised bed modelling plan and stroke admission SOP now in place. Daily escalation to site commanders for medical outliers on the stroke unit to be moved off.

When will we be back on track: October

Accountable : Dr Rob Moisey

Caring Executive Summary - Julie Dawes Director of Nursing

Year To Date

	Report For: September 2015	Indicator Source	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Trend (Rolling 12 Month)	Direcion of travel (past 4 months)	Financial Penalities/Non Financial Impact	Year End Forecast	Data Quality
Complaints	Number of Mixed Sex Accommodation Breaches	National & Contract	0	0	0	0	0	n/a	0	0	0	0	0	n/a		→			
	% Complaints closed within target timeframe	Local	100.00%	51.85%	40.00%	64.29%	73.33%	0.00%	100.00%	51.27%	45.60%	47.24%	70.83%	73.33%		↓			
	Total Complaints received in the month	Monitor	-	48	17	13	14	2	-	311	105	100	71	15		↓			
	Complaints acknowledged within 3 working days	Local	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	83.59%	83.02%	89.90%	87.32%	73.33%		↑			
	Total Concerns in the month	Monitor	-	60	15	27	16	0	-	335	104	116	70	17		↓			
Friends & Family Test	Friends & Family Test (IP Survey) - Response Rate	Contract	40.00%	24.40%	26.20%	21.90%	24.80%	-	40.00%	24.60%	27.10%	24.50%	24.90%	-		↓			
	Friends & Family Test (IP Survey) - % would recommend the Service	Contract	95.00%	96.50%	97.00%	95.00%	98.80%	-	95.00%	96.90%	97.30%	95.70%	98.00%	-		↓			
	Friends and Family Test A & E Survey - Response Rate	Contract	30.00%	9.50%	-	9.50%	-	-	30.00%	7.20%	-	7.20%	-	-		↑			
	Friends and Family Test A & E Survey - % would recommend the Service	Contract	95.00%	86.20%	-	86.20%	-	-	95.00%	89.40%	-	89.40%	-	-		↓			
	Friends & Family Test (Maternity) - % would recommend the Service	Contract	95.00%	98.80%	-	-	98.80%	-	95.00%	95.70%	-	-	95.70%	-		↑			
	Friends and Family Test Community Survey - % would recommend the Service	Local	95.00%	92.00%	-	-	-	92.00%	95.00%	90.80%	-	-	-	90.80%		↑			
Caring Maternity	Proportion of Women with a concern about safety during labour and birth not taken seriously		6.50%	0.00%	-	-	0.00%	-	6.50%	1.70%	-	-	1.70%	-		↓			
	Proportion of women who were left alone at a time that worried them during labour		4.50%	4.10%	-	-	4.10%	-	4.50%	3.50%	-	-	3.50%	-		↑			
	Proportion of Women who received Physical 'Harm Free' Care		70.00%	73.50%	-	-	73.50%	-	70.00%	72.40%	-	-	72.40%	-		↑			
	Proportion of Women with a perception of safety		90.40%	95.90%	-	-	95.90%	-	90.40%	95.40%	-	-	95.40%	-		↓			
	Proportion of Women who received Combined 'Harm Free' Care		70.90%	73.50%	-	-	73.50%	-	70.90%	69.00%	-	-	69.00%	-		↑			

Report For: September 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
% Complaints closed within target timeframe	100.00%	51.85%	40.00%	64.29%	73.33%	0.00%

% Complaints closed within target timeframe

Why off Plan: 52% complaints were closed within time frame, reduction of 4 % compared to August 2015. Responses from Divisions overdue at the end of September were: 33 overdue (up to 1 month), 9 (up to 2 months), 6 (up to 3 months), 2 (up to 4 months) . An increased focus on quality assurance by the complaints team has resulted in a number of responses being returned to the divisions for additional details which has added some delay into the process., however this should reduce the number of cases re-opened; 25 complaints were re-opened in quarter 2 of this year.

Actions to get back on plan: There is continued focus on closing overdue cases and managing new cases within timescales through use of weekly performance report on complaints to divisions to highlight overdue complaints and complete these as soon as possible. Weekly meetings with Medical Division to progress overdue cases.

When will we be back on track All cases ongoing over target to be completed by divisions as a matter of urgency, with new cases managed in target.

Accountable: Head of Governance and Risk

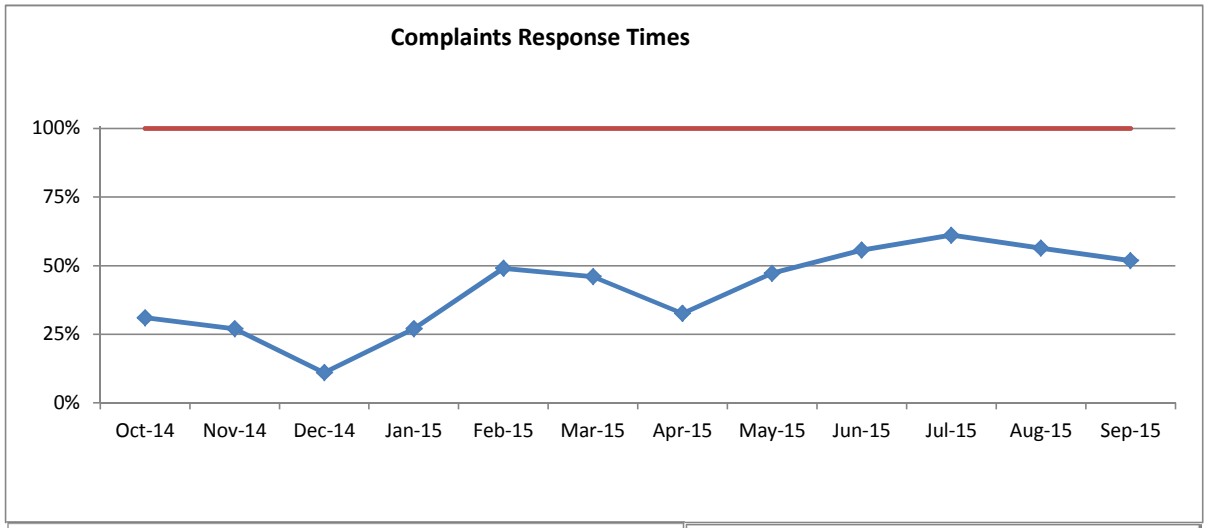
Complaints Overview:

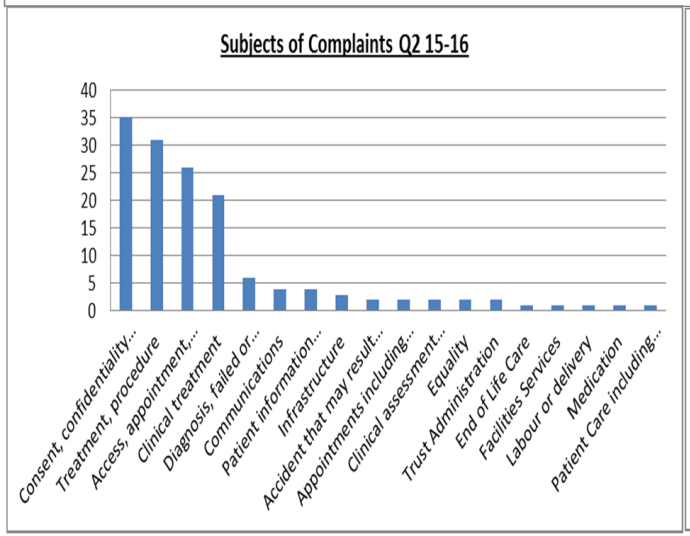
As shown on the chart to the right, during Q2, the top 3 complaint subjects, were consistent with previous quarters . These were:

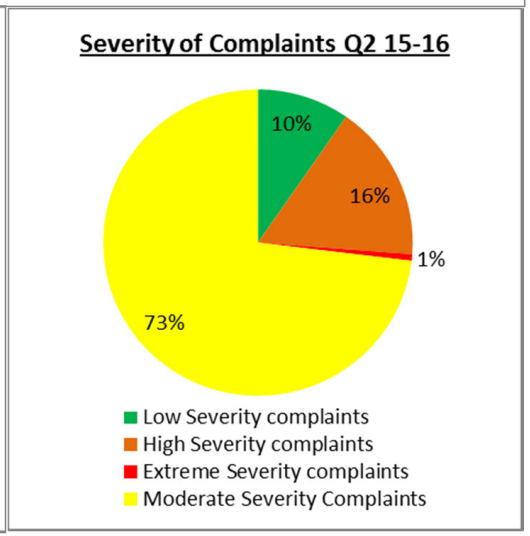
1) Clinical Treatment/Treatment Procedure , 2) Consent, confidentiality, communication – majority relate to communication issues with patients , 3) Access, Appointment, Admission, Transfer and discharge.

Ombudsman (PHSO)

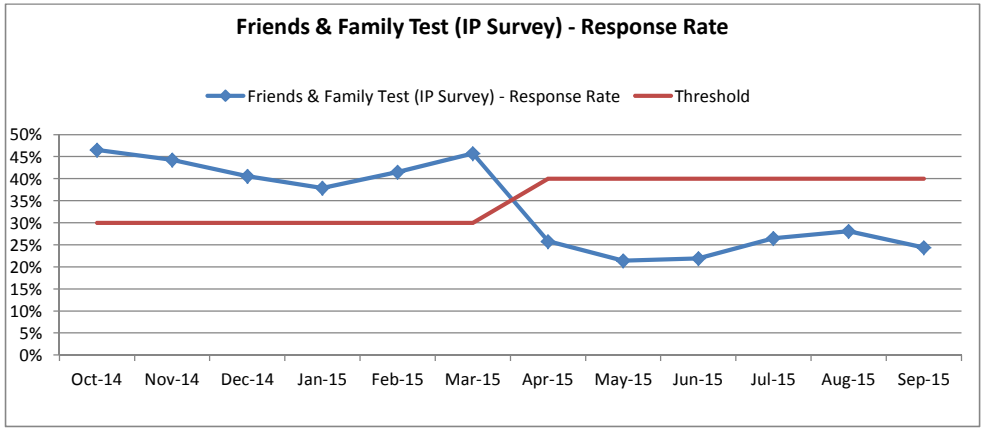
There were no new cases referred to the Trust for investigation by the Ombudsman (PHSO) in September 2015. There are 13 active Ombudsman cases, 7 of which were received from the Ombudsman for investigation in this financial year. 6 Ombudsman cases have been closed within this financial year to date. Between 2 -3 % of all Trust complaints are investigated by the Ombudsman.







Report For: September 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Friends & Family Test (IP Survey) - Response Rate	40.00%	24.40%	26.20%	21.90%	24.80%	-
Friends and Family Test A & E Survey - Response Rate	30.00%	9.50%	-	9.50%	-	-
Friends and Family Test A & E Survey - % would recommend the Service	95.00%	86.20%	-	86.20%	-	-
Friends and Family Test Community Survey - % would recommend the Service	95.00%	92.00%	-	-	-	92.00%



Community FFT - Would Recommend:

1. Why off plan? Performance remains below target. but an improvement has been seen on the previous month
As planned, a review is currently taking place of all the negative comments. It appears that most of these refer to the long waiting times for out-patient Physio . There is a lack of availability of suitable candidates to fill current vacancies.

2. Actions to get back on plan: In the short term 2 locums are due to start in the coming months. There are longer term plans working closely with Calderdale CCG , specifically on a task and finish group for Physio. This will include reviewing referral criteria, clinical pathways etc.

3. Achieved by date: Improvements are expected in the waiting times once the Locums are in place and as such patient should have a more favourable experience.

Accountable: Deputy Director of Nursing

A&E FFT - Would recommend:

1. Why off plan: there has been a slight improvement in month, however not yet back at the Q1 position of 90%. Recent results have been analysed which show that there are 3 specific themes in the patients feedback 1) Delays in waiting time 2) Poor Communication 3) Staff attitude/professionalism.
2. Actions to get back on plan: Father analysis of the comments is being undertaken to better understand the reasons for the slip in performance and any cross site differences. this will enable more targeted action planning.
3. When will we be on track: In is anticipated that any improvements identified will take some time to embed and will use a 90 day plan approach.

A&E FFT - Reponses Rate :
1. Why off plan: As expected the changes in process has resulted in a much improved positions 2.7% to 9.5% however it is acknowledged that this is still short of the target of 30%.
2. Actions to get back on plan: Work has already begun to understand how we can better encourage people to respond to the text message when they receive it. this will be discussed at the Task and finish group.
3. When will we be on track: Now that the baseline is known a trajectory for further improvement and achievement of the response rate target will be set

Accountable: Deputy Director of Nursing

Inpatient FFT Response Rate:

1.Why off plan: As discussed last month the Trust is aware
that this low response rate is associated with the spread to all 'day case' areas in April 2015. Using the pre April 15 criteria for inpatients FFT, the Trust would continue to score above 40%.

2.Actions to get back on plan: Throughout September there has been further engagement with the individual department leads to resolve any process issues that are contributing to poor response rates. It is clear from the September data that some areas are seeing much improved response rates, however these are masked by poor performing areas which are yet to fully engaged with the process. There has been a 'go see' exercise in order to better understand the process issues which highlighted a step in the process which is causing a technological barrier to staff issuing the cards to patients. The aim is to resolve this issue during October.

3. Achieved by date: The level of improvement required will require some time to embed the changes and ensure all potential areas have been identified, there is a trajectory in place to achieve this by Quarter

Accountable: Deputy Director of Nursing

Calderdale and Huddersfield NHS Foundation Trust

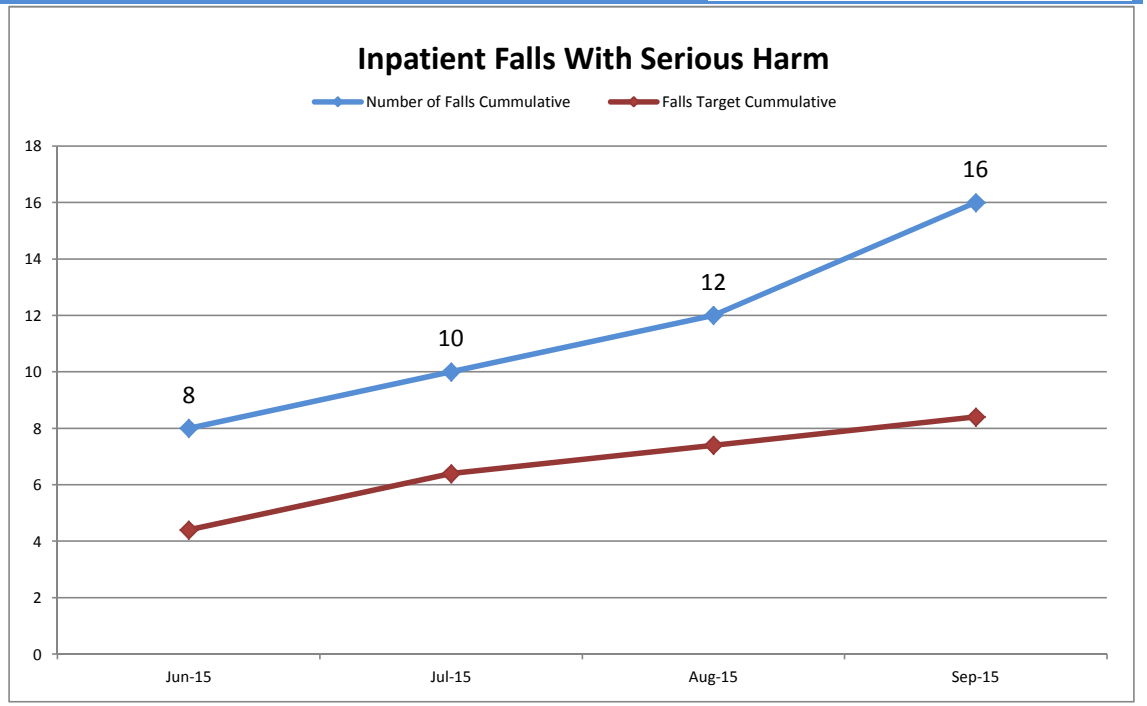
Safety Executive Summary - Julie Dawes Director of Nursing

compassionate care

Report For: September 2015

		Indicator Source	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Trend (Rolling 12 Month)	Direction of travel (past 4 months)	Financial Penalties/Non Financial Impact	Year End Forecast	Data Quality
									Year To Date										
Safety	Inpatient Falls with Serious Harm (10% reduction on 14/15)	Local	1	4	0	3	1	0	6	16	1	14	1	0		→			
	All Falls	Local	-	175	35	133	2	5	-	1005	164	791	22	28		↑			
	Number of Trust Pressure Ulcers Acquired at CHFT	Local	25	33	6	14	0	13	150	331	40	86	2	203		↓			
	Number of Category 2 Pressure Ulcers Acquired at CHFT	Local	17	24	5	10	0	9	102	248	29	63	2	154		↓			
	Number of Category 3 Pressure Ulcers Acquired at CHFT	Local	7	8	1	4	0	3	42	74	10	21	0	43		↓			
	Number of Category 4 Pressure Ulcers Acquired at CHFT	Local	1	1	0	0	0	1	6	9	1	2	0	6		↓			
	Number of Category 3 & 4 Pressure Ulcers Acquired at CHFT	Local	8	9	1	4	0	4	48	83	11	23	0	49		↓			
Safety 2	Percentage of Completed VTE Risk Assessments	National & Contract	95.00%	95.20%	95.30%	96.30%	92.70%	-	95.00%	95.40%	95.00%	95.20%	96.80%	-		→			
	Percentage of Stage 1 RCAs completed for all Hospital Acquired Thrombosis	Local	100.00%	100.00%	100.00%	100.00%	n/a	-	100.00%	100.00%	100.00%	100.00%	100.00%	-		→			
	% Harm Free Care	CQUIN	95.00%	93.46%	92.44%	90.58%	100.00%	95.51%	95.00%	93.31%	94.42%	90.68%	99.73%	93.79%		↓			
	Safeguarding Alerts made by the Trust	Local	-	8	-	-	-	-	-	97	-	-	-	-		↓			
	Safeguarding Alerts made against the Trust	Local	-	4	-	-	-	-	-	44	-	-	-	-		↓			
	World Health Organisation Check List	National	100.00%	97.76%	-	-	-	-	100.00%	98.02%	-	-	-	-		↑			
	Missed Doses (Reported quarterly)	National	10.00%	8.68%	7.30%	8.49%	18.36%	-	10.00%	8.24%	8.47%	7.80%	12.46%	-					
Safety 3	Number of Patient Incidents	Monitor	-	626	143	327	126	29	-	4026	744	1889	1064	355		↑			
	Number of SI's	Monitor	-	7	2	3	0	2	-	83	13	24	4	42		↓			
	Number of Incidents with Harm	Monitor	-	176	29	106	27	14	-	1143	141	521	251	229		↓			
	Never Events	National	0	0	0	0	0	0	0	0	0	0	0	0		→			
	Percentage of SI's reported externally within timescale (2 days)	Local	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	-	-	-	-	-	-		↑			
	Percentage of SI's investigations where reports submitted within timescale (45 days unless extension agreed)	Local	100.00%	90.00%	100.00%	100.00%	100.00%	50.00%	100.00%	45.45%	100.00%	46.15%	100.00%	50.00%		↑			
	Percentage of Non-Compliant Duty of Candour informed within 10 days	National & Contract	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	-	-	-	-	-	-		→			
	Total Duty of Candour informed within 10 days	National & Contract	0	0	0	0	0	0	0	5	3	4	0	0		↑			
Safety - Maternity	Elective C-Section Rate		10.00%	9.60%	-	-	9.60%	-	10.00%	8.70%	-	-	8.70%	-		↑			
	Total C-Section Rate		22.50%	20.40%	-	-	20.40%	-	22.50%	23.40%	-	-	23.40%	-		↓			
	No. of Babies over 37 weeks with APGAR5<7		8.00%	0.60%	-	-	0.60%	-	8.00%	0.60%	-	-	0.60%	-		↓			
	Full Term to SCBU (NNU)		4.00%	1.70%	-	-	1.70%	-	4.00%	2.70%	-	-	2.70%	-		↓			
	Major PPH - Greater than 1000mls		8.00%	7.60%	-	-	7.60%	-	8.00%	9.80%	-	-	9.80%	-		↓			
	3rd or 4th Degree tear from ANY delivery		3.00%	2.80%	-	-	2.80%	-	3.00%	2.40%	-	-	2.40%	-		↑			
	Planned Home Births	National	2.30%	1.70%	-	-	1.70%	-	2.30%	1.60%	-	-	1.60%	-		↑			

Report For: September 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Inpatient Falls with Serious Harm (10% reduction on 14/15)	1	4	0	3	1	0
Number of Trust Pressure Ulcers Acquired at CHFT	25	33	6	14	0	13
Number of Category 2 Pressure Ulcers Acquired at CHFT	17	24	5	10	0	9
Number of Category 3 Pressure Ulcers Acquired at CHFT	7	8	1	4	0	3
Number of Category 4 Pressure Ulcers Acquired at CHFT	1	1	0	0	0	1
Number of Category 3 & 4 Pressure Ulcers Acquired at CHFT	8	9	1	4	0	4



Falls with Serious Harm

Why off Plan: During the first six months of 2015/16 the Trust has had 16 falls with harm, which is 10 above the trajectory target of 6, and results in the trust breaching its annual threshold of 14. There have been 10 falls with harm at the CRH site with 6 falls with harm at the HRI site.

Actions to get back on plan: An internal harm summit has been instigated by the Trust on the 10th November. This summit will focus on key patient harm areas, such as falls, pressure ulcers and medication safety and will result in action learning for these areas

When will we be back on track: As the 10% reduction target has already been passed future work focuses on reversing the current trends. This reserval will be expected to be seen as a result of outcomes of the safety sumit and as such impact not likely to be seen until Q4.

Accountable: Deputy Director of Nursing

Pressure Ulcers:

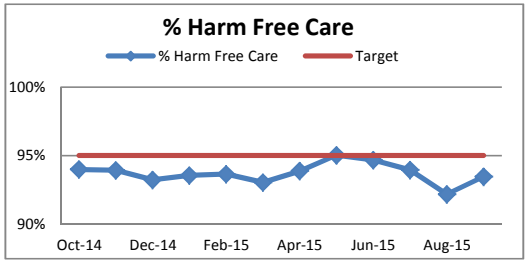
Why off Plan: The improvement target has been readjusted for community which has impacted on overall performance as the community directorate is significantly off trajectory and has already exceeded annual target. Hospital performance is also above target & if performance continues to match the existing pattern the target will be exceeded by year end. An increased awareness of pressure ulcer incident reporting, unplanned capacity/ use of agency staff and increased demand on TV team (in relation to referrals) has impacted on performance.

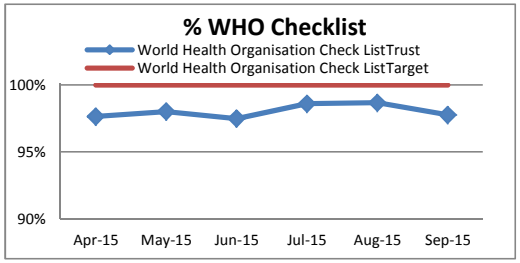
Actions to get back on plan: An internal harm summit has been instigated by the Trust on the 10th November. This will include a focus on pressure ulcers amongst other harm topics. Wards that are off their own trajectory have been asked to develop improvement plans in preparation. The community directorate will also hold a multi-professional forum in November to launch initiatives to improve communication between community agencies & share learning from RCAs. Community are planning to test the safety huddle approach with a community nursing team with input from other professionals in the coming months.

When we will be back on track: Following the safety summit and associated changes a trajectory for improvement will be devised and adhered to.

Accountable: Deputy Director of Nursing

Report For: September 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
% Harm Free Care	95.00%	93.46%	92.44%	90.58%	100.00%	95.51%
World Health Organisation Check List	100.00%	97.76%	-	-	-	-





World Health Organisation Check List

1. Why off plan? There are groups of patients who don't require the WHO checklist. The current theatre system is unable to exempt these cases. There are also a few technical issues where part of the form is not saved which leads to an uncompleted case being noted. It is very rare event that a person does not have a checklist completed.

2. Actions to get it back on plan: Performance monitoring for the small number of non-compliant cases. For the exempt patients a theatre system upgrade has been requested to have a N/A option included, this was originally planned for September 2015 but has been delayed by the system supplier.

3.Achieved by date: Awaiting confirmation of system upgrade date from supplier.

4. Accountable: GM for Theatres

Harm Free Care:

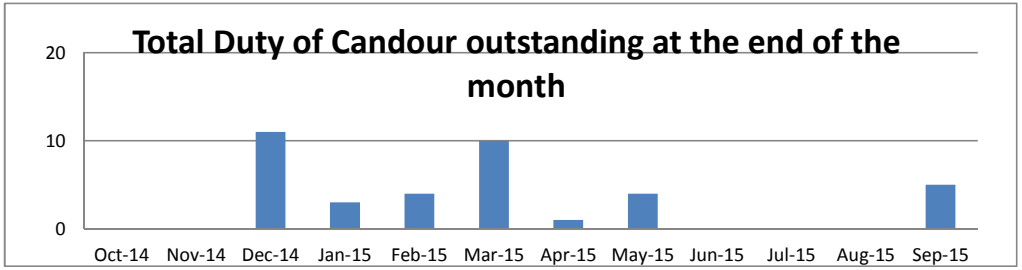
1. Why off plan? Harm free care for the trust is at 93.46%. With all divisions, bar Medical, seeing a better position that the previous month. The harm events contributing to this are primarily old pressure ulcers, of which there were 35, this is a decrease from the 55 in August. These are ulcers which are present on admission or developed within the first 72 hours of admission. Alongside this there were also 9 new Pressure Ulcers, 12 harm falls 12 UTIs in patients with a catheter and 2 VTEs.

2. Actions to get back to plan: Work is ongoing to improve the trust position in relation to the number of Ulcers and Falls occurring in the trust (Please see detail p22) In relation to the UTIs, phase two of the indwelling improvement work continues and an associated drop in infection rates is anticipated when the work in more wide spread at the end of the year.

3. Achieved by date: See individual subject areas for Ulcers and Falls (page 22)

4. Accountable: Deputy Director of Nursing

Report For: September 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Percentage of SI's investigations where reports submitted within timescale (45 days unless extension agreed)	100.00%	90.00%	100.00%	100.00%	100.00%	50.00%



Percentage of SI's investigations where reports submitted within timescale (45 days unless extension agreed)

Why off Plan: 10 reports were due for submission in September. Of these: 1 were submitted late by one day due to an error in the administrative scheduling .

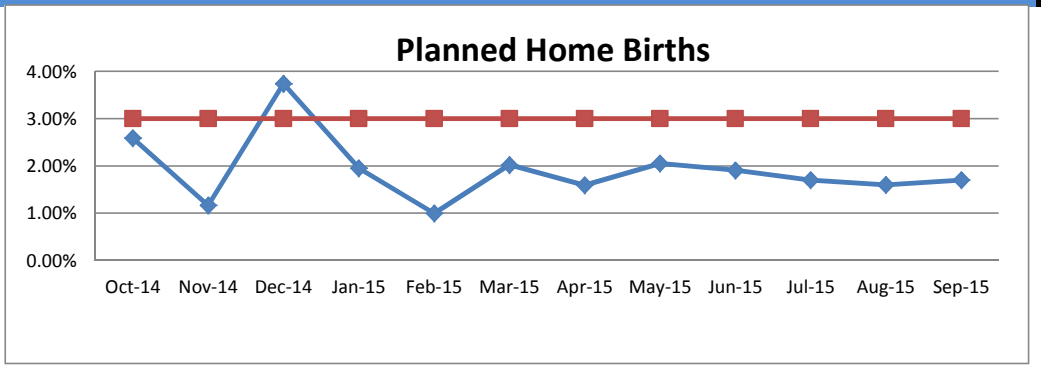
Actions to get back on plan: Administrative Scheduling has been reviewed, and corrective action in place.

When will we be back on track: October 2015

Accountable : Head of Risk and Governance

Exception Report - Safety - Director of Nursing

Report For: September 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Planned Home Births	2.30%	1.70%	-	-	1.70%	-



Planned Home Births:

Why off plan: The % of home births consistently performs around 1.7%, which despite being above the north of England average, is still below the national average of 2.3% and CHFTs internal target. The Community Midwifery Manager, Home Birth Team midwives and midwives do champion and promote home birth however there is little movement in the % of mother opting for a home birth.

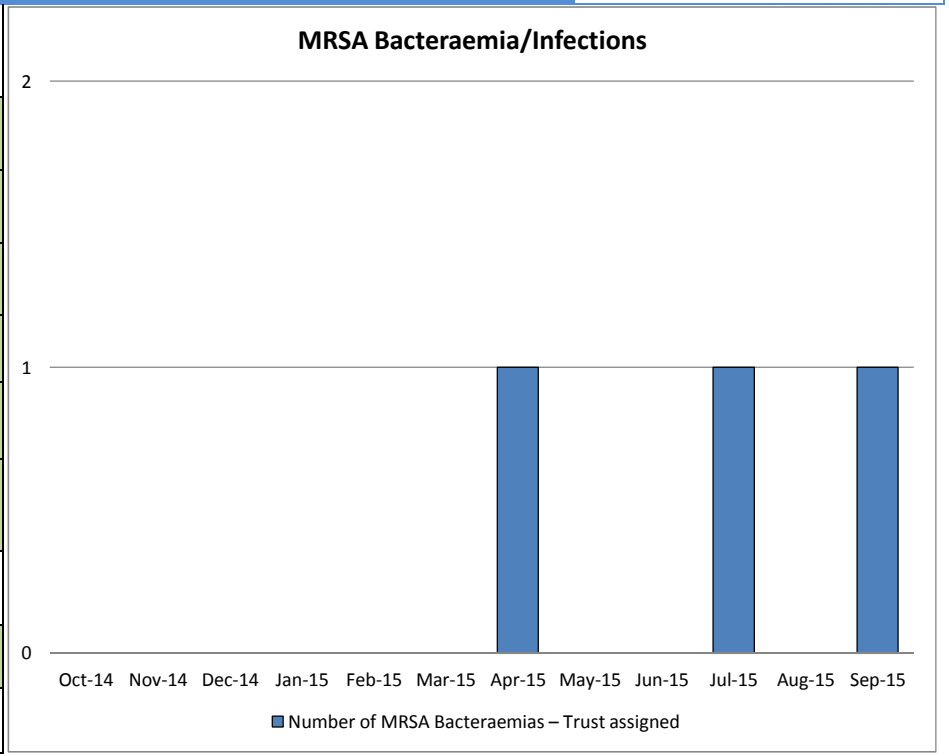
Actions to get back on plan: The Community Midwifery Manager, Home Birth Team midwives and midwives will continue to champion and promote home birth. A review of regional performance is taking place in November which will enable the trust to better understand relative performance.

When will we be back to target? End Q4 2015-2016

Accountable: Midwifery Senior Clinical Manager

	Report For: September 2015	Indicator Source	Target	Trust	Year To Date: Surgical	Medical	Families and Specialist Services	Community	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Trend (Rolling 12 Month)	Direction of travel (past 4 months)	Financial Penalties/Non Financial Impact	Year End Forecast	Data Quality
Effectiveness	Number of MRSA Bacteraemias – Trust assigned	National & Contract	0	1	0	1	0	0	0	3	0	2	0	1		↑			
	Total Number of Clostridium Difficile Cases - Trust assigned	National & Contract	2	3	1	2	0	0	13	10	2	8	0	-		↑			
	Avoidable number of Clostridium Difficile Cases	National & Contract	0	1	0	1	0	0	0	3	1	2	0	0		→			
	Unavoidable Number of Clostridium Difficile Cases	National & Contract	2	2	0	2	0	0	13	7	0	7	0	0		↑			
	Number of MSSA Bacteraemias - Post 48 Hours	National	1	0	0	0	0	0	6	5	1	4	0	-		↓			
	% Hand Hygiene Compliance	Local	95.00%	99.51%	98.92%	99.86%	99.57%	100.00%	95.00%	99.66%	99.08%	99.82%	99.94%	100.00%		↑			
	MRSA Screening - Percentage of Inpatients Matched	Local	95.00%	95.29%	92.30%	100.00%	91.67%	n/a	95.00%	95.06%	92.00%	99.00%	95.00%	-		↓			
	Number of E.Coli - Post 48 Hours	Local	3	0	0	0	0	0	16	15	4	11	0	-		↓			
	Central Line Infection rate per 1000 Central Venous Catheter days	Local	1.50	1.43	-	-	-	-	1.50	0.77	-	-	-	-					
Effectiveness 2	Stillbirths Rate (including intrapartum & Other)	National	0.50%	0.64%	-	-	0.64%	-	0.50%	0.36%	-	-	0.36%	-		↓			
	Perinatal Deaths (0-7 days)	Local	0.10%	0.00%	-	-	0.00%	-	0.10%	0.10%	-	-	0.10%	-		↓			
	Neonatal Deaths (8-28 days)	Local	0.10%	0.00%	-	-	0.00%	-	0.10%	0.00%	-	-	0.00%	-		↓			
	Local SHMI - Relative Risk (1yr Rolling Data Jan14- Dec 14)	National	100	109.3	-	-	-	-	100	109.1	-	-	-	-		↑			
	Hospital Standardised Mortality Rate (1 yr Rolling Data Jul 14 - Jun 15)	National	100.00	113.00	-	-	-	-	100.00	113.00	-	-	-	-		↑			
	Mortality Reviews – August Deaths	local	100.00%	50.80%	60.00%	49.50%	n/a	n/a	100.00%	40.80%	47.30%	40.00%	n/a	-		↑			
	Crude Mortality Rate (Latest Month Sep 15)	National	1.21%	1.22%	0.37%	2.72%	0.17%	n/a	1.17%	1.28%	0.39%	3.07%	0.07%	-		↑			
	Completion of NHS numbers within acute commissioning datasets submitted via SUS	Contract	99.00%	99.90%	99.90%	100.00%	99.90%	n/a	99.00%	99.90%	99.90%	99.90%	99.90%	-		→			
	Completion of NHS numbers within A&E commissioning datasets submitted via SUS	Contract	95.00%	99.10%	-	99.10%	-	n/a	95.00%	99.10%	-	99.10%	-	-		→			
	Average Diagnosis per Coded Episode	National	4.90	4.35	3.58	5.91	2.53	n/a	4.90	4.05	3.45	5.63	2.30	-		↑			
Effectiveness3	Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours	National	85.00%	55.56%	55.56%	-	-	-	85.00%	65.23%	65.23%	-	-	-		↓			
	IPMR - Breastfeeding Initiated rates		70.00%	80.20%	-	-	80.20%	-	70.00%	79.30%	-	-	79.30%	-					
	Emergency Readmissions Within 30 Days (With PbR Exclusions)		7.40%	6.57%	4.32%	11.99%	4.89%	-	7.53%	8.03%	4.59%	12.71%	6.27%	-					
	Emergency Readmissions Within 30 Days (With PbR Exclusions) - Calderdale CCG		7.67%	7.13%	-	-	-	-	8.15%	8.25%	-	-	-	-					
	Emergency Readmissions Within 30 Days (With PbR Exclusions) - Greater Huddersfield CCG		6.77%	6.45%	-	-	-	-	7.11%	8.41%	-	-	-	-					
	CHFT Research Recruitment Target		92	68	-	-	-	-	552	315	-	-	-	-					

Report For: September 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Number of MRSA Bacteraemias – Trust assigned	0	1	0	1	0	0
Total Number of Clostridium Difficile Cases - Trust assigned	2	3	1	2	0	0
Avoidable number of Clostridium Difficile Cases	0	1	0	1	0	0
Unavoidable Number of Clostridium Difficile Cases	2	2	0	2	0	0
Number of MSSA Bacteraemias - Post 48 Hours	1	0	0	0	0	0
% Hand Hygiene Compliance	95.00%	99.51%	98.92%	99.86%	99.57%	100.00%
MRSA Screening - Percentage of Inpatients Matched	95.00%	95.29%	92.30%	100.00%	91.67%	-
Number of E.Coli - Post 48 Hours	3	0	0	0	0	0
Central Line Infection rate per 1000 Central Venous Catheter days	1.50	1.43	-	-	-	-



MRSA Bacteraemia - Trust assigned

Why off Plan: Patient developed an MRSA bacteraemia one week after hospital admission, having been found to be MRSA screen negative at the time of admission. The patient was initially treated for a chest infection, prior to a clinical deterioration when MRSA was isolated from blood cultures. The MRSA bacteraemia was deemed to be avoidable as assurance was felt to be lacking around ANTT practice, given the patient had undergone several cannulations, it is felt at the post infection review there was scope for this to have been prevented through better ANTT practice.

Actions to get back on plan: The Infection Prevention and Control Team have taken over responsibility for delivering ANTT from the Surgical Division. An action plan to restore the training infrastructure has been developed. Divisions will support ensuring that each clinical area has enough assessors, and that all those who need to be assessed are assessed.

When will we be back on track: Robust reports will be in place from November 15, resulting in relevant staff being identified for training and booked into assessment.

Accountable: Lead Consultant for Infection Control

Total Number of Clostridium Difficile Cases - Trust assigned

Why off Plan: Of the three cases, only 1 was deemed avoidable at post infection review. The patient was known to carry C. difficile and had a unnecessary sample taken . The patient should have been treated on the basis of the initial positive result. however in light of the second positive result, The C.diff was deemed an avoidable case due to there not being evidence of an appropriate medication review.

Actions to get back on plan: Recognising that we must only sample when clinically indicated to do so it is important the medical division share the learning around repeat sampling. The microbiology laboratory will ensure there is a more robust process to prevent repeat, unnecessary testing.

When will we be back on track: in relation to removing unnecessary repeat sampling, processes in place from next month.

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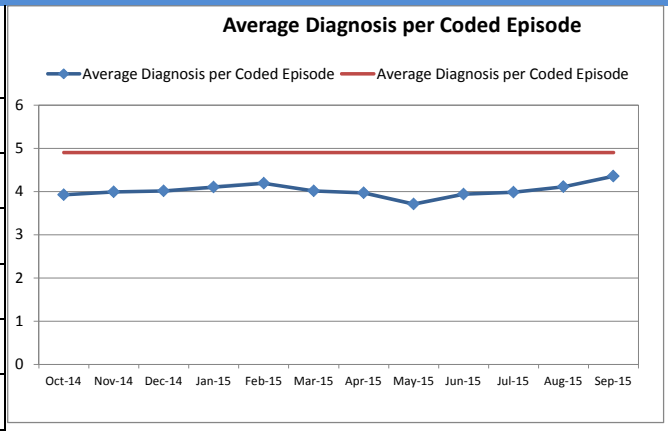
Accountable: Lead Consultant for Infection Control

Report For: September 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Stillbirths Rate (including intrapartum & Other)	0.50%	0.64%	-	-	0.64%	-
Local SHMI - Relative Risk (1yr Rolling Data Jan14- Dec 14)	100	109.3	-	-	-	-
Hospital Standardised Mortality Rate (1 yr. Rolling Data Jul 14 - Jun 15)						
Crude Mortality Rate (Latest Month Sep 15)	1.21%	1.22%	0.37%	2.72%	0.17%	n/a
Mortality Reviews – August Deaths	100.00%	50.80%	60.00%	49.50%	n/a	n/a
Average Diagnosis per Coded Episode	4.90	4.35	3.58	5.91	2.53	n/a



Average Diagnosis per Coded Episode

1. Why off plan? CHFT depth of coding is less than plan due to missed or undocumented relevant secondary diagnoses/complexities/comorbidities within the coding source documentation. This may also be due to incomplete coding documentation at the time of coding. Clinical Coding depth fell initially at the start of 2015-16 due to changes to coding rules. Since May coding depth has gradually improved although not to national average levels there is variable improvement across specialties.

2. Action to get it back on plan: Clinical engagement and presentations continue around importance of complete and accurate documentation – this included presentations to junior doctors and registrars. Work continues to develop existing documentation to assist coding process e.g. inclusion of co-morbidity pro-forma in Surgical and Medical assessment clerking in documentation and in pre-operative assessment documentation. Co-morbidity form compliance continues to be monitored on a fortnightly basis. Recruitment process is ongoing and a clinical coding trainer will start with the team in mid-October and 2 ACC qualified coders in November. A pilot is to commence in October 15 of 3 coders attending the ward round with 3 Upper GI clinicians in order to gain better mutual understanding.

3.Achieved By: Expect to see continued improvement month on month, with a trajectory to hit target by March 2016

4. Accountable: Head of Clinical Coding

SHMI/HSMR/Crude Mortality

1. Why it is off plan? The most recent release indicated a SHMI which was maintained at 109 the 12 months of Jan 14 to Dec14. It remains in the "as expected" category, indicating that there are not significantly more deaths than would be expected for the trust's patient population. The most recent 12 months data for HSMR indicates a score of 113, which is an increase from previous release and continues to be an outlying position. The September 2015 crude mortality is however in line with the same point in the previous year

2.Action to get back on plan: A draft of the revised Acutely ill Patient (CAIP) plan was finalised in September 2015, although it remains a working document. It focuses on six areas: mortality reviews and learning; reliability; deteriorating patients; end of life care; frailty; and coding.

External support in further understanding our HSMR position has been sought from Professor Mohammed Mohammed of Bradford University. There are regular meetings as he begins to look for patterns in the data that allow the formulation of hypotheses to be tested.

The latest figure of the number of mortality reviews carried out in September (August's deaths) is 50.8%. This is a slight setback from last month, but close performance management of the process will be greatly aided by the development of an electronic data collection process which is now possible after testing of redesigned review tools. Thematic reports from the reviews are now being received at the CEAM group.

Additionally, The need for a number of focused reviews has been identified: a review of all patients who died in HRI in March is being undertaken as a result of a sharp rise in the HSMR in March. This is still underway. In terms of reliability of care, a PMO work stream is redesigning a number of care bundles, revamping the process for measurement of reliability of delivery, and planning their integration with routine documentation. The Nervecentre rollout is progressing well, and there is project work underway on frailty.

3.Achieved By: Progressive improvement in mortality review completion is expected month on month.

4. Accountability: Medical Director

Still Birth Rates:

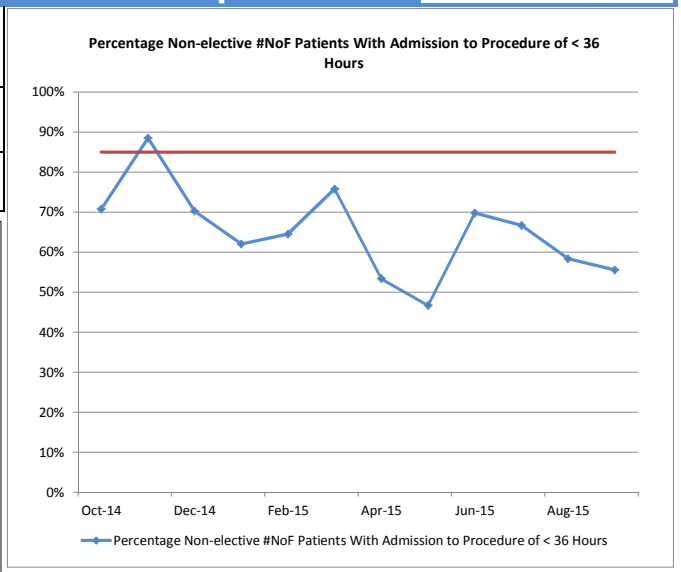
Why off plan – Two babies had known congenital abnormalities, parents chose to continue with their pregnancies rather than terminate. One baby was stillborn at 25 weeks gestation to a woman with risk factors for stillbirth.

Action to get back on plan – Continue with focused stillbirth reduction work (including participation in NHS England SABiNE project and roll out of NHSLA funded patient safety improvement work around intrapartum fetal surveillance.

Achieved by – Year end continued reduction of stillbirth (14 cases YTD 2015-2016 vs 27 cases YTD 2014-2015)

Accountability: head of Midwifery Clinical Senior Manager

Report For: September 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours	85.00%	55.56%	55.56%	-	-	-
CHFT Research Recruitment Target	92	68	-	-	-	-



Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours

Why off plan?
There were 2 weekends in September where large numbers of #NOF patients were admitted. There were a number who were delayed for clinical reasons.
Of 58 patients in September 16 were not done within 36 hours. Of those 5 were not operated on and 5 more were delayed for clinical reasons so there were 6 patients who were delayed for organisational reasons. 42 patients had their operation within 36 hours.

Actions to get back on plan:
Additional trauma lists identified through the theatre scheduling meeting to leave the main trauma list free for #NOF patients. This is still being worked on as there is some difficulty aligning available fallow lists and surgeons. During October we are also trialling moving appropriate trauma patients to CRH to fit onto elective lists.

When we be on track?
We anticipate an improvement trajectory over the next 2 months although the target of 85% will be a significant challenge .

CHFT Research Recruitment Target

Why off plan: The Trust has entered a partnership agreement with the Y&H Clinical Research Network (CRN) to accept research funding in return for contribution to deliver research. The target of 1,100 for 2015-16 was set by the CRN. As funding is performance related, the current position of achieving much less than 50% of its recruitment target at month 6 is of concern. This has resulted from a number of factors including having studies which are of a small recruiting nature –specialised studies which wouldn't expect a large number of applicable participants. There is a lack of large recruiting studies to balance this out. Alongside this the service pressures are resulting in clinical teams being unable to commit to opening new studies. Should the Trust not achieve target then research support funding for 2016-17 will decrease, adding further pressure for 2016-17.
Actions to get back on plan: A new research nurse structure has been implemented from the 1st of October in order to generate more capacity by enabling more flexible working across a range of studies. A review of non-recruiting studies has also taken place and closure of studies where appropriate. A number of high recruiting studies are being set up, this will increase the number of participants however it is not yet known the full impact these will have.
When will we be back on plan? The actions above will enable us to bring together a recovery plan with divisional engagement to encourage greater participation to meet our target and put trajectories in place for modelling predicted performance at year end

Accountable: Head of R&D

Fracture Neck of Femur	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD
Number of fragility hip fracture discharges recorded on the National Hip Fracture Database	45	46	43	39	38	43							**256**
% achieving Best Practice Tariff	53.33%	45.65%	69.77%	66.67%	57.89%	55.56%							**57.81%**
a) time to surgery within 36 hours from arrival in an emergency department, or time of diagnosis if an admitted patient, to the start of anaesthesia.	73.33%	56.52%	76.74%	66.67%	63.16%	55.56%							**65.23%**
(b) admitted under the joint care of a consultant geriatrician and a consultant orthopaedic surgeon.	97.78%	91.30%	100.00%	100.00%	100.00%	97.78%							**97.66%**
(c) admitted using an assessment protocol agreed by geriatric medicine, orthopaedic surgery and anaesthesia.	100.00%	100.00%	97.67%	100.00%	100.00%	100.00%							**99.61%**
(d) assessed by a geriatrician in the perioperative period (within 72 hours of admission).	93.33%	82.61%	95.35%	100.00%	97.37%	86.67%							**92.19%**
(e) postoperative geriatrician-directed multi-professional rehabilitation team	82.22%	91.30%	93.02%	97.44%	92.11%	94.74%							**87.72%**
(f i) fracture prevention assessments (Falls)	82.22%	80.43%	88.37%	92.31%	84.21%	92.11%							**85.38%**
(f ii) fracture prevention assessments (Bone health)	100.00%	93.48%	100.00%	94.87%	94.74%	94.74%							**97.08%**
(g i) two Abbreviated Mental Tests (AMT) performed and all the scores recorded in NHFD with the first test carried out prior to surgery and the second post-surgery but within the same spell - Pre-Op	93.33%	91.30%	97.67%	100.00%	94.74%	100.00%							**95.32%**
(g ii) two Abbreviated Mental Tests (AMT) performed and all the scores recorded in NHFD with the first test carried out prior to surgery and the second post-surgery but within the same spell - Post-Op	91.11%	84.78%	90.70%	97.44%	94.74%	97.37%							**91.23%**

Workforce indicators

The first row of tables look at the year to date performance of CHFT and the divisions against the 4% target. The second looks at performance by staff group against the 4% threshold.
The Second row of tables below show sickness absence rates for CHFT during July and August 2015, broken down by division, identifying movement from the previous month, performance against the 4% threshold, the average length of a sickness episode, identifying movement from the previous month.
The final table looks at staff in post by headcount and full time equivalent (FTE).

FTE Days Lost is calculated by taking the FTE of the employee and multiplying by the length of sickness (in days). For example an employee on 0.5 FTE who is sick for 4 days would equate to an FTE Days Lost of 2.0
FTE Days Available is calculated by taking the FTE of the employee and multiplying by the number of days in the reporting period. For example during May an employee on 0.5 FTE would have 15.5 FTE Days Available.

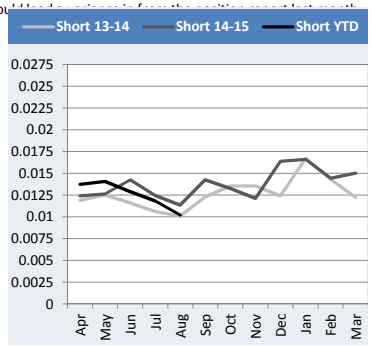
NB: Each month the month end sickness absence figures are adjusted to take account of all sickness absence returns. This could lead to variances in figures from the position reported last month.

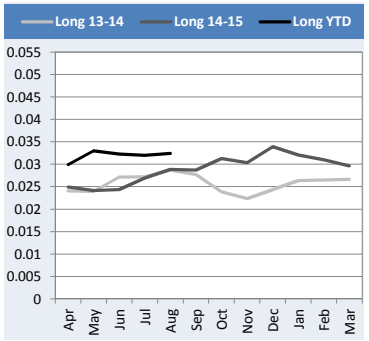
Sickness Absence full time equivalent (FTE) breakdown Year to Date

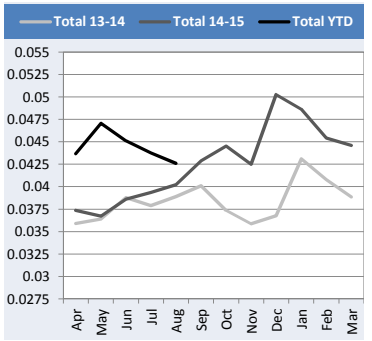
Division	Available FTE	FTE Days Lost	YTD Sickness %	RAG
Surgery	396660.09	17325.87	4.37%	
Medical	469447.33	25351.58	5.40%	
Community	228494.94	8554.82	3.74%	
FSS	490914.93	22970.57	4.68%	
Estates	104719.11	5311.66	5.07%	
Corporate	100904.71	1751.91	1.74%	
THIS	67665.87	2557.12	3.78%	
Trust	**1858806.98**	**83823.52**	**4.51%**	

Sickness Absence full time equivalent (FTE) breakdown Year to Date

Division	Available FTE	FTE Days Lost	YTD Sickness %	RAG
Add Sci & Tech	23162.40	552.53	2.39%	
ACS	161423.73	10916.72	6.76%	
Admin & Clerical	151120.25	5468.45	3.62%	
AHP	58507.30	1400.39	2.39%	
Estates & Ancil.	21907.47	1206.80	5.51%	
Healthcare Scientists	17586.45	401.93	2.29%	
Medical and Dental	77411.54	774.27	1.00%	
Nursing & Midwifery	250548.66	13190.13	5.26%	







In month Sickness Absence rate (%) (1 Month Behind)

Division	Short Term	Long Term	Overall %	RAG
Surgery	1.35%	3.12%	4.47%	
Medical	1.39%	4.20%	5.59%	
Community	0.95%	2.92%	3.87%	
FSS	0.80%	3.12%	3.92%	
Estates	0.22%	2.97%	3.19%	
Corporate	0.30%	1.85%	2.15%	
THIS	0.46%	1.62%	2.08%	
Trust	**1.02%**	**3.24%**	**4.26%**	

In month Sickness Absence rate (%) (1 Month Behind)

Division	Jul-15	Aug-15	Movement
Surgery	4.25%	4.47%	↑
Medical	5.00%	5.59%	↑
Community	4.01%	3.87%	↓
FSS	4.73%	3.92%	↓
Estates	3.76%	3.19%	↓
Corporate	2.10%	2.15%	↑
THIS	3.77%	2.08%	↓
Trust	**4.38%**	**4.26%**	↓

In month Sickness Average FTE Lost per Episode

Division	Jul-15	Aug-15	Movement
Surgery	9.32	10.44	↑
Medical	9.13	9.29	↑
Community	9.92	10.33	↑
FSS	9.07	11.67	↑
Estates	8.94	16.38	↑
Corporate	7.42	13.85	↑
THIS	10.68	10.85	↑
Trust	**9.21**	**10.48**	↑

In month Sickness Absence full time equivalent (FTE) breakdown (1 Month Behind)

Division	Available FTE	Short Term FTE	Long Term FTE	FTE Days Lost
Surgery	33131.53	447.80	1034.43	1482.23
Medical	39342.89	548.36	1652.73	2201.09
Community	18665.96	177.75	545.28	723.03
FSS	39903.73	317.73	1245.46	1563.19
Estates	8217.50	18.00	244.00	262.00
Corporate	8385.98	25.00	155.00	180.00
THIS	5736.65	26.40	93.00	119.40
Trust	**153384.24**	**1561.04**	**4969.90**	6530.94

In month Sickness Absence rate (%) (1 Month Behind)

Staff Group	Jul-15	Aug-15	Movement
Add Sci & Tech	2.51%	2.58%	↑
ACS	6.63%	6.50%	↓
Admin & Clerical	3.68%	3.17%	↓
AHP	1.93%	2.35%	↑
Estates & Ancil.	4.30%	3.79%	↓
Healthcare Scientists	2.05%	1.75%	↓
Medical and Dental	1.46%	0.96%	↓
Nursing & Midwifery	5.13%	5.28%	↑

Staff in Post (FTE)

Division	Aug-15	Sep-15	Movement
Surgery	1069.98	1079.68	↑
Medical	1267.54	1285.79	↑
Community	605.58	605.01	↓
FSS	1282.93	1280.10	↓
Estates	264.04	263.86	↓
Corporate	274.25	284.11	↑
THIS	187.45	188.49	↑
Trust	**4951.77**	**4987.03**	↑

Staff in Post (Headcount)

Division	Aug-15	Sep-15	Movement
Surgery	1193	1204	↑
Medical	1413	1430	↑
Community	745	744	↓
FSS	1501	1498	↓
Estates	348	347	↓
Corporate	314	325	↑
THIS	194	196	↑
Trust	**5708**	**5744**	↑

Sickness Absence/Attendance Management at work

Why are we away from plan -

The 2015-16 year to date sickness rate of 4.51% compares to a 2014-15 outturn sickness rate of 4.26%. The Aug 2015 year to date figure of 4.51% compares to the year to date at Aug 2014 figure of 3.85%. Community ,THIS and Corporate have a YTD % below the 4% threshold identified. Community , Families & Specialist Services, Estates and Facilities, THIS and Corporate have a % below the 4% threshold identified . Short term sickness absence for the Trust is at 1.02% long term absence at 3.24% . The Aug 2015 figure compares to a Aug 2014 figure of 1.08% short term absence and long term absence of 2.93 %.

Action to get on plan -

There are a number of key interventions planned to address the current rate of sickness absence:-
dedicated absence management resource to support divisional activity/line managers (Establishment of a dedicated Attendance Management team is progressing. A team leader has been appointed and a recruitment plan is in place and being actioned for the remaining posts in the team.)
increasing awareness of health and lifestyle choices(a comprehensive colleague health and wellbeing strategy is in development and will be available at the end of November 2015)
Evidence based data driven – target action (BI)
Clear and simple attendance management policy (The Attendance Management policy has been updated to include a case management approach, early intervention, fast access to Occupational Health and Physiotherapy, robust return to work process, meetings and action plans, revised triggers for short term episodes and active management. The policy has been approved by staff side representatives of the Staff Management Partnership Forum and Local Negotiating Committee and will now progress to Executive Board for ratification)
Joined up approach – line manager/HR/Occupational Health/Staff Side
Fast access to Occupational Health and Physiotherapy
Robust return to work process – meetings and plans
Training for managers – " how to ….."
Realistic improvement targets
Case management approach
Early intervention Active management.
A 'go see' activity planned with Leeds Teaching Hospitals NHS Trust takes place on 14 October 2015.

Training indicators

Mandatory Training Indicators compliance from April 2015

Division	Prevent	Equality & Diversity	Information Governance	Infection Control	Health & Safety	Manual Handling	Safeguarding	Fire Safety	Overall Compliance*
Surgery	22.50%	61.30%	64.30%	35.70%	35.10%	35.60%	24.0%	27.90%	18.11%
Medical	31.70%	70.30%	69.20%	37.80%	36.90%	37.70%	24.7%	28.00%	18.91%
FSS	39.40%	78.00%	77.30%	47.00%	46.80%	46.80%	27.9%	41.30%	7.72%
Community	78.50%	73.40%	75.00%	36.80%	36.20%	38.70%	22.6%	34.20%	9.82%
Estates	16.80%	81.00%	82.60%	19.30%	18.20%	18.50%	15.5%	47.90%	8.29%
Corporate	47.20%	78.20%	79.80%	30.30%	30.70%	31.00%	24.7%	40.30%	9.69%
THIS	28.40%	83.40%	81.50%	62.80%	56.30%	62.80%	28.8%	26.20%	6.99%
Trust	**37.5%**	**72.10%**	**70.90%**	**39.20%**	**38.50%**	**39.30%**	**25.2%**	**34.40%**	**10.33%**

Medical Devices Training

Division	Compliance	100% Target
Surgery	71.00%	●
Medical	63.00%	●
FSS	75.00%	●
Community	81.00%	●
Estates	98.00%	●
Corporate	79.00%	●
THIS	-	-
Trust	**78.00%**	●

Mandatory Training Indicators completed in last 12 Months

Division	Prevent	Equality & Diversity	Information Governance	Infection Control	Health & Safety	Manual Handling	Safeguarding	Fire Safety	Overall Compliance*
Surgery	22.50%	61.30%	64.30%	62.90%	62.90%	61.50%	58.30%	51.20%	10.90%
Medical	31.70%	70.30%	69.20%	66.70%	67.30%	67.70%	64.30%	57.10%	16.30%
FSS	39.40%	78.00%	77.30%	73.40%	73.20%	71.90%	68.80%	70.10%	23.10%
Community	78.50%	73.40%	75.00%	74.30%	72.50%	74.30%	71.30%	67.70%	46.30%
Estates	16.80%	81.00%	82.60%	83.10%	81.50%	81.40%	80.10%	67.90%	11.70%
Corporate	47.20%	78.20%	79.80%	71.50%	74.20%	73.20%	68.50%	65.20%	19.90%
THIS	28.40%	83.40%	81.50%	80.20%	79.20%	79.20%	74.70%	65.50%	17.20%
Trust	**37.5%**	**72.10%**	**70.90%**	**71.10%**	**72.10%**	**70.90%**	**68.3%**	**63.70%**	**20.40%**

Mandatory Training

Why are we away from plan?

The new mandatory training approach (the Core Skills Training Framework or CSTF) has been in operation since 1st June 2015. Colleagues are still becoming familiar with the new approach and this will factor into the compliance data reported through the IBR. Steady progress has been made. 88% of colleagues have commenced completion of the new programme of mandatory training since 1st June 2015, this is an increase of 28% from last month. However, increased participation and completion across all of the 8 available programme elements is low.

Action to get on plan including timescales

An intranet portal has been established giving access into the Electronic Staff Record (ESR) to complete the mandatory training elements. The web pages contain comprehensive support materials including videos and scripts which are to be used by colleagues enabling them to access the training and complete it satisfactory. A help facility has been established as well as an FAQ which sets out issues colleagues have raised in using the system and the solutions to them. Extra PREVENT classroom sessions have now been scheduled to increase availability for colleagues. Information about home access for colleagues who wish to complete training outside of the workplace has been strengthened on the mandatory training web page and the possibility of loan devices to increase home accessibility is being explored. Work to ascertain which of the mandatory subjects might have alternate, higher level qualifications which might satisfy the learning outcomes for the mandatory subjects and therefore prevent the need for colleagues to complete the awareness level mandatory packages has also commenced.

Medical Devices

Medical Devices Training is currently at 79% compliance across the Trust.

Action to get on Plan - (1) Regular reminders to all staff re Medical Devices training requirements via newsletter, intranet notices, link nurse, matrons and department managers group emails (2)Discuss and remind Medical Devices training group and link nurse meeting members to cascade Medical Devices Training requirements throughout divisions. (3) Organise and promote medical devices training events (4) Contact all areas below 75% compliance (in the red) to develop an action plan to improve training compliance

By Who- (1) Director of Planning, Performance, Estates & Facilities, ADN's, Matrons, General Managers, Department Heads, Line Managers and link nurses (2) Medical Devices Training Coordinator and Medical Devices Training support on-going throughout the year

Appraisal Activity

The first table shows the Number of non medical and medical Appraisal activity completed this has been RAG rated against divisional activity plans. The second table shows the number of appraisals completed in the last 12 months against the 100% target.

NB: ESR is the only accepted reporting tool for appraisal compliance. The deadline for inputting appraisal activity data each month is 1st working day of month for previous months appraisals. Activity recorded after this data will only be included in compliance reports in the following months.

Appraisal-Completed Since April 2015

Division	Compliance	Projected activity as of 30.09.2015	RAG
Surgery	7.20%	30.00%	
Medical	28.70%	**	
FSS	32.20%	33.00%	
Community	29.90%	27.00%	
Estates	23.70%	54.00%	
Corporate	26.00%	32.00%	
THIS	40.40%	38.00%	
Trust	**25.17%**	-	

Key

Compliance	RAG
Equal or Above Plan	
less than 2% off plan	
More than 2% off plan	

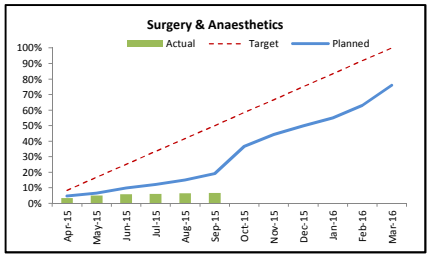
Appraisal- Completed in last 12 Months

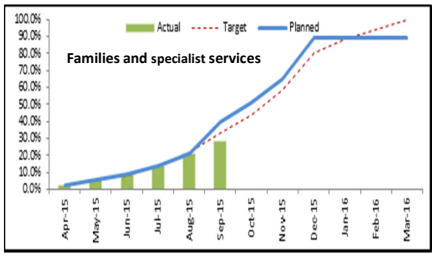
Division	Compliance	100% Target
Surgery	58.80%	
Medical	66.50%	
FSS	82.50%	
Community	71.80%	
Estates	77.60%	
Corporate	74.90%	
THIS	80.20%	

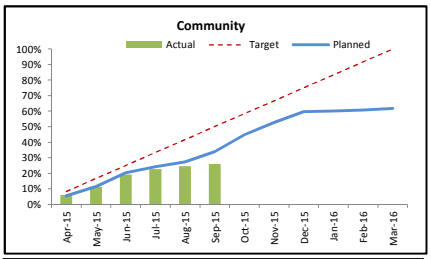
** Medical division has not returned their appraisal profiler

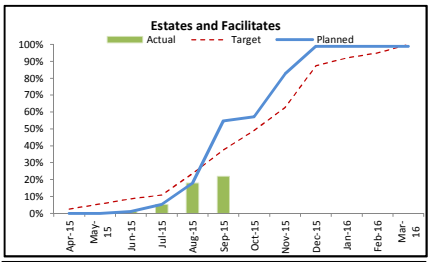
Appraisal Activity

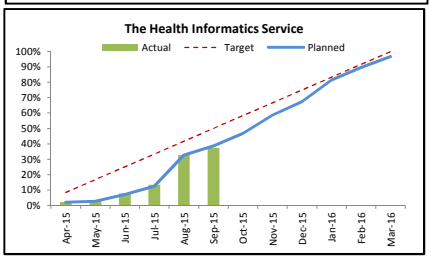
The graphs below showed planned activity to reach the 100% target by 31st March 2015.

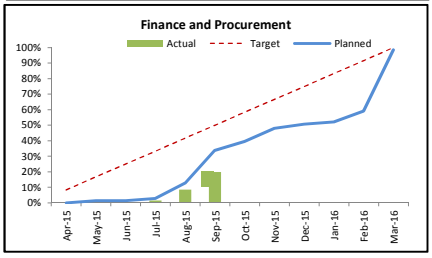


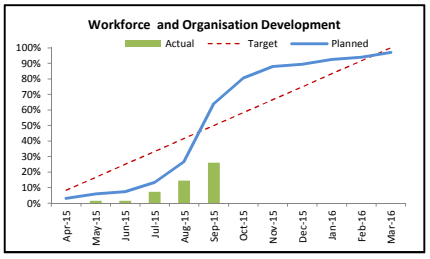


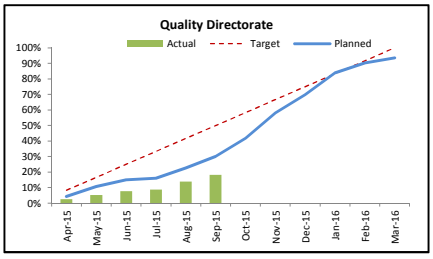












Mandatory Training and Appraisal commentary

The narrative below is provided by divisional leads to about the current position for Mandatory Training and Appraisal for their area.

Medical

Why are we away from plan?

September figures for medicine show a significant improvement in the numbers of completed appraisals having improved from 13% up to 28% this month. Current vacancy levels and additional capacity areas are placing pressure on staff.

Action to get on Plan including timescales

The new appraisal profile tool is currently being implemented within the division. All ward / department managers are being asked to populate the booked appraisal dates so that we can track our progress to achieving 100% by the end of the year. This is currently work in progress and it is expected a further improvement against both the actual appraisals undertaken and booked will be noted.

A directorate, ward and departmental level breakdown showing compliance is now available and areas below expected performance are being asked to put in place corrective action. Matrons and GMs are proactively managing under performance.

Surgery

Why are we away from plan?

Appraisal – Current performance April to September suggests 7.2% based on the available information within ESR. The Division has now trained two members of the Divisional workforce to ensure that the ESR system is the key data source for this information and over the coming month appraisals completed will now be captured in the ESR system. Based on a manual completion of the Appraisal Profiler it would suggest that the performance April to September is in the region of 18%.

Mandatory training, Prevent and Safeguarding remain key areas of performance.

Action to get on Plan including timescales

Appraisal – Administration support training completed as referenced above. Appraisal Profiler now 87% completed for monthly monitoring. Gap relates medical staffing data to be collated as well a recognition of a level of staff on maternity leave, long term sickness and within the probationary period. Dates will be confirmed for these staff as they return to work etc

Continued focus on Mandatory training across the Board with key reference to Prevent and Safeguarding

Structured performance management at Directorate level established via Divisional Board. Directorate Objectives clearly set incorporating Appraisal and Mandatory Training

Community

Why are we away from plan?

Appraisal

Detailed review of appraisal position undertaken and identified a lack of understanding of operational teams on the requirements for appraisal within the financial year. Requirement clarified and all staff in work have an appraisal date agreed which will be monitored and will bring the Division into compliance

Mandatory Training

Several elements of Mandatory training are only required to be updated bi-annually or every three years. The Division had been under the misinterpretation that this did not have to be undertaken until due rather than understanding April 2015 was a new clock start for all training. This has now been communicated and dates for all staff will be aligned with appraisal dates; the Division is now looking at how to recover lost performance from April to September and will update at a future performance meeting

FSS

Why are we away from plan?

Mandatory training - broadly meeting plan in a number of areas including E&D, IG, Infection control, Health & Safety and Manual Handling.

Prevent- lack of availability of sessions has proved challenging but additional capacity now planned. Fire training (marginally below plan) and Safeguarding trajectory not currently being met.

Appraisal – performance at 30.9% against set trajectory of 33%. Teams now all using planning tool to promote with teams

Action to get on Plan including timescales

Continued monitoring and support via weekly team meetings

Closely working with ward teams to identify limiting factors and support completion. Focused work being undertaken during October to ensure safeguarding training sessions and PREVENT booked for all staff

Estates

Why are we away from plan?

Mandatory Training

1) A significant number of staff do not have access to PC's during their normal working day.

2) A number of challenges have been made in relation to specific training (eg: Health & Safety 2 day training should negate the need to do H&S Awareness training). This is being addresses with the topic expert and Bev France to ensure subjects are not duplicated

3) Some staff do not have time available during the day due to other pressures.

Appraisals

1) The Division has been through a Business Redesign Programme (BRP) and management restructure. Staff were given new Job Description and revised responsibilities. The Division felt it important to complete the BRP, give staff the opportunity to understand their new roles and be clear about the revised services model and divisional objectives so that this could be used to form the basis of the appraisal programme, in particular for the new senior management team. This resulted in a delay in starting the appraisal programme.

Action to get on Plan

Mandatory Training

training events planned for staff unable to access PC's (use of IT training rooms on a weekly basis). Sessions to be completed by end Dec 15.

ACTION: C Gorman to organise with IT (for training rooms) and L&D (for facilitation) and Heads of Services to release staff for training

2) Knowledge experts working with B France to map key learning outcomes to awareness training (eg: Health & Safety) to reduce duplication of effort. Exercise for Health & Safety completed 10th Oct 15.

ACTION: A Wilson & B France (complete)

3) Staff are reminded they can access mandatory training "remotely". This is being cascaded again via to all Managers with a view that all Managers can access the database and Managers training is complete by end Nov 15. (http://nww.cht.nhs.uk/divisions/corporate/workforce-and-organisational-development/mandatory-training/accessing-esr-from-home/)

ACTION: D McGarrigan & Heads of Services to lead by example and have all mandatory training complete.

Appraisals

1) The BRP is now complete and the appraisal programme has started. A number of staff have received an appraisal, mainly the senior/middle management teams, with all other staff, apart from those on long term sick, having dates in the diary when their appraisal will take place. The objective is to complete all appraisals by the end of December 2015.

Corporate

Appraisal

Why are we away from plan?

Significant progress has made for all corporate function in completing appraisal profiler. dates for majority of appraisal for corporate function have been scheduled . Activity recorded in ESR does not match planned activity.

Action to get on plan

Review of the reasons appraisal are not being completed as identified within the plan, immediate action to be taken to set revised dates for appraisals not done. Appraisal profiler to be refreshed at end of quarter 3.Th emphasis of appraisals to be reinforced across the corporate function grouping.

Mandatory Training

Why are we away from plan?

There remains an element of the workforce in corporate function that has not commenced any element of the mandatory training programme. Additional, whilst there is a significant number of colleagues that have commenced one or more of the elements there remains low completion of the full 8 elements .

Action to get on plan

The actions detailed in the Quality committee update report in September are been actioned. an emphasis on mandatory training completion specifically across corporate functions is to be progressed.

THIS

Why are we away from plan?

Appraisals – The profile tracker has been submitted showing THIS just off plan at the half year point but with a clear profile to track just below target, meeting it before year end. THIS has seen a good increase across the board between August and September stats. Whilst this is still not 'on-plan', it does show that the steps been taken (outlined in the actions below) are working and if it were not for the slow start progress would be as expected. The change to a monthly plan is taking time to be acknowledged/understood by all staff who are used to completing training and appraisals once within each financial year. Appraisals have been taking place but those involved (either the manager or staff), were not informing the divisional training co-ordinator that they were complete, this has been addressed.

Mandatory Training: - THIS are now above 50% at the half year point on some of the modules. The attendance modules have staff booked on over the next couple of months to bring those in line. Access to some training modules was difficult at the start of the financial year again contributing to a slow start, still difficulties with Safeguarding which is one of THISs lowest compliances.

Action to get on Plan including timescales

THIS has seen good progress towards plan in the first half of the year after a slow start in both Mandatory Training and Appraisals. The actions below are in place to track the profile submitted for Appraisals and to meet training targets by the end of the financial year. Reports and the reasons for delivering against the targets are discussed in divisional communications as well as departmental team meetings. Each head of department has a responsibility to monitor activity against plan and manage it accordingly. Meeting trust targets for mandatory training and appraisals will form part of the personal appraisal objectives of Heads of Departments and Managers within THIS. Communications have been sent out (and will continue every month) by the divisional training co-ordinator reminding staff to inform them of when an appraisal has taken place. The managers have been informed that this is part of their responsibility. The relevant slide from IBR (as well as the HR report) is discussed at the THIS monthly board to ensure the senior team are clear on progress and activity against plan. THIS holds division wide staff briefing sessions at least twice a year and Training/Appraisals is on the agenda for both. THIS understands that this is a transitional year and is working with departmental managers to pull together a clearer process around when Training/appraisals are completed by each department giving a more balanced spread throughout the year.

Well Led indicators

The first row of tables below show the performance against the Friends and Family test scores for the quarter 4 identifying movement from the previous quarters performance.

The second row of tables show the Hard Truths staffing level indicators.

FFTStaff - Would you recommend us to your friends and family as a place to receive treatment? (Quarterly)			
Division	Quarter 4	Quarter 1	**Movement**
Surgery	**79.00%**	**79.00%**	→
Medical	**80.00%**	**76.00%**	↓
FSS	**74.00%**	**76.00%**	↑
Community	-	**77.00%**	
Estates	**89.00%**	**83.00%**	↓
Corporate	**79.00%**	**82.00%**	↑
THIS	**75.00%**	**72.00%**	↓
Trust	**81.00%**	**77.00%**	↓

FFT Staff - Would you recommend us to your friends and family as a place to work? (Quarterly)			
Division	Quarter 4	Quarter 1	**Movement**
Surgery	**55.00%**	**55.00%**	→
Medical	**54.00%**	**49.00%**	↓
FSS	**49.00%**	**47.00%**	↓
Community	-	**49.00%**	
Estates	**53.00%**	**45.00%**	↓
Corporate	**57.00%**	**52.00%**	↓
THIS	**66.00%**	**72.00%**	↑
Trust	**59.00%**	**51.00%**	↓

Hard Truths Summary Day - Nurses/Midwives		
Division	Sep-15	95% Target
Surgery	93.71%	
Medical	83.33%	
FSS	89.66%	
Trust	**87.47%**	

Hard Truths Summary - Day Care Staff		
Division	Sep-15	95% Target
Surgery	94.06%	
Medical	97.28%	
FSS	79.52%	
Trust	**94.31%**	

Hard Truths Summary - Night Nurses/Midwives		
Division	Sep-15	95% Target
Surgery	91.08%	
Medical	90.44%	
FSS	85.58%	
Trust	**89.37%**	

Hard Truths Summary - Night Care Staff		
Division	Sep-15	95% Target
Surgery	112.27%	
Medical	118.34%	
FSS	69.85%	
Trust	**110.06%**	

Hard Truths Staffing Levels

Why we are away from plan

The overall average fill rate for qualified nurses (day and night) has increased in September on both sites in comparison to August 2015. On the HRI site the average fill rate for qualified nurses was 92 % (day and night) in comparison to 88.85% in August 2015. At CRH the average fill rate for qualified nurses was 85.49% in comparison to 83.3% in August 2015.
For unqualified staff the average fill rate (day and night) has remained largely static from the August position on the HRI site to 104.6% and reduced on the CRH site to 100.5%

	Day		Night		
	Qualified	Unqualified	Qualified	Unqualified	Combined
Red (less than 75% fill rate)	6	7	1	3	17
Amber (75 – 89% fill rate)	11	6	13	1	31
Green (90-100% fill rate)	16	10	18	5	49
Blue (greater than 100%)	2	12	2	16	32

The number of areas rag rated red in September increased in comparison to August 2015.
At present the nursing workforce continues to have a number of vacancies and a sickness rate for colleagues above the threshold built into the workforce model which has impacted upon fill rates. Increased demand on additional capacity areas has also contributed to reduced fill rates.
An increase in areas with an average fill rate of above 100% has been reported in comparison to August, but this remains less than the June and July position.
Five areas reported an average fill rate of over 100% for qualified nurses. Ward 3 (119.5%) has been attributed to newly qualified nurses starting who have yet to receive their NMC registration. The remaining 4 areas reporting an overfill had fill rates of less than 102% attributed to a combination of achieving an element of supervisory status and newly qualified nurses arriving, but awaiting their NMC registration.

Table 2: Analysis of areas with unqualified average fill rates above 105%

Area	Day	Night	Reason
MAU (HRI)		113.3%	• Supporting reduced fill rate of 86% for qualified nurses • Additional 6 shifts required to support 1-1 care
2AB		115.5%	• Supporting reduced fill rate of 89% for qualified nurses • Additional 8 shifts required to support 1-1 care
4	124%		• Supporting reduced fill rate of 93% for qualified nurses
5 (11)		180%	• Trial of increased HCA on nights resulting in overfill. Associate Director of Nursing monitoring.
5AD	126.2%	130%	• Supporting reduced fill rate for qualified nurses on days of 67.9%. • Clarification on planned hours against workforce required • 21 Additional shifts required for 1-1 support and specialist care
5B	143.4%	134.9%	• Supporting additional capacity requirement • Additional 22 shifts required to support 1-1 care
6	112%	112%	• Supporting Qualified nurse fill rate of 93.6 – 98.4%
6A	113%	120%	• Supporting additional capacity requirement • Additional 15 shifts required to support 1-1 care
6BC		116%	• Supporting Qualified nurse fill rate of 92.5%
6D	108%		• Supporting reduced Qualified nurse fill rate of 74% • Additional 12 shifts required to support 1-1 care
7AD		141.2%	• Supporting reduced qualified nurse fill rate of 80.8%
7BC		136.1%	• Supporting reduced qualified nurse fill rate of 93.6%
8		111.1%	• Supporting reduced qualified nurse fill rate of 81.7%
12		170%	• Supporting reduced qualified nurse fill rate of 76.7%
17		144.8%	• Supporting reduced qualified nurse fill rate of 87.9%
21	119.2%		• Supporting reduced qualified nurse fill rate of 68.8%
8AB		117.3%	• Supporting reduced qualified nurse fill rate of 81.7% • Additional 6 shifts required to support 1-1 care
10	136.7%		• Supporting reduced qualified nurse fill rate of 90.6% • Additional 6 shifts required to support 1-1 care
SAU		155.5%	• Supporting reduced qualified nurse fill rate of 92.4%

Table 3: Analysis of reduced fill rate for Qualified Planned Hours

Area	Day	Night	Reason
MAU CRH	71.4%		Vacancies, Sickness
5AD	67.8%		Vacancies; Increased number of long shifts worked against planned resulting in decreased fill rate.
6D	74%		Vacancies; Sickness
21	68.8%		Supporting additional capacity areas; Sickness
8D	51.7%		Vacancies; Supported by additional unqualified nurses risk assessed by matron of the day.
4C	74.6%		Vacancies;
9	69.6%		Sickness; vacancies

Matron of the day role commenced in September 2015 to provide increased support in achieving safe staffing levels across the Trust.
Action Plan
Review of agency spend on qualified nurses on a weekly basis to monitor position against agency ceiling cap received in September 2015.
Focused recruitment for unqualified nurse vacancies both planned, and completed within September 2015. Future unqualified nurse recruitment events planned to ensure continuation of pipeline workforce.
Focused recruitment both UK based and International to recruit to vacancies.
Winter planning for safe staffing across the nursing workforce to be completed.
Reduction in higher cost agency use, with Director level approval for any tier 3 (high cost) agency required.
Induction and increased support for both newly qualified and newly recruited nurses (both qualified and unqualified).
Review of additional roles to support 1-1 requirements.
Daily review of staffing across site by matron to ensure the most effective use of resources.

Achieved by Date
The Trust has started to realise the increased fill rate and decreased vacancy position expected through the recruitment of qualified nurses and midwives.
Increased fill rates will be monitored by the Associate Directors of Nursing.
Winter planning for the nursing workforce will be completed and monitored through the Nursing Workforce Strategy Group.

Calderdale and Huddersfield NHS Foundation Trust

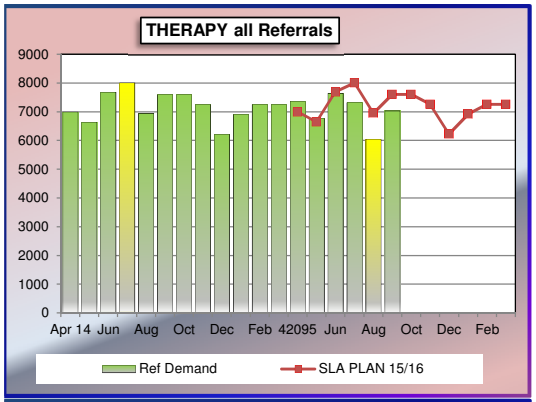
INTERMEDIATE CARE AND COMMUNITY DIRECTORATE

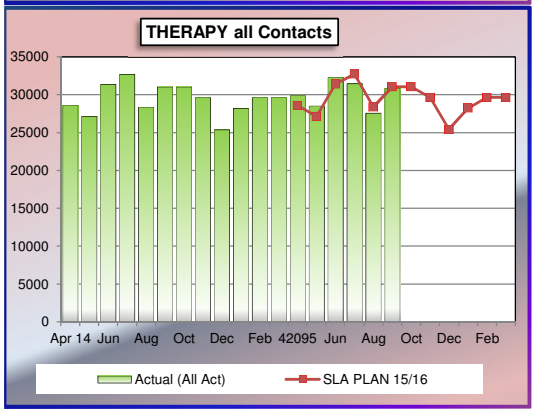
DIRECTORATE PERFORMANCE DASHBOARD

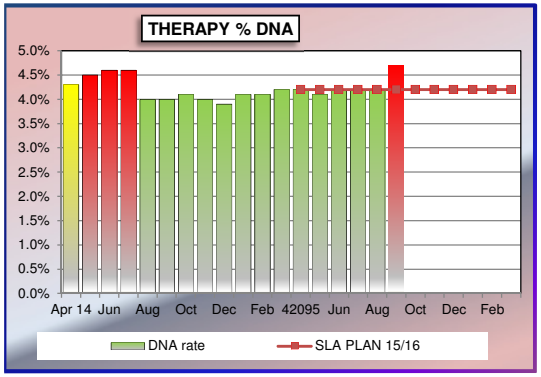
MONTH : SEPTEMBER 2015

compassionate care

CLINICAL THERAPY SERVICES







ACTIVITY EFFICIENCIES - PERFORMANCE v PLAN

ALL THERAPY CONTACTS (includes Inpatients & All Commissioners)

CLINICAL THERAPIES : Activity Metric	Curr Month	YTD actual	YTD PROFILE	Actual 14/15	POSITION
Referral Demand	7,036	42,544	43,877	86,372	-3.0%
Initial Contacts	5,523	32,276	34,604	68,118	-6.7%
Follow Up Contacts	24,354	143,417	139,839	275,273	2.6%
Telephone Contacts	966	5,204	4,842	9,531	7.5%
THERAPY CONTACTS - including Inpatients	**30,843**	**180,897**	**179,284**	**352,922**	**0.9%**
CTR Podiatry	6,346	35,199	37,409	73,640	-5.9%
CTR Therapies Outpatients	5,657	34,090	35,094	69,082	-2.9%
CTR Inpatient Therapies	9,460	55,902	47,926	94,342	16.6%
CTR Long Term Conditions and Rehab	4,995	31,124	32,521	64,018	-4.3%
CTR Acute & Planned Care is 'Other Outpatients'	1,605	9,655	10,431	20,534	-7.4%
CTR Childrens Therapies	1,814	9,723	11,062	21,775	-12.1%
Telephone Contacts	966	5,204	4,842	9,531	7.5%
THERAPY CONTACTS - including Inpatients	**30,843**	**180,897**	**179,284**	**352,922**	**0.9%**

First DNAs	303	1515
First DNAs % Rate	5.2%	4.5%
Total DNAs	1506	8159
Total DNA % Rate	4.7%	4.3%

Snapshot : Waiting List - Waiting for First Appt	8324

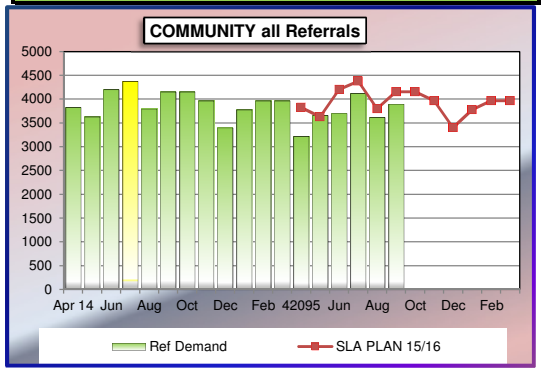
COMMUNITY ADULT : Activity Metric	Curr Month	YTD actual	YTD COMM	COMM PLAN	POSITION
Referral Demand	3,898	24,260	23,987	47,219	1.1%
Initial Contacts*	2,615	15,636	17,589	34,624	-11.1%
Follow Up Contacts	22,059	136,872	131,817	259,482	3.8%
Telephone Contacts	3,248	18,161	16,629	32,735	9.2%
ALL Clinical Contacts - Face to Face & Telephone	27,922	170,669	166,035	326,841	2.8%

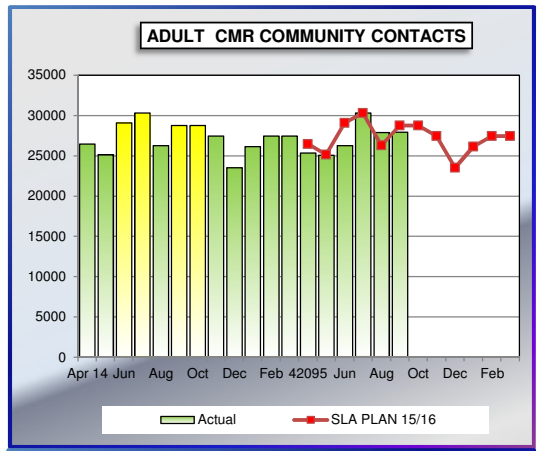
* From changes to recording of referrals introduced this financial year - this will reduce the number of initial contacts

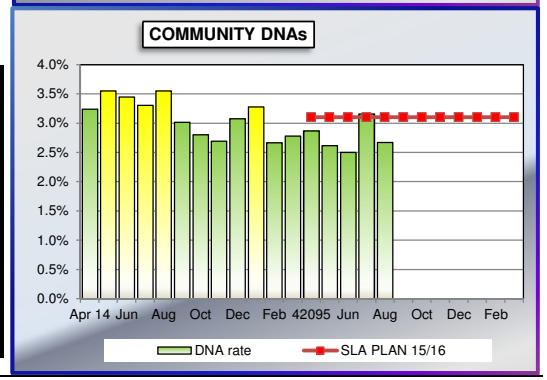
Total DNAs - No Access Visits + DNAs	817	4764
Total DNA (No Access) % Rate	2.84%	2.72%

DIRECTORATE SUMMARY KPIs	Curr Month	YTD actual	YTD COMM	Actual 14/15	POSITION
Referral Demand	10,934	66,804	67,864	133,591	-1.6%
Total Contacts	54,551	328,201	323,848	637,497	1.3%
Telephone Contacts	4,214	23,365	21,471	42,266	8.8%
TOTAL CONTACTS - ALL SERVICES	**58,765**	**351,566**	**345,320**	**679,763**	**1.8%**
Total DNAs	2323	12923			
Total DNA % Rate	4.1%	3.8%			
Snapshot : Waiting List - Waiting for First Appt	8,324				

CALDERDALE COMMUNITY ADULT







Calderdale and Huddersfield NHS
NHS Foundation Trust

COMMUNITY DIVISIONAL PERFORMANCE REPORT & DASHBOARD

PROVIDING AN ASSESSMENT OF QUALITY ACROSS THE DOMAINS OF THE NHS OUTCOMES FRAMEWORK

SEPTEMBER 2015

compassionate care

Key Points

September 2015
Performance Summary

A - Why the target is away from plan
B - What are we doing to get it back to plan
C - When will this be achieved

(1c) Advance care plan
Individualised Care of the Dying (ICOD) training being rolled out across teams. First trial has been evaluated and changes are being mad eto the document

(1e) % with Calderdale Care Plan

Improvement seen in this area as all care plans completed in full within 2 weeks of arrival onto caseload as expected

(4a) Pressure ulcer screening
A - Work to do around how we report this as the screening is reflected in the holistic assessment in all cases and in the care plans where there is an issue.
B - Developed outcome measures for completion when a pressure ulcer care plan has been performed and there is targeted work ongoing to improve data capture
C - November

(4b) Community acquired pressure ulcers
A- Thematic review of RCAs has been performed and used to develop community wide action plan. Need to have a more joined dup approach across all professionals and agencies to pressure ulcer prevention
B - Multi professional forum planned for 13th November with plans to launch 2 trials aimed at working with care staff and care agencies
C- Unlikely to meet 10% reduction target as planned need to set revised target to monitor improvement work month on month

(4f) Safeguarding training
A - Recording is over a 36 month period therefore the target for the year is not in line with the current calculation methodology. clarification has been requested around whether this training has to be repeated to allow data capture on ESR - informed that this is currently not shown for staff who have completed within a 3 year period prior to launch of ESR
B - Investigations around how best to represent this indicator with information available is ongoing
C - December

(5a) Community DNA rates
A - Number of patients have multiple DNAs and therefore inflate the percentage
B - .
The housebound policy second draft has gone to CCG and primary care for comments. Need to scope estates in terms of clinic space and understand the percentage of DV that can be converted to clinic setting. Managed through PMO as part of efficiency stream
C - March 2016

252

	1 Enhancing quality of life for people with a Long Term condition (LTC)	Target	Current Month		YTD		YTD 14/15
a	Home equipment delivery < 7 days	95%	99.2%		99.4%		96.3%
b	% Patient died in preferred place of death	95%	100.0%		100.0%		95.6%
c	% of people that died who were expected to die and had an advance care plan	Indicator suspended pending new 'ICOD' pathway					
d	% District Nursing Patients with a care plan	90%	98.0%		98.2%		94.6%
e	% of patients with a LTC with a Calderdale Care Plan	90%	100.0%		87.7%		59.5%
f	% of patients under the care of the community specialist matron who have been readmitted to hospital with the same LTC in less than 30 days	<10%	3.3%		3.9%		1.4%

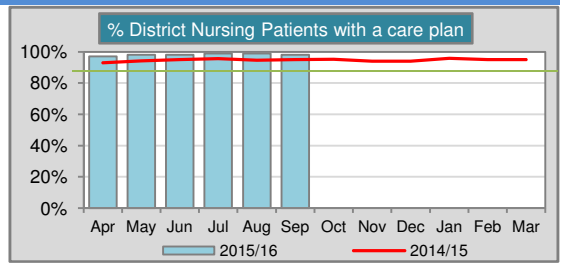
	2 Helping people to recover from episodes of ill health or following injury	Target	Current Month		YTD		YTD 14/15
a	% of leg ulcers healed within 12 weeks from diagnosis	75%	83.7%		93.0%		97.6%

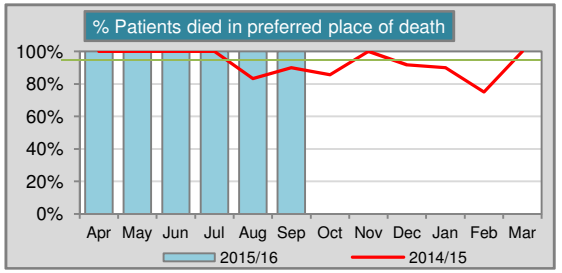
	3 Ensuring people have positive experience of care	Target	Current Month		YTD		YTD 14/15
a	Number of complaints	n/a	TBC		13		13
b	Number of complaints about staff attitude	n/a	TBC		0		0
c	Community AHP - 18 week RTT Snapshot at month end	95%	TBC		92.8%		89.7%
d	Community Friends and Family Test	n/a	92.0%		90.8%		N/A

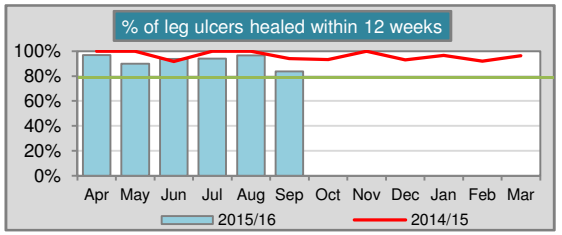
	4 Treating and caring for people in a safe environment; and protecting them from avoidable harm	Target	Current Month		YTD		YTD 14/15
a	% of patients in receipt of community nursing services that have had a pressure ulcer screening and this is documented in their care plan	90%	84.0%		84.8%		89.6%
b	Number of community acquired grade 3 or 4 pressure ulcers	<1.8	TBC		14		7
c	Number of falls that caused harm whilst patient was in receipt of Comm Services	<1.1	TBC		12		9
d	Patient safety thermometer - coverage - Harm free	>95%	95.5%		94.8%		94.1%
e	Patient safety thermometer - No of Harms Reported	<22.1	18		120		151
f	% of staff that have undertaken safeguarding / mental capacity act training	95%	46.7%		64.1%		67.8%

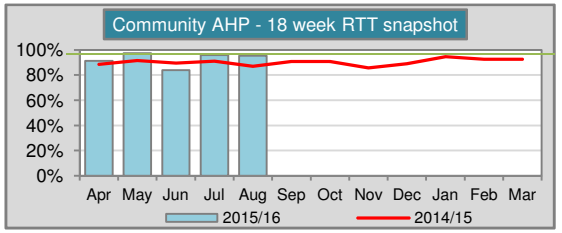
	5 Activity & Resource efficiency	Baseline	Current Month		YTD		YTD 14/15
a	Community DNA Rates	<1%	1.4%		1.2%		1.1%
b	Sickness Absence rate	<4%	TBC		3.0%		4%

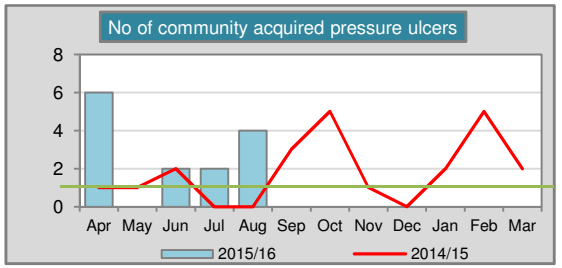
Target











INCOME AND EXPENDITURE COMPARED TO PLAN SUBMITTED TO MONITOR IN MAY 2015

YEAR TO DATE POSITION: M06

CLINICAL ACTIVITY

	M06 Plan	M06 Actual	Var
Elective	4,532	4,180	(352)
Non Elective	24,216	24,939	723
Daycase	21,757	20,065	(1,692)
Outpatients	164,663	160,951	(3,712)
A & E	75,173	73,652	(1,521)

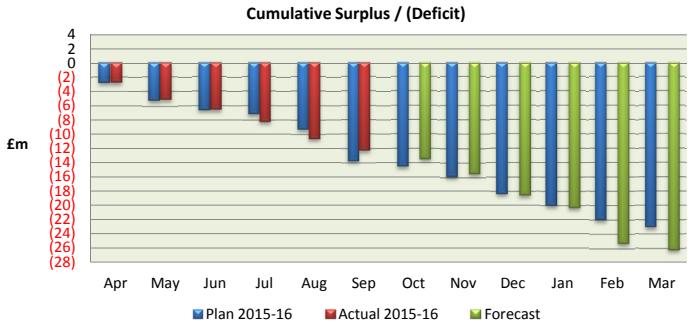
TRUST: INCOME AND EXPENDITURE

	M06 Plan	M06 Actual	Var
	£m	£m	£m
Elective	£11.41	£10.68	(£0.74)
Non Elective	£39.55	£41.07	£1.52
Daycase	£14.78	£12.92	(£1.87)
Outpatients	£19.82	£19.62	(£0.20)
A & E	£7.91	£7.97	£0.06
Other-NHS Clinical	£58.10	£58.34	£0.24
CQUIN	£3.35	£3.36	£0.01
Other Income	£18.70	£18.09	(£0.62)
Total Income	**£173.63**	**£172.04**	**(£1.59)**
Pay	(£111.59)	(£112.02)	(£0.43)
Drug Costs	(£15.66)	(£15.46)	£0.20
Clinical Support	(£15.53)	(£15.06)	£0.47
Other Costs	(£22.88)	(£23.18)	(£0.30)
PFI Costs	(£5.96)	(£5.91)	£0.05
Total Expenditure	**(£171.62)**	**(£171.63)**	**(£0.01)**
EBITDA	**£2.01**	**£0.41**	**(£1.60)**
Non Operating Expenditure	(£12.72)	(£12.55)	£0.16
Deficit excl. Restructuring	**(£10.71)**	**(£12.14)**	**(£1.43)**
Restructuring Costs	(£3.00)	(£0.10)	£2.90
Surplus / (Deficit)	**(£13.71)**	**(£12.24)**	**£1.47**

DIVISIONS: INCOME AND EXPENDITURE

	M06 Plan	M06 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	£10.36	£9.20	(£1.16)
Medical	£13.40	£11.53	(£1.88)
Families & Specialist Services	(£1.25)	(£1.43)	(£0.19)
Community	£2.95	£3.19	£0.25
Estates & Facilities	(£14.18)	(£13.03)	£1.15
Corporate	(£10.20)	(£10.68)	(£0.49)
THIS	£0.19	£0.14	(£0.05)
PMU	£1.41	£0.82	(£0.59)
Central Inc/Technical Accounts	(£14.96)	(£11.42)	£3.54
Reserves	(£1.44)	(£0.56)	£0.88
Surplus / (Deficit)	**(£13.71)**	**(£12.24)**	**£1.47**

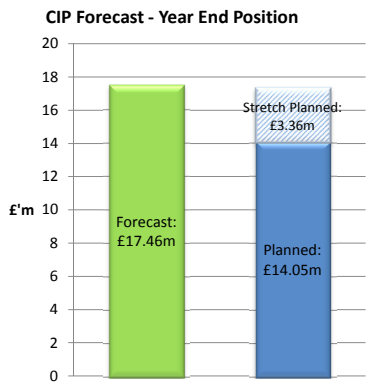
TRUST SURPLUS / (DEFICIT)



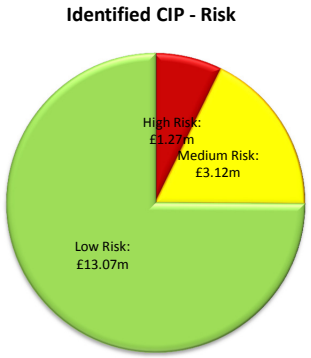
KEY METRICS

	Year To Date M06 Plan	Year To Date M06 Actual	Year To Date Var	Year End: Forecast Plan	Year End: Forecast Forecast	Year End: Forecast Var
	£m	£m	£m	£m	£m	£m
I&E: Surplus / (Deficit)	(£13.71)	(£12.24)	£1.47	(£23.01)	(£26.21)	(£3.20)
Capital (forecast Plan)	£12.66	£9.62	£3.04	£20.72	£20.53	£0.19
Cash	£1.92	£8.61	£6.69	£1.92	£1.97	£0.05
CIP	£5.64	£6.93	£1.29	£14.05	£17.46	£3.41
	Plan	**Actual**		**Plan**	**Forecast**	
Financial Sustainability Risk Rating	2	2		2	2	

COST IMPROVEMENT PROGRAMME (CIP)



Total Planned: £14.05m



Total Forecast £17.46m

YEAR END 2015/16

CLINICAL ACTIVITY

	Plan	Forecast	Var
Elective	9,185	8,446	(739)
Non Elective	49,263	50,908	1,645
Daycase	43,731	40,950	(2,781)
Outpatients	327,200	322,051	(5,149)
A & E	146,774	143,804	(2,970)

TRUST: INCOME AND EXPENDITURE

	Plan	Forecast	Var
	£m	£m	£m
Elective	£23.39	£21.75	(£1.64)
Non Elective	£79.89	£83.45	£3.56
Daycase	£30.25	£26.52	(£3.73)
Outpatients	£39.45	£39.95	£0.50
A & E	£15.49	£15.57	£0.08
Other-NHS Clinical	£117.49	£115.17	(£2.32)
CQUIN	£6.69	£6.75	£0.06
Other Income	£38.90	£38.44	(£0.46)
Total Income	**£351.55**	**£347.60**	**(£3.95)**
Pay	(£224.98)	(£226.80)	(£1.82)
Drug Costs	(£32.05)	(£30.83)	£1.21
Clinical Support	(£31.15)	(£29.60)	£1.55
Other Costs	(£45.94)	(£45.60)	£0.34
PFI Costs	(£11.92)	(£11.87)	£0.05
Total Expenditure	**(£346.04)**	**(£344.70)**	**£1.34**
EBITDA	**£5.51**	**£2.90**	**(£2.61)**
Non Operating Expenditure	(£25.52)	(£25.11)	£0.41
Deficit excl. Restructuring	**(£20.01)**	**(£22.21)**	**(£2.20)**
Restructuring Costs	(£3.00)	(£4.00)	(£1.00)
Surplus / (Deficit)	**(£23.01)**	**(£26.21)**	**(£3.20)**

DIVISIONS: INCOME AND EXPENDITURE

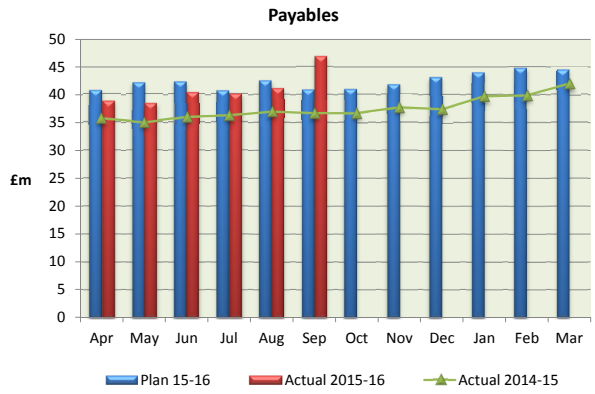
	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	£21.30	£19.35	(£1.95)
Medical	£26.18	£21.88	(£4.30)
Families & Specialist Services	(£1.56)	(£1.69)	(£0.13)
Community	£5.77	£5.75	(£0.01)
Estates & Facilities	(£28.64)	(£27.52)	£1.12
Corporate	(£20.18)	(£22.35)	(£2.18)
THIS	£0.53	£0.42	(£0.11)
PMU	£3.16	£2.96	(£0.20)
Central Inc/Technical Accounts	(£25.20)	(£25.01)	£0.19
Reserves	(£4.38)	£0.00	£4.38
Surplus / (Deficit)	**(£23.01)**	**(£26.21)**	**(£3.20)**

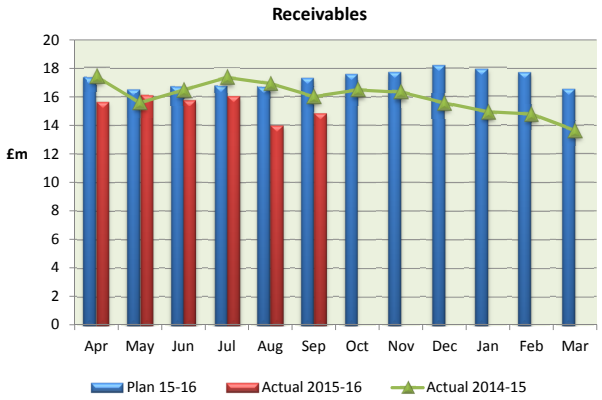
Board of Directors Integrated Performance Report

CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO MONITOR IN MAY 2015

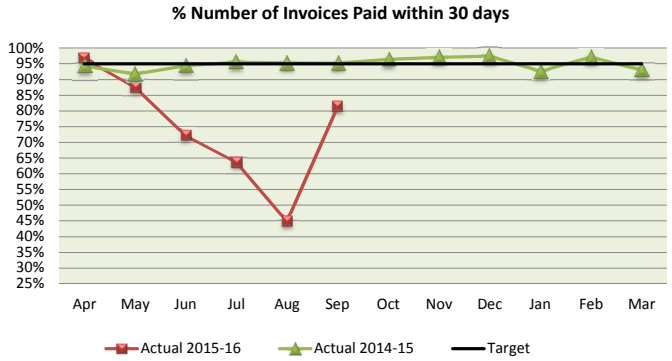
WORKING CAPITAL

	M06 Plan £m	M06 Actual £m	Var £m	M06
Payables	(£40.91)	(£46.93)	£6.02	
Receivables	£17.31	£14.84	£2.47	



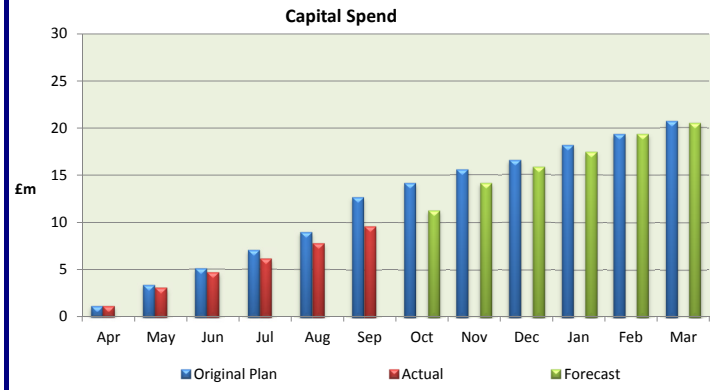


BETTER PAYMENT PRACTICE CODE



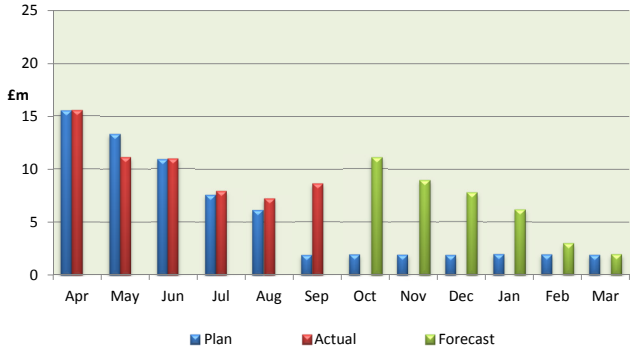
CAPITAL

	M06 Plan £m	M06 Actual £m	Var £m	M06
Capital	£12.66	£9.62	£3.04	

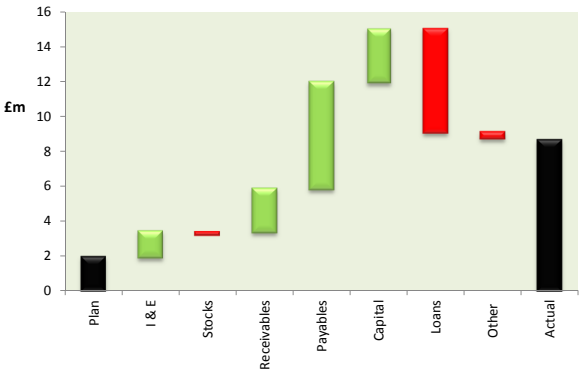


CASH

	M06 Plan £m	M06 Actual £m	Var £m	M06
Cash	£1.92	£8.61	£6.69	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- The year to date deficit (excluding restructuring costs) is £12.14m versus a planned deficit of £10.71m.
- The overall deficit is £12.24m less than the planned £13.71m, due to restructuring costs not being incurred in the year to date
- Elective and daycase activity have fallen further behind planned levels in month with an adverse impact on income.
- Pay expenditure remains high including significant levels of agency staffing expenditure.
- Capital expenditure year to date is £9.62m against the planned £12.66m with due to timing differences mainly on IT spend.
- Cash balance is £8.61m against a planed £1.92m, due predominantly to securing cash payments in advance for clinical activity
- CIP schemes delivered £6.93m in the year to date against a planned target of £5.64m.
- The new Monitor performance measure Financial Sustainability Risk Rating (FSRR) stands at 2 against a planned level of 2.

SUMMARY FORECAST

- The forecast year end deficit (excluding restructuring costs) is £22.21m against a planned £20.01m, an adverse variance of £2.20m. This position includes full release of remaining contingency reserves and delivery of £17.46m CIP against the original planned £14m.
- This is a slight worsening on the forecast at Month 5. This adverse position is driven by the ongoing impact of the activity, income and pay expenditure pressures seen in the year to date and costs associated with additional bed capacity.
- No further contingency reserves remain to cover other pressures and risks.
- Efforts must continue to be focussed on delivering planned activity by increasing productivity and containing pay spend particularly agency costs.
- The year end cash balance relies on external cash support of £18m, this is higher than originally planned due to the forecast increased deficit.
- Year end capital expenditure is forecast to be £20.53m against the planned planned £20.72m. The year end FSRR is forecast to be at level 2.

RAG KEY: (Excl: Cash)

- Actual / Forecast is on plan or an improvement on plan
- Actual / Forecast is worse than planned by <2%
- Actual / Forecast is worse than planned by >2%

NB. In addition to the above rules, if Capital expenditure <85% of that planned then Red, (per Monitor risk indicator).

RAG KEY - Cash:

- At or above planned level or > £18.6m (20 working days cash)
- < £18.6m (unless planned) but > £9.3m (10 working days cash)
- < £9.3m (less than 10 working days cash)

Calderdale and Huddersfield NHS
NHS Foundation Trust

CQUINS Performance Report 2015-16

compassionate care

Goal Number	Goal Name	Current Target	Q1	Q2	Q3	Q4	Q4 Target	Commentary
1	Acute Kidney Injury	21%	22%	32%			90%	Improvement Work Required
2a	Sepsis	Baseline	88%	40%			90%	Improvement Work Required
2b	Sepsis	Baseline	41%	63%			90%	Improvement Work Required
3	Urgent care	85%	86%	88%			85%	On Plan
4.1	Dementia	90%/90%/90%	91%/99%/100%	91%/99%/100%			90%/90%/90%	On Plan
4.2	Dementia	Written Report	n/a	Y			Written Report	On Plan
4.3	Dementia	Written Report	n/a	Y			Written Report	On Plan
5.1	Respiratory - Asthma	Q2 = 70%	66%	80%			75%	On Plan
5.2	Respiratory - Pneumonia	Q2 = 65%	70%	78%			75%	On Plan
6	Diabetes	50%	74%	64%			50%	On Plan
7.1	Improving Medicines Safety	80%/70%	80%/73%	82%/88%			80%/70%	On Plan
7.2	Improving Medicines Safety	Development	Y	Y			TBC	Target to be set after Q2
8	End of Life Care	Monitoring	36%	44%			Monitoring	On Plan
9.1	Hospital Food	Baselining	78%	76%			TBC	Target to be set after Q2
9.2	Hospital Food	Baselining	5.48%	0.0%			TBC	Target to be set after Q2
9.3	Hospital Food	Written Report	Y	Y			Written Report	On Plan

Acute Kidney Injury - Q4 Achievement Plan

A step change in performance is expected d once the changes to the Electronic Discharge summary take effect. This was implemented it the end of September 2015 and early results are promising.
In additional the to the changes on technology, the CQUIN concept and components were introduced to new junior doctors through Trust induction in August 2015

Divisional directors have been contacted regarding the CQUIN elements and importance of delivery via e-mail in August 2015

A procedure for informing non-complying clinical team for auctioning in Q3 has been agreed
Weekly monitoring of the CQUIN to commence in Q3 to allow a more proactive management of the CQUIN delivery programme

Weekly Monitoring of performance sine October 2015

Sepsis - Q4 Achievement Plan

Intensive improvement work is needed throughout the trust to ensure robust processes for screening applicable patients on admission, and ensuring that when indicated those patient get antibiotics within an 1hour.

There is some way to go to achieve the Q4 position, as such a safety and improvement nurse has been deployed to work with the ward and Sepsis Nurse Consultant to implement sustainable and high quality processes.

There has been additional education rolled out to junior ED and medical teams on induction.
Improvement is expected gradually over the next 6 months and a trajectory will be in place to ensure we are on track. Weekly monitoring programme agreed with the audit team and results will be fed back to the clinical teams.

Financial CQUINS Performance Report as at month 6

Goals - CCG CQUINs **6,270,712**

Goal Number	Goal Name	Value of CQUIN (£)	Q1	Q2	Q3	Q4
1	Acute Kidney Injury	627,071	62,707	125,414	125,414	313,536
2a	Sepsis	313,536	78,384	78,384	78,384	78,384
2b	Sepsis	313,536		62,707	125,414	125,414
3	Urgent care	1,254,142	125,414	376,243	376,243	376,243
4.1	Dementia	250,828	62,707	62,707	62,707	62,707
4.2	Dementia	125,414		62,707		62,707
4.3	Dementia	250,828		125,414		125,414
5.1	Respiratory - Asthma	250,828	62,707	62,707	62,707	62,707
5.2	Respiratory - Pneumonia	376,243	94,061	94,061	94,061	94,061
6	Diabetes	627,071	156,768	156,768	156,768	156,768
7.1	Improving Medicines Safety	125,414	31,354	31,354	31,354	31,354
7.2	Improving Medicines Safety	501,657	125,414	125,414	125,414	125,414
8	End of Life Care	627,071		313,536		313,536
9.1	Hospital Food	250,828		125,414		125,414
9.2	Hospital Food	250,828		50,166	100,331	100,331
9.3	Hospital Food	125,414				125,414
	TOTAL	**6,270,712**	**799,516**	**1,852,995**	**1,338,797**	**2,279,404**

High risk
Moderate risk
No known risk

NHS England **421,193**

Goal Name	Value of CQUIN (£)	Q1	Q2	Q3	Q4
NICU	38,051	9,513	9,513	9,513	9,513
Oncotype DX	38,051	9,513	9,513	9,513	9,513
QIPP	126,836	31,709	31,709	31,709	31,709
Vac and Immunisations	90,860	22,715	22,715	22,715	22,715
National CQUIN	22,715	5,679	5,679	5,679	5,679
Health Visitor Building Community Capacity	104,680	26,170	26,170	26,170	26,170
TOTAL	**421,193**	**105,298**	**105,298**	**105,298**	**105,298**

GRAND TOTAL	**6,691,905**	**904,814**	**1,958,294**	**1,444,095**	**2,384,702**

Calderdale and Huddersfield NHS
NHS Foundation Trust

Best Practice Tariff

compassionate care

BPT No.	INDICATOR	METRIC	Q1 Apr	Q1 May	Q1 Jun	Q2 Jul	Q2 Aug	Q2 Sep	Q3 Oct	Q3 Nov	Q3 Dec	Q4 Jan	Q4 Feb	Q4 Mar	YTD	Q1	Q2	Q3	Q4
BP01	BPT STROKE DIRECT ADMISSION AND 90% STAY	No. of stroke patients directly admitted to ASU, who also spent 90% of their spell on ASU	26	28	30	22	25								131	84	47		
		% Achieved BPT	59.1%	66.7%	68.2%	48.9%	46.3%								57.2%	64.6%	48.9%		
		Additional Income Available	£45,144	£43,092	£45,144	£46,170	£55,404								£234,954	£133,380	£101,574		
	TARIFF PER SPELL £1,026	Income Achieved	£26,676	£28,728	£30,780	£22,572	£25,650								£134,406	£86,184	£48,222		
		Income Lost	£18,468	£14,364	£14,364	£23,598	£29,754								£100,548	£47,196	£53,352		
BP01	RAPID BRAIN IMAGING	No. of stroke patients who had their initial brain imaging delivered in accordance with best practice guidelines**	32	33	33	35	48								181	98	83		
		% Achieved BPT	72.7%	78.6%	75.0%	77.8%	88.9%								79.0%	75.4%	77.8%		
		Additional Income Available	£17,556	£16,758	£17,556	£17,955	£21,546								£91,371	£51,870	£39,501		
	TARIFF PER SPELL £399	Income Achieved	£12,768	£13,167	£13,167	£13,965	£19,152								£72,219	£39,102	£33,117		
		Income Lost	£4,788	£3,591	£4,389	£3,990	£2,394								£19,152	£12,768	£6,384		
BP17	DIAGNOSIS AND TREATMENT WITHIN 24 HOURS	No. of high risk TIA patients diagnosed and treated within 24 hours	22	35	31	23	32								143	88	55		
		% Achieved BPT	68.8%	85.4%	86.1%	69.7%	86.5%								79.9%	80.7%	69.7%		
		Additional Income Available	£3,232	£4,141	£3,636	£3,333	£3,737								£18,079	£11,009	£7,070		
	TARIFF PER ATTENDANCE £101	Income Achieved	£2,222	£3,535	£3,131	£2,323	£3,232								£14,443	£8,888	£5,555		
		Income Lost	£1,010	£606	£505	£1,010	£505								£3,636	£2,121	£1,515		
BP02		Adult Renal Dialysis	Not applicable to CHFT																
BP03	Daycase	No. of Daycase	140	131	154	155	116	135							831	425	406		
		% Achieved BPT	53.6%	58.0%	57.8%	63.2%	50.0%	64.4%							58.1%	56.5%	59.9%		
		Additional Income Available																	
	TARIFF PER SPELL	Income Achieved																	
		Income Lost																	

BPT No.	INDICATOR	METRIC	Q1 Apr	Q1 May	Q1 Jun	Q2 Jul	Q2 Aug	Q2 Sep	Q3 Oct	Q3 Nov	Q3 Dec	Q4 Jan	Q4 Feb	Q4 Mar	YTD	Q1	Q2	Q3	Q4
BP04	Diabetic Ketoacidosis Hypoglycaemia	No of patients diagnosed with Diabetic Ketoacidosis Hypoglycaemia	8	6	6	4	13	7							44	20	24		
		No of patients who met all criteria of the BPT	5	4	1	2	4	4							20	10	10		
		% Achieved BPT	62.5%	66.7%	16.7%	50.0%	30.8%	57.1%							45.5%	50.0%	41.7%		
	TARIFF PER SPELL	Additional Income Available	£1,348	£1,011	£1,011	£1,072	£2,376	£1,147							£7,964	£3,369	£4,595		
		Income Achieved	£842	£674	£168	£252	£742	£742							£3,421	£1,685	£1,736		
		Income Lost	£505	£337	£842	£820	£1,634	£405							£4,544	£1,685	£2,859		
BP05		Early Inflammatory Arthritis	currently not being captured by the Service																
BP06	Endoscopy	No. of Endoscopy																	
		% Achieved BPT																	
	TARIFF PER SPELL	Additional Income Available																	
		Income Achieved																	
		Income Lost																	
BP07	Fragility Hip Fracture (inc #NOF)	No. of Fragility Hip Fracture (inc #NOF)	45	45	43	39	36								208	133	75		
		No of patients who met all criteria of the BPT	24	21	30	26	21								122	75	47		
		% Achieved BPT	53.3%	46.7%	69.8%	66.7%	58.3%	0.0%							58.7%	56.4%	62.7%		
	TARIFF PER SPELL	Additional Income Available	-	-	-	-	-								-	-	-	-	-
		Income Achieved	£32,040	£28,035	£40,050	£34,710	£28,035									£100,125	£62,745		
		Income Lost	£28,035	£32,040	£17,355	£17,355	£20,025									£77,430	£37,380		
BP08	Interventional Radiology	No. of Interventional Radiology																	
		% Achieved BPT																	
	TARIFF PER SPELL	Additional Income Available																	
		Income Achieved																	
		Income Lost																	
		No. of Major Trauma																	

Calderdale and Huddersfield NHS
NHS Foundation Trust

Best Practice Tariff

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			Q1			Q2			Q3			Q4							
BPT No.	INDICATOR	METRIC	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Q1	Q2	Q3	Q4
BP09	Major Trauma	% Achieved BPT		0.0%	0.0%	0.0%	0.0%												
		Additional Income Available																	
	TARIFF PER SPELL	Income Achieved																	
		Income Lost																	
BP10	Outpatient Procedures	No. of Outpatient Procedures																	
		% Achieved BPT																	
		Additional Income Available																	
	TARIFF PER SPELL	Income Achieved																	
		Income Lost																	
BP11	Paediatric Diabetes	No. of Paediatric Diabetes	14	14	16	20	16	19							99	44	55		
		% Achieving BPT	94.4%	94.4%	94.4%	93.2%	93.2%	93.2%							93.8%	94.4%	93.2%		
		Additional Income Available	-	-	-	-	-	-											
	TARIFF PER SPELL	Income Achieved	£42,803	£42,803	£49,918	£61,147	£48,918	£58,090							£303,679	£135,524	£168,155		
		Income Lost	£0	£0	£0	£0	£0	£0							£0	£0	£0		
BP12	Paediatric Epilepsy	No. of Paediatric Epilepsy	50	33	35	32	53	30							233	118	115		
		% Achieved BPT	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%							100.0%	100.0%	100.0%		
		Additional Income Available	-	-	-	-	-	-							-				
	TARIFF PER SPELL	Income Achieved	£1,800	£1,188	£1,260	£1,152	£1,908	£1,080							£8,388	£4,248	£4,140		
		Income Lost	£0	£0	£0	£0	£0	£0							£0	£0	£0		
BP13		Parkinsons	currently not being captured by the Service																

Calderdale and Huddersfield NHS
NHS Foundation Trust

Best Practice Tariff

compassionate care

BPT No.	INDICATOR	METRIC	Q1 Apr	Q1 May	Q1 Jun	Q2 Jul	Q2 Aug	Q2 Sep	Q3 Oct	Q3 Nov	Q3 Dec	Q4 Jan	Q4 Feb	Q4 Mar	YTD	Q1	Q2	Q3	Q4
BP14	Pleural Effusion	No of Pleural Effusion HRG Spells - DZ06Z, DZ16B, DZ16C	4	7	5	3	3	9							31	16	15		
		No of Planned Day Case Spells		1	4	1		1							7	5	2		
		% Achieving BPT as a D/C	0.0%	14.3%	80.0%	33.3%	0.0%	11.1%							22.6%	31.3%	13.3%		
		Income Achieved		£1,361	£5,444	£1,361		£1,361							£9,527	£6,805	£2,722		
BP15	Primary Total Hip and Knee Replacement	No. of Primary Total Hip and Knee Replacement																	
		% Achieved BPT																	
		Additional Income Available																	
	TARIFF PER SPELL	Income Achieved																	
		Income Lost																	
BP16	Same day Emergency Care	No. of Same day Emergency Care	613	711	713	731	681	736							4185	2037	2148		
		Zero Length of Stay	254	299	284	316	288	324							1765	837	928		
		% Achieved BPT	41.4%	42.1%	39.8%	43.2%	42.3%	44.0%							42.2%	41.1%	43.2%		
		Additional Income Available																	
	TARIFF PER SPELL	Income Achieved																	
		Income Lost																	
BP18	Heart Failure	No. of Non Elective Inpatient Spells with HRG EB03H or EB03I who had a primary diagnosis of Heart Failure	72	62	50	48	38								270	184	86		
		No. of HF patients who have had a face-to-face review with a specialist member of the HF team.	32	25	18	21	25								121	75	46		
		% Achieved BPT	44.4%	40.3%	36.0%	43.8%	65.8%								44.8%	40.8%	53.5%		
		Additional Income Available	£23,157	£20,837	£16,509	£15,393	£13,788								£89,684	£60,503	£29,181		
	TARIFF PER SPELL	Income Achieved	£0	£0	£0	£0	£13,788								£13,788		£13,788		
		Income Lost	£23,157	£20,837	£16,509	£15,393	£0								£75,896	£60,503	£15,393		

Board of Directors Integrated Performance Report

A "Data Quality Assessment" is now being made for each indicator. These assessments are being provided by those responsible for the indicator's information provision each month, and then signed off by the indicator's lead manager.

It is a Red, Amber, Green (RAG) rating based on the evaluation of the following three questions -

1.What is the overall view for the robustness of the indicator documentation regards construction and completeness (RAG)?
2.What is the overall view regards the timeliness of the information for this indicator (RAG)?
3.What is the overall view regards the robustness of the collection for this indicator (RAG)?

The final rating for an indicator of Red Amber Green is assessed as follows -

Answers to the 3 Questions :	3 Green or 2 Green, 1 Amber	Final rating Green
	1 Green, 2 Amber or 3 Amber or 2 Green 1 Amber or 1 Green 1 Amber 1 Red	Final rating Amber
	Any other combination	Final rating Red

Any indicator that has its data quality assessment currently white has yet to be assessed or have its assessment signed off by the lead manager for the indicator.

Indicator	Board of Directors Integrated Performance Report	Source	Target/Threshold
% Variance against Plan	The actual activity levels against the planned activity levels. (Plan based on previous activity, financial / clinical constraints)	Trust reporting tool - Knowledge Portal.	Internally set target of 0% RED – More than 2% below plan GREEN – above plan AMBER – less than 2% below plan
Theatre Utilisation (TT)	The utilisation of theatre capacity, indicating how much time in theatre is lost due to lack of utilisation. TT stands for Touch Time and this utilisation is assessing the proportion of patient facing time against the time available.	Bluespier	Target Local of 92.5%. RED <90% AMBER between 90% and 92.5% GREEN >= 92.5%
% Daily Discharges - Pre 11am	% patients discharged from hospital prior to 11 am	Sophia database - admitted data sets (PAS)	Target Local of 40% RED <35% AMBER between 35% and 92.5% GREEN >= 92.5%.
Delayed Transfers of Care	% patients who discharge from hospital has been delayed (Delayed nights divided by Total Occupied nights in month (KH03))	Bed Nights - Sophia database (PAS feed) Delayed Bed Nights - Spreadsheet looked after by patient flow.	Target Local of 5% RED >5.5% AMBER between 5% and 5.5% GREEN < 5%
Green Cross Patients (Snapshot at month end)	Count of patients on wards who are recorded on the Visual Hospital as medically stable for discharge.	Visual Hospital (HRI and CRH)	Target Local of 40 RED >44 AMBER between 40 and 44 GREEN <= 40
Number of Outliers (Bed Days)	The sum of bed-days within the month under the clinical care of one division (eg. a medical divisional consultant) but actually located in a ward that is managed by another division (eg. an orthopaedic ward) at midnight. If a patient is in the wrong divisions bed for more than one night, then each night is counted. Please note paediatrics wards, Intensive care wards and surgical patients on the Gynaecology ward are excluded from this indicator.	Bed Occupancy Cube from Sophia warehouse. Patients with a Treatment Function Code other than the Ward Divisions are classed as an outlier.	Target Local. Currently comparing to previous years actual figures. RED >= last year AMBER between 90% and 100% of last year GREEN < 90% of last year.
First DNA Rate	Patients that did not attend their first outpatient appointment, the threshold is less than or equal to 10% of all first appointments	Sophia database - outpatient data sets (PAS)	Target Local of 7% RED > 7.7% AMBER between 7% and 7.7% GREEN <= 7%
% Hospital Initiated Outpatient Cancellations	% outpatient appointments cancelled by the Trust	Trust reporting tool - Knowledge Portal. Target 17.6% based on previous years outturn.	Target Local RED > 18% AMBER between 17.60% and 18% GREEN <= 17.60%
Appointment Slot Issues on Choose & Book	% of patients who experience an appointment slot issue when attempting to use Choose and book to book an appointment	Choose & Book Website	Target Local. 5% RED > 18% AMBER between 17.60% and 18% GREEN <= 17.60%

Indicator	Board of Directors Integrated Performance Report	Source	Target/Threshold
No of Spells with Ward Movements	Patients on all wards who have moved from one ward to another more than twice in their stay. Excludes specific wards to account for diagnostic tests etc.	Sophia data warehouse (APCEncounter, WardStay, LastWardStayInSpell and WardStay)	Target Local. 2% RED > 2.2% AMBER between 2.0% and 2.2% GREEN <= 2.0%
% Non-admitted closed Pathways under 18 weeks	Patients that are referred for treatment that doesn't involve an admission receive their first definitive treatment within 18 weeks of referral. The threshold is 95%.	Sophia database	Nationally set target of 95%. RED – below 94% GREEN – 95% or above AMBER – 94% to 95%
% Admitted Closed Pathways Under 18 Weeks	Patients that have a decision to treat should be admitted within 18 weeks of the start of their referral to treatment pathway. The threshold is 90%.	Sophia database	Nationally set target of 90%. RED – below 89% GREEN – 90% or above AMBER – 89% to 90%
% Incomplete Pathways <18 Weeks	Incomplete pathways are waiting times for patients still waiting to start treatment. The threshold is 92%	Sophia database	Nationally set target of 92%. RED – below 91% GREEN – 92% or above AMBER – 91% to 92%
18 weeks Pathways >=26 weeks open		Sophia database	Locally set target of zero patients. .RED – greater than 10 patients GREEN – zero patients AMBER – 1 - 9 patients Not available at divisional level
18 weeks Pathways >=40 weeks open		Sophia database	Locally set target of zero patients. RED – greater than 10 patients GREEN – zero patients AMBER – 1 - 9 patients Not available at divisional level
% Diagnostic Waiting List Within 6 Weeks	Patients referred into the hospital for a diagnostic test will wait no longer than 6 weeks for that test as the percentage of the total volume waiting. Target 99%	Sophia database	Nationally set target of 99%. RED – below 98% GREEN – 99% or above AMBER – 98% to 99%
Community AHP - 18 Week RTT Activity	% Patients who have completed an 18 weeks pathway for community services	SystmOne reporting tool	Internally set target of 95%. RED – below 91% GREEN – 95% or above AMBER – 92 to 94% to 99%
Cancellations to Elective Surgery	Patients who are listed for a surgical procedure who are cancelled by the Hospital with less than 24 hours' notice. The threshold is less than or equal to 0.6% of elective admissions.	Elective admissions - Sophia database (PAS admitted dataset) Cancellations - Theatres Manual SitRep process spreadsheet	Target Local. 0.6% RED > 0.66% AMBER between 0.60% and 0.66% GREEN <= 0.60%
Two Week Wait From Referral to Date First Seen	Patients that have a suspected cancer diagnosis and sent on a 2 week wait faxed proforma should receive an appointment within 2 weeks of the date of the referral. The threshold is 93%	PPM	Target National. 93% RED < 92% AMBER between 92% and 93% GREEN >= 93%

Indicator	Board of Directors Integrated Performance Report	Source	Target/Threshold
Two Week Wait From Referral to Date First Seen: Breast Symptoms	Patients that have a suspected breast cancer diagnosis and sent on a 2 week wait faxed proforma should receive an appointment within 2 weeks of the date of the referral. The threshold is 93%	PPM	Target National. 93% RED < 92% AMBER between 92% and 93% GREEN >= 93%
31 Days From Diagnosis to First Treatment	Patients that have a cancer diagnosis should have a date for treatment within 31 days of the decision to treat them. The threshold is 96%	PPM	Target National. 96% RED < 95% AMBER between 95% and 96% GREEN >= 96%
31 Day Subsequent Surgery Treatment	Patients that have a decision to treat them surgically for a cancer diagnosis should have a date for their treatment within 31 days of the decision to treat them. The threshold is greater than or equal to 94%.	PPM	Target National. 94% RED < 93% AMBER between 93% and 94% GREEN >= 94%
31 day wait for second or subsequent treatment drug treatments	Patients that have a decision to treat with medication for a diagnosis of cancer should receive their first definitive treatment of drugs within 31 days of the decision to treat them. The threshold is greater than or equal to 98%	PPM	Target National. 98% RED < 96% AMBER between 96% and 98% GREEN >= 98%
62 Day Aggregated Gp Urgent Referral To Treatment And Screening Referral To Treatment	Patients that are referred via the screening service with a suspected cancer diagnosis should receive their first definitive treatment within 62 days of the date of the referral. The threshold is 86%	PPM	Target National. 86% RED < 85% AMBER between 85% and 86% GREEN >= 86%
62 Day Gp Referral to Treatment	Patients that are referred to the hospital with a suspected diagnosis of cancer should be treated within 62 days of the date of the referral. The threshold is 85%	PPM	Target National. 85% RED < 84% AMBER between 84% and 85% GREEN >= 85%
62 Day Referral From Screening to Treatment	Patients that are referred via the screening service with a suspected cancer diagnosis should receive their first definitive treatment within 62 days of the date of the referral. The threshold is 90%	PPM	Target National. 90% RED < 89% AMBER between 89% and 90% GREEN >= 90%
A & E Targets	Measures the length of time the patients wait to be seen, have a decision to treat and spend in the department prior to either being discharged or admitted.	EDIS	Target National/Monitor. 95% RED < 94% AMBER between 94% and 95% GREEN >= 95%
Number of Mixed Sex Accommodation Breaches	Patients should be accommodated in single sex accommodation unless clinically indicated. Target is zero breaches of this indicator	Sophia database	Target National. 0 RED 1 and above GREEN 0
Complaints	All complaints received by the hospital from a patient or relative	Datix	
Total Concerns in the month	The number of patient concerns that have been raised	Datix	

Indicator	Board of Directors Integrated Performance Report	Source	Target/Threshold
CQUINS - % of diabetic patients supported to self-care	Commissioning for Quality innovation	Various sources	
CQUINS - Nutrition and Hydration			
CQUINS - Improving Medicines Safety			
CQUINS - Acute Kidney Injury (Reported quarterly)			
CQUINS - Sepsis Screening			
CQUINS - Respiratory Care Bundle			
CQUINS - End of Life Care Plan in place			
Percentage of non-elective inpatients 75+ screened for dementia	Assesses the proportion of patients aged 75+ who are at risk of dementia and ensures they are referred onward appropriately	Sophia Database	
Friends & Family Test	% of patients who complete a friends and family questionnaire following an inpatient admission	Ward Audits	
Falls	The number of patients who have fallen during their stay in hospital	Datix	
Pressure Ulcers Acquired at CHFT	The number of pressure ulcers reported as developed during a patients stay in hospital	Datix	
Percentage of Completed VTE Risk Assessments	% of Admissions in month that have had a VTE Risk Assessment on Admission.	PAS / K2 Maternity System / Manual Validations. (Future data source to include nerve centre forms)	Target National. 95% RED < 93% AMBER between 93% and 95% GREEN >= 95%
Percentage of Stage 1 RCAs completed for all Hospital Acquired Thrombosis	The stage 1 process for RCA's is to identify any Hospital Acquired Thrombosis (HAT) and investigate the episode of care to ensure the trusts VTE prevention policy has been followed correctly.	Episodes are identified from the certification database and reports from Radiology on positive PE's and DVT's	
% Harm Free Care	A tool which is used by clinician to monitor and record the presence and absence of pressure ulcers, falls, Urinary tract infections and New venous thromboembolisms (VTEs)		
Safeguarding Alerts	An alert is the formal raising with Social Services of a concern, suspicion or allegation of potential abuse or harm or neglect which may have arisen	Alerts recorded on Datix whether received by the Trust from Social Services or made by the Trust to Social Services	
World Health Organisation Check List	The WHO Surgical Safety Checklist was developed after extensive consultation aiming to decrease errors and adverse events, and increase teamwork and communication in surgery. The 19-item checklist is now used by a majority of surgical providers around the world.		

Indicator	Board of Directors Integrated Performance Report	Source	Target/Threshold
Missed Doses	Where medicine doses have been omitted, delayed or missed during shifts.	Ward Audits	
Patient Incidents	A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients	Datix	
Never Events	An event that should never happen, for example wrong site surgery or an instrument left in the patient post-surgery. The threshold is zero cases per year.	Datix	Target National. 0 RED 1 and above GREEN = 0
Duty of Candour	To ensure that providers are open and transparent with people who use their services and that Trusts act lawfully on their behalf when things go wrong with care and treatment	Datix and Risk Management incident register.	
Number of MRSA Bacteraemias – Trust assigned	Methicillin-resistant Staphylococcus aureus, This is no longer a monitor requirement however continuing to work to a de minimus of 6 cases after which contract penalties apply.	Infection Control Net (IC Net)	
Total Number of Clostridium Difficile Cases	The Foundation Trust has a target of no more than 21 cases per year attributable to the organisation.	Infection Control Net (IC Net)	
Number of MSSA Bacteraemias - Post 48 Hours	The number of MSSA infections acquired after 48 hours of a hospital stay	Infection Control Net (IC Net)	
% Hand Hygiene Compliance	The percentage of monthly hand hygiene observations which have been done to the required standard.	Hand Hygiene System	
MRSA Screening - Percentage of Inpatients Matched		Infection Control Net (IC Net)	
Number of E.Coli - Post 48 Hours	The number of E.Coli infections acquired after 48 hours of a hospital stay	Infection Control Net (IC Net)	
Central Line Infection rate per 1000 Central Venous Catheter days	The number of infection acquired in patient with a CVC line in situ. Each day a line is in is counted as one calendar day. This is scaled up to the number of patients with a line present	Departmental Audits	
Emergency Readmissions Within 30 Days	% patients readmitted (unplanned) back into hospital within 30 days of their discharge	Sophia database	Target Local (varies month on month for seasonality) 7.40% RED above 7.6% AMBER between 7.4% and 7.6% GREEN below 7.4%

Indicator	Board of Directors Integrated Performance Report	Source	Target/Threshold
Local SHMI - Relative Risk (1yr Rolling Data Oct 13- Sept 14)	The SHMI (Summary Hospital Mortality Index) is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It includes deaths which occur in hospital and deaths which occur outside of hospital within 30 days (inclusive) of discharge	HSCIC and summary analysis via HED (www.hed.nhs.uk)	
Hospital Standardised Mortality Rate (1 yr. Rolling Data Apr 14 - Mar 15)	The HSMR (Hospital Standardised Mortality Rate) is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 diagnosis groups in a specified patient group. The expected deaths are calculated from logistic regression models with a case-mix of: age band, sex, deprivation, interaction between age band and co-morbidities, month of admission, admission method, source of admission, the presence of palliative care, number of previous emergency admissions and financial year of discharge.	HED (www.hed.nhs.uk)	
Mortality Reviews – Month Deaths	The number of in hospital adult deaths which have been reviewed using the local mortality proforma	Mortality Knowledge Portal	Target Local. 100% RED below 95% AMBER between 95% and 100% GREEN = 100%
Crude Mortality Rate (Latest Month June 15)	Crude mortality is the number of inpatient and Daycase deaths as a proportion of all discharges	Knowledge Portal	Target Local. 1.21% RED above 1.23% AMBER between 1.21% and 1.23% GREEN below 1.21%
Average Diagnosis per Coded Episode	The average number of clinical diagnostic codes that each admitted finished consultant episode attracts based on the information that can be coded from the clinical record	Knowledge Portal	Target Local. 4.9 RED < 4.7 AMBER between 4.7 and 4.9 GREEN >= 4.9
Completion of NHS numbers within commissioning datasets submitted via SUS	The activity submitted to the Secondary Care User Service is fully complete with the patient NHS number	Knowledge Portal	Target Contract 99% RED < 98.8% AMBER between 98.8% and 99% GREEN >= 99%

Indicator	Board of Directors Integrated Performance Report	Source	Target/Threshold
Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours	% of hip fracture patients who are receive surgery within 36 hours as a percentage of those receiving surgery.	The National Hip Fracture Database	Internally set target at 85% to allow for patients who are too ill and will not be operated on as this is in their best interest.
↑ ↓ →	Flow of direction of activity		
RAG Rating (Also called Traffic light rating)	RED – Not achieving the set target GREEN – Achieving the set target AMBER – Not achieving the target by 10%	-	-

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 29th October 2015	**Sponsoring Director:** Keith Griffiths, Director of Finance
Title and brief summary: MONTH 6 - FINANCIAL NARRATIVE - SEPTEMBER 2015 - The Board is asked to approve the Month 6 Financial Narrative.	
Action required: Approve	
Strategic Direction area supported by this paper: Financial Sustainability	
Forums where this paper has previously been considered: Finance and Performance Committee - 20.10.15	
Governance Requirements: Financial Sustainability	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve the Month 6 Financial Narrative.

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

The Board is asked to approve the Month 5 Financial Narrative.

Appendix

Attachment:

BOD Financial Narrative Month 6 15_16.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

MONTH 6 SEPTEMBER 2015/16 FINANCIAL NARRATIVE

Purpose
This paper provides a narrative to accompany the monthly financial dashboard and will focus on the key messages within the month and year-end forecast and is presented in three sections**:**

- Key messages;
- Detailed Commentary for the Reporting Period;
- Financial Sustainability Risk Rating (FSRR) and forecast.

This paper has previously been discussed at the Finance & Performance Committee held on 20 September 2015.

1. Key Messages

The year to date financial position is in line with last month's forecast trajectory at a £1.43m year to date adverse variance from plan (excluding restructuring costs). The forecast year end position is also maintained close to the level forecast last month at a £22.21m deficit against a planned deficit of £20.00m excluding restructuring costs.

As reported previously, the downturn in the elective trading position seen from July, coupled with the Board's decision to increase bed capacity to accommodate increasing non elective activity, has impacted on the year-end forecast.

Month 6, September Position

Income and Expenditure Summary	Plan £m	Actual £m	Variance £m
EBITDA	**2.01**	**0.41**	**(1.60)**
Deficit excluding restructuring	**(10.71)**	**(12.14)**	**(1.43)**
Restructuring costs	**(3.00)**	**(0.10)**	**2.90**
Deficit including restructuring	**(13.71)**	**(12.24)**	**1.47**

- An EBITDA of £0.41m, an adverse variance from plan of 1.60m.
- A deficit of £12.14m, an adverse variance of £1.43m from the planned position.
- Delivery of CIP of £6.88m against the planned level of £5.64m.
- Contingency reserves released of £0.95m against year to date pressures.
- Capital expenditure of £9.62m, below the planned level of £12.66m.
- A cash balance of £8.61m, above the planned level of £1.92m.
- A Financial Sustainability Risk Rating (FSRR) of level 2, in line with plan (restated from Continuity of Service Risk Rating of level 1).

2. Detailed Commentary for the Reporting Period

Statement of Comprehensive Income (SOCI)

The month 6 position has held in line with the forecast projections made last month at the bottom line although there have been some variations within individual elements of

the position. Planned day case and elective income is beneath the forecast levels, offset in part by associated expenditure reductions. Commercial income generation has also delivered below the forecast level. Offsetting these pressures in month, the Trust has been successful in securing other non-clinical income which had previously been provided against as bad debt.

Within the year to date, the planned bed capacity has been exceeded across the entirety of quarters 1 and 2. The plan anticipated a reduction in the required bed capacity in quarter 2 based on the seasonality of demand, and the actual number of beds has reduced but is still in excess of plan overall. This continues to drive additional medical and nursing pay spend. In mitigation, £0.35m contingency reserves have been released in Month 6 in line with forecast requirements and in addition to the £0.60m already released.

In summary the main cumulative variances behind the year to date position are:

Operating income	(£1.59m) adverse variance
Operating expenditure	(£0.01m) adverse variance
EBITDA for calculation of FSRR	**(£1.60m) adverse variance**
Non-Operating items	£0.16m favourable variance
Restructuring costs	(£2.90m) favourable variance
Total	**£1.47m favourable variance**

Operating Income

There is a cumulative £1.59m adverse variance from plan within operating income.

NHS Clinical Income

Of the £1.59m adverse income variance, £0.97m is driven by NHS clinical income; the year to date over performance in non-elective activity is now outweighed by the underperformance against elective and day case activity

The activity position driving the reported PbR income is as follows:

- Planned day case and elective activity has continued to perform below plan by 7.8% (2044 spells) in the year to date. This is deterioration from month 5 with the worsening being mainly within day case.

- Non-elective admissions overall are above the month 6 plan by 6.7% (261 spells) which is an upturn from the performance seen in month 5. The increase from month 5 to month 6 is within both emergency long and short stay admissions. Cumulatively activity is now 3% above plan (723 spells).

- A&E attendances continue to be below plan and are 1.6% (195 attendances) below the month 6 plan. Cumulatively attendances are now below plan by 2% (1,521 attendances).

- Outpatient attendances are 3.5% (1,025 attendances) below plan in month 6 which is a continuation of the trend seen in prior months. The under-performance continues to be predominantly within follow-up attendances. Cumulatively outpatient activity is now 2.2% below plan (3,712 attendances).

- Adult Critical Care has seen an increase in month 6 and in the year to date is 3.5% (69 bed days) above plan.

- Pass through high cost drugs costs are below plan by £0.47m in the year to date.

In line with plan and in recognition of the outstanding income risks, allowance to the value of £1.04m has been made in the year to date in the anticipation of contract sanctions; any shortfall on CQUIN performance; and contract challenges under a full PbR contract.

Other income

Overall other income is £0.62m below the planned level. The Trust's Pharmacy Manufacturing Unit which generates commercial income had planned to exceed their prior year surplus delivery. As previously reported, there is a shortfall against this plan and this has increased from last month's forecast. This is now not expected to be fully recovered back to plan by year end, though plans for 16/17 are more resilient as sales and marketing efforts are paying dividends. There are a number of smaller adverse variances across other areas in the year to date. The Health Informatics Service which is also hosted by the Trust and operates commercially continues to generate revenue in excess of plan in the year to date.

Operating expenditure

There was a cumulative £0.01m adverse variance within operating expenditure across the following areas:

Pay costs	(£0.43m) adverse variance
Drugs costs	£0.20m favourable variance
Clinical supply and other costs	£0.22m favourable variance

Employee benefits expenses (Pay costs)

Pay costs are £0.43m above the planned level. However, within the pay position there is a benefit of £1.0m versus plan against contingency reserves as this has been released to mitigate against the pay pressures experienced in the clinical divisions. The value of the overall pay pressure seen operationally in the year to date is therefore £1.43m. Pay costs by staff group are analysed in detail at Appendix 1.

As previously reported, the largest single driver of the additional costs which have been incurred in the year to date is as a result of the Board recognising it needed additional bed capacity over and above the planned level. This is directly linked to dealing with the wider system resilience issues and has to be covered being by high cost non-contracted medical and nursing staff. In addition, recruitment difficulties continue to be an issue in certain specialties for medical staff.

The Trust is ensuring that pro-active measures are being taken to ensure that everything that is within our control to manage is duly focussed. As previously reported, the Trust is pursuing alternative options for the management of the flexible workforce to convert more nursing agency and overtime usage to bank staff removing premium payments where possible. A rolling programme to recruit substantive nursing staffing continues alongside this with a cohort of new graduate staff having recently started. In addition, the Monitor regulations introducing a percentage cap on agency nursing expenditure has been used as a lever in negotiation with agency providers. The Trust has taken on new providers through procurement frameworks and successfully agreed lower rates with some existing suppliers.

The next step that is being taken is the introduction of a new dedicated task force to refocus attention on attendance management through appropriate management of sickness absence, particularly for junior medical staff. This is with a view to further support managers to reduce call on non-contracted pay spend particularly in clinical staff groups.

Drug costs

Year to date expenditure on drugs was £0.20m below plan. The spend on 'pass through' high cost drugs is below plan matched by a corresponding income reduction.

Clinical supply and other costs

Clinical supply and other costs, including PFI costs, are £0.22m below plan in the year to date position.

Activity driven non-pay costs vary significantly by division in the year to date reflecting the shape of the clinical activity delivery. Pressures on clinical supply costs are seen across the Medical and Families & Specialist Services divisions combined at £0.45m overspend driven by the additional non-elective activity. Whilst the Surgery division shows a £0.72m underspend against planned expenditure on clinical supply costs aligned to the shortfall in elective and day case activity. Further savings have been realised by the successful delivery of CIP over and above the planned level, exemplified by procurement work to drive out benefits against telecoms and waste expenditure.

The recognition of a bad debt provision against invoices raised to Calderdale CCG in the early part of the year for system resilience pressures at £0.42m brings a pressure to non-pay, as previously reported. However, in-month the Trust has successfully settled a long outstanding issue around transport services supplied to other organisations within the local health community. £0.2m has been agreed to be paid to the Trust which had previously been provided against as a bad debt and as such benefits non-pay through the reversal of this provision.

Non-operating Items and Restructuring Costs

Non-operating items show a favourable £0.16m variance from plan. In the year to date this continues to be due to lower than planned inflationary charges on the PFI contract with actual RPI being lower than the projected level.

Cost Improvement Programme (CIP) delivery

The CIP and revenue generation schemes have delivered in excess of plan in the year to date with £6.88m achieved against a planned £5.64m. The over performance is seen in the same areas as in previous months; achieving additional revenue from pricing through greater depth of clinical coding and delivery of additional non pay savings.

Statement of Financial Position and Cash Flow

At the end of September 2015 the Trust had a cash balance of £8.61m against a planned position of £1.92m, a favourable variance of £6.69m, the key movements are summarised below.

		Variance £m
Operating activities	Deficit excluding restructuring	(1.43)
	Restructuring costs	2.90
	Deficit including restructuring	**1.47**
	Non cash flows in operating deficit	(0.14)
	Re-profiling of commissioner contract income	5.90
	Other working capital movements	2.01
	Sub Total	**9.24**
Investing activities	Capital expenditure	3.04
	Movement in capital creditors	0.52
	Sub Total	**3.56**
Financing activities	Drawdown of external DoH cash support	(5.90)
	Other financing activities	(0.21)
	Sub Total	**(6.11)**
	Grand Total	**6.69**

Operating activities

Operating activities show a favourable £9.24m variance against plan. This is driven by the favourable cash impact of the I&E position of £1.33m (£1.47m favourable I&E variance offset by £0.14m adverse variance against non-cash flows in operating deficit) coupled with positive working capital variances from plan. The I&E benefit to cash is driven by the fact that the plan assumed payment of one-off restructuring costs in respect of redundancy in September. These enabling costs are now anticipated to be incurred at a later date. This has brought a short term cash benefit of £2.90m. In addition, as described in previous reports, agreement has been reached with our main commissioners to re-phase the contract income payments over eleven months rather than the standard twelve. As expected, this has brought a significant cash benefit in September.

This has enabled a managed improvement to be delivered against the Better Payment Practice Code. In the year to date 74% of invoices have been paid within 30 days. This represents a shortfall against the 95% target, but a considerable improvement in-month versus last month. Whilst balancing the need for careful treasury management, the Trust continues to understand the importance of meeting obligations to suppliers and maintaining good relationships, payments continue to be prioritised accordingly.

Investing activities (Capital)

Capital expenditure in the year to date is £9.62m, £3.04m below the planned level of £12.66m. In aggregate across the range of schemes the latest forecast year end position is slightly below planned levels at £20.53m against a planned £20.72m.

Against the Estates element of the capital expenditure plan the year to date expenditure is £4.15m against a planned £4.86m. The main areas of spend in month were the continuation of the Ward 7 upgrade at £0.39m, continuation of the Theatre refurbishment at £0.22m and £0.18m across investments in the Child Development Unit and staff residences. The main contributors to the underspend are timing differences from plan on the Theatres scheme and across a number of other smaller schemes which in aggregate are forecast to balance back to plan by year end.

IM&T investments total £4.60m against a year to date plan of £6.80m. The main areas of spend in month are on the continuation of the Electronic Patient Record (EPR) at £0.31m and Electronic Document Management System at £0.19m. The key area of underspend in month is the EPR driving £2.02m of the shortfall. The scale of the underspend is not reflective of operational slippage on the scheme but rather positive action that the Trust has taken to schedule the commitments to payments based on staged deliverables from the supplier. This will also bring a timing benefit to cash.

The favourable cash impact of this £3.04m under spend is coupled with a £0.52m favourable variance against capital creditors, explaining the overall £3.56m positive cash variance against investing activities.

Financing activities

As reported last month, the Trust has an approved working capital loan facility in place with the Independent Trust Financing Facility which is available to draw against up to a total value of £13.1m. The original plan anticipated the need for this external cash in support of the trading position from September but the factors described above mean that this facility, which will bring interest charges at 3.5%, is not immediately required but is available as a 'safety net' in the short term.

Financing activities show a £6.11m adverse variance from plan. The key driver for this variance is the fact that the Trust did not need to take out external DoH loans that were originally expected to be necessary in September at £5.90m. It is indeed positive news that this funding has not been required in the year to date for the reasons described above and previously stated on many occasions. It is an undeniable indicator that the actions being taken by the Trust to micro manage its cash is having a real impact. The Trust reports daily on any variance from plan and as has been stated on many occasions, verified independently, and verbally acknowledged at recent PRM meetings with Monitor, is doing more than comparable organizations to protect its cash.

Finally and again as previously reported on several occasions, the £10m loan to support the EPR deployment was drawn down from the Independent Trusts Financing Facility (ITFF) in April in line with the plan.

3. Financial Sustainability Risk Rating (FSRR) and forecast

FSRR

Under the original Continuity of Service Risk Rating the performance is at level 1 in line with the planned position in the year to date and forecast.

The new FSRR measures bring this up to level 2 in both the year to date and forecast position. This change is due to the introduction of the I&E Margin variance rating against which the Trust scores a 3 due to being away from the planned deficit but within the percentage tolerance for this metric. This individual metric brings the overall FSRR up to an overall level 2.

Forecast – Income and Expenditure

The latest forecast position has been revised to a year end deficit of £22.21m against the planned £20.0m deficit (excluding restructuring costs).

The main reason for the adverse variance to plan is the pressure on the Trust caused by a reduction in intermediate / nursing home capacity in the health economy. Alongside this sits the financial pressure caused by the CCG's decision on the Care Closer to Home tender.

Specifically, system wide pressures in intermediate / residential care provision across Calderdale and Kirklees continue to drive the need for a greater level of bed capacity within the Trust. TH Board accepted the need to spend an additional £1.6m ensure the basic standards on patient safety could be maintained.

The revised forecast deficit has already called upon the additional 'stretch' CIP which had been conceived to guard against such risks. The forecast year end position includes delivery of £17.33m CIP against the original plan of £14m. The full £3m of contingency reserves is also forecast to be released. The additional activity / income pressures seen in September have been mitigated in the most part by forecast CIP delivery and other benefits.

As previously reported and discussed on many occasions, the forecast also includes an additional £1m restructuring costs in respect of the appointment of Ernst & Young (to provide capacity and specialist capability to the development of the transformational five year strategic plan). As previously discussed and agreed with Monitor this sits alongside the costs of restructuring (which in original plan was estimated to be £3m so has now risen to £4m and as such is included here as an authorised increase to the year-end deficit. Thus when viewed overall, the forecast I&E position remains close to that forecast at the end on month 5, being a bottom line deficit of £26.21m including restructuring costs, against the originally planned £23.01m deficit.

The described forecast position is summarised at headline level below:

Year-end Forecast Position

Income and Expenditure Summary	**Plan £m**	**Actual £m**	**Var £m**
EBITDA	**5.51**	**2.90**	**(2.61)**
Deficit excluding restructuring	**(20.01)**	**(22.21)**	**(2.20)**
Restructuring costs	(3.00)	(4.00)	(1.00)
Deficit including restructuring	**(23.01)**	**(26.21)**	**(3.20)**

Forecast – Cash

The year-end I&E forecast will bring an equivalent increased requirement for external cash support. The total cash support now anticipated to be required is £18.0m against the planned £14.9m. The pro-active measures that have been put in place to secure and preserve cash mean that the timing of this need is pushed back from the original plan and is now not forecast to be required until March 2016. This is consistent with the messages reported in previous months which reaffirms the strong, professional practices in place at the Trust are performing well.

Finally it must be again clearly stated that the Trust does not accept that the trading deficit of £22.2m cannot be brought back to planned levels by year end, and through a number of ongoing specific programmes and strong leadership is optimistic of hitting the original target. Similarly there will be continued pressures in the health system over the winter, which combined with the intensity of the strategic planning being led by the Trust for the health system, means achieving this original plan will be a challenge and thus there is no scope to exceed our original expectations.

Conclusion

The Trust will continue to strive to improve upon the year end forecast and build upon our current successes in over delivering on CIP delivery and minimising the cash support required. The strong ambition remains to deliver the year end forecast as originally planned.

There continue to be a range of risks and opportunities.

Keith Griffiths
Executive Director of Finance

Month 6 - Detailed Pay Analysis

Year to Date

Pay Expenditure including Agency

Forecast

Pay Expenditure including Agency

	M6 YTD Budget	M6 YTD Actual					M6 YTD Variance	15/16 Budget	15/16 Year End Forecast					Year End Forecast Variance
	Total Budget	Total Actual	Substantive Pay	Agency / Locum	Bank	Overtime / WLI		Total Budget	Total Forecast	Substantive Pay	Agency / Locum	Bank	Overtime / WLI	
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m
Medical Staffing:	29.96	31.06	23.88	6.59		0.59	1.10	60.53	64.07	50.60	12.27		1.21	3.54
Nursing, Midwives and HCAs:	44.43	44.98	40.08	2.50	1.23	1.18	0.55	90.20	91.68	82.42	5.04	2.39	1.82	1.48
Other Clinical Staff:	15.95	16.08	15.62	0.12	0.09	0.24	0.12	32.10	30.99	30.59	0.14	0.11	0.15	-1.11
Non- Clinical Staff:	19.97	19.90	18.09	0.96	0.37	0.48	-0.07	39.62	40.06	37.55	1.70	0.33	0.48	0.44
Pay Reserves	1.28						-1.28	2.54	0.00					-2.54
TRUST TOTAL	**111.590**	**112.019**	**97.673**	**10.171**	**1.685**	**2.490**	**0.430**	**224.983**	**226.803**	**201.165**	**19.145**	**2.830**	**3.663**	**1.820**

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Jason Eddleston, Deputy Director of Workforce and Organisational Development
Date: Thursday, 29th October 2015	**Sponsoring Director:** Julie Dawes, Director of Nursing
Title and brief summary: Disclosure and Barring Service (DBS) - This paper sets out the framework for securing DBS disclosures and identifies options for the Trust's future approach.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Executive Board 29 October 2015	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

Please see attached paper.

Main Body

Purpose:

Please see attached paper.

Background/Overview:

Please see attached paper.

The Issue:

Please see attached paper.

Next Steps:

Please see attached paper.

Recommendations:

Please see attached paper.

Appendix

Attachment:

DBS update paper - October 2015.pdf

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

BOARD OF DIRECTORS

29 OCTOBER 2015

DISCLOSURE AND BARRING SERVICE (DBS)

1. Purpose

This paper sets out the framework for securing DBS disclosures and identifies options for the Trust's future approach.

2. Background

The role of the Disclosure and Barring Service (DBS) employment check is to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups including children. The Trust currently undertakes its DBS checks within the framework of the DBS Code of Practice and in accordance with NHS mandatory employment check standards issued by NHS Employers. The framework within which the Trust operates incorporates the Rehabilitation of Offenders Act (1974) and the Police Act (1997).

There are two types of DBS employment disclosure, a standard disclosure and an enhanced disclosure. The standard disclosure provides details of spent/unspent convictions, cautions and reprimands. An enhanced disclosure provides the same information contained in a standard disclosure plus additional information held by local police deemed relevant and a check of the DBS Barred Lists for those working with vulnerable adults and children. In the majority of cases, the Trust seeks enhanced disclosures for its employees when a DBS employment check is made.

The cost of an enhanced disclosure is £44.00 and £26.00 for a standard disclosure. The Trust requires the disclosure applicant to cover the cost of an application. There is no cost for a DBS application from an individual engaged as a volunteer.

Employment checks are undertaken for new starters and those individuals moving between roles in the Trust as well as for volunteers.

3. Legal context

The law provides a clear position on what employment requires a disclosure to be obtained. It is unlawful to obtain a disclosure from the DBS for an individual who is not employed in an eligible position or who does not undertake 'regulated activities'.

An eligible position is a post working with children, young people or vulnerable adults. 'Regulated activities' include providing healthcare, providing personal care and the transportation of people.

The DBS can remove an employer's registration with it if there is evidence of 'serious misdirection'. An example of this is where an employer seeks and obtains DBS disclosures for

individuals in contravention of the DBS Code of Practice and guidance. In such circumstances, an employer will not independently be able to process its DBS disclosure applications.

4. DBS check validity

A DBS check is only one aspect of ensuring effective and safe recruitment practices. In accordance with the NHS Employers' mandatory NHS employment checks standard the following are validated in the recruitment/selection process – an individual's identity, right to work in the UK, professional registration and qualifications, employment history, references and work health assessments. The guidance is clear that DBS checks should not be used and/or relied on in isolation from good employment practice.

Information provided as part of a DBS issued disclosure certificate has no term of validity as it only provides information in relation to what is known about an individual up to the point of its issue.

5. DBS Update Service

The DBS has a voluntary electronic update service that provides up to date information for individuals opting into the service. The service has an annual cost to the individual of £13.00. Nationally, participation in the scheme at this point is low.

The benefit afforded by the scheme to the employee is that a disclosure application is only required once if their service subscription is maintained. An employer has the ability thereafter to check DBS status on-line.

The benefit for the employer is that the service eliminates the need for repeat checks and with permission from the employee allows notification of any new information about them which enhances the safeguarding aspects of the DBS scheme.

The Trust promotes the DBS Update Service and encourages registration for it when recruiting to posts. Leeds Teachings Hospitals NHS Trust is currently the only local NHS Trust to make registration to the DBS Update Service mandatory as a condition of employment.

6. Retrospective and periodic employment checks

There is currently no legal requirement or national policy mandate for NHS organisations to undertake retrospective or periodic DBS checks for employees. The Trust has not implemented retrospective DBS checks nor does it have a programme of periodic DBS checks.

The Trust's approach to obtaining DBS disclosures is consistent with the DBS Code of Practice and guidance and the NHS Employers' mandatory employment checks standard. Its approach is also consistent with that adopted by acute NHS Trusts in Bradford, Harrogate, Hull and Sheffield.

7. Savile Inquiry recommendation

The Savile Inquiry recommended that NHS hospitals undertake periodic DBS checks on their eligible employees and volunteers at least once every three years. This recommendation has been accepted by the Government. At this stage, however, no mandatory guidance had been

issued by the Secretary of State to NHS organisations. NHS Employers has not amended the mandatory employment check standards to incorporate the recommendation. Further direction for The Secretary of State is awaited. Leeds Teaching Hospitals NHS Trust is the only local acute NHS Trust to have implemented a retrospective check on its employees.

8. Options for consideration

The Board is asked to consider the following:-

Who to seek and obtain DBS disclosures for

Option 1

Continue to seek and obtain DBS disclosures for new employees and those moving between posts in the Trust in accordance with current practice (for those in eligible posts and/or in 'regulated activities').

Option 2

Seek and obtain disclosures for all new employees and those moving between posts irrespective of their role.

Recommendation

Option 1 is recommended.

DBS Update Service

Option 1

Continue with voluntary participation in the DBS Update Service.

Option 2

Introduce mandatory subscription to the DBS Update Service as a condition of employment for new employees in eligible roles and/or involved in 'regulated activities'.

Recommendation

Option 2 is recommended.

Periodic DBS checks

Option 1

Continue to seek and obtain DBS disclosures for new employees and those moving between posts in the Trust in accordance with current practice (for those in eligible posts and/or in 'regulated activities') and await further direction from the Secretary of State.

Option 2

Introduce a rolling programme of DBS checks for all employees in eligible roles and/or involved in ‘regulated activities’.

Recommendation

Option 1 is recommended.

Charlotte Baldwin
Assistant Director of Human Resources
October 2015

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 29th October 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: QUALITY COMMITTEE MINUTES - UPDATE - The Board is asked to receive a verbal update from the Quality Committee held on 27.10.15 and the minutes held on 22.9.15.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive a verbal update from the Quality Committee held on 27.10.15 and the minutes held on 22.9.15.

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

The Board is asked to receive a verbal update from the
Quality Committee held on 27.10.15 and the minutes held on 22.9.15.

Appendix

Attachment:

QC 22 09 15 - draft.pdf

Minutes of the QUALITY COMMITTEE held on Tuesday 22 September 2015, 2pm – 5pm in Boardroom, HRI

PRESENT:
Andrea McCourt, Head of Governance & Risk
Anne-Marie Henshaw, Associate Director of Nursing, Family and Specialist Services Division
David Birkenhead, Medical Director
Jan Wilson, Non-Executive Director
Jackie Murphy, Deputy Director of Nursing - Modernisation
Helen Barker, Assistant Director of Operations and Community Services
Jason Eddleston, Deputy Director and Workforce and OD
Jeremy Pease, Non-Executive Director (Chair)
Julie Dawes, Executive Director of Nursing & Operations
Juliette Cosgrove, Assistant Director for Quality
Joanne Middleton, Matron, Community Service Division
Julie O'Riordan, Divisional Director, Surgery & Anaesthetic Services Division
Linda Patterson, Non-Executive Director
Lindsay Rudge, Associate Director of Nursing, Medical Division

IN ATTENDANCE:
Stephanie Jones, Personal Assistant (Minutes)
Alison Wilson, Head of Estates, Operations and Compliance (on behalf of Lesley Hill)
Dr Rob Moisey, Consultant Endocrinology & Diabetes and Acute Medicine, Medical Division
Dr Julie Kyaw-Tun, Diabetes and Endocrinology, Medical Division

01/09/15	**WELCOME AND INTRODUCTIONS** The Chair welcomed members to the meeting. The meeting was confirmed as quorate. There were no declarations of interest.
02/09/15	**APOLOGIES FOR ABSENCE AND ATTENDANCE REGISTER** Jo Middleton, Matron, is a new member of the group and will represent the Community Services Division. **Apologies for absence were received from:** Keith Griffiths, Finance Director Lesley Hill, Executive Director of Planning, Performance, Estates and Facilities Lynne Moore, Membership Council Representative Martin DeBono, Divisional Director, Family and Specialist Services Division Sal Uka, Divisional Director, 7-day Services & Hospital at Night Victoria Pickles, Company Secretary
03/09/15	**MINUTES OF THE MEETING HELD ON 23 JUNE 2015** The minutes of the meeting held on 25 August 2015 were approved as a true record.

04/09/15	**ACTION LOG & MATTERS ARISING** (Items due this month) All items on the action log due this month were items on the agenda.
05/09/15	**5. MAIN AGENDA ITEMS** **<u>5.1 Presentation of the work of the Diabetes Collaborative</u>** Dr Rob Moisey, Consultant in Endocrinology, Diabetes and Acute Medicine and Dr Julie Kyaw-Tun, Consultant in Endocrinology & Diabetes were in attendance to give a update of the work of the Diabetes Collaborative. The following was noted: • **Membership:** included a mixture of consultants, diabetes specialist nurses, ward nursing staff, Clinical Governance Support Unit, pharmacy, junior doctors, Health Informatics and managerial support. • **Strategic narrative:** is based around the 3R's ***Reality*** - 1 in 5 people in hospital have diabetes - People with diabetes stay in hospital 2 days longer than other patients - 40% of in patients experience an insulin prescribing or management error ***Response*** - Enable patients on insulin to self-manage - 100% staff compliance with the insulin training package - Introduce linked Wi-Fi CBG meters ***Result*** - Reduce length of stay for people with Diabetes by 0.5 days or more - Safer care for people with diabetes with a 50% reduction in insulin prescribing and management errors • **Achievements to date:** - redesigned monitoring and prescribing charts - written care plans and patient information leaflets - campaign encourages patients to bring their own medication into hospital - e-based insulin training package available through EST, which is a one off training programme. Current Trust performance stands at 43.5% - CQUIN – self management: for 2015/16 has a value of £630K. Self- management has increased from 8 wards in 2014/15 to 16 wards in 2015/16. Performance against the CQUIN for 2014/15 was 70%. Variability in process remains a struggle due to inconsistency. Junior doctors are visiting wards to measure the clinical benefits of self-management. Each year the Trust part take in a National inpatient diabetes audit. Data from this audit will be received going forward. - LOS reduced from 6.6 to 5.5 with 900 bed days saved at a cost of £300K. • **Ongoing work:** the introduction of Wi-Fi linked capillary blood glucose

meters allows remote monitoring of patients from anywhere in the hospital, which will improve the quality of testing.

- **Support from the Quality Committee:** The Committee were asked for support in:
  - Getting all staff trained in the use of the capillary blood glucose meters.
  ACTION: Divisions to address. As well as roll out it is important Divisions understand what the collaborative are doing and why.

  - Self-management programme on the ward and especially reliability of processes and how it's embedded into the Trust.
  ACTION: Julie Dawes to address this outside the meeting with Jackie Murphy.

  - Oversight of performance with insulin training.
  ACTION: To be picked up by the Divisions.

Questions raised by the Committee

Q1 (Jackie Murphy): What about training for bank and agency staff?
A1 (Rob Moisey): currently looking at this.

Q2 (Jeremy Pease): Any benefits of expanding to the Community?
A2 (Rob Moisey): currently working closely with Locala District Nurses. CRH have a community based programme.

Q3 (Juliette Cosgrove): What feedback is being received from the patients?
A3 (Rob Moisey): No formal feedback is documented, but it is understood patients feel they have more freedom when they self-manage.

Q4 (Jan Wilson): How many patients come into hospital purely for diabetes episode?
A4 (Rob Moisey): the number of admission is roughly about 100; most patients are in for other reasons that just diabetes.

The Chair thanked Dr Moisey and Dr Kyaw-Tun for their informative presentation. The Committee **ACKNOWLEDGED** and gave **RECOGNITION** for the successful work by Diabetes Collaborative.

5.2 Update on the Stroke Service

Rob Moisey presented a paper to give an update on the Stroke Service. The paper described the aims and objectives of work, current performance, actions taken to improve performance, including the improvement plans for 2015/16. The following highlights were noted:

- **SHMI:** no change was noted since the last report. SHMI stands at 109.55, but there were no stroke deaths subject to second stage mortality reviews for the period December 2014 to May 2015.
- **Good news**: Improvement in SSNAP performance data shows the overall score

	has improved from an E to D. - **Key area of focus:** 100% of thrombolysis patients receive thrombolysis within 60 mins. The Trust are currently in line with the National average but further improvement needs to be seen and is a key focus of the current stroke improvement work. - **Admin/LOS:** not far from the National average 28 days to 20 days. Looking at additional stroke beds to improve patient flow. In August 65 patients were seen as opposed to an average of 50. - **7 Day working:** Feasible with stroke as have 4 stroke consultants and have received approval for a 5th. **Questions raised by the Committee:** Q1 (Jeremy Pease): Are ambulance Trusts part of the framework? A1 (Rob Moisey): Yorkshire Ambulance Services (YAS) site on the Stroke Board and review their performance. The main issues for paramedics are identifying a stroke and YAS are looking at training for paramedics around this. Q2 (Linda Patterson): Plan for Every Patient (PFEP) is not as high as it should be in relation to compliance on Ward 6D? A2 (Rob Moisey): Performance over time has improved although is not consistently over 90%. The recent drop in performance may reflect changes in ward leadership on Ward 6D. Performance is being reviewed weekly and support is being offered to the ward and the new managers. Q3 (Linda Patterson): Are stroke beds being occupied by general patients – is this still happening? A3 (Rob Moisey): In the last 6 months this has gone quiet. Patients sometimes come into these beds and are then move onto a more appropriate area for their needs. Q4 (Juliette Cosgrove): In relation to thrombolysis, how far in excess of 60mins are patients receiving thrombolysis? A4 (Rob Moisey): Between 10 to 15 minutes. Q5 (Juliette Cosgrove): With regards to the actual management of patients – is it managed timely? A5 (Rob Moisey): Management by stroke nurses and radiology is good. Out of hours is not as good, but Dr H Panditaratne, Consultant Radiologist, is addressing this. Q6 (Helen Barker): Visibility of time to scan/request to scan within 1 hour of hospital arrival? A7 (Rob Moisey): Rob gave assurance around this. Q7 (Helen Barker): In relation to direct admissions, Helen expressed concern that the step down ward 5B was having a negative impact on the 90% target. Helen agreed this would be discussed further outside the meeting with Julie Dawes and Medical Division. Q8 (Jan Wilson): Is physiotherapy given 7 day a week? A8 (Rob Moisey): 5 sessions are given over 7 days. One session equates to 45mins Q9: (David Birkenhead): Looking at mortality statistics, HSMR has stayed the

	same and there has been a noted improvement in SSNAP data. What is the overall view on the quality of care given on the Stroke Unit? A9: (Rob Moisey): SSNAP data score of D is = joining the pack. SSNAP data is 6 months old so further improvements should be seen. Unclear as to why HSMR remains the same as good improvements are being made. Q10 (Julie O'Riordan): Thrombolysis figures last year were better, but this year have gone down. Are they aware of anything that is getting in the way to achieve better performance? A10 (Rob Moisey): It remains unclear why performance is not where it was and there is no particular reason for it. The Chair thanked Rob Moisey for the update and **ACKNOWLEDGED** there is a lot of improvement work ongoing, but lots yet to do. ACTION: Further progress report to be brought to the Committee in February 2016. **5.3 Regulation 28 Action Plan (Medical Division: JS)** Lindsay Rudge, Associate Nurse Director, Medical Division, presented the action plan drawn up following the Regulation 28 letter from Her Majesty's Coroner (HMC). The initial action plan and HMC's report had previously been shared with the Committee. The following progress was highlighted from the action plan: Assessment and review prior to discharge HMC raised concern about the discharge process in relation to the deceased patient. In response to this a Discharge Improvement Group had been formed, discharge co-ordinators are in place and discharge training commenced to all services allied to medicine since the beginning of September 2015. A criteria led discharge policy has also been developed. These will need to be embedded and audited in terms of assurance. An audit on patients' perceptions of involvement in planning their care had been undertaken, the results of which will be shared with the Committee at a future meeting. Lessons learnt will be shared through the Divisional and professional groups. The Standard of Physiotherapy records The importance of discussing standards of documentation is included during supervision. This has been included in the Therapy Supervision guidelines. Falls Lessons learnt around falls will be shared with nursing colleagues via organisation wide nursing cascade. **Questions raised by the Committee:** Q1 (Linda Patterson): How do we report back to HMC. Do Regulation 28 letters have a timescale? A1 (Julie Dawes): HMC don't ask for a notification that actions have been

implemented, however the Trust should do this proactively which will be picked up by the Medical Division.

Q2 (Jeremy Pease): How many wards are on the Safety Huddle?
A2 (Lindsay Rudge): There are currently Ward 5 at HRI, MAU and 7AD at CRH. We would like to increase the pace, but need to be clear on the support from the Improvement Academy.

The Committee **RECEIVED** and **NOTED** the report.

5.4 Post Mortem Information Guidance

David Birkenhead, Medical Director, presented guidance to support staff in cases where a family requests a Post-mortem examination (PME).

The report detailed the two types of PME (coroner and hospital) and gave guidance on considering a family's request for a hospital PME. It also detailed how the results of a PME can be obtained.

In relation to a family's request for a hospital PMEs, the Committee were asked to consider who should pick up the cost of the PME. The guidance currently states such requests are unusual and present a very sensitive scenario if there is no legal duty or requirement and the decision on how to proceed with the request should be decided on a case-by-case basis.

The Committee **RECEIVED** and **NOTED** the report and **AGREED** this statement should remain and the cost should be met by the family, however each case should be decided on an individual basis.

5.5 Incident Reporting, Management and Investigation Policy

Andrea McCourt, Head of Governance and Risk, presented the Incident Reporting, Management and Investigation Policy. The policy is now a standalone policy and had been separated from the Learning from Experience Policy. It includes the Trust's new Serious Incident Investigation panel process, along with the revised Never Events List and National Serious Incident Framework, which were both updated in March 2015.

Within the policy there are templates/action plans/guidance for use when undertaking investigations. It was noted the policy has been to the Patient Safety Group and Risk & Compliance Committee for comment and approval.

It was suggested a link should be added to the policy Information Governance and Serious Incident Policy. Andrea McCourt confirmed some narrative will be added and emailed out to Committee members.

Anne-Marie Henshaw welcomed the policy and acknowledged all the hard work that had gone into its production.

Questioned raised by the Committee:

Q1 (Alison Wilson): Will there be more training sessions available?
A1 (Andrea McCourt): Yes, with the first being in October and a further 10 more throughout the year. The sessions will be focussed using the tools in the policy.

Q2 (Jeremy Pease): The Chair brought the Committee's attention to page 8 of the policy under heading Quality Committee and its sub-groups and asked members to note the Quality Committee's responsibility. The Committee **NOTED** and **AGREED** their responsibility.

In relation to orange and red incidents it was confirmed that Divisional Patient Safety and Quality Boards (PSQB) will take away learning and share across the Trust. The PSQB quarterly reports to the Committee will include a section on learning and how the learning has been shared throughout the organisation.

Helen Barker, Assistant Director of Operations and Community Services highlighted the importance whatever action is taken should be reported back to the member of staff who raised the incident. This should be added to the flow chart of (appendix 1) if not already documented within the narrative.

Duty of Candour was discussed and the importance of it being followed whether it be a green/yellow, orange or red incident.

It was **AGREED** any named members of staff should be removed from the policy and replaced with their title.

It was noted that each Division will have the responsibility to implement the policy. It was suggested there should be a more formal launch of the policy and it could perhaps be done through Team Brief.

The Committee **RECEIVED** and **NOTED** the policy and gave **APPROVAL,** once the discussed amendments have been made, for it to be submitted to the Weekly Executive Board (WEB) for final ratification. The Chair asked that thanks be passed on to Kath Thorley (Lead for Patient Safety and Risk Management) for hard work in producing the policy.

5.6 Inquest Policy

Andrea McCourt, Head of Governance and Risk, presented the Inquest Policy which had been to the Patient Safety Group and the Risk and Compliance Committee for approval.

The Committee **RECEIVED** and **APPROVED** the policy for submission to the Weekly Executive Board (WEB).

5.7 Review of Process for NICE Guidance

Juliette Cosgrove, Assistant Director for Quality, presented a report to inform the Committee of the Trust's position with all NICE Guidance, which provided the current compliance for all three types of guidance. Juliette explained the process and the progress to date. It was noted that a lot of work had been done to ensure anything non-compliant had moved to partially or fully compliant.

Instances where a decision has been taken by a service not to comply with the guidance, the nominated divisional lead will report the reason(s) to the Divisional Forum who will in turn inform the Trust Clinical Effectiveness, Audit and Mortality (CEAM) group who will be responsible for reviewing the guidance that falls into this category and form a view regarding whether the position is acceptable.

Anne-Marie Henshaw, Associate Nurse Director, FSS/Head of Midwifery commented that 10 of the 11 non-compliant cases sits with the FSS Division, but there is robust evidence and rational documented to the reason why they are non-compliant.

A figure within the report was noted to be incorrect and the correction report would be emailed to Committee members.

ACTION: Further updated would be brought to the Committee quarterly.

The Committee **RECEIVED** and **NOTED** the report.

5.8 Progress report on the completion of the Action Plan from the Morecombe Bay (Kirkup) Investigation.

Anne-Marie Henshaw, Associate Nurse Director, FSS/Head of Midwifery presented a report to update the Committee on the progress made on the CHFT Action Plan in response to the recommendations of the Morecombe Bay (Kirkup) Investigation. This is the 3rd paper presented to the Committee with updates previously being presented in May and July.

It was noted whilst some slippage has occurred in some actions, each has a defined recovery plan, lead and timescale which was detailed in Table 1.

The action plan has been submitted to the CCG Quality Board, who have shared it with other organisations as the CHFT action plan was noted to be well managed.

Questions raised by the Committee:

Q1 (Jeremy Pease): Where progress is not being made has it been reflected in the CQC Action Plan?
A1 (Anne-Marie Henshaw): Yes.

Q2 (Julie Dawes): When will all actions be implemented?
A2 (Anne-Marie Henshaw): It is hoped by the end of September 2015, but the whole action plan should be fully complete by the end of April 2015

ACTION: Further update to be brought to the Committee in January 2016. Reference to the action plan should also be well documented in the PSQB Divisional report in November 2015.

The Committee **RECEIVED** and **NOTED** the content of the report.

5.9 QIA Action Plan Update.

Julie Dawes, Executive Director of Nursing and Operations reported that the QIA process is in the process of being reviewed. The matrix previously received by the Committee is in the process of being updated and then will be brought to the Committee on a regular basis in order for the Committee to have an overview of the CIP process and its impact.

It is thought once the CIP progress is tracked, issues can be escalated to Exec Turnaround or the Star Chamber, which will strengthen the process.

It was requested that Divisional PSQB reports should detail the impact of CIP within their quarterly reports.

ACTION: Updated matrix to be brought to future Committee meeting.

The Committee **RECEIVED** and **NOTED** the verbal update.

5.10 Mandatory Training, Essential Skills and Induction Update Report

Jason Eddleston, Deputy Director of Workforce and Organisational Development presented a paper to provide the Committee with an update on the new approach to mandatory training (Core Skills Training Framework) that was implemented on the 1 June 2015.

It was noted that overall compliance to date for the financial year 2015/16 stood at 0.90%. It is anticipate that by the end of 2015 less than 1% of staff will have completed all 8 elements and members were asked to encourage staff to complete their mandatory training.

Questions raised by the Committee:

Q1 (Julie Dawes): Is there a facility to capture when training has already taken place, albeit not specifically CHFT training, but outside the organisation?
A1 (Jason Eddleston): Currently looking at this, but there is no easy solution to how this data can be captured on ESR.

Q2 (Juliette Cosgrove): Prevent training compliance noted to be low.
A2 (Jason Eddleston): Prevent training is class room based and is dependent on trainers being available. Looking at an e-learning version option.

Q3 (Alison Wilson): How can additional training be added to the mandatory training list as Environmental training may need to be added.
A3 (Jason Eddleston): Any additions to mandatory training will have to go through the Education Board.

ACTION: Further update on Mandatory Training, Essential Skills and Induction to be brought to the Committee in December 2015.

The Committee **RECEIVED** and **NOTED** the report and **SUPPORTED** the action detailed.

5.11 Seven Day Service Report: Result, Reality and Response

David Birkenhead, Medical Director, presented a report on Seven Day Services.

The report describes, using the 3Rs (Result, Reality and Response), the drivers of why the move to a seven day service is required and follows on from the Seven Day Services Programme Management Strategy – Supporting the Transformation which was presented to the Weekly Executive Board (WEB) in June 2015.

	The Strategic Executive Board (SEB) in July 2015 was dedicated to Seven Day Services, facilitated by Greengage Consulting. The session focussed on the vision, barriers and concerns about Seven Day Services. This vision was in favour of a *Transformational Response* delivering what *patients need* through a system wide approach. There was also an agreement for a *Transactional Response* that is 'affordable' delivering 'equality in the standard outcomes' with Consultant access 24/7 supported by hospital services 24/7. Result: The result from the National perspective is the contractual delivery of all ten clinical standards by April 2017. In 2015/16 Trusts are expected to make significant progress with at least five of the standards that will have the greatest impact locally. The Trust has agreed with Commissioners to prioritise Time to First Consultant Review, MDT reviews, Shift Handovers Interventions / Key Service Changes and On-going Review. Reality: the current reality was described in the report and incorporates analysis of CHFT mortality, medical workforce and self-assessment against the ten clinical standards. The Committee **RECEIVED** and **NOTED** the content of the report. The Chair asked that thanks be passed to Sal Uka, Divisional Director for Seven Day Service, for producing the informative report.
06/09/15	**CQC PREPARATION AND ACTION PLAN** <u>6.1 Update on CQC Action Plan</u> Juliette Cosgrove, Assistant Director of Quality, presented to the Committee a further update of the progress being made in advance of the forth coming CQC inspection. The CQC Steering Group continues to meet on a weekly basis, with a programme of presentations scheduled based on the 90 day plans for core services, Divisions and CQC domains. A first round of presentations has been received for all areas and a second round has now commenced. Since the last report to the Committee, presentations from the following areas detailed below* show that initial self-assessment for these services/domains were predominately rated as "Requires Improvement", but a shift is now starting to be seen to "Good" particularly in relation to the Caring domain. * • Emergency department core service • Medical care core service • Children and young people core service • Safe domain In relation to the Safe domain, harm falls continues to be a concern with a rating of inadequate/requires improvement. Opportunities to improve areas, over the next 3 months, have been identified across the 5 domains and are now key focus for the organisation. The CQC Steering Group next month will focus on looking at the data pack being prepared by the Health Informatics Service that will help develop any further

	areas for improvement. The Committee **RECEIVED** and **NOTED** the content of the report.
07/09/15	**RESPONSIVE** <u>7.1 Integrated Quality and Performance Report</u> The Integrated Quality and Performance Report was presented and the following highlights were noted: **Responsiveness** • The 4 hour Emergency Care Standard was delivered, but remains volatile with attendance being high. Plans in place to address this and the use of additional beds will help National Cancer Standards were met, but there is still work to be done in relation to Day 38 target and target performance in each tumour site. • Calderdale and Huddersfield Health Watch to visit the Trust and learn from patients, looking at why they had come to A&E and no other alternatives, experience of those patients waiting longer than 4 hours in A&E, patient discharge arrangements and what could be improved. • Cancelled operations performance was achieved in August. • Elective activity continues to track below plan, exception report taken through F&P Committee. • No ASI data available due to production issues from the national centre, actions plan currently being refined based on local knowledge. • More detailed report on DTOC to be submitted to the Committee in October 2015 **Caring** • Complaint performance continues to improve. • Friends and Family Test remains challenging. **Safety** • Pressure ulcers and falls continue to be a cause for concern. Work was underway to examine examples where reviewed bundles have been implemented and reductions noted. • Harm free care is running below Contract standard. • 3 Duty of candours remained open at month end. **Effectiveness** • Slight increase in C Difficile cases in August as reported in the DIPC report • Excellent performance on MRSA continues. • Emergency Readmissions within 30 days delivered. • HSMR remains a key area of concern. No change to Standardised Hospital Mortality Indicators. • # Neck of Femur, time to theatre deteriorated significantly in August as predicted in the July report plus otherwise good performance on the other best practice areas. **Well led** • Sickness has improved in 5 of the 8 areas reported. • Staff in post, FTE, remains static.

	• Appraisal and Mandatory training remains red but significant actions taken in month to ensure improvement. Divisions were setting their own targets from September 2015. • No reds noted in summary hard truths data however 14 individual shifts in the month were rated red, 9 qualified and 5 unqualified cover. • The weekly performance meetings continue with an increasing suite of reports reviewed and proactive actions agreed to improve delivery. The Divisional performance packs are currently being refined to compliment the IPR and enhance Ward to Board escalation. The Committee **RECEIVED** and **NOTED** the report.
08/09/15	**SAFETY** <u>8.1 Serious Incident Register</u> The Serious Incident Register was presented for the week ending 11 September 2015. It was noted that incidents are being closed down in a timelier manner; however the quality of the incident reports need further work. A meeting with investigators will be set up to address this. ACTION: Claire Gruszka (Patient Safety/Risk Manager) has commenced a piece of work, commissioned by the Patient Safety Group, to look at themes of oranges incidents, which will be brought to the Committee for information once complete. The Committee **RECEIVED** and **NOTED** the content of the register. <u>8.2 Patient Safety Group Update</u> At the last meeting of the Patient Safety Group, the following items were asked to be brought to the attention of the Committee. - Harms Summit: Summit to be arranged focussing upon falls, pressure ulcers and medication. Date of summit to be confirmed. Divisional representatives are asked to release staff to attend this important event. - Falls: At the request of the Patient Safety Group, Mary Hytch, Matron, presented a detailed report on falls and what action is being taken to improve performance. The Group will continue to closely monitor falls performance. - Pressure Ulcers: At the request of the Patient Safety Group, Helen Fearnley presented a report on the current position in relation to pressure ulcers and what action is being taken to ensure improvements are seen. The Group will monitor progress on a monthly basis. The Committee **RECEIVED** and **NOTED** the update and the items that had been escalated to the Committee by the Patient Safety Group.
09/09/15	**COMPLIANCE** <u>9.1 Corporate Risk Register</u> The Executive Director of Nursing and Operations presented the Corporate Risk Register. A new table within the report detailed the current risk score and its

	position. This would allow members to monitor the score trend with regards to whether the incident had increased, decreased or stayed the same since the last report. The Committee **RECEIVED** and **NOTED** the content of the register.
10/09/15	**EFFECTIVENESS** <u>10.1 Clinical Effectiveness and Outcomes Group</u> The Executive Medical Director presented the report from the Clinical Outcomes Group. The following key highlights were noted from the report: - HSMR and SHMI continue to rise and this may rise further with later releases. - Mortality review process is becoming established and there has been a big rise in the number of reviews completed in August 2015 (July's deaths). Some special reviews have been identified as a result of the review data that would be followed up. Professor Mohammed from Bradford University was working with the Trust to carry out some analysis of HSMR/SHMI data - Compliance with the NICE recommendations had seen improvement and with the seven best practice indicators for fractured neck of femur. - Crude mortality: 67th in the country. - PRISM study; 3% to 4% of unavoidable deaths. The Committee **RECEIVED** and **NOTED** the content of the report and in particular the items that were asked to be brought to the attention of the Committee.
11/09/15	**WELL LED ORGANISATION** <u>11.1 Well Led Organisation Group</u> An update was received from Jason Eddleston, Deputy Director of Workforce and Organisational Development. The following was noted: - Staff Friends and Family Test commenced in 2104, with surveys being conducted in Q1, Q2, and Q4. The National Staff Survey captures FFT questions in Q3. Two specific questions were asked regarding recommending the Trust as a place to receive treatment and recommending the Trust as a place to work. Analysis of the results had yet to be done. The Executive Board had requested that this be progressed as soon as possible in order to identify themes for incorporation into an action plan that also captures the results from the National NHS Staff Survey. - Investors in People: In the past the Trust has achieved the Investors in People Standard. The Trust will be assessed against the core standards in January 2016. - Appraisal: an appraisal planning tool has been developed, which enables an assessment to be made of planned activity against actual activity each month. The Committee **RECEIVED** and **NOTED** the content of the report.

12/09/15	**CARING** 12.1 Patient Experience and Caring Group Juliette Cosgrove, Assistant Director for Quality presented an update from the Patient Experience and Caring Group. The following was noted: - Friends and Family Test (FFT): Divisions have been asked to look at the feedback and how they respond. - Complaints: have been mainly around car parking; however these have started to reduce as a consequence of better information being sent out. - RIDDOR: working with Kath Thorley (Patient Safety Lead) to look at staff incidents. The Committee **RECEIVED** and **NOTED** the content of the report.
13/09/15	**HEALTH AND SAFETY ISSUES RELATING TO QUALITY AND CARE** 13.1 Operational Health and Safety Group The Committee received the minutes from the Health and Safety Operational Group for information. The Director for PPE&F reported work is ongoing with the Risk Department and the Divisions to ensure staff are trained in moving and handling. The Committee **RECEIVED** and **NOTED** the verbal update.
14/09/15	**MATTERS TO BE ESCALATED TO THE BOARD OF DIRECTORS** The Committee agreed the following items would be highlighted to the Board of Directors at the meeting on 24 September 2015. • **Stroke Report** • **Investigations Policy** • **NICE Guidance**
15/09/15	**ITEMS TO NOTE** 15.1 Quality Committee Work Plan The Committee received the Quality Committee Work Plan for 2015/16 for information. The Committee **RECEIVED** and **NOTED** the updated work plan.
16/09/15	**ANY OTHER BUSINESS** There was no other business.

17/09/15	**DATE AND TIME OF NEXT MEETING** Tuesday 27 October 2015 2pm – 5pm Boardroom, HRI **DATE MINUTES APPROVED:**

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 29th October 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: FINANCE AND PERFORMANCE COMMITTEE - UPDATE - The Board is asked to receive a verbal update from the Finance and Performance Committee held on 20.10.15 and the minutes held on 15.9.15.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive a verbal update from the Finance and Performance Committee held on 20.10.15 and the minutes held on 15.9.15.

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

The Board is asked to receive a verbal update from the Finance and Performance Committee held on 20.10.15 and the minutes held on 15.9.15.

Appendix

Attachment:

F&P Draft Minutes of the meeting held on 15 Sept 2015.pdf

Minutes of the Finance & Performance Committee held on Tuesday 15 September 2015
Meeting Room 4, 3rd Floor, Acre Mill, Huddersfield Royal Infirmary commencing at 9.00am

PRESENT

Anna Basford	Director of Transformation & Partnerships
David Birkenhead	Executive Medical Director
Julie Dawes	Executive Director of Nursing
Keith Griffiths	Executive Director of Finance
Lesley Hill	Executive Director of Planning, Performance, Estates & Facilities
Phil Oldfield	Non-Executive Director - Chair
Peter Roberts	Non-Executive Director
Owen Williams	Chief Executive
Jan Wilson	Non Executive Director

IN ATTENDANCE

Andrew Haigh	Chair
Stuart Baron	Assistant Director of Finance – Financial Planning and Efficiencies (In part)
Mandy Griffin	Acting Director of the Health Informatics Service
Betty Sewell	PA (minutes)

ITEM

WELCOME AND INTRODUCTIONS

208/09/15 The Chair of the Committee welcomed attendees.

209/09/15 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Jeremy Pease, Non-Executive Director
Linda Patterson, Membership Councillor
Peter Middleton, Membership Councillor
Victoria Pickles, Company Secretary

210/09/15 DECLARATIONS OF INTEREST

There were no declarations of interest.

211/09/15 MINUTES OF THE MEETINGS HELD 18 AUGUST 2015

The minutes were approved as a correct record.

212/09/15 MATTERS ARISING AND ACTION LOG

The Director of Transformation & Partnerships confirmed that contracts have been signed and that information which is readily available would be circulated to the Committee.

192/08/15 – Star Chamber - The Committee received a paper outlining the background and purpose of the Star Chamber process, it detailed the four Star Chambers which have already taken place and confirmation of further sessions which are due to take place within September. The approach has developed with the number of Star Chambers being held and it was thought that the last two sessions followed the correct operational model. The balance of challenge and support has been acknowledged by the attendee feedback and that the role of the panel is key to keep the discipline.

In addition to the information provided in the paper it was agreed that generic key learnings should also be recorded and it was agreed that moving forward this would be addressed.

In summary, it was noted that the Star Chamber process is evolving and proving to be a useful tool, the amount of preparation and level of resource required was acknowledged.

ACTION : The Chief Executive asked for an electronic star chamber repository to be created to house the minutes and associated actions to enable Board access – **AB &PMO Team**

193/08/15 – Month 4 - Issues affecting activity/recovery plan – The Director of Transformation & Partnerships provided a paper which summarised those specialties for day case and elective, which were experiencing under-performance at Month 4 with a recovery plan for those specialties, the paper had been updated to reflect the Month 5 position. It was noted that it is apparent from the information that it is a workforce capacity issue and whilst the recovery actions mitigate the impact none lead to the full recovery of the original contract and CIP.

In depth discussions followed covering waiting list initiatives, limited liability partnerships, theatre productivity work, job plans and cost reduction. It was agreed that we are at the point where we need to think about reducing capacity. The Director of Transformation & Partnerships confirmed that a piece of work is being commissioned, between now and December, to look at capacity and demand. It was noted that a key action from the last Star Chamber was that there is a need for dialogue to ensure that the job planning policy is being refreshed for the rigour that is required to adjust job planning immediately. It was decided that in advance of the outcome of the Four Eyes work we should have a mechanism in place to be ready to implement by the start of 2016 taking on board the comment from Lesley Hill that we need to be even-handed, noting the fact that we will have to complete the surgery work first. In addition to the mechanism pre-engagement would also be required.

The Chair of the Committee highlighted that several things that had come out of the in-depth conversations, one is demand and capacity and the second is around matching job plans and basically being organised over the next couple of months so that they both come together and there is an action plan in place.

It was acknowledged by the Non-Executive attendees that emerging discussions had taken place, however, it was difficult to gauge improvement and to gain assurance without a written report and supporting information. To ensure strategic clarity it was requested that a report would be provided.

The following actions were taken out of the discussions:

ACTIONS:
Waiting List – information/explanation to be circulated – **LH**

Theatre Productivity – A one-off report that details the work that Four Eyes has done with a set of simple graphs showing how things have improved, secondly, to review the monthly standard report to consider including additional matrix to be incorporated to regular update the Committee. The report should include a Glossary to explain acronyms and terminology. – **LH/AB**

LLP – to ensure a mechanism is in place to avoid duplicate payments – **LH**

Job Planning – In terms of the Four Eyes work, this will be brought together by **KG/AB & DB** and will be taken to the Turnaround Executive.

200/08/15 – SLR and PLICS position statement – In response to the request to provide a position statement, the Assistant Director of Finance (SB) presented a paper which outlined the background, the current position and future direction for Service Line Reporting and Patient Level Costing (SLR/PLICS). PLICS is already rolled out and used extensively throughout the Trust though take up is variable at consultant level. Training and workshops are held continually.

It was noted that the future ambition over the next 2 months would be to widen the use of the system throughout the Trust, increase the frequency of reporting from quarterly to monthly to utilise the information available from the new datasets. In achieving this ambition it would put us in 'best in class' across the country. The long term ambition is to develop the end user Knowledge Portal system and continue to increase the support to the Trust's cost improvement programme.

SLR and PLICS currently enables us to review, as part of CIP, if specialties are profitable, including costing individual theatre session and helps with productivity and gives us opportunity to do more regarding standardised care. As a general manager or clinician you could look at variations through this data to start to develop standard operating procedures.

At the present time reporting is too slow and infrequent and Keith Griffiths highlighted various areas which will be improved by the implementation. It is expected that once we start to report monthly and the information is seen as reliable there will be a huge impact, however, it was noted that there is a realism regarding engagement, engagement is crucial and should not be underestimated. It is a powerful tool and the vision is clear and ties into everything the organisation does in real time.

The Committee noted the paper.

FINANCE AND PERFORMANCE

213/09/15 MONTH 5 PERFORMANCE SUMMARY REPORT

The Director of Transformation and Partnerships presented the main headlines, it was noted that between April and August we have seen an increase in referrals, however, this is largely due to an increase in dermatology and if the impact of dermatology was aggregated out we would be seeing a 1% reduction in referrals compared to the same

period last year. In terms of waiting lists we are continuing to see a reduction with 500 fewer people waiting for surgery. With regard to the actual performance in Month 5, we are showing across all areas, with the exception of non-elective admissions, an under-performance, however, we are also seeing stabilisation and improvements from Month 4. The YTD position, across the board, remains below our plan with the exception of non-elective. Non-elective admissions have slowed but we are still 2.1% above plan and the aggregate impact of activity is that the YTD position is £0.45m below plan.

The report, for the first time, included a beds summary, average length of stay summary and occupied bed nights summary, the information reported is consistent with over-performance around non-elective admissions where we are seeing the number of beds open in August above plan and a higher length of stay compared to last year.

Discussions took place around referrals and it was agreed that contact should be made to try to understand why referrals are eroding. Anna Basford agreed to speak with NK CCG and practice managers.

It was acknowledged that the information included in the reports is improving; however, the Chief Executive asked if a comparison against other trusts on length of stay could be provided quarterly.

The Chair of the Committee asked how much physical bed space the Trust had and it was agreed that Julie Dawes would provide the information.

214/09/15 MONTH 5 CONTRACT ACTIVITY AND INCOME PERFORMANCE

The headlines from this report had been covered within the previous item.

215/09/15 MONTH 5 FINANCIAL NARRATIVE AND MONTHLY DASHBOARD

The Executive Director of Finance reported that the year to date financial position is in line with last month's forecast. The year-end forecast is reporting a potential £22.2m deficit against a planned deficit of £20.0m excluding restructuring costs.

There are areas which need particular focus and a closer look at controls around medical and nursing agency spend will continue. If things stay as they are now, medicine will be £5m overspent at year-end, this has already been picked up within the Star Chambers and it will continue to be monitored.

To enable us to protect our cash position the decision to hold back on the payment of invoices was made, however, we have negotiated with Commissioners that they will pay us 12 month's contract income over 11 months and additional cash has been received. There is a continual scrutiny to balance the cash position but what we are committed to is by the time we draw down any further monies from the DoH our payment terms will be back to 30 days. Part of the plan moving forward would be to review our credit terms with suppliers and breakdown payment terms.

The Director of Finance was asked to provide 3 / 4 key points for the PRM discussion to substantiate the comments in the last paragraph of the report with regard to the Trust

remaining confident to still deliver on its original plan.

ACTIONS : To provide key points to substantiate the conclusions in the report by Tuesday next week for the PRM script **- KG**

The Director of Finance updated the Committee with regard to the request to Monitor to confirm in writing that the extra £1m spend on the agency support for the 5 Year Plan would go to our restructuring costs. They have not formally accepted yet but this has been included in the forecast to force the issue.

The Committee were asked to note that the Trust is behind on capital spend due to issues with regard to the mobilisation of some projects namely, EDMS and EPR due to the complexity and size of the projects.

The Committee had a lengthy discussion on the issues facing the Trust operationally which is driving the forecast overspend.

The Committee approved the paper.

216/09/15 MONTH 5 COMMENTARY ON MONITOR FINANCIAL RETURN

The paper provides confirmation that what we report to Monitor is consistent with what we report to the Board.

The Committee noted the paper.

217/09/15 CONTRACTUAL MEDIATION UPDATE

The Director of Commissioning and Partnerships reported that the 2015/16 contact had been signed off last week subject to conclusion. A number of schedules are being worked through by the Contracts Team and we are operating under full Payment by Results (PbR) arrangements.

STRATEGIC ITEMS

218/09/15 & 219/09/15 TURNAROUND PROGRAMME & CIP 15/16 £14m/£18m PROGRESS AND PLANNING

The Chief Executive announced that the core messages with regard to the plan is that we are online to deliver £14m CIP. With regard to the contingency built in has reduced to £16m, this links into Star Chamber conversations where we are working hard to rebalance the reduction with varying success. It was noted that it is important to recognise that we are in a different place re CIP and in terms of reaching the plan the confidence is reasonably high to achieve £14m, but we need to achieve as much as the £16m+ to make sure we are closer to the £20m moving forward.

The planning around year ending 2016/17 has seen a slow increase and we appear to have got to the optimum point regarding the transactional routine ideas and transformational ideas are required to get us back up to the target of £18m.

ACTION : Recurrent CIP information should be routinely included in the CIP Report **- KG**

Peter Roberts referenced a Treasury / National Audit paper re transactional friction and suggested looking at these transactions and the lowering the delegation decisions.

ACTION : To provide details of the paper referenced, for review by the Committee **- PR**

The slippage with CIP for 16/17 was noted, progress is being made but it was acknowledged that it is getting increasingly harder and the Trust will need to look at things differently.

220/9/15 EPR UPDATE

The Acting Director of Health Informatics Service provided a paper for the Committee which gave an update of the current EPR position. The project is still forecasting an underspend which is predominantly linked to the initial profile which was based as March on the original business case. The Committee where asked to reference Section 4 of the paper which detailed the re-forecast of the key milestones across to August and a re-profile of the expenditure against this plan will be reported back to the Committee meeting in October. In addition, the use of NHS staff as opposed to contract staff has also lead to a recurrent saving.

A supplier presentation took place yesterday for external assurance and GE Healthcare were awarded the contract they are due to submit their initial report at the end of October and this will be presented to the Board in November.

The Chief Executive informed the Committee that Monitor have requested an overview of the gateway review timeline and Mandy Griffin was asked to provide this to Vicky Pickles for submission. The gateway review will take the form of three separate reviews the first being governance, secondly, the state of the project and thirdly, business readiness. There is also a fourth post go-live review looking at how to continue to maximise the benefit of implementation and engagement which we may consider to put in place.

TREASURY MANAGEMENT

221/09/15 CASH FLOW 13 WEEK FORECAST

The Executive Director of Finance presented a paper to provide reassurance to colleagues of the profile scrutinised on a daily basis. To get to the granularity focus has been made to financial systems and it was recognised that there is more work to do with regard to clinical areas to pick up on cash. It was highlighted that key milestones and Terms of Reference for the Cash Committee have been requested by Monitor and will be provided in advance of the next PRM.

GOVERNANCE

222/09/15 WORKPLAN

There were no items added to the Workplan.

223/09/15 MATTERS FOR THE BOARD AND OTHER COMMITTEES

- EPR External Assurance Report – November Board
- Nursing Agency Cap – Board

- Job Planning – Turnaround Executive

224/09/15 ANY OTHER BUSINESS

DoH Consultation on the Objection Mechanism and CHFT response

The Director of Finance advised the Committee that the DoH had opened a consultation period for a proposal to revise the objection mechanism as part of the statutory consultation on the national tariff and following discussions with NHS Providers a response on behalf of the Trust had been submitted. The Committee were asked to note the contents for information.

Nursing Agency Cap

The Director of Finance asked the Committee to be aware that Monitor had issued a policy to all providers. The Executive Director of Nursing gave a quick explanation of the policy which has been designed to deal with the issue of high cost agencies. Each Trust has been given a percentage cap and the CHFT cap has been confirmed as 3% in October and 4% in the last 4 months of the year. The cap is on agency trained nurses as a proportion of our total trained nurse bank including NHS bank and our current spend is 5.8%.

To off-set the need for agency staff we are increasing substantive recruitment within September/October of newly qualified nurses, in addition we are working to get more of our agency workers onto bank plus we have Tier 1, 2 and 3 agencies 3 being the really high-cost agencies which we are reducing.

We have met with a number of Tier 1 agencies to lower the overall costs, but this will need to be off-set by the opening of the additional beds in October. There are a complex set of assumptions to be worked through but we are saying we need an average of 6% going forward rather than 3% and 4%. The Trust submitted a return yesterday and await the outcome. In addition, if we want to use high cost agencies we have to put in another submission by the 18 October and it is our intention to request permission, in exceptional circumstances, to use high cost agencies.

The Chief Executive asked Julie Dawes to arrange for the Trust to have site of the West Yorkshire returns to look at the percentages for the region. It was also suggested that if Monitor came back to us and declined our request to increase our cap, this should be shared with the CQC to have something on record.

ACTION : It was agreed to escalate this item to the Board **- JD**

The Director of Transformation & Partnerships asked the Committee to be aware that following a call with Monitor they have advised that we should make an amendment to our business case to inform suppliers via the procurement portal that it is up to them to source their own sub-contractor, Four Eyes are aware of this change.

DATE AND TIME OF NEXT MEETINGS

Tuesday 20 October, 8.30am – 10.30am, Meeting Room 4, 3rd Floor, Acre Mill Outpatients

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 29th October 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: AUDIT AND RISK COMMITTEE - DRAFT SUMMARY NOTES - 20.10.14 - The Board is asked to receive and note the draft Summary Notes from the Audit and Risk Committee held on Tuesday 20.10.15.	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive and note the draft Summary Notes from the Audit and Risk Committee held on Tuesday 20.10.15.

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

The Board is asked to receive and note the draft Summary Notes from the Audit and Risk Committee held on Tuesday 20.10.15.

Appendix

Attachment:

DRAFT SUMMARY ON A PAGE - 20 10 15.pdf

SUMMARY ON A PAGE

MEETING OF: AUDIT AND RISK COMMITTEE

DATE OF MEETING: 20 October 2015

FREQUENCY OF MEETINGS: 5 PER ANNUM

CHAIR OF MEETING: Prof. Peter Roberts

WAS MEETING QUORATE? Yes

SUMMARY OF KEY BUSINESS/ACTIONS AT THE MEETING:

1. **MATTERS ARISING AND ACTION LOG – No issues outstanding**
   - **Payroll Report** – update not available from Workforce and OD. Agreed that update be available from them by the next meeting. **ACTION: VP**
   - **Review of SFI/SoD** – Updated version of documents to be received at January 2016 ARC Meeting. **ACTION: VP**
   - **Review of Outstanding Internal Audit Recommendations**.
     - **Medical Devices** – Vic Wotherspoon attended and gave an update on the current position around the Internal Audit recommendations. A number of actions agreed including a clear understanding of equipment review dates to take into account manufacturers guidance and consideration of CQC inspection reports in relation to medical devices. An updated report to be brought back to ARC in January via the Internal Audit progress report.

     Agreed that all IA recommendation be reviewed to ensure that they were reasonable and achievable. Updated report be brought back to ARC in January – **ACTION: VP/CB**
   - **Governance Structures –** Agreed that Internal Audit would review the PWC recommendations.
   - **Clinical Audit & IA reports –** Peter Middleton updated on his attendance at a seminar on audit committee responsibilities in relation to clinical audit. It was agreed that the ARC should receive the clinical audit plan alongside the internal audit plan. It was agreed that this would be discussed further with Quality Committee.

2. COMPANY SECRETARY'S BUSINESS:

a. Review of TOR – one small amendment to include Quality Directorate representation in attendance – approved.
b. Review of Board Assurance Framework – agreed – live document.
c. Standards of Business Conduct Policy – tracked changes approved.
d. Review ARC Committee Self-assessment – collated responses received. Action plan drawn up and agreed.
e. Declaration of Interests Registers - updated registers received.
f. Regulatory Compliance Issues – updated template received and noted. No issues to note.
g. ARC Annual Workplan – updated workplan received and approved.

3. REVIEW OF RISK MANAGEMENT SYSTEM

Update received on the development of risk management systems within the organisation, particularly progress in the development of the Board Assurance Framework and Corporate Risk Register. It was noted that an internal audit of the risk register and board assurance framework had received significant assurance.

4. EXECUTIVE DIRECTOR OF FINANCE'S BUSINESS

a. Reference Costs 2013/14 Audit and Costing Submissions 2014/15 – The outcome of the audit of 2013/14 costing and clinical coding were received together

with a response to the issues raised during the audit and progress against the resulting action plan. Also included was an overview of the 2014/15 submissions for reference costs and the Patient Level Costing (PLICS) & Materiality and Quality Score (MAQS) voluntary submissions.

b. Review of Waiving of Standing Orders – Received and approved.

c. Review of Losses and Special Payments – Received and noted.

5. INTERNAL AUDIT

a. Outstanding Internal Audit Recommendations – The Committee agreed the need for it to be proactive and hold managers to account in the future when agreed actions in response to recommendations are not delivered. Agreed that the Internal Audit Manager and Company Secretary would work together to prioritise and invite appropriate personnel to attend future Audit and Risk Committee Meetings.

ACTION: CB/VP

b. Progress Report – Total of 11 Reports received. 3 Limited Assurance Reports:- Availability of critical medicines (missed doses), Medicines – community midwives (compliance with updated PGDs), Authorisation Level Approvals (weaknesses in the authorised signatory list control type systems for both pay or non-pay systems)

Agreed to cascade IA recommendations re critical medicines to Quality Committee.

Action: VP

6. LOCAL COUNTER FRAUD SPECIALIST REPORT

Updated progress report received and noted. Progress with joint exercise noted. 20 members of staff yet to respond. Agreed final reminder to be sent on behalf of the Committee. **Action: VP**

7. EXTERNAL AUDIT – Technical Update received and noted. No specific issues to bring to the Board's attention.

8. INFORMATION TO RECEIVE

a. Quality Committee Minutes – 28.7.15, 25.8.15
b. Risk & Compliance Group Minutes – 14.7.15, 11.8.15, 8.9.15
c. THIS Management Board – 29.7.15, 2.9.15
d. Audit and Risk Meeting Dates 2016 – Amendments required:-
19.4.16 to move to 20.4.16. 19.7.16 meeting to be moved to another date.
26.5.16 possible to move 1 hour to accommodate External Audit - TBC

9. RE-TENDERING OF EXTERNAL AUDITORS

Contract to be extended to a further 2 years. Fee negotiations to be pursued.

ACTION: KG/PR/PO

10. ANY OTHER BUSINESS – No matters to report

11. MATTERS TO CASCADE TO BOARD OF DIRECTORS:-

- Board Assurance Framework
- Audit and Risk Committee Terms of Reference
- Internal Audit Follow-up Recommendations
- Internal Audit Progress Report – 3 Limited Opinion Audits
- Local Counter Fraud Services Progress Report
- Clinical Audit Plans
- Audit and Risk Committee Work Plan
- Clinical Negligence costs – discussion from F&P Committee – to be reviewed by IA
- External Audit Re-tender

15. DATE AND TIME OF THE NEXT MEETING:

Wednesday 20 January 2016 at 10.45 am

AUTHOR OF THIS REPORT
NAME: Kathy Bray
POSITION: Board Secretary