Leicester
City Council

MEETING OF THE HEALTH AND WELLBEING SCRUTINY COMMISSION

DATE: **WEDNESDAY, 6 AUGUST 2014**
TIME: **5:30 pm**
PLACE: **THE TEA ROOM - FIRST FLOOR, TOWN HALL, TOWN HALL SQUARE, LEICESTER**

Members of the Commission

Councillor Cooke (Chair)
Councillor Cutkelvin (Vice-Chair)

Councillors Bajaj, Chaplin, Glover, Grant, Sangster and Wann

Members of the Commission are invited to attend the above meeting to consider the items of business listed overleaf.

G. J. Carey

For Monitoring Officer

Officer contacts:
Graham Carey (Democratic Support Officer):
Tel: 0116 454 6356, e-mail: Graham.Carey@leicester.gov.uk
Anita Patel (Members Support Officer):
Tel: 0116 454 6342, e-mail: Anita.Patel@leicester.gov.uk)
Leicester City Council, City Hall, 115 Charles Street, Leicester, LE1 1FZ

Information for members of the public

Attending meetings and access to information

You have the right to attend formal meetings such as full Council, committee meetings, City Mayor & Executive Public Briefing and Scrutiny Commissions and see copies of agendas and minutes. On occasion however, meetings may, for reasons set out in law, need to consider some items in private.

Dates of meetings and copies of public agendas and minutes are available on the Council's website at www.cabinet.leicester.gov.uk, from the Council's Customer Service Centre (91, Granby Street Leicester) or by contacting us using the details below.

Making meetings accessible to all

Wheelchair access – Public meeting rooms at the Town Hall are accessible to wheelchair users. Wheelchair access to the Town Hall is from Horsefair Street (Press the buzzer on the left hand side of the door to be let in to the building, then take the lift to the ground floor and go straight ahead to the main reception).

Braille/audio tape/translation - If you require this please contact the Democratic Support Officer (production times will depend upon equipment/facility availability).

Induction loops - There are induction loop facilities in Town Hall meeting rooms. Please speak to reception staff at the Town Hall or the Democratic Support Officer at the meeting if you wish to use this facility or contact us using the details below.

Filming and social media

The Council is committed to transparency and supports efforts to record and share reports of proceedings of public meetings through a variety of means, including social media.

Please feel free to use social media during this meeting.

If you wish to film proceedings at a meeting please let us know as far in advance as you can so that it can be considered by the Chair of the meeting who has the responsibility to ensure that the key principles set out below are adhered to at the meeting.

Key Principles. In recording or reporting on proceedings you are asked:

- ✓ to respect the right of others to view and hear debates without interruption;
- ✓ to ensure that the sound on any device is fully muted;
- ✓ where filming, to only focus on those people actively participating in the meeting;
- ✓ where filming, to (via the Chair of the meeting) ensure that those present are aware that they may be filmed and respect any requests to not be filmed.

Further information

If you have any queries about any of the above or the business to be discussed, please contact Graham Carey**, Democratic Support on (0116) 454 6356 or email graham.carey@leicester.gov.uk** or call in at the Town Hall.

For Press Enquiries - please phone the **Communications Unit on 454 4151**

THE 6 PRINCIPLES OF EFFECTIVE SCRUTINY

In March 2014, the Health & Wellbeing Scrutiny Commission adopted 6 principles of effective scrutiny and subsequently agreed that these would be included on all agenda to enable anyone observing or attending meetings to be clear about the role of the Commission. These are:-

1. **To provide a 'critical friend' challenge to executive policy- makers and decision-makers.**

2. **To carry out scrutiny by 'independent minded governors' who lead and own the scrutiny process.**

3. **To drive improvements in services and finds efficiencies.**

4. **To enable the voice and concerns of the public and its communities to be heard.**

5. **To prevent duplication of effort and resources.**

6. **To seek assurances of quality from stakeholders and providers of services.**

TERMS OF REFERENCE OF SCRUTINY COMMISSIONS

Scrutiny Committees hold the executive and partners to account by reviewing and scrutinising policy and practices. Scrutiny Committees will have regard to the Political Conventions and the Scrutiny Operating Protocols and Handbook in fulfilling their work.

The Overview and Select Committee and each Scrutiny Commission will perform the role as set out in Article 8 of the Constitution in relation to the functions set out in its

Scrutiny Commissions may:-

i. review and scrutinise the decisions made by and performance of the City Mayor, Executive, Committees and Council officers both in relation to individual decisions and over time.

ii. develop policy, generate ideas, review and scrutinise the performance of the Council in relation to its policy objectives, performance targets and/or particular service areas.

iii. question the City Mayor, members of the Executive, committees and Directors about their decisions and performance, whether generally in comparison with service plans and targets over a period of time, or in relation to particular decisions, initiatives or projects.

iv. make recommendations to the City Mayor, Executive, committees and the

Council arising from the outcome of the scrutiny process.

v. review and scrutinise the performance of other public bodies in the area and invite reports from them by requesting them to address the Scrutiny Committee and local people about their activities and performance; and

vi. question and gather evidence from any person (with their consent).

Annual report: The Overview Select Committee will report annually to Full Council on its work and make recommendations for future work programmes and amended working methods if appropriate. Scrutiny Commissions / committees will report from time to time as appropriate to Council.

SCRUTINY COMMISSIONS will:-

- Be aligned with the appropriate Executive portfolio.
- Normally undertake overview of Executive work, reviewing items for Executive decision where it chooses.
- Engage in policy development within its remit.
- Normally be attended by the relevant Executive Member, who will be a standing invitee.
- Have their own work programme and will make recommendations to the Executive where appropriate.
- Consider requests by the Executive to carry forward items of work and report to the Executive as appropriate.
- Report on their work to Council from time to time as required.
- Be classed as specific Scrutiny Committees in terms of legislation but will refer cross cutting work to the OSC.
- Consider the training requirements of Members who undertake Scrutiny and seek to secure such training as appropriate.

PUBLIC SESSION

AGENDA

1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

Members are asked to declare any interests they may have in the business on the agenda.

3. MEMBERSHIP OF THE COMMISSION

The Monitoring Officer to report that Councillor Bajaj has been appointed to the Commission to fill the vacancy for the Labour Group vacancy, which was reported at the last meeting.

4. MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on 1 July 2014 have been circulated and the Commission will be asked to confirm them as a correct record.

The minutes can be found on the Council's website at the following link:-

http://www.cabinet.leicester.gov.uk:8071/ieListDocuments.aspx?CId=737&MId=6479&Ver=4

5. PETITIONS

The Monitoring Officer to report on the receipt of any petitions submitted in accordance with the Council's procedures.

6. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer to report on the receipt of any questions, representations and statements of case submitted in accordance with the Council's procedures.

7. WORK PROGRAMME

Appendix A (Page 1)

The Scrutiny Support Officer submits a document that outlines the Health and Wellbeing Scrutiny Commission's Work Programme for 2014/15. The Commission is asked to consider the Programme and make comments and/or amendments as it considers necessary.

8. CORPORATE PLAN OF KEY DECISIONS **Appendix B (Page 7)**

The Commission is recommended to note the items that are relevant to its work in the Corporate Plan of Key Decisions that will be taken after 1 August 2014.

9. EMAS - PROGRESS FOLLOWING RISK SUMMITS AND OUTCOME OF CARE QUALITY COMMISSION INSPECTION **Appendix C (Page 13)**

To receive a report on the East Midland's Ambulance Service NHS Trust. The report outlines the achievements in relation to key national performance standards. The report also sets out the challenges faced in 2013/14 and the actions taken, together with outlining the two risk summits in 2013/14 and the progress made with the EMAS Better Care Patient Care Quality Improvement Programme. It also outlines the findings of the Care Quality Commission inspection and the actions taken to address the areas of shortfall/non-compliance. The report also identifies the Trust's performance both within the context of the City and specifically compared to the East Midlands as a whole.

Sue Noyes, Chief Executive and Paul St Clair, Assistant Director Operations, East Midlands Ambulance Service NHS Trust will attend the meeting to present the report.

10. DIRECTOR OF PUBLIC HEALTH'S ANNUAL REPORT **Appendix D (Page 25)**

To receive a report on the Director of Public Health's Annual Report 2013-14. The Strategic Director of Adult Social Care and Health will give a presentation on the Annual Report.

A copy of the Annual Report for 2013-14 can be found at the following link:-

http://www.cabinet.leicester.gov.uk/mgConvert2PDF.aspx?ID=64402

11. CCG JOINT COMMISSIONING WITH NHS ENGLAND **Appendix E (Page 27)**

To receive a report from Leicester City Clinical Commissioning Group on the proposal for co-commissioning arrangements with NHS England in relation to GP services. A copy of a hand-out from the LCCCG on the inspections by the Care Quality Commission together with a copy of a presentation on the inspections is attached for members' information.

12. REVIEW OF CONGENITAL HEART SURGERY REVIEW **Appendix F (Page 67)**

The Chair to lead a discussion on the current progress of the Congenital Heart Services Review being undertaken by NHS England.

The last update report is attached and can be accessed at the following link. The link will also allow access to previous update reports.

http://www.england.nhs.uk/category/publications/blogs/john-holden/

HealthWatch Leicester, Heartlink, University Hospitals Leicester NHS Trust, Keep The Beat, and representatives of East Midlands Health Scrutiny have been invited to contribute to the update.

13. NHS QUALITY ACCOUNTS

The Chair will provide feedback on discussions with the Healthwatch representative on how the Commission should consider the Quality Accounts in the future as agreed at the last meeting of the Commission.

14. ITEMS FOR INFORMATION / NOTING ONLY

Appendix G (Page 67)

a) Public Health England - Leicester Health Profile 2014

Public Health England published the Health Profile 2014 for Leicester on 8 July 2014.

15. ANY OTHER URGENT BUSINESS

Health & Wellbeing Scrutiny Commission

DRAFT Work Programme 2014 to 2015 (and 2015 to 2016) – updated 18th July 2014

Meeting Date	Topic	Actions Arising	Progress
25th June 2014	**Special joint meeting with CYPS** LPT Proposed Relocation of CAMHS Inpatient Service (HSC members to join CYPS for this item)	Chairs to send a letter to LPT re: comments /outcomes	
1st July 2014	Introduction to Health Scrutiny and the Health Economy (Chair and Rod Moore)		
	Discussion on future Work Programme to include vcs stakeholder event outcomes, fit for purpose action plan and corporate plan of key decisions (Chair)	1) W/P to be updated 2) Visits to vcs orgs to be arranged. 3) Fit for Purpose Implementation Plan to progress to Executive (Anita to draft cover report)	
	Healthwatch Protocol (Chair and Surinder Sharma)	1) Photo of protocol signing to be inserted into the scrutiny annual report 2) To progress with legal re: co-opting healthwatch to health scrutiny	
	Review of Mental Health Services for Black/Black British Young Men in Leicester – Update (Chair)	Draft report of findings to Aug / Sept meeting	
	Child & Adolescent Mental Health Service (CAMHS) Review (Chair)	To be raised at Health & Wellbeing Board	
	UHL and EMAS Quality Accounts 2013/14 (Chair)	Small working group set up to look at these Quality Accounts	

1

Appendix A

	Topic	Actions Arising	Progress
	Items for information: a) Health & Wellbeing Board b) CQC Programme of Inspections June to Sept 2014 c) Checking the Nation's Health, CfPS health scrutiny tool. d) New Guidance for Health Scrutiny – Dept of Health	 Sept hsc meeting to allocate timeslot for members development session – led by Rod Moore Agreed to set up small working group to understand the changes and report back to hsc (Anita to arrange suitable date).	
8th July 2014 1st REVIEW MEETING	Briefing for members only re: Mental Health Services for Black British Young Men (age 18 to 25) in Leicester *- To determine the current service provision, highlighting the key issues, trends, comparable data, quality of services and good practice.*		
22nd July 2014 2nd REVIEW MEETING	Review of Mental Health Services for Black British Young (age 18 to 25) Men in Leicester *– to determine how service providers and commissioners address the issues/ problems?*		
Date tbc (possibly 5th August 1pm) 3rd REVIEW MEETING	Review of Mental Health Services for Black British Young (age 18 to 25) Men in Leicester *- Draft report of findings and recommendations?*		

Meeting Date	Topic	Actions Arising	Progress
6th August 2014 (Agenda meeting 29th July 2014)	EMAS – HSC agreed in Jan 2014 to receive report in 6 months, on Trusts achievements in relation to key performance indicators. Future reports to identify the Trusts performance both within the context of Leicester City specifically compared to the East Midlands as a whole (CEO)		
	Public Health Annual Report – presentation for members on key issues (Rod Moore / Deb Watson)		
	Department of Health new Guidance for Health Scrutiny – the changes and impacts (if any) to health scrutiny and the council. a) Feedback from legal (Pretty Patel) b) Feedback from chair following sub group work.		
	Nhs Quality Accounts – Feedback from Chair following sub group work.		
	GP Service in the City – CCG briefing (Richard Morris)		
	Child & Adolescent Mental Health Service Review (CAMHS) – CCG to provide a briefing paper on the proposals / application (Richard Morris)		
	Glenfield Heart Unit – Update on progress. (Healthwatch, UHL, Heartlink, NHS England, Lincoln Health Scrutiny Chair & East Midlands Health Scrutiny Chairs).		
	Department of Health Annual Report – For members information		

Meeting Date	Topic	Actions Arising	Progress
23rd September 2014	Checking the Nation's Health, cfps guidance. members development session led by Rod Moore (to allocate 20 minutes approx. within hsc agenda)		
	Immunisation – Rod to provide report		
	Nhs Health Checks – Rod to provide report on comparison data and progress so far		
	Better Care Together, 5 yr Plan (dependent on whether members have received briefing??)		
	Mental Health Challenge (Pledge)		
	Mental Health Services Scrutiny Review Young Black British Men in Leicester – DRAFT Report?		
	Healthwatch Reports – briefing on current issues, including information on patients concerns & experiences (Philip / Surinder)		
	Implementation Plan for Fit for Purpose – Chair to provide update on progress		
4th November 2014	City Mayor's Delivery Plan – HSC agreed in May 2013 to receive report in 6 months on progress – joint with ASC?		
	Mental Health Awareness – progress		
	Air Quality in Leicester – impact to health of residents		
16th Dec 2014	NHS & Leicester City Council Complaints		
27th January 2015			
10th March 2015			
21st April 2015	NHS trusts annual Quality Accounts during April to May- LPT, UHL, EMAS – to receive and comment.		Dates tbc

Health & Wellbeing Scrutiny Commission

Forward Planning 2014 – 2015 (and 2015 – 2016)

Topic	Detail	Proposed Date
JOINT / SHARED WORK WITH OTHER SCRUTINY COMMISSIONS		
Winter Care Plan – joint with ASC (to include Befriending Service)	Response from the Executive and CCG to the report recommendations and evaluation of last winter's care – Lead Member: Cllr Rita Patel	tbc
Better Care Fund – joint with ASC?	Anita liaise with ASC wp	tbc
Better Care Together 5 yr Plan - joint with ASC?	September 2014 (dependent on members briefing taken place)	tbc
Health & Social Care Act – joint with ASC	Anita liaise with ASC wp	tbc
Contracts, Commissioning & Procurement – Joint with ASC?	Anita liaise with ASC wp	tbc
Dementia Strategy – Joint with ASC	Anita liaise with ASC wp	tbc
Lack of support for carers – Joint with ASC	Anita liaise with ASC wp	tbc
Care Quality Commission – to invite ASC members	Anita to contact CQC to arrange date	tbc
School Nurses (transferred over to lcc) – Joint with CYPS	Anita to liaise with CYPS wp	tbc
Food Banks & Health – Minutes from N/hoods?	To invite Carolina Jackson & check minutes from n/hood for this item	tbc
Homelessness & Health – Joint with Housing	Initially to seek views from nhs England and Jane Grey	tbc

RESERVED LIST OF ITEMS (to be populated into work programme timetable)		
Topic	**Details**	**Proposed Date**
City Mayor's Delivery Plan	Miranda Cannon / Rod Moore	tbc
Public Health Budgets	Cllr Palmer / Rod	tbc
Capital Programme	City Mayor & Executive	
Closing the Gap and Corporate Strategies relating to health & wellbeing – to monitor	Cllr Palmer / Rod	tbc
Mental Health – needs assessment and councils pledge	Tracie Rees / Rod	tbc
Health Visitors (transferred to lcc)	Rod	tbc
MSK Pain	Initially to seek views of the LCCCG	tbc
Talking Therapies	To see views on this issue	tbc
Annual Reports e.g. Healthwatch, UHL, LPT, EMAS, Public Health)	Anita to gather further details re publish dates	tbc
To seek CCCG Views on: 1) Primary Care in the City 2) Community Services with LPT 3) G.P. Services in the City	Richard Morris	tbc

Leicester City Council

CORPORATE PLAN OF KEY DECISIONS

On or after 1 August 2014

What is the plan of key decisions?

Each month, the Council publishes a forward plan to show all the key decisions, which are currently known about, that are intended to be taken by the Council's Executive (City Mayor, Deputy City Mayor and Assistant City Mayors) over the next few months. Each plan runs from the first of each month.

What is a key decision?

A key decision is an executive decision which is likely:

- to result in the Council incurring expenditure which is, or the making of savings which are, significant having regard to the Council's budget for the service or function to which the decision relates; or
- to be significant in terms of its effects on communities living or working in two or more wards in the City.

In addition to the key decisions, the City Mayor and the Executive also take other non-key decisions. Details of these can be found at www.cabinet.leicester.gov.uk/mgdelegateddecisions.aspx?bcr=1

What information is included in the plan?

The plan identifies how, when and who will take the decision and in addition who will be consulted before the decision is taken and who to contact for more information or to make representations.

The plan is published on the Council's website.

Prior to taking each executive decision, please note that the relevant decision notice and accompanying report will be published on the Council's website and can be found at www.cabinet.leicester.gov.uk/mgdelegateddecisions.aspx?bcr=1

Corporate Plan of Key Decisions

On or after 1 August 2014

Contents

1. A place to do business

No key decisions are scheduled to be taken during this current period.

2. Getting about in Leicester

What is the Decision to be taken?	BUS LANE ENFORCEMENT - AYLESTONE QUALITY BUS CORRIDOR Decision to implement Bus Lane Enforcement on the Aylestone Road corridor bus lanes. Funding for this project is included in the approved capital programme budget allocation for the A426 project.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Aug 2014
Who will be consulted and how?	Done as part of Aylestone Bus Corridor Scheme.
Who can I contact for further information or to make representations	AndrewL.Smith@leicester.gov.uk

What is the Decision to be taken?	CONNECTING LEICESTER STREET IMPROVEMENT SCHEME/S Approval of funding for second phase of Connecting Leicester street improvement projects. Up to £4.1m from resources set aside for the Economic Action Plan. Note, the precise amount for which approval will be sought depends upon the scope of the schemes brought forward.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Aug 2014
Who will be consulted and how?	Consultation through Connecting Leicester initiative and TRO process.
Who can I contact for further information or to make representations	AndrewL.Smith@leicester.gov.uk

3. A low carbon city

No key decisions are scheduled to be taken during this current period.

4. The built and natural environment

What is the Decision to be taken?	RELEASE OF THE PROPERTY MAINTENANCE PROVISIONS 2014/15 Release of £1.7 million block fund from Capital Programme.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Aug 2014
Who will be consulted and how?	Not applicable.
Who can I contact for further information or to make representations	Mark.Lloyd@leicester.gov.uk

5. A healthy and active city

No key decisions are scheduled to be taken during this current period.

6. Providing care and support

What is the Decision to be taken?	EXTRA CARE Release of £1.2million monies from the Capital Programme.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Aug 2014
Who will be consulted and how?	Not applicable.
Who can I contact for further information or to make representations	Tracie.Rees@leicester.gov.uk

What is the Decision to be taken?	SPENDING REVIEW OF SUBSTANCE MISUSE SERVICES
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Aug 2014
Who will be consulted and how?	Still to be confirmed.
Who can I contact for further information or to make representations	Tracie.Rees@leicester.gov.uk

7. Our children and young people

No key decisions are scheduled to be taken during this current period.

8. Our neighbourhoods and communities

What is the Decision to be taken?	DEVELOPMENT OF A COMMUNITY SPORTS ARENA The expected financial parameters have not yet been confirmed.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Aug 2014
Who will be consulted and how?	Consultation with a range of stakeholders.
Who can I contact for further information or to make representations	Liz.Blyth@leicester.gov.uk

What is the Decision to be taken?	AFFORDABLE HOUSING PROGRAMME 2014-18
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Aug 2014
Who will be consulted and how?	Ward Members and Local Residents Group on individual sites within the programme.
Who can I contact for further information or to make representations	Simon.Nicholls@leicester.gov.uk

What is the Decision to be taken?	HOME MAINTENANCE SUPPORT FOR LOW INCOME OWNER OCCUPIERS Finance from Housing General Fund Revenue Budget.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Aug 2014
Who will be consulted and how?	Consultation ends 28 March 2014.
Who can I contact for further information or to make representations	Ann.Branson@leicester.gov.uk

9. A strong and democratic council

No key decisions are scheduled to be taken during this current period.

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East Midlands Ambulance Service NHS Trust

HEALTH AND WELLBEING SCRUTINY COMMISSION: 6th August 2014

REPORT OF EAST MIDLANDS AMBULANCE SERVICE NHS TRUST

PROGRESS FOLLOWING RISK SUMMITS AND OUTCOME OF CARE QUALITY COMMISSION INSPECTION

Purpose of the Report

1. The purpose of the report is to:

- Provide an update on the successful delivery of key national performance standards, in light of significant increased demand.

- Provide an honest, open and transparent report about the challenges faced by East Midlands Ambulance Service NHS Trust (EMAS) in 2013/14 and the action taken.

- Outline, therefore, the two "Risk Summits" required of the Trust in 2013/14 and the establishment and progress of the EMAS Better Patient Care Quality Improvement Programme, designed to put the organisation on a credible trajectory to, within a short time frame, markedly improve patient care, resetting the role, culture and effectiveness of the organisation.

- Outline the findings from the Care Quality Commission (CQC) inspection of the Trust in January 2014 and the actions being taken to address the identified areas of shortfall/non-compliance.

- Demonstrate public accountability and set out how the Trust is working to restore confidence in its services.

Overview of the recent "Risk Summits"

2. The non-delivery of core service performance and quality standards by EMAS through the first half of 2013 gained sufficient attention and concern that NHS England required the Trust to attend a "Risk Summit" in October 2013. The Risk Summit was attended by the relevant commissioning bodies responsible for the EMAS contract plus NHS England, The Trust Development Authority (TDA) and the CQC.

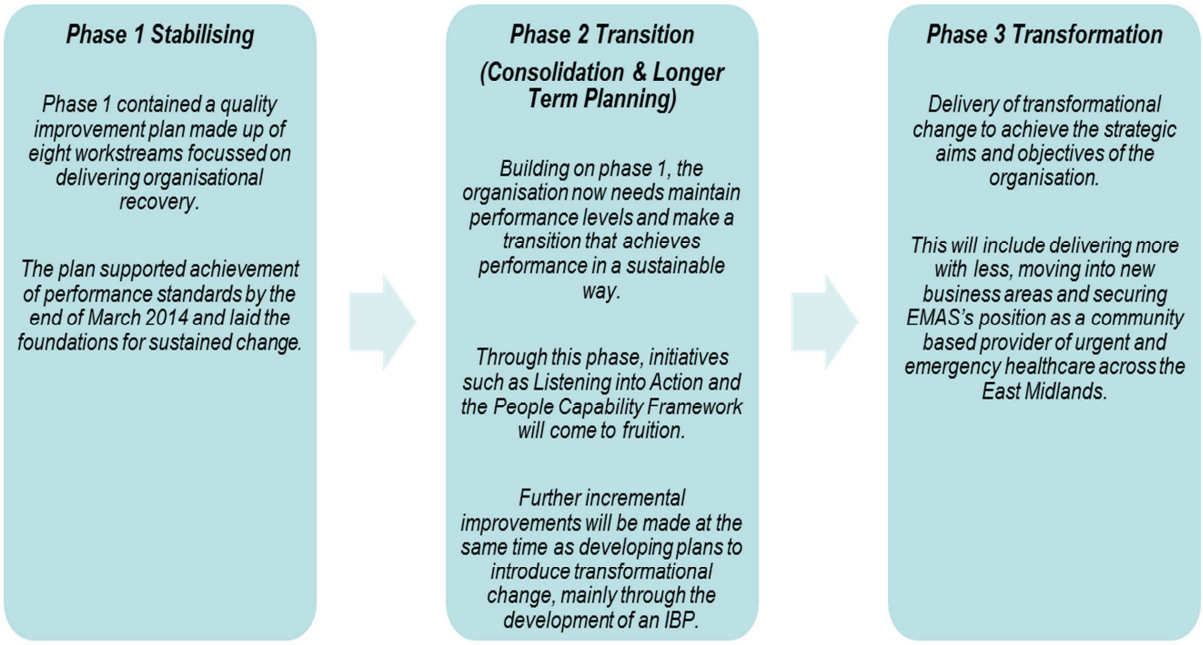
3. With the appointment in October of our interim CEO, Sue Noyes, a focused recovery plan was developed and approved by the same agencies, following

the Risk Summit. EMAS term this the “Better Patient Care” plan. This plan has been mobilised and implemented Trust Wide and is monitored through a PMO office and a dedicated Board, chaired by the CEO.

4. A copy of the plan can be found at - http://www.emas.nhs.uk/ under the tab ‘Our Services’.

Better Patient Care

5. As detailed above, recognising the specific quality, finance and performance challenges faced by the organisation during 2013/14, EMAS established its Better Patient Care Programme (summarised in the diagram below) in Quarter Three of 2013/14 as the quality improvement programme to put the organisation on a credible trajectory to, within a short time frame, markedly improve patient care, resetting the role, culture and effectiveness of the organisation.



6. Phase one of the Programme, completed in March 2014, consisted of a quality improvement plan made up of eight workstreams focussed on the delivery of organisational recovery. The plan was designed to stabilise the organisation, putting in place the infrastructure to support the delivery of high quality patient care, achieving performance standards and quality indicators in 2014/15 and laying the foundations for sustained change.

7. Phase Two of the Programme, that commenced in April 2014, is a transition phase, continuing with the actions to maintain performance delivery by the organisation, consolidating activities to ensure performance is achieved sustainably, and planning for long term transformation.

8. The core workstreams within the plan are:

- Responding to our Patients
- Our People
- Our Leadership
- Clinical Effectiveness
- Patient Safety and Experience
- Our Money
- Our Estate, IT and Fleet
- Our Communications

9. Following implementation of the Better Patient Care plan, fortnightly progress reviews were conducted with the agencies who attended the Risk Summit, this continued until a second Risk Summit was convened in February 2014.

10. The second Risk Summit was attended by all organisations that had attended the original summit.

11. Progress against the Better Patient Care plan was further reviewed at this second Risk Summit and key performance interrogated. The EMAS Executive Director team attended all review meetings.

12. Following this meeting the substantial progress made by EMAS against the Better Patient Care plan and the approved trajectory of further improvement provided sufficient surety that the monitoring of EMAS was reduced to a monthly frequency. The meeting chair complimented EMAS on the very positive progress made and felt this needed to be recognised, this view was also supported by the lead commissioners and the CQC.

13. The first oversight meeting this financial year, with the TDA, held on 19 May 2014 was very positive and EMAS was commended on the continued positive progress made to date and since 01 April in continuing further to improve organisational performance.

14. At the second TDA oversight meeting held on 22nd July, the continuing performance improvement delivered by EMAS resulted in the TDA and CCG Commissioners jointly agreeing to stand down these oversight meetings for the foreseeable future.

15. Patient care measured through the key performance indicators of response time (Red 1/Red 2 and Red 19) were delivered above target for the Trust in the first quarter April to June 2014. The Trust also ended the period with a small financial surplus, recognising the on-going success of the Better Patient Care plan and management rigour.

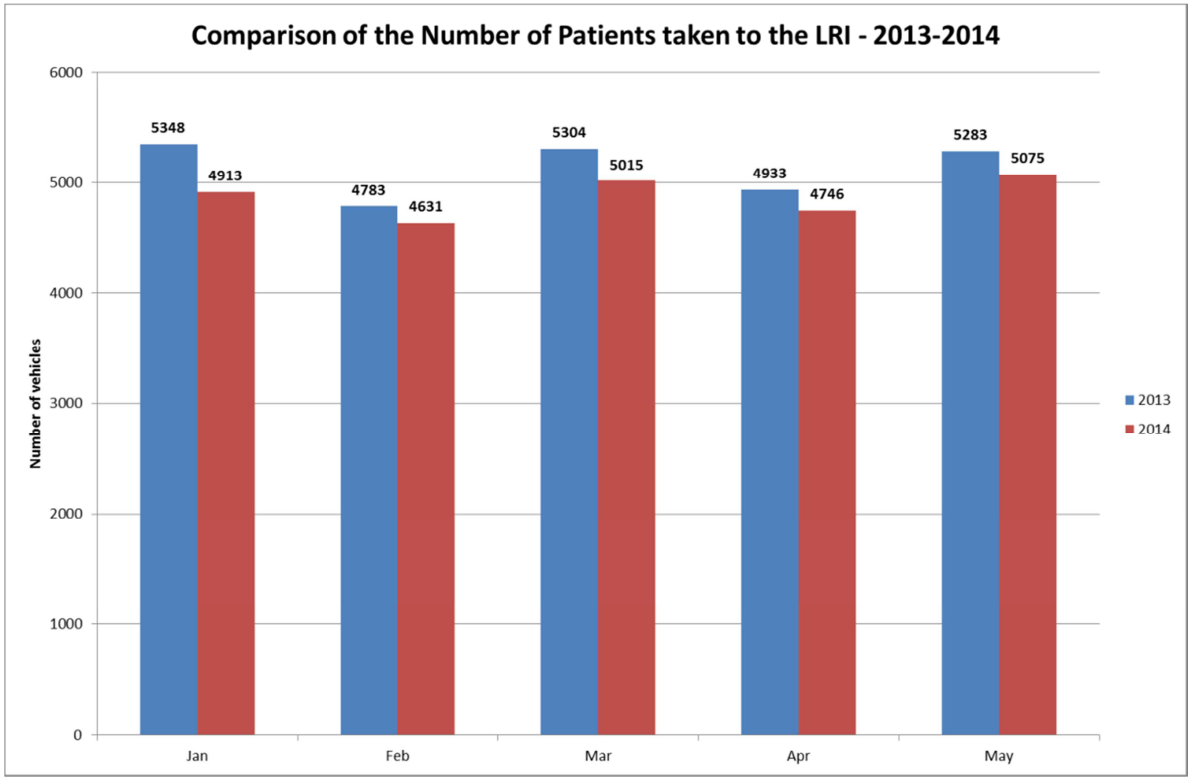
16. For EMAS and the Leicester City CCG the performance achieved for the first quarter of 2014 (April to June)

Category	Performance Standard %	Leicester City Performance Actual %	EMAS Performance Actual %
Red 1	75	83.66	75.01
Red 2	75	84.90	75.25
Red 19	95	97.09	95.27
Green 1	85	81.23	84
Green 2	85	84.16	85.42
Green 3	85	92.17	95.78
Green 4	85	100	99.77
Urgent	90	84.30	85.58

17. Performance in treating patients in their home location and / or through other more suitable referral pathways (non-conveyance to LRI A&E) is another key metric and links to recent wider work in the health economy and the Keogh report on Emergency Care. The performance for this in Leicester City and EMAS, for the period April to June 2104 is detailed below.

Patient non-conveyance Performance Target %	Leicester City Performance %	EMAS Performance %
40	48.15	41.88

18. Patient care delivered through alternative pathways, supports the "Better Care Fund" objectives and recognises the benefits this brings. EMAS has worked well in this area and reduced patients attending LRI A&E by between 3% and 8% per month since January 2014. The table below shows the 2013 versus 2014 EMAS patient taken to LRI A&E following a 999 call.



- A new and expanded team of substantive Executive Directors, as approved by the TDA have been recruited to the Trust, and all have now started . (NB The Medical Director and Director of Workforce posts will be recruited to by the end of 2014/15)

- A revised local management structure has been introduced to focus more on local delivery, partner and cooperative working and resolution of issues arising. An Assistant Director of Operations was appointed for LLR on 16th December 2013, to lead the Leicestershire element of the Better Patient Care plan.

- Staff engagement and recruitment has seen greater emphasis, being mobilised through an NHS initiative termed “Listening into Action” that is being led personally by our CEO.

- Staff recruitment and the workforce plan is fully committed for the current financial year with new staff joining the service in April, June, July, September, October and March 2015.

- Investment in 46 new “front line” vehicles has been committed by the Trust this year to improve fleet reliability and age profile. Delivery of these vehicles is expected in Quarter 3 / 4 of 2014. Further vehicles will be approved for procurement in 2015/6 to reflect the on-going renewal process and capital investment programme.

- Partner initiatives with CCGs, County Council, University Hospitals of Leicester (UHL) and voluntary bodies are in place and being further explored linked to the “Better Care Fund” and in particular providing more appropriate and targeted care in the right setting, not necessarily the Emergency Department. This has so far resulted in LLR achieving the highest “non-conveyance” rate, at 48%, for patients in the East Midlands ensuring care is delivered in the most appropriate setting.

- Quality, Patient Safety and Clinical Effectiveness and the data used to measure these criteria have all been reviewed and revised in addition to being externally audited by Price Waterhouse Coopers. This work has shown substantial progress in the reduction of patient complaints and investigations.

- The financial position for the Trust, year ending 31 March 2014, showed a break even position after agreement from commissioners for the reinvestment of fines imposed.

- The very positive progress across the eight facets of the Better Patient Care Plan continue and provide on-going service improvement month on month and are allowing EMAS to build a stronger organisation for future service delivery in Leicester and Leicestershire.

20. A full report on the Better Patient Care Plan can be located at http://www.emas.nhs.uk/ document reference PB.14.0132.4 Better Patient Care Next Stage of Development Report May 2014.

Vision and Strategy

21. 2014/15 is the first year in the five year planning cycle (2014/15 to 2018/19).Our focus this year is very much on delivering and maintaining performance levels and ensuring a transition that achieves performance in a sustainable way and places great emphasis on engaging with and supporting our staff.

22. All NHS Trusts were required to produce strategic plans by 20 June 2014. These plans were collected through the production of a five-year Integrated Business Plan (IBP) and Long Term Financial Model (LTFM) that respond to the substantial challenges faced by the NHS.

23. As part of this planning process, we have developed our vision for the organisation:

    We are a healthcare provider. We provide healthcare on the move and in the community, and our vision is for EMAS ***to play a leading role in the provision, facilitation and transformation of clinically effective urgent and emergency care delivered by highly skilled, compassionate staff, proud to work at the heart of their local community***.

24. We believe this will support CCGs and other health and social care providers across the East Midlands in the delivery of a long-term, sustainable healthcare system.

25. The five-year Integrated Business Plan maps our transformation journey from a mainly emergency focused service in 2014/15 to a future operating model whereby the organisation sits at the centre of the urgent and emergency care system.

26. This means it is our ambition for EMAS to act as the co-ordinating NHS organisation at the centre of the system, either providing care directly (e.g. over the phone or on the scene) or signposting/referring patients to the best service to support them in their homes and the community, reducing admissions to hospitals where appropriate.

27. This model is designed to ensure the most appropriate and effective response to meet the needs of our patients and/or the referring clinicians. Put simply:

    "…..supporting delivery of the right care, with the right resource, in the right place and at the right time."

28. We will use our Better Patient Care Programme to manage the delivery of our Vision and Strategic Objectives through the development, implementation and

monitoring of our specific strategies via eight key governance workstreams. (see Appendix A).

Overview of the CQC Visits January and February 2014

29. The Care Quality Commission (CQC) carried out a routine annual inspection of the Trust in January and February 2014. The CQC inspected six outcomes. These are listed below with the CQC's judgement:

- Outcome 4 Care and welfare of people who use services - Action needed
- Outcome 8 Cleanliness and Infection Control - Standard met
- Outcome 10 Safety, availability and suitability of equipment - Action needed
- Outcome 13 Staffing - Action needed
- Outcome 14 Supporting workers - Action needed
- Outcome 17 Complaints - Standard met.

30. The main areas of concern the CQC has identified are as follows:

- response standards were not being met;
- lack of staff resources;
- coverage of shifts;
- availability of vehicles;
- equipment availability;
- equipment checks on vehicles were not always carried out;
- lack of performance appraisals in some areas;
- low staff morale; and
- lack of time for management duties.

Key actions being taken to address outcome 4

- Operations Management Structure
- Recruitment of frontline staff
- Tactical management arrangements 24/7
- EOC resources – dispatcher secondments and agency nurses
- Dispatch Protocols
- Service Delivery Model, EOC Strategy, Fleet Strategy
- Arrangements for forecasting demand
- Dynamic System Status Plan
- Reduce conveyance and on-scene times
- Divisional performance management regime

Key actions being taken to address outcome 10

- Fleet Strategy
- Use of technology to determine vehicle requirements
- Fleet Wave system to manage vehicle and equipment availability
- Integration of existing systems to match daily vehicle needs

- Review Make Ready arrangements to improve vehicle availability
- Revise Safer Ambulance Checklist
- Regular reporting on vehicle requirements vs. actual availability

Key actions being taken to address outcome 13

- Recruitment Plan for 2014/15
- Use of VAS/PAS, bank staff and overtime to cover vacancies
- Career development routes – Technician to Paramedic and ECA to Paramedic
- Manage abstractions at 28% through sickness management and revised Education Programme
- Improvements to sickness absence management
- Review supplementary contracts which affect core rotas
- Post implementation review of 2013/14 operational management restructure including management time vs. operational response

Key actions being taken to address outcome 14

- Recruit to Team Leader and Clinical Team Mentor vacancies
- Post implementation review of 2013/14 operational management restructure including management time vs. operational response to ensure time for appraisal and supervision
- New appraisal system
- Appraisal training update
- Targets for completion of appraisal and clinical supervision – at least 75% of available staff to have an appraisal in 2014/15

31. The full CQC report can be found at http://www.emas.nhs.uk/ document reference PB.0101.2 CQC Inspection Report Final Published Version April 2014.

32. The Better Patient Care improvement programme which the Trust is currently implementing will address a number of the weaknesses. Action has already been taken which has resulted in improvements since the inspection.

33. The Trust responded to the CQC on 07 May 2014, setting out the actions, noted above, and associated timescales for addressing concerns and ensuring compliance with the four standards which the CQC determined that the Trust had not met.

34. A report including this response and the detailed actions which the Trust will take to address all weaknesses in the report, not just those relating to the standards not met, will be presented to the Trust Quality and Governance Committee. That Committee will continue to monitor compliance with all of the CQC standards.

35. The actions required to address the issues identified by the CQC and any other actions required to ensure compliance on other standards not reviewed at the recent inspection, will be incorporated into the Better Patient Care Programme, where they are not already included.

36. The Better Patient Care Programme Board is responsible for monitoring progress against those actions. The Programme Board reports to each meeting of the Trust Board and therefore the Board will receive information on progress and any areas of concern through that mechanism.

Public accountability and working to restore confidence in services

37. As a Trust, and with the support and challenge of partner and external agencies previously mentioned, EMAS has had to address some very difficult issues over the last nine months, but has made significant recognised improvement across all areas of the service.

38. The two “Risk Summits” were seen as watersheds for the Trust and all staff understand that the Better Patient Care Plan is not just an immediate action plan but one that will and must deliver continual sustained improvement.

39. Now that the Trust has moved beyond the second Risk Summit and seen substantial positive progress against the Better Patient Care Plan, momentum in wider involvement and engagement is expanding and EMAS is being embraced as a partner organisation that can and does play a significant role within the health care community in Leicester.

40. The Trust is active with HealthWatch and has formed an EMAS HealthWatch Task Group to look at and action initiatives in response to local needs.

41. Engagement with both Urgent Care Board (UCB) and Urgent Care Working Groups is well established and representation and participation is regular and inclusive.

42. Work on unique initiatives with partner organisations such as CCGs, the Integration Executive, Local Resilience Forum (LRF) and others are on-going in support of the improvements necessary for the wider Leicester health economy.

43. Pro-active work on hospital delays with UHL staff has shown improvement, but there is a lot more work to do in this area. UHL presented an action plan on this to the Urgent Care Board during June 2014 and work with the Trust Development Agency on this is monitored weekly.

44. New Executive Director appointments to strengthen the EMAS senior management team have been made and a new local operational area management structure will be embedded by the end of July / August 2014 to

strengthen local accountability in the delivery of the Better Patient Care plan and further enhance visibility.

45. External expert and consultant support, advice, critique and audit has been sourced and the results of this work and findings shared with commissioners to ensure the EMAS plan is robust and sufficiently focussed to deliver the required outcomes. Commissioner feedback on this has been very positive and supportive through their attendance at all relevant Board and Working Group meetings.

46. Continuing proactive engagement across stakeholders, public and staff engagement has been identified for future work, this will include: -

    - Station and Quality visits
    - ECHO (interactive online platform)
    - Listening into Action 'pulse check'
    - Staff opinion survey
    - Healthwatch organisations, Health & Wellbeing Boards and Overview & Scrutiny Committees (OSCs)

- Listening into Action events are building the Trust priorities and vision

- Planned engagement that are ongoing include:-

    - Commissioners
    - OSCs
    - Healthwatch
    - Trade Unions (Partnership Forum)
    - CEO – team brief/ bulletin

47. Our Board stands accountable for the impact the current position of the Trust has had on public confidence. Through being completely open and honest in our communication and engagement in these matters concerning the progress and substantial improvements we are making, the population of Leicestershire can be assured of the commitment to deliver Better Patient Care.

Sources of reference data and information

- All sources of information and data referred to in this report can be found on the EMAS Trust website www.emas.nhs.uk.

Officer to Contact

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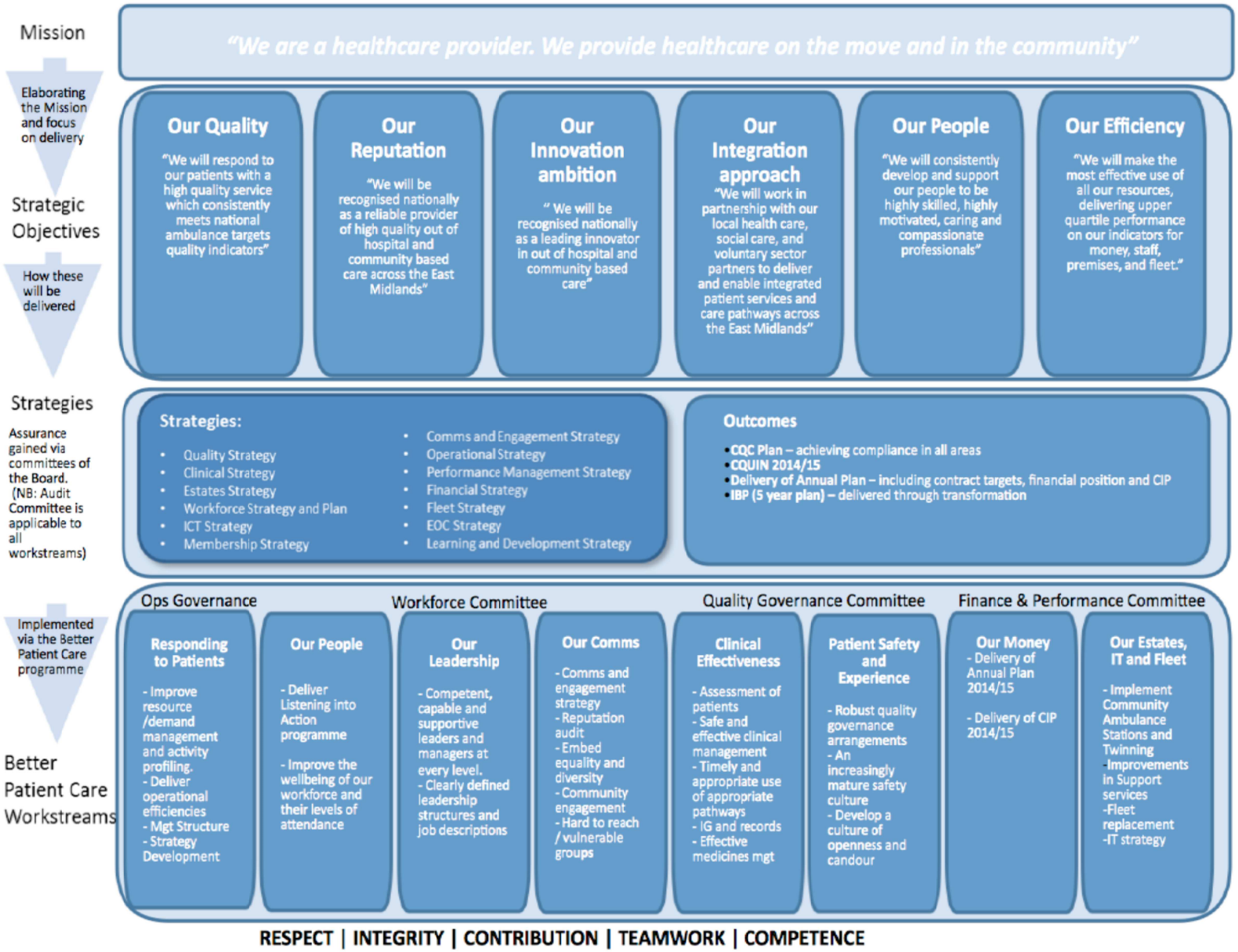
Leicester, Leicestershire and Rutland

EMAS BETTER PATIENT CARE PROGRAMME 2014/15 AND BEYOND



Leicester City Council

LEICESTER CITY HEALTH AND WELLBEING SCRUTINY COMMISSION
6 August 2014

Subject:	Director of Public Health Annual Report 2013/14
Presented to the Health and Wellbeing Board by:	Deb Watson, Strategic Director: Adult Social Care and Health, Leicester City Council
Author:	Rod Moore, Divisional Director of Public Health, Leicester City Council

Accompanying this summary report is the first annual report of the Director of Public Health for Leicester since 1st April 2013, when responsibility for the leadership of public health in England transferred from the NHS to local authorities. In this respect, the report marks a significant milestone and addresses the newly reformed health and public health system locally.

All Directors of Public Health in England are required to produce an independent annual report on the health of the population they serve, highlighting key health issues for the population.

There is no national guidance regarding the content or structure of such reports, however the broad purpose given to this year's report is to:

- inform the City Council, the Health and Wellbeing Board, the Clinical Commissioning Group, NHS England, Public Health England, other partners and the public about the health of the resident population, identifying areas for improvement;
- provide information on health needs to inform the planning and commissioning of health care, health protection and health improvement services and efforts;
- provide a record of the health of the population for comparison over time and with other places.

EXECUTIVE SUMMARY

The report itself paints a picture of health in the city and considers a number of topics, mostly linked to the theme of health inequalities which continues to be a key issue for Leicester. In doing this, it builds upon previous annual reports relating to health inequalities and notes progress in several areas. The Health Facts section at the back of the report provides key demographic data relating to health, allowing a degree of comparability over time, including at ward level.

In the sections on alcohol, smoking, obesity, sexual health and oral health this report provides a description of the relationship of these issues to health and wellbeing and some brief commentary about what we are and can do about them. There are sections also on mental health and long term conditions and finally, sections on protecting health in Leicester, looking at tuberculosis, childhood immunisations and screening programmes in the city.

Each of the main sections of the report contains a number of recommendations to be considered by policy makers and commissioners. These recommendations resonate with existing commitments and actions, such as those set out in 'Closing the Gap: Leicester's Joint Health and Wellbeing Strategy 2013-16'.

The report identifies both progress and challenges. It confirms that, on average, the health of the population of Leicester is relatively poor compared to the rest of the country on average. The main causes of death in Leicester are CVD (heart attacks and strokes), cancer and respiratory disease, all of which are associated with deprivation and all of which are amenable to prevention. Risks of these conditions are substantially increased by smoking, drinking too much alcohol, lack of physical activity and poor diet.

However, on the other side of the balance sheet, the life expectancy gap between Leicester and England, which has been widening for the last ten years, is now beginning to close. Further years of data is required before claiming definitely a narrowing trend, but it seems likely that the hard work put in by many people and organisations to improving health over the last ten years is beginning to make a measurable difference. This provides real encouragement for the future.

The report also identifies a number of areas where particular good progress has been made. These include:

- the high take up of NHS Health Checks for 40 to 74 year old people;
- sustained increases in breastfeeding;
- the high coverage of childhood immunisations in the city
- sustained reduction in the rate of teenage pregnancies.

The introduction to the report recognises that improving health is a complex combination of individual choice, the way we live and the social and economic circumstances that affect our lives, making it easier or harder for us to make healthier choices and sustain them. Invariably, improving or protecting health also involves motivating, supporting and working with the strengths of individuals and communities. Some community norms and expectations are protective of health, others put health at risk. As set out in 'Closing the Gap', there is a need to engage with communities and to work together with them to improve health. 'Closing the Gap' also stresses the importance of the wider influences on health and wellbeing such as housing, education, employment and income, transport, planning, recreation and access to health care.

The transfer of responsibility for the local leadership of public health to Leicester City Council provides opportunities for new partnerships and integration of effort both within the City Council and with wider partners through the Health and Wellbeing Board. It is intended that next year's Director of Public Health Annual Report will consider some of these wider determinants. In the meantime, it is important that all agencies within the newly reformed health and public health system continue to make the most of the new opportunities in partnership to ensure that the health of the population in Leicester continues to improve.

RECOMMENDATIONS:

The Health and Wellbeing Scrutiny Commission is requested to:

- Receive and note the Director of Public Health Annual Report 2013/14

- Consider its contents when developing priorities for the Commission's work programme

- Promote consideration of the recommendations made by partner organisations and others.

Appendix E

NHS
Leicester City
Clinical Commissioning Group

NURSING AND QUALITY TEAM

Title of the report:	Outcomes of CQC inspections in GP practices
Author:	Manjit Singh, Quality Officer
Presenter:	Manjit Singh, Quality Officer
Date:	8 July 2014

1. Purpose of Report

1.1 The purpose of this report is to summarise the outcomes of CQC inspection of GP services between September 2013 to the end of March 2014, so that the reasons for aspects being identified as good practice and reasons why other aspects were deemed not to be compliant with key standards can be used to support continuous professional development and service improvements.

1.2 This report covers the areas and standards inspected by the CQC, the outcome of inspections completed between September 2013 and the end of March 2014, summary bullet points by standard of the aspects identified as good practice and those found to be non-compliant, and two annexes providing detail of good practice and non-compliance from the inspection reports. Individual GP practices are not identified.

2. Background

2.1 General Practitioner (GP) services are usually the first point of contact for a patient seeking healthcare; they treat patients; and they refer them on for further care or treatment. They play a vital role in making sure that people's care is properly organised when more than one type of care service is involved, eg, when people leave hospital and are visited in their own home by a district nurse. Practices are often at the centre of a network of local community-based services, working closely with both NHS and social care providers.

2.2 Because of their vital role, a poor quality GP practice can have serious consequences for the health and wellbeing of a large number of people. To address this the Care Quality Commission (CQC) monitors, inspects and regulates GP services to make sure they meet fundamental standards of quality and safety, so that people have access to health provision that is safe, effective, compassionate, high quality and improving. The CQC's approach is to focus on identifying non-compliance against key national standards, although where there is compliance it is described to provide a balanced view when the CQC reports its findings and judgements. The CQC's first 1,000 inspections of GP surgeries across England have demonstrated that there are a minority of practices providing unacceptable care that need to improve, as well as some good and outstanding practices.

2.3 Inspections take place against sixteen key standards in five areas. The five areas are:

1. Standards of treating people with respect and involving them in their care
2. Standards of providing care, treatment and support that meets people's needs
3. Standards of caring for people safely and protecting them from harm
4. Standards of staffing
5. Standards of quality and management

2.4 The sixteen standards are:

Area 1:	**Standards of treating people with respect and involving them in their care**
St 1	**Respecting and involving people who use services -** People should be treated with respect, involved in discussions about their treatment and able to influence how the service is run
St 2	**Consent to care and treatment** - Before people are given any examination, care, treatment or support, they should be asked if they agree to it
Area 2:	**Standards of providing care, treatment and support that meets people's needs**
St 4	**Care and welfare of people who use services** - People should get safe and appropriate care that meets their needs and supports their rights
St 5	**Meeting nutritional needs** - Food and drink should meet people's individual dietary needs
St 6	**Co-operating with other providers** - People should get safe and coordinated care when they move between different services
Area 3:	**Standards of caring for people safely and protecting them from harm**
St 7	**Safeguarding people who use services from abuse** - People should be protected from abuse and staff should respect

	their human rights
St 8	**Cleanliness and infection control** - People should be cared for in a clean environment and protected from the risk of infection
St 9	**Management of medicines** - People should be given the medicines they need when they need them, and in a safe way
St 10	**Safety and suitability of premises** - People should be cared for in safe and accessible surroundings that support their health and welfare
St 11	**Safety, availability and suitability of equipment** - People should be safe from harm from unsafe or unsuitable equipment
Area 4:	**Standards of staffing**
St 12	**Requirements relating to workers** - People should be cared for by staff who are properly qualified to do their job
St 13	**Staffing** - There should be enough members of staff to keep people safe and meet their health and welfare needs
St 14	**Supporting workers -** Staff should be properly trained and supervised, and have the chance to develop and improve their skills
Area 5:	**Standards of quality and suitability of management**
St 16	**Assessing and monitoring the quality of service provision** - The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care
St 17	**Complaints** - People should have their complaints listened to and acted on properly
St 21	**Records** - People's personal records, including medical records should be accurate and kept safe and confidential

3. Position

3.1 Between the months of September 2013 and the end of March 2014 the CQC have undertaken thirteen inspections and published reports of GP practices located in the Leicester City CCG area.

3.2 In five of these inspections all standards across the five areas that were inspected against were met. Good practices was identified in nine standards across these five inspections. The details are as below:

1. **Standards of treating people with respect and involving them in their care**
   St 1 Respecting and involving people who use services **x 4**
2. **Standards of providing care, treatment and support that meets people's needs**
   St 4 Care and welfare of people who use services **x 5**
3. **Standards of caring for people safely and protecting them from harm**
   St 7 Safeguarding people who use services from abuse **x 3**
   St 8 Cleanliness and infection control **x 2**
   St 9 Management of medicines **x 2**
4. **Standards of staffing**
   St 12 Requirements relating to workers **x5**
   St 14 Supporting workers **x 1**
5. **Standards of quality and management**
   St 16 Assessing and monitoring the quality of service provision **x 4**
   St 21 Records **x 1**

3.3 In each of the remaining eight inspections between one and six standards were not met across the five areas. In these eight inspections ten standards did not meet the required outcomes a total of 26 times. The details are as below:

1. **Standards of treating people with respect and involving them in their care**
   St 1 Respecting and involving people who use services **x 1**
   St 2 Consent to care and treatment **x 1**
2. **Standards of providing care, treatment and support that meets people's needs**
   St 4 Care and welfare of people who use services **x 3**
3. **Standards of caring for people safely and protecting them from harm**
   St 7 Safeguarding people who use services from abuse **x 3**
   St 8 Cleanliness and infection control **x 4**
   St 10 Safety and suitability of premises **x 3**
4. **Standards of staffing**
   St 12 Requirements relating to workers **x5**

St 14 Supporting workers **x 1**

5. **Standards of quality and management**

St 16 Assessing and monitoring the quality of service provision **x 4**

St 17 Complaints **x 1**

4. Aspects identified as good practice, and the reasons

Area 1	**St 1**	**Respecting and involving people who use services** - People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run.
		• a range of methods used to gain the views of patients, eg, quarterly questionnaires, PPGs involved in decision making, comments box in waiting area; • displays of information for patients include photographs and names of staff, patient charter, Freedom of Information Act information, hygiene advice, baby changing information, use of chaperone details, fire alarm info, complaints information, home visiting arrangements, and emergency evacuation; • support to gain access to the building, modifications for wheelchair users, pictorial explanations for people with LD, hearing loops, interpreter services • respecting patient dignity and privacy, ensuring confidentiality at reception, use of chaperones for sensitive examinations; • a comprehensive system for managing complaints, accidents and incidents, and subsequent learning.
Area 2	**St 4**	**Care and welfare of people who use services** - People should get safe and appropriate care that meets their needs and supports their rights.
		• patient needs are assessed, and care and treatment is planned and delivered in line with individual care plans, with patients informed of and involved in decisions about their care; • emergency appointments are provided on the day of contact, vulnerable patients are given priority appointments, patients see the same GP, telephone appointments have been introduced; average waiting times are monitored daily; • the delivery of care and treatment aims to ensure patient safety and welfare; • a range of timetabled audits and quality assurance tools are used to check quality and safety, necessary action is recorded in an electronic diary system to remind staff of targets for action, audit results and records of discussions are stored centrally so that all staff can access them; • actions have been taken to improve health outcomes for particular groups, eg, Polish women; • there are good arrangements for foreseeable emergencies: emergency and continuity plans exist with info for each staff role; also available are defibrillators, oxygen, emergency medication, staff training in first aid and cardiopulmonary resuscitation, and emergency procedures posted on walls for patients; • patients with a terminal illness are allocated a named and deputy doctor to ensure continuity of care, systems are in place to ensure the patient is seen by their named doctor, multidisciplinary team meetings are convened to review care, appropriate agencies are informed of care needs.
Area 3	**St 7**	**Safeguarding people who use services from abuse** - People should be protected from abuse and staff should respect their human rights.
		• there are policies for safeguarding children, vulnerable adults, and whistle blowing; staff are aware of the content and where to locate the policies, and who to go to if they needed to report any safeguarding concerns; • alerts exist in the electronic record system to inform staff if there are safeguarding concerns; systems are in place to share information with the local authority; monthly staff meetings discuss child protection; • chaperones are available for patients who require a sensitive examination by a doctor; • attendance for childhood vaccinations is monitored; • a list of people caring for vulnerable people is maintained to offer them regular health care assessments; • patients with learning difficulties are invited to attend an annual health check.
	St 8	**Cleanliness and infection control** - People should be cared for in a clean environment and protected from the risk of infection.
		• consultation and treatment rooms were always clean and regularly monitored by the practice manager; • personal protective equipment, eg, gloves and aprons were readily available, and sanitizing hand gel available for staff and patients throughout the practice; • staff were aware of the infection control policy and received infection control training which was updated regularly • the cleaning schedule covered all areas in the practice and was monitored by the practice manager and practice nurse; staff using treatment rooms were trained in aseptic procedures and cleaned all surfaces and equipment used between patients; • systems were in place for the appropriate disposal of clinical waste, including needles and blades; • staff received relevant immunisations to help protect from infection risks.
	St 9	**Management of medicines** - People should be given the medicines they need when they need them, and in a safe way

		• the practice had developed a formulary for medicines prescribed by their GPs, which included information about the purpose and dose of medicines; the practice manager regularly audited prescribing and addressed any issues formally with individual GPs • the service was signed up to a Prescribing Quality Scheme with the CCG • prescription pads were kept in lockable cupboards and drawers; • the storage of medicines and the emergency drug box dressing, sharps and swabs appropriate and in date, with a system for checking medicines that was regularly reviewed by the practice manager; • nurses and administration staff monitored the vaccines fridge on a daily basis; all medicines were in date and in stock order • medicines were disposed of appropriately, with a pharmacist regularly collecting for disposal any out of date medicines and unused medicines brought in by patients.
Area 4	**St 12**	**Requirements relating to workers** - People should be cared for by staff who are properly qualified and able to do their job.
		• appropriate checks were undertaken before staff began work; a new policy introduced by the practice manager ensured all relevant checks were done before staff were employed, and all existing and prospective staff were checked with the Disclosure and Barring Service (DBS) and to repeat checks every three years; any declared convictions would be risk assessed in relation to risks to patients and staff; • all relevant checks had been done for the GPs including their registration with the General Medical Council • effective recruitment and selection practice was in place and a specialist human resources company was used for advice and to ensure compliance with employment legislation
	St 14	**Supporting workers -** Staff should be properly trained and supervised, and have the chance to develop and improve their skills.
		• The senior GP had already been through the GP revalidation scheme; all the GPs undertook training that contributed to their continuous professional development; • Records confirmed training received by staff and when it needed to be updated; • Staff received induction training and shadowed other staff if appropriate, the regular practice meeting often had a training element, eg, learning from incidents; • Staff received supervision and annual appraisal where they could identify training and development needs; • Staff enjoyed working at the practice and felt supported and valued by the manager and GPs, and that colleagues were helpful
Area 5	**St 16**	**Assessing and monitoring the quality of service provision -** The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care.
		• The provider regularly monitored the quality of its service through surveys for patient' views, through regular meetings and feedback from their PPG, and a comments box in the waiting area; any issues identified were addressed through action plans; the PPG felt that the practice listened to their feedback and acted upon it; • The practice had an effective system to identify, assess and manage risks, eg, through audits of aspects such as infection control, clinical waste management and medicines management, as well as ad-hoc audits such as immunisation uptake; all audits were evaluated and action plans to improve quality put in place where needed; • A business continuity plan was in place • The project manager audited some aspects through regular spot checks to ensure cleanliness and safety, eg, maintenance and cleaning , electrical equipment, air-conditioning units, monthly fire alarm testing, and water and heating system tests for Legionnaire's disease; • Staff received training which was updated as required; there were regular staff meetings, staff supervision, and opportunities for staff to identify their training and development needs; • Appropriate changes were implemented as a result of learning from incidents and complaints; • There were systems in place to share learning from complaints and significant events with all staff; discussions at practice meetings were not about blame but for ideas about how something could have been done differently not about blame but for ideas about how something could have been done differently the complaints procedure was available in the waiting area and on the practice website.
	St 21	**Complaints -** People should have their complaints listened to and acted on properly.
		• Records were kept securely and can be located promptly when needed; all staff had signed confidentiality statements and had a good understanding of how to protect patient confidentiality and keep written records secure; • Medical records were accurate and fit for purpose; patient information was on the SystemOne computerised system; quality audits included checks of medical records; • Staff records and other records relevant to the management were stored electronically and could only be accessed by appropriate staff; • All staff knew how to access shared management records, as well as staff and PPG meeting minutes

5. Aspects identified as non-compliant, with the reasons presented as suggestions for improvement

Area 1	**St 1**	**Respecting and involving people who use services -** People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run.
		• take patient views into account in the way the service and care for patients is delivered; • ensure formal mechanisms for people with decision making responsibility to be able to listen to patient views; • ensure access to information in an appropriate format, including systems for translation and interpretation.
	St 2	**Consent to care and treatment -** Before people are given any examination, care, treatment or support, they should be asked if they agree to it.
		• where patients do not have the capacity to consent the practice must ensure it can demonstrate it has acted in accordance with legal requirements; • be able to evidence before patients receive any care or treatment they are asked for their consent and the provision acts in accordance with their wishes; • be able to demonstrate that mental capacity assessments are carried out in accordance with the Mental Capacity Act (2005). The Act states every adult has the right to make their own decisions if they have the capacity to do so and that any act done for, or any decision made on behalf of, someone who lacks the capacity must be in their best interests; • ensure staff have a full understanding of gaining and documenting consent or assessing people's mental capacity.
Area 2	**St 4**	**Care and welfare of people who use services -** People should get safe and appropriate care that meets their needs and supports their rights.
		• ensure there is appropriate and sufficient emergency medical equipment and medication at the practice for both adults and children, including oxygen and defibrillator; • ensure patients using the service can receive appropriate care, treatment and support should a foreseeable emergency occur; • ensure care and treatment is planned and delivered in a way that intends to ensure people's safety and welfare; • always consider and respect patient's equality and diversity by providing signage, leaflets and interpretation services in relevant languages; • ensure all emergency drugs and single use equipment, eg syringes, are in date; • ensure all other medication is in date and stored correctly; • ensure that all relevant staff have received training in medical emergencies, that it is up to date, and training records are available.
Area 3	**St 7**	**Safeguarding people who use services from abuse -** People should be protected from abuse and staff should respect their human rights.
		Ensure patients are protected from the risk of abuse by identifying the possibility of abuse and preventing the abuse from happening by: • having systems that identify and respond to risks to children and vulnerable adults; • ensuring all staff have up to date safeguarding training to the correct level and that records are available; • ensuring there are clear internal policies, protocols and procedures for helping staff to identify and protect vulnerable adults and children from abuse.
	St 8	**Cleanliness and infection control -** People should be cared for in a clean environment and protected from the risk of infection.
		• ensure the cleaning schedules available for inspection and that staff are aware of the details and extent of the cleaning regime; • in treatment rooms ensure there are no piles of debris on the floor under treatment couches, dust on top of cupboards, around door frames, picture frames, a build-up of dust around the skirting boards, dust on blinds or dity curtains, etc, and that patient's accessible toilets are clean; • ensure practice cleaning records which confirm the cleaning standards are always maintained and that arrangements for assuring cleanliness of the premises are in place; • adequate arrangements must be in place for the safe disposal of clinical waste and sharps, such as needles and blades; • staff must have access to spill kits to deal with bodily spillages; • the information in the infection control policies and procedures must be up to date and accurate; • there needs to be an infection prevention and control lead and regular infection control checks undertaken; • staff should be trained in infection prevention and control practice and evidence of recent staff training needs to be kept available; • maintain a record of the latest infection control audit, an infection control policy and a copy of the 'Code of Practice on the prevention and control of infections and related guidance' that is available for staff information; • cleaning equipment and cleaning materials need to be safely stored with designated colour coded cleaning buckets or mops so that cleaning staff cannot be confused over what equipment should be used in any area, so as to remove the possibilities of cross contamination or cross infection; • ensure systems and checks are in place to prevent risks associated with Legionella from the water supply.
	St 10	

		Safety and suitability of premises - People should be cared for in safe and accessible surroundings that support their health and welfare.
		• where treatment rooms are on the first floor ensure access for people in a wheel chair; • ensure that the reception area and reception desk height is designed to be suitable for people in a wheel chair so that they have appropriate access to the reception desk or staff; • ensure that the reception area is kept clean and free of debris as part of a cleaning regime aimed at reducing the possibilities of cross infection; • there should be firefighting equipment throughout the building which has been serviced and in date; • there should be evidence of staff fire training or emergency evacuation drills, and nominated fire marshals; • the latest fire certificate for the premises must be available as well as a risk assessment for Legionella testing of the water supply; • the hot water temperature must be adequately maintained, and must be available in all the toilets; • the recent health and safety risk assessments and a copy of the electrical tests for the building must be kept available.
Area 4	**St 12**	**Requirements relating to workers -** People should be cared for by staff who are properly qualified and able to do their job.
		• all practice staff, temporary or permanent, must be subject to full recruitment checks that are currently in place; • effective recruitment checks include documented CRB/DBS checks, written personal references, fully completed application forms with a full employment history, explanations for gaps in employment, relevant experience, skills or training relevant to the job applied for, qualification checks, proofs of identification or photographs, etc, in order to assess staff suitability before they can start work within the practice; • the practice manager must be able to clearly describe the recruitment and selection process in place; • there should be a written recruitment policy or procedure to explain how the process must be operated to ensure that it is operated consistently and securely; • the provider must have a system in place to check and record that GPs and nurses remain registered with their professional body, and hold copies of these documents.
	St 14	**Supporting workers -** Staff should be properly trained and supervised, and have the chance to develop and improve their skills.
		• patients must be cared for by staff who are supported to deliver care and treatment safely and to an appropriate standard • there should be evidence of completed induction programmes to demonstrate that new members of staff completed an induction programme or relevant mandatory training. • staff should receive formal opportunities to discuss their performance and needs, such as supervision sessions, and annual appraisals must be completed; • staff should receive relevant training to prepare them for their role • staff performing delegated tasks should receive appropriate supervision or competency assessments so that they appropriately trained.
Area 5	**St 16**	**Assessing and monitoring the quality of service provision -** The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care.
		• an infection control lead needs to maintain oversight that infection prevention and control checks have been undertaken and recorded; • regular and robust checks need to be undertaken of the cleanliness of the building; • systems for checking and maintaining equipment need to be in place; • the practice manager should be able to confirm that no out of date equipment has been left in storage on the premises, including items that should have been destroyed once opened; • there must be checks in place to ensure a thorough recruitment process has been undertaken; • the practice should have a Patient Participation Group; • there needs to be records on the practice nurses' qualifications, professional development and pin number; • there must be formal processes in place for reviewing and monitoring the quality of care and service provided; • there must be evidence of audits or reviews for areas such as record keeping, documentation, infection and control practices, buildings' maintenance and clinical practices, the storage and availability of emergency medicines, so that regular monitoring and review of care and services can ensure that patients receive quality care in a safe environment; • there must be an up to date documented risk assessment for the premises and regular Legionella checks carried out • any action points recommended from a fire risk assessment should be promptly implemented; • fire doors should not have ventilation holes cut out of the door as this prevents the door being fire resistant. • learning from serious incidents and investigations needs to be evidenced and documented and appropriate changes implemented; • serious incidents must be reported to the Care Quality Commission as is required by law, and processes need to be in place to report and deal with less serious incidents, for example slip trips and falls or staff accidents.
	St 17	**Complaints -** People should have their complaints listened to and acted on properly.
		• comments and complaints patients make must be responded to appropriately and outcomes recorded;

		• patients should know how to complain as a result providers making their procedure available; • patients who do not speak or read English should not experience any difficulty using it • complaints from patients should not be recorded on their medical records As this would place them at risk of discrimination; • there should be documented reviews of complaints that include analysis and evidence that complaints have been used for learning and service improvement.

Annexe A

Detail of Areas & Standards of good practice identified through Inspection

Area 1: Standards of treating people with respect and involving them in their care

St 1 – Respecting and involving people who use services

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

- The provider used a range of methods to gain the views of patients and there was good evidence of patients' views were taken into account. A questionnaire had been developed which was used quarterly to capture the views of patients. The results of the questionnaires were collated and shared in meetings where staff were involved in deciding what action to take as a result. The Patient Participation Group's (PPG's) was also involved in decision making about action from the questionnaire. Information about the PPG's work was displayed in the waiting area and there was a visible comments box for all patients to submit written comments if they wished.
- On entering the building there was a variety of displays and information for patients including photographs and names of staff, a patient charter, Freedom of Information Act information, hygiene advice, baby changing information, use of chaperone, fire alarm, complaints information, home visiting arrangements and emergency evacuation.
- The provider was continuously reviewing advice from a variety of sources and made and reviewed decisions with staff and patient representatives.
- The building had parking spaces reserved for people with disabilities. The provider had talked to patients and provided a bell and sign at the front door advising wheelchair users and other people with restricted mobility to ring the bell if they needed any assistance getting through the door. The reception desk had a dropped area so that people who used a wheelchair could easily talk to the receptionist and all public areas and consulting rooms were on the ground floor, including a toilet suitable for patients with restricted mobility.
- The provider had also introduced information with pictorial explanations to support people with a learning disability to understand how to make appointments and what would happen during an appointment.
- Hearing loops and interpreter services were made available to patients and the practice had made considerable efforts to ensure information and support was available to patients in different formats. A summary of the services in Polish had been developed to reflect patients registered at the service. A number of languages were spoken by receptionists including Hindi and Gujarati. The provider had also developed a guide to common vaccinations for the nursing staff in Polish, Lithuanian and German.
- Staff spoke with people in a friendly and courteous manner both on the telephone and when they attended the surgery. Patients found staff helpful and friendly. The practice was also able to arrange interpreters for patients. There was information about this in the waiting area. The practice tried to ensure that all its patients were able to understand and consider diagnoses and treatment options.
- Conversations at reception could not be overheard. Reception staff had been trained not to talk loudly and to avoid repeating patient's names to help preserve their privacy.
- At another practice where conversations at reception could sometimes be overheard by other people in the waiting area, reception staff were able to speak privately with a patient in the lobby near reception or in the treatment room when this was required. This option was offered on a notice in the waiting area.
- Patient's dignity and privacy were respected. Consultations took place in private rooms behind closed doors. There were privacy curtains around the examination couches. Patients confirmed these were used during examinations. There was information about chaperones being available in the waiting area and on the doors of the consulting rooms. Staff explained that chaperones were offered when performing sensitive examinations. Reception staff were trained to undertake this role. Staff told us that some patients preferred to have a family member act as a chaperone and the practice allowed this.
- There was a comprehensive system for managing complaints, accidents and incidents. All reported issues were investigated with a root cause analysis. This is a detailed investigation to identify why something has gone wrong. These investigations were analysed for any themes and the results shared with all staff, to ensure there was learning from any untoward incidents.

Area 2: Standards of providing care, treatment and support that meets people's needs

St 4 – Care and welfare of people who use services

People should get safe and appropriate care that meets their needs and supports their rights

- Patients' needs were assessed and care and treatment was planned and delivered in line with their individual care plan. Plans were in place to manage their care and treatment. Patients told us they were informed of and involved in the decisions about their care.
- Patients confirmed that they got an emergency appointment on the day they contacted the practice. This meant that the provider had a system in place to ensure that vulnerable patients were given priority appointments. Most patients we spoke with told us that the doctors and nurses gave them all the time they needed to discuss their concerns, and most patients could see the same GP.
- The practice had also introduced a system of telephone appointments. Reception staff were trained to identify situations when this might be suitable. The GPs had several appointments which they could offer later that day if they felt the patient needed to be seen. A patient who had used this process found it to be very helpful. The GPs indicated that it was useful for patients to be able to seek advice about matters such as viral illnesses, sickness certificates or to follow up a previous consultation.
- Care and treatment was planned and delivered in a way that was intended to ensure patients' safety and welfare. Patients confirmed they found it easy to book an appointment. Appointment booking was regularly monitored through the patient questionnaire. Average waiting times to be seen were also monitored on a daily basis during clinical sessions. There were never more than two patients waiting at any one time. This was because appointments with both GPs were running on time, so patients were not waiting long periods.
- The practice manager used a range of audits and quality assurance tools to check the quality and safety of care and treatment. Audits were timetabled and any necessary action was also recorded in an electronic diary system so staff were reminded of targets for action. Results from the audits and minutes of discussions were stored in a central place on the computer system so all staff could access them. Staff stated they attended all meetings, even if they were not supposed to be working. This was because they found the meetings useful for their work.
- There was evidence of action taken to improve health outcomes for particular groups. For example, a recent demography search on those women who had not taken up cervical screening service revealed a high percentage of Polish nationality. The service translated an information leaflet about cervical screening into Polish and sent it to every eligible Polish woman registered with the service. This showed how the provider used quality assurance information to ensure the health and welfare of patients.
- There were arrangements in place to deal with foreseeable emergencies. The service had an emergency and continuity plan which included information for each member of staff role in case of emergency. Plans included the role of the sister service in sharing resources and premises in case of premises or service delivery emergency. Staff had access to defibrillators, oxygen, and emergency drugs. Staff had received training in first aid and also in cardiopulmonary resuscitation and demonstrated a good knowledge of what they would do in the event of a medical emergency. There were systems in place to ensure that the emergency drugs and oxygen were in date. Emergency procedures were posted on walls so patients and staff could see what to do if there were an emergency and they needed to provide cardio-pulmonary resuscitation (CPR) or if there was a fire.
- All patients with a terminal illness were allocated a named and deputy doctor. The receptionists used systems to ensure patients were seen by their named doctor. Multi-disciplinary team meetings were held between the practice staff, the community nursing team and palliative care nurses to review the care of patients with a terminal illness. This meant that these patients received continuity of care because appropriate agencies were informed of their care needs.

Area 3: Standards of caring for people safely and protecting them from harm

St 7 – Safeguarding people who use services from abuse

People should be protected from abuse and staff should respect their human rights

- The provider had policies in place for the safeguarding of children, the safeguarding of vulnerable adults and whistle blowing. Whistle blowing occurs when an internal member of staff reveals concerns to the organisation or the public, and their employment rights are protected. Staff were aware of the information

contained in the policies and where to locate them. This meant that staff were supported in their decision making about the safe protection of patients because they had guidelines to refer to.

- There was a GP safeguarding lead at the practice who had completed the higher level three safeguarding training for children and vulnerable adults. The GP safeguarding lead demonstrated a good knowledge of their role and responsibilities in protecting children and vulnerable adults from the risk of abuse. This meant that patients were protected from the risk of abuse because the GP had updated their safeguarding knowledge to reflect current guidelines. All the practice staff we spoke with knew who to go to within the practice if they needed to report safeguarding concerns.
- The training records confirmed that staff had received safeguarding training at a level appropriate for their role. Staff were aware of the various types of abuse and the appropriate agencies to refer safeguarding concerns to ensure that patients were kept safe from harm. Staff were aware of the importance of reporting all bruising in babies less than six months of age.
- Alerts within the electronic record system informed staff if there were safeguarding concerns about a child or vulnerable adult. There were systems in place for the provider to share information with the local authority if a child had a child protection plan in place. Monthly face to face meetings took place between practice staff and the practice's designated Health Visitor to discuss child protection concerns. This meant that there were effective systems in place to share information of concern and protect patients at risk from abuse.
- There was a chaperoning policy in place for patients who require a sensitive examination by a doctor. There were posters displayed throughout the practice informing patients of their right to be accompanied by a chaperone if they required a sensitive examination. Staff demonstrated a good knowledge of their responsibilities and were able to describe what they would do if they had any concerns regarding an examination.
- The practice monitored attendance for childhood vaccinations and raised any concerns appropriately.
- The practice also kept a list of people they knew to be caring for vulnerable people primarily in order to offer them regular health care assessments. Patients with learning difficulties were also invited to attend for an annual health check.

St 8 – Cleanliness and infection control

People should be cared for in a clean environment and protected from the risk of infection

- There were effective systems in place to reduce the risk and spread of infection.
- Patients said that the consultation and treatment rooms were always clean. The practice manager regularly monitored the cleanliness of the practice.
- There were effective systems in place to reduce the risk of infection. Personal protective equipment such as gloves and aprons were readily available. Patients confirmed that staff wore protective equipment and washed their hands and wore gloves during any procedure. Sanitizing hand gel was available for staff and patients throughout the practice. The practice had an infection control policy which all staff were aware of.
- Staff responsible for infection control received training which was updated on a regular basis. This meant the service kept up to date with current infection control methods. There was a cleaning schedule which covered all areas in the practice. This was monitored by the practice manager and practice nurse.
- There were systems in place for the appropriate disposal of any clinical waste, including needles and blades. Staff using treatment rooms were trained in aseptic procedures and cleaned all surfaces and equipment used between patients.
- Staff had also received relevant immunisations to help protect them from infection risks. This meant the provider had taken appropriate steps to protect patients, staff, and visitors to the surgery from healthcare associated infections.

St 9 – Management of medicines

People should be given the medicines they need when they need them, and in a safe way

- Medicines were prescribed and given to patients appropriately. The provider had developed a formulary for medicines prescribed by GPs at the service. This provided information about the purpose and dose of medicines as well as providing standard information for patients on labels printed at the pharmacy. The formulary also linked to national guidance on medicines in the British National Formulary (BNF). The practice manager regularly audited prescribing and addressed any issues formally with individual GPs. The service had also signed up to a Prescribing Quality Scheme with their Clinical Commissioning Group (CCG). This involved auditing prescribing of specific drug types and taking action to improve

- Medicines were kept safely. Prescription pads were kept in lockable cupboards and drawers. The provider had recently identified that they needed a clear policy for use of scripts on home visits. This showed the provider was continuously assessing risks identified with medicines and taking action to reduce risks.
- In the storage of medicines and the emergency drug box the dressings, sharps and swabs were found in date and a number were labelled for use by individual patients. There was a system for checking medicines in the emergency drug box and was regularly reviewed by the practice manager.
- The vaccines fridge was temperature monitored daily both by the nurses and the administration team. All medicines were in-date, and in stock order.
- Medicines were disposed of appropriately. A pharmacist regularly (usually daily) collected any medicines for disposal. This included medicines brought in by patients and any out of date medicines held by the service as emergency medicines or for use by the practice nurse. There were effective systems for recording medicines brought to the surgery by patients for disposal.

Area 4: Standards of staffing

St 12 – Requirements relating to workers

People should be cared for by staff who are properly qualified and able to do their job

- Appropriate checks were undertaken before staff began work. The practice manager had introduced new recruitment procedures to ensure all relevant checks were done before staff were employed. The provider had introduced a policy to check all existing and prospective staff with the Disclosure and Barring Service (DBS) and to repeat checks every three years.
- The practice confirmed that they would risk assess any declared convictions and decide whether someone could be employed on the basis of the risk to patients and staff.
- Employment records for the GPs employed at the service confirmed all relevant checks had been done, including their registration with the General Medical Council (GMC), inclusion on the local 'performers' list, a list of GPs held by the local commissioning organisation approving GPs to work in the area, and appropriate professional indemnity.
- There were effective recruitment and selection processes in place. The provider used a specialist human resources company to support the practice manager with recruitment and selection. They provided advice to ensure the provider was meeting the requirements of employment legislation, and ensured that staff were recruited in accordance with the provider's policies.

St 14 – Supporting workers

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

- All staff had received appropriate training. The senior GP confirmed that they had already been through the GP revalidation scheme by which doctors are required to demonstrate every five years that their skills and knowledge are up to date and they are fit to practise. The GP was also doing further training related to diabetes. All the GPs working at the practice undertook training which contributed to their continuing professional development, for example online training about child protection.
- Records were available to confirm the training staff had received and when it needed to be updated. Staff indicated that they had received induction training and shadowed other staff if appropriate. There were regular practice meetings which often had a training element, for example, looking at learning from incidents. Staff received supervision and an annual appraisal where they could identify any training and development needs.
- Several staff indicated they enjoyed working at the practice, that colleagues were helpful, and felt supported and valued by the manager and GPs. One associate GP also told us that they had been supported and enabled to learn a great deal about the practice and how it operated which was contributing to their professional development.

Area 5: Standards of quality and suitability of management

St 16 – Assessing and monitoring the quality of service provision

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

- The provider regularly monitored the quality of its service. This included the use of surveys to gather views of patients who used the service. Systems were in place for the provider to analyse the results of the survey for information so that any issues identified were addressed. A four point action plan had been put in place to address patient concerns. The changes had been carried out in line with the action plan such as how patients book appointments and telephone access to the practice. Patients were encouraged to provide feedback about the practice and the care they received through the comments box in the reception area. There were systems in place for this feedback to be reviewed and action plans were put in place where a need was identified.
- The practice had an established PPG that encouraged patients to share their views and highlight areas for improvement at the practice. A PPG representative indicated that they held regular meetings and the practice listened to their feedback and acted upon it. For example, after feedback the practice introduced the facility to book appointments online by their website.
- The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of patients who used the service, eg, audits had been conducted, such as infection control, clinical waste management and medicines management. The information technology manager had carried out adhoc audits in areas such as immunisation uptake. All audits were evaluated and action plans to improve quality were put in place where needed.
- There was a business continuity plan in place which meant that in the event of the failure of domestic services or information technology, patients would continue to receive a service that met their needs.
- The practice manager monitored and audited a number of aspects of the service through regular spot-checks to ensure the surgery was kept clean and safe, eg, the maintenance and cleaning of the premises , which included electrical equipment and air-conditioning units, monthly fire alarm testing, and the water and heating systems were tested to ensure they were free from Legionnaire's disease.
- A training matrix showed staff had received training which was updated as required. Records also showed that there were regular staff meetings, staff supervision, and opportunities for staff to identify their training and development needs. Learning from incidents and complaints took place and appropriate changes were implemented. There were systems in place for the practice to share learning from complaints and significant events with all staff. These were discussed at practice meetings and the discussions were not about blame but for ideas about how something could have been done better or differently. The practice kept copies of its complaints procedure in the waiting area and on its website. The provider completed the Quality and Outcomes Framework (QOF). This is a government initiative concerned with chronic disease management (for example, diabetes). There are financial incentives for practices meeting set targets.

St 21 – Records

People's personal records, including medical records, should be accurate and kept safe and confidential

- Records were kept securely and can be located promptly when needed. All staff had signed confidentiality statements. Staff members had a good understanding of how to protect patient confidentiality and how to keep written records secure.
- Patients' personal records including medical records were accurate and fit for purpose. All new records for patients were recorded and stored on the SystemOne computerised system. Medical records recorded all important information. The service's quality audits included checks of medical records. Staff records and other records relevant to the management of the services were accurate and fit for purpose. Staff records and other management records were all stored electronically and could only be accessed by appropriate staff. All staff knew how to access shared management records including minutes from staff meetings and Patient Participation Group meetings. All of the records were accurate and fit for purpose.

Annexe B

Detail of Areas & Standards Failing at Inspection and Requiring Improvement to achieve Compliance

Area 1: Standards of treating people with respect and involving them in their care

St 1 – People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Patients' views and experiences were not always taken into account in the way the service was provided and delivered in relation to their care (moderate impact).

- The three PPG members spoken to could not describe any formal mechanism for ensuring that people with decision-making responsibility listened to their views. Patients did not have access to information in an appropriate format because the provider did not have effective systems to access translation and interpretation.

St 2 – Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Before people received any care or treatment they were not asked for written consent and the provider was unable to demonstrate they acted in accordance with their wishes.

Where people did not have the capacity to consent, the provider was unable to demonstrate they acted in accordance with legal requirements (moderate impact).

- From what we saw and heard we were unable to evidence before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.
  We were also unable to locate evidence to demonstrate that mental capacity assessments were carried out in accordance with the Mental Capacity Act (2005). The Act states every adult has the right to make their own decisions if they have the capacity to do so and that any act done for, or any decision made on behalf of, someone who lacks the capacity must be in their best interests. We also reviewed the provider's MCA policy, which stated that consideration must be given to assuring patients understood, are able to retain and access information and are able to communicate their decision.
  We asked to see evidence that the two stage question test or the assessment of capacity checklist detailed in the provider's policy had been carried out for people who were suspected of lacking capacity. Where people did not have the capacity to consent, the provider did not act in accordance with legal requirements because the provider had not acted in accordance with their own policy or the MCA (2005).
  We spoke to the provider and manager who explained to us that mental capacity assessments were not carried out but patients were referred to the memory clinic at the local hospital. The provider was unable to demonstrate how they were ensuring that care was planned with the consent of people using the service or their representative. We saw no evidence that any best interest meetings had been held for any of the people using the service who had been deemed to lack capacity.
  We spoke with a number of staff during our inspection and asked them to describe their approach to ensuring people were involved and understood their care and treatment. Their responses indicated that the staff were respectful of people's wishes but all had very little understanding of gaining and documenting consent or assessing people's mental capacity.

Area 2: Standards of providing care, treatment and support that meets people's needs

St 4 – People should get safe and appropriate care that meets their needs and supports their rights

People did not always experience care, treatment and support that met their needs and protected their rights as arrangements were not in place to deal with foreseeable emergencies (minor impact).

- We saw that there was some emergency medical equipment and medication at the practice for both adults and children. However there was no oxygen or defibrillator available. A defibrillator is a lifesaving machine that gives the heart an electric shock in some cases of cardiac arrest or irregular heart rhythm. The provider told us that this was not required as they would call an emergency ambulance. This meant that people using the

service were at risk of not receiving appropriate care, treatment and support should an emergency occur. These are required to be available as part of the arrangements in place to deal with foreseeable emergencies.

People did not always experience care, treatment and support that met their needs and protected their rights as arrangements were not in place to deal with foreseeable emergencies (minor impact).

- We saw that there was some emergency medical equipment and medication at the practice for both adults and children. However there was no oxygen or defibrillator available. A defibrillator is a lifesaving machine that gives the heart an electric shock in some cases of cardiac arrest or irregular heart rhythm. The provider told us that this was not required as they would call an emergency ambulance. This meant that people using the service were at risk of not receiving appropriate care, treatment and support should an emergency occur. These are required to be available as part of the arrangements in place to deal with foreseeable emergencies.

Care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare (minor impact).

- People's equality and diversity was not always considered and respected because we found that all the signage and leaflets available were all written in English. The manager explained to us the surgery provided health care to a varied and diverse community. We asked if information was available in different languages or whether staff accessed interpreting services. We were told that services were available but staff were reluctant to use them, preferring to use relatives as interpreters and they did not provide leaflets in other languages.
  We reviewed the emergency drugs and saw they were in date, however some of the single use equipment, such as syringes, were out of date. We also reviewed all other medication which were in date and stored correctly. However, there was no lock on the cupboard, the fridge or the door to the store room. This demonstrated to us that medication was not stored safety and securely.
  We asked to see the training records for all staff who had received the appropriate training in medical emergencies and cardio – pulmonary resuscitation. Some staff had received basic life support training within the last three years, whilst others were out of date or had not received the training at all.

Area 3: Standards of caring for people safely and protecting them from harm

St 7 – People should be protected from abuse and staff should respect their human rights

Patients were not protected from the risk of abuse because the provider had not taken reasonable steps to identify the possibility of abuse and prevent the abuse from happening (moderate impact).

- The provider's systems were not appropriate for identifying and responding to risks to children and vulnerable adults. We saw safeguarding training records for only seven staff of a team of more than 20. The provider's child protection protocol stated that clinicians should be trained in child protection every year and other staff every three years. The protocol did not state what level of training each staff role should complete. The provider did not keep any records of the training expected of each staff role and training completed. There were no internal policies or procedures for protecting vulnerable adults from abuse. Vulnerable adults were not protected from the risk of abuse because the provider had no internal guidance for staff and some staff had not been trained to respond to concerns about vulnerable adults. There was no system for identifying vulnerable adults at risk of abuse.

Patients were not protected due to some staff being untrained and unaware of child and adult protection protocols (minor impact).

- We spoke with reception staff about the safeguarding of children and vulnerable adults. The staff we spoke with did not demonstrate a good knowledge of these vulnerable groups. Staff told us they had not been trained about the types of abuse and prompts to look out for. This meant that important safeguarding information could be missed due to some staff not being trained or aware what safeguarding prompts to look for.

Patients were not protected from the risk of abuse due to a inadequately trained and poorly managed staff group (minor impact).

- We saw where staff had regular discussions about peoples' safety, as this was recorded in minutes of meetings. We were told by the practice manager that staff have been trained to recognise where people may

be vulnerable and at risk. However, the reception staff were not familiar with what they should be observing for or the terminology around safeguarding and protection. This means children and vulnerable adults may be placed at risk from staff who are not well informed or adequately trained.

St 8 – People should be cared for in a clean environment and protected from the risk of infection
Patients were not protected from the risk of infection because an effective system was not in place for the appropriate disposal of clinical waste, an absence of appropriate equipment to deal with bodily spillages and lack of detailed information around the cleaning of the building (minor impact).

- We saw that all areas of the practice were clean and organised. We saw that patients and staff had good access to hand washing facilities and to antibacterial gels. However, the staff had no copies of the cleaning schedules available for inspection. This meant that staff were unaware of the details and extent of the cleaning regime, so patients could be placed in danger from an unclean or unhygienic environment. There were adequate arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. However, we saw that staff did not have access to cytotoxic sharps bin, which must be used for the disposal of cytotoxic and cytostatic medicines. These medications include most hormonal preparations, some anti-viral drugs and some antibiotics. We also noted that staff did not have access to spill kits. This meant that patients and staff were not fully protected from risks of harm.

The provider does not have an effective system in place to regularly assess and monitor infection prevention and control practices and cleanliness of the premises (moderate impact).

- We looked at the infection control policies and procedures needed review as the information was not accurate. The manager informed us that no infection control checks were undertaken and there was no identified infection control lead. We asked whether staff had been trained in infection prevention and control practice and found no evidence of recent staff training. We saw dust around the metal base of the treatment couch and a pile of debris on the floor underneath in one treatment room. We found the treatment couch was not in a good state of repair and had been taped up as part of the surface area had split. We found dust on top of a cupboard. In another treatment room we found a build-up of dust around the skirting boards, and underneath the treatment couch on the metal base we found dust. We saw the patient's accessible toilet was dirty. This means that areas in the practice which patient's would access were not cleaned to an appropriate standard. We saw a practice cleaning record which confirmed the cleaning standards were not always maintained. We found that the arrangements for assuring cleanliness of the premises were not in place.

Patients were not protected from the risk of infection because cleaning schedules, Legionella risk assessment and infection control policy and procedure were not in place; treatment rooms did not meet infection control requirements, and cleaning equipment and chemicals were not stored or used correctly (moderate impact).

- We looked around the practice in treatment rooms and in the surgeries where patients saw their doctor. We looked to see if the staff had access to, and knowledge about spill kits for bodily fluids. There were none in any of the treatment rooms. We looked at the examination couches in the treatment rooms, these had disposable paper covers in use. We noted that in one treatment room that there was a cloth cover under the disposable paper which was marked and soiled. We also noted there was a portable screen in another treatment area. Though this had a wipe clean surface, this was again marked. That meant that patients were placed at risk of cross infection or cross contamination due to areas not being cleaned regularly or appropriately.
  We asked to look at the cleaning schedules to see how often areas were cleaned. We were told there were no cleaning schedules in place, and cleaning staff knew what and how often they had to clean. That meant that there was no staff guidance in place to ensure areas were cleaned regularly enough to protect patients from the risk of infection.
  We asked to see the latest infection control audit, but were told there had not been one done recently, and staff were unsure when the last audit was undertaken. There was no infection control policy in place and no copy of the 'Code of Practice on the prevention and control of infections and related guidance' was available for staff information. That meant that there was no overall quality assurance around infection control which placed patients at risk.
  We looked at where the cleaning equipment and cleaning materials were being stored. We noted that there were no designated colour coded cleaning buckets or mops. This meant that cleaning staff could be confused over what equipment should be used in any area. That meant that patients were open to the possibilities of cross contamination or cross infection whilst visiting the health centre.
  We asked about systems in place to prevent risks associated with Legionella. There was no risk assessment to protect patients from the possibilities of contracting Legionella.

People were not protected from the risk of infection because appropriate guidance was not followed (moderate impact).

- The main areas and the treatment rooms were not clean. We found that the door frames, picture frames and cupboards were dusty throughout the surgery. We examined the treatment couches in the consultation rooms. We found there was a build-up of dust and other debris under the couches and in the joints and hinges. This meant the provider could not be sure that all cleaning tasks were undertaken to prevent the spread of infection through the build-up of dust.
  We asked to see a cleaning schedule which detailed what should be cleaned and how often. We saw a schedule of daily and weekly cleaning tasks. However, there were no documented checks on the cleanliness of the surgery.
  We spoke with the lead for infection prevention and control and asked them to show us their schedule for reviewing and monitoring the quality of cleaning and infection prevention. We were told that no such quality checks were undertaken. We asked whether staff had been trained in infection prevention and control practices. We asked to see the training records but were told that the training had not taken place.

St 10 – People should be cared for in safe and accessible surroundings that support their health and welfare
Patients, staff and visitors were not protected against the risks of unsafe or unsuitable premises due to a poor cleaning regime and missing health and safety information (minor impact).

- Most of the treatment rooms are situated on the ground floor; those on the first floor were accessible only by a flight of stairs. The reception area had a glazed front which was not designed to be accessible for people in a wheel chair. This meant that people using wheelchairs or of restricted height would not have suitable access to the reception desk or staff.
  The reception area had seats which could be wiped clean. However the floor was dirty and had debris on it. Though there was evidence of cleaning schedules in place, the premises were only visited by a cleaner twice a week. This was not adequate to ensure a suitable environment for patients and staff. This meant the provider had not taken steps to provide an environment that was adequately cleaned to reduce the possibilities of cross infection. We saw that the wallpaper was coming away and patches of bare walls were exposed. This meant that the provider had not taken steps to provide an environment that was adequately maintained to reduce the possibilities of cross infection.
  We saw there was firefighting equipment throughout the building; this had been serviced and was in date. The manager was not able to provide any evidence of staff fire training or emergency evacuation drills. This showed us that the provider had not taken the necessary steps to ensure people using the service, staff and visitors were protected from an unsafe environment.
  The practice manager could not produce the latest fire certificate for the premises and was unable to produce a risk assessment for legionella testing of the water supply. This showed us that the provider had not taken steps to ensure safety procedures and precautions were in place to protect patients and staff against the risks associated with unsafe or unsuitable premises.

Patients were not protected from the possibilities of a poorly maintained environment (minor impact).

- The practice manager told us that the hot water temperature was recognised as being too hot, but no accurate temperature had been taken. The practice manager said they were looking at reducing the hot water temperature. We also found that there was not hot water available in the men's toilets. That meant there was a health and safety risk to patients from the hot water system.

Patients who use the service, staff and visitors were not protected against the risks of unsafe or unsuitable premises due to missing health and safety information and checks (minor impact).

- We saw there was firefighting equipment throughout the building; this had been serviced and was in date. The manager was not able to provide any evidence of staff fire training or emergency evacuation drills. Staff told us there were no nominated fire marshals. This showed us that the provider had not taken the necessary steps to ensure people using the service, staff and visitors were protected from an unsafe environment.
  The practice manager could not produce the latest fire certificate for the premises and was unable to produce a risk assessment for Legionella testing of the water supply. The manager was also able to provide us with recent health and safety risk assessments and a copy of the electrical tests for the building. This showed us the provider had not taken steps to ensure safety procedures and precautions were in place to protect patients and staff against the risks associated with unsafe or unsuitable premises.

Area 4: Standards of staffing

St 12 – People should be cared for by staff who are properly qualified and able to do their job

People were not protected because the provider had not carried out an effective recruitment process (minor impact).

- A number of practice staff have been employed for many years, and were not subject to the recruitment checks that are currently in place. The provider had carried out some CRB checks on the newer member of staff to assess their suitability with work within the practice.
  When we looked at a member of staff recruited recently there were no CRB or DBS checks in place, nor were there any personal references taken up by the provider. The practice manager had not attempted to follow up references for the person. This means that people are not adequately protected by the appropriate recruitment checks being in place.
  The practice manager was unable to clearly describe the recruitment and selection process in place. There was no written recruitment policy or procedure to explain how the process should be operated. This means that there was nothing to back up the recruitment process to ensure that it was operated consistently and securely.
  The provider told us that he had a system in place to check that GPs and nurses remained registered with their professional body. The practice manager told us that the registration status of staff was checked when they are employed and then on an on-going basis. However the practice did not hold copies of these documents, and were not able to produce all of these even being given time to do so following the inspection visit.

People were not protected because the provider had not carried out an effective recruitment process (minor impact).

- The majority of practice staff have been employed for many years, and were not subject to the recruitment checks that are currently in place. The provider had carried out some CRB checks on the newer member of staff to assess their suitability with work within the practice.
  When we looked at the staff that had been recruited recently, there were no CRB or DBS checks in place, nor were there any personal referee details provided by the applicant. The practice manager had not attempted to follow up references for the person. This means that people are not adequately protected by the appropriate recruitment checks being in place.
  The practice manager was unable to clearly describe the recruitment and selection process in place. There was no written recruitment policy or procedure to explain how the process should be operated. This means that there was nothing to back up the recruitment process to ensure that it was operated consistently and securely.

The provider did not follow effective recruitment and selection checks (minor impact).

- We found in one staff record the applicant had supplied the provider a curriculum vitae (CV), the names of two referees, and their qualifications. The manager told us that verbal references were sought but had not obtained the required two references. A new check had not been obtained for the applicant with the Disclosures and Barring Service (DBS), before they started work at the practice.

Patients were placed at risk by a lack of clear guidance on the recruitment and selection procedures (minor impact).

- A group of staff we looked at, who did not have 'hands on' activity with patients did not have any checks in place. We looked at the recruitment files of staff and noted there were no proofs of identification or photographs, though there were references in place. The practice manager was unable to clearly describe the recruitment and selection process in place. There is no written recruitment process to support this. That meant that patients are not protected by a secure and detailed recruitment process.

*The provider did not carry out the relevant recruitment checks to assure themselves that patients were cared for, or supported by, suitably qualified, skilled and experienced staff (*moderate impact).

- We looked at three staff files to see if there were effective recruitment and selection processes in place, and whether appropriate checks were undertaken before staff began work. We found that one staff member did not have appropriate checks in place.
  The file did not contain a completed application form giving a full employment history, relevant experience, skills or training for the job they had applied for. The provider did not ask for satisfactory references or ask staff to explain gaps in their employment history prior to them commencing their employment at the surgery. They did not feel it was necessary to complete a full recruitment and selection process when staff were temporarily employed. All staff, whether temporary or permanent, must have the appropriate checks

undertaken before they can begin work, ensuring staff who were employed to work at the surgery were suitable and of a good character.
The provider did not have a process for checking and recording professional registration.

St 14 – staff should be properly trained and supervised, and have the chance to develop and improve their skills
The provider did not ensure there were suitable arrangements for staff to receive appropriate training, development and supervision. Patients were not cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard (moderate impact).

- We asked to see evidence of a completed induction programme. The manager was unable to demonstrate that new members of staff completed an induction programme or relevant mandatory training.
  We found that staff did not always receive formal opportunities to discuss their performance and needs, such as supervision sessions. We were told no formal supervision took place although we found annual appraisals were completed.
  We spoke to staff and asked them to describe what training they had received to prepare them for their role. We received mixed responses; two members of staff told us they had received no training in the last twelve months. One member of staff told us they had attended training when employed with another provider and another member of staff described a variety of clinical training sessions. We found that staff who performed delegated tasks had not received appropriate supervision or competency assessments. The provider did not ensure delegated tasks were undertaken by appropriately trained staff.

Area 5: Standards of quality and suitability of management

St 16 – The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care
The provider does not have an effective system in place to regularly assess and monitor infection prevention and control practices, cleanliness of premises, and the storage of clinical equipment (minor impact).

- The infection control lead informed us that no infection control checks were undertaken. Senior staff told us they carried out regular checks with the cleaning service that cleaned the practice. In one room used for patients we found the vertical window blinds were dirty and a dirty white curtain. We found systems for maintaining equipment were not in place: and arrangements for assuring cleanliness of the premises were not robust. We found out of date equipment in the locked treatment store room. They included items which should have been destroyed once opened and not left in storage. We found items had been opened from their packaging and left in cupboards. The practice manager was not aware out of date equipment was stored in this area.

The provider does not have an effective system in place to regularly identify, assess and manage risks to the health, welfare and safety of people who may be at risk from the carrying on of the regulated activity (minor impact).

- We saw evidence of some internal audits undertaken by staff which covered a number of clinical areas and the storage and availability of emergency medicines. However a number of these have not been recorded to provide an on-going audit trail of information. For example we looked at staff recruitment files and training records. We noted there were no checks in place to ensure a thorough recruitment process had been undertaken. We noted a number of training services had been undertaken and completed, but the information was not readily available to the practice manager. This means there is an absence of monitoring systems to ensure patients health and safety whilst visiting the practice.

Patients, staff and visitors were not protected against the risks of unsafe or unsuitable treatment or support because the provider did not have an appropriate system for gathering recording and evaluating information about quality and safety of care, treatment and support (minor impact).

- The practice did not have a Patient Participation Group. We saw evidence of some internal audits undertaken by staff which covered a number of clinical areas and the storage and availability of emergency medicines. However a number of these have not been recorded to provide an on-going audit trail of information. For example we looked at staff recruitment files and training records. We noted there were no checks in place to ensure a thorough recruitment process had been undertaken. We noted a number of training services had been undertaken and completed, but the information was not readily available to the practice manager. We also noted that there were no records on the practice nurses' qualifications, professional development and pin

number. A pin number is a recognised system to identify individual nurses and if they are still qualified to work in this country. This meant there was an absence of monitoring systems to ensure patients health and safety whilst visiting the practice.

The provider did not have an effective system to regularly assess and monitor the quality of service that people receive. There were no processes in place to identify, assess and manage the risks to the health, safety and welfare of people who use the service and others (moderate impact).

- We were told there were no formal processes for reviewing and monitoring the quality of care and service provided. We saw no evidence of audits or reviews for areas such as record keeping, documentation, infection and control practices, buildings' maintenance or clinical practices. Regular monitoring and review of care and services ensures that patients receive quality care in a safe environment.
  There were no risk assessment for the premises and no Legionella checks had been carried out. The provider was unable to show us that the premises and water supply were safe for patients use.
  A fire risk assessment had been undertaken in November 2010 and was due for review in November 2011. The review was not undertaken. The level of risk from the 2010 review was normal however there was 11 action points recommended. We saw that only three recommendations were completed. During our visit we raised our concern that the electrical cupboard was extremely hot. The risk assessment carried out in 2010 had recommended a fire door be fitted. We were told by the provider that the door was fire resistant. However, there was a ventilation hole cut out of the door, approximately four by five inches wide, thus preventing the door being fire resistant.
  There was evidence that learning from serious incidents and investigations took place and appropriate changes were implemented. We saw they were shared with the CCG and appropriate actions taken. However, these serious incidents had not been reported to the Care Quality Commission as is required by law. Staff told us there were no processes in place to report less serious incidents, for example slip trips and falls or staff accidents.

St 17 – People should have their complaints listened to and acted on properly

There was not an effective complaints system available. Comments and complaints patients made were not responded to appropriately (minor impact).

- Patients knew how to complain because the provider made their procedure available, although patients who did not speak or read English might have difficulty using it. Complaints from a patient were recorded on their medical records. Not all staff were aware of the provider's complaints procedure which meant patients were at risk of discrimination because their complaints were kept on the personal medical records. We saw a review of complaints from 2012. The review lacked any analysis or evidence that complaints were used for learning and service improvement. Some had no outcome recorded.

NHS

Leicester City Clinical Commissioning Group

Outcomes of CQC Inspections in GP Practices

Manjit Singh, Quality Officer, July 2014

Content of Presentation

NHS
Leicester City Clinical Commissioning Group

- **Types of Inspection**
- **What is inspected?**
- **Inspections Sept 2013 – March 2014 :**
  - key areas of good practice
  - aspects found to be non-compliant and requiring actions to improve

Types of CQC Inspection

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Responsive inspections

- inspections as a result of identified concerns

Routine inspections

- planned inspections that can occur at any time

Themed inspections

- targeted to focus on specific standards, sectors or types of care

What is inspected?

Leicester City Clinical Commissioning Group

Sixteen standards in 5 areas

- **Area 1**: standards of treating people with respect and involving them in their care
- **Area 2**: Standards of providing care, treatment and support that meets people's needs
- **Area 3**: Standards for caring for people safely and protecting them from harm
- **Area 4**: Standards of staffing
- **Area 5**: Standards of quality and management

Sept 13 – March 14
Inspection Outcomes

Leicester City Clinical Commissioning Group

- 13 GP practices were inspected in the period

- In 5 practices all standards across the five areas were met
- This involved 9 different standards across the 5 inspections

- In each of the remaining 8 inspections between 1 and 6 standards were not met
- A total of 10 different standards were non compliant across these 8 inspections

Sept 13 – March 14
Good practice identified
Area 1

Leicester City Clinical Commissioning Group

St 1 Respecting and involving people who use services (4)

•good use of questionnaires, PPGs and comments box to ascertain views of patients

•wide range of displays for patients

•positive actions to improve access to services

•respecting patient dignity and privacy

•good systems for managing complaints, accidents, incidents, and subsequent learning

Sept 13 – March 14
Good practice identified
Area 2

Leicester City Clinical Commissioning Group

St 4 Care and welfare of people who use services (5)

- treatment planned and delivered in line with indiv care plans
- emergency appointments on day of contact
- timetabled audits and QA tools used – actions taken/recorded
- focus on improving health outcomes for specific groups
- good arrangements for foreseeable emergencies
- focus on patients with a terminal illness

Sept 13 – March 14
Good practice identified
Area 3

Leicester City Clinical Commissioning Group

St 7 Safeguarding people who use services from abuse (3)

- policies for safeguarding children and adults, whistleblowing
- alerts on electronic recording systems
- use of chaperones
- monitoring of vulnerable groups

St 8 Cleanliness and infection control (2)

- cleaning schedule covered all areas, monitored by PM & PN
- staff aware of and trained in aseptic procedures, infection control policy, and immunised
- appropriate disposal of clinical waste, needles and blades
- personal protective equipment/sanitizing gel readily available

Sept 13 – March 14
Good practice identified
Area 3

Leicester City Clinical Commissioning Group

St 9 Management of medicines (2)

•formulary for prescribed medicines – purpose and dose

•prescription pads in lockable drawers

•storage of medicines & emergency drug box – in date, appropriate, and regularly checked

•vaccines fridge monitored daily – in date & in stock order

•disposal of out-of-date medicines and returns from patients – collected daily by pharmacist

Sept 13 – March 14
Good practice identified
Area 4

Leicester City Clinical Commissioning Group

St 12 Requirements relating to workers (5)

- all relevant checks completed before staff started, DBS checks for all staff,
- all relevant checks completed for GPs, incl reg with GMC
- specialist HR company used for advice, recruitment and to ensure compliance with employment legislation

St 14 Supporting workers (1)

- records confirmed all necessary checks had been received by staff and when to update, regular supervision, and annual appraisal
- induction training and shadowing, training at practice meetings
- staff enjoyed working at practice and felt supported and valued

Sept 13 – March 14
Good practice identified
Area 5

Leicester City Clinical Commissioning Group

St 16 Assessing and monitoring the quality of service provision (4)

- surveys, questionnaires, comments box, PPG meetings, > action plans
- effective systems for identifying, assessing and managing risk through spot checks and audits > action plans
- business continuity plan in place
- staff trained, regular supervision and team meetings
- changes implemented as a result of learning from significant incidents and complaints
- discussions at practice meetings – not to find fault but for ideas about doing things differently and improving practice

Sept 13 – March 14
Good practice identified
Area 5

Leicester City Clinical Commissioning Group

St 21 Records (1)

- records kept secure and located promptly when needed, stored electronically, and only accessible to appropriate person
- medical records fit for purpose, audited, on SystemOne
- staff access to shared records, staff & PPG meetings minutes

Sept 13 – March 14
Non-compliant aspects:
Area 1

Leicester City Clinical Commissioning Group

St 1 Respecting and involving people who use services (1)

•formal mechanisms are required for decision makers to take patient views into account in the way the service and care is delivered

St 2 Consent to care and treatment (1)

•MCAs need to be documented and carried out in accordance with legal requirements set out in Mental Capacity Act 2005

•staff must understand the requirement to gain and document consent, and

•be able to assess people's mental capacity

Sept 13 – March 14
Non-compliant aspects:
Area 2

Leicester City Clinical Commissioning Group

St 4 Care and welfare of people who use services (3)

•appropriate and sufficient in-date emergency medical equipment and medication needs to be available at the practice for both adults and children, including oxygen and defibrillator , to deal with foreseeable emergencies

•staff need to be trained to handle medical emergencies

•patient diversity is respected, and

•information is provided in appropriate languages

Sept 13 – March 14
Non-compliant aspects:
Area 3

Leicester City Clinical Commissioning Group

St 7 Safeguarding people who use services from abuse (3)

- policies, guidance and systems are in place that enable risks to children and vulnerable adults to be identified and responded to
- with staff having received up-to-date safeguarding training to the correct level.

St 10 Safety and suitability of premises (3)

- access to all reception and treatment rooms needs to be available for all users, eg, people in a wheelchair
- all safety processes and equipment is checked, up to date, and documented

Sept 13 – March 14
Non-compliant aspects:
Area 3

Leicester City Clinical Commissioning Group

St 8 Cleanliness and infection control (4)

- there needs to be an infection prevention and control policy and lead person that ensures regular infection control checks are undertaken and recorded
- staff need to be aware of the cleaning regime and standards to assure cleanliness of the premises
- cleaning equipment and materials must be safely stored
- systems and checks are in place to prevent risks associated with Legionella from the water supply
- arrangements are in place for the safe disposal of clinical waste and sharps
- spill kits must be available to deal with bodily spillages

Sept 13 – March 14
Non-compliant aspects:
Area 4

Leicester City Clinical Commissioning Group

St 12 Requirements relating to workers (5)

- all practice staff, temporary or permanent, must be subject to full recruitment checks
- there must be a written recruitment policy, with
- systems in place to ensure GPs and nurses remain registered

St 14 Supporting workers (1)

- all new staff should have completed an induction programme and relevant mandatory training
- regular supervision and support must be provided to all staff to ensure that they are appropriately trained

Sept 13 – March 14
Non-compliant aspects:
Area 5

Leicester City Clinical Commissioning Group

St16 Assessing and monitoring the quality of service provision (4)

•Regular checks and records need to be maintained for:

- infection prevention and control
- cleanliness of the building
- equipment
- the recruitment process and qualifications
- reviewing and monitoring the quality of care and service provided
- buildings' maintenance
- clinical practices
- the storage and availability of emergency medicines
- an up to date documented risk assessment for the premises
- regular Legionella checks completed

•Learning from serious incidents and investigations needs to be evidenced and documented, and appropriate changes implemented

Sept 13 – March 14
Non-compliant aspects:
Area 5

Leicester City Clinical Commissioning Group

St 17 Complaints

•all patients should be able to complain if they wish to and must receive an appropriate response

•these complaints need to be documented separately from the patient's medical records, and

•reviewed by the practice to inform learning and service improvement

What does this mean for PNs & HCAs?

Leicester City Clinical Commissioning Group

- Examples of Good practice and reasons for judgement of non compliance provide an agenda that supports the review of practice in your surgery
- Identify areas where practice can be improved
- Identify areas for professional development and training
- Supports continuous professional development and service improvement
- Detailed notes are available to support this work.

The new Congenital Heart Disease review: 28th update – John Holden

22 July 2014 - 12:26

It's a short blog this week, reflecting the fact that there have not been lots of meetings, with all the associated paperwork that is the staple diet of the usual blog. Instead, we have been focused on preparing for the 25 July 2014 event which brings together all our engagement and advisory groups; developing a first draft of the consultation document (more about that below); and doing some of the necessary thinking and background work on our other objectives besides Objective 1 (the standards).

Your feedback

Thank you for continuing to comment on the issues we cover in the blog. We do not respond to every individual comment, but we do look at all contributions to consider any implications for the review.

Patients, families and their representatives

Following publication of the papers considered by the review's Clinical Advisory Panel at its meeting on 18 June 2014, we received an email from The Somerville Foundation (TSF) raising their concerns about some content in Item 6, relating to transplantation for adults with CHD. In line with our commitment to transparency, you can read the correspondence from TSF here.

Clinicians and their organisations

Following the planned programme of visits to units providing CHD services, Professor Kelly (chair of our clinicians' engagement and advisory group) has agreed to visit a representative sample of units providing ACHD procedures outside the specialist congenital surgery centres. Visits are now planned to Blackpool on 30 July 2014, Brighton on 13 August 2014, and Papworth on 15 August 2014.

NHS England and other partners

Our Programme Board meets on Monday 28 July and has a refreshed membership. The agenda for the meeting will include consideration of a draft of the consultation document which will accompany the proposed CHD standards when they are published for consultation. This is NOT

the beginning of consultation on the standards, but there will be a limited opportunity for stakeholders to comment on how we could improve the shape/style/format of this consultation document before it is finalised. In addition to the standard consultation document we still intend to produce a very simple “easy read” version as well as a more comprehensive “reference document”, to suit different audiences.

Introduction and background

NHS England, as the body responsible for commissioning specialised congenital heart services, is currently undertaking a national review of congenital heart services for children and adults.

The review considers the whole lifetime pathway of care for people with congenital heart disease (CHD) to achieve:

- the best outcomes for all patients, not just lowest mortality but reduced disability and an improved opportunity for survivors to lead better lives.
- tackling variation so that services across the country consistently meet demanding performance standards and are able to offer resilient 24/7 care
- great patient experience, which includes how information is provided to patients and their families, considerations of access and support for families when they have to be away from home.

A paper providing a summary of progress at one year, including a tentative date for consultation of September 2014, was received and noted by the NHS England Board on 3 July 2014. A copy of that paper can be found here: http://www.england.nhs.uk/wp-content/uploads/2014/06/item10h-board-0714.pdf

Objectives of the review

The objectives of the new CHD review programme are:

- to develop standards to give improved outcomes, minimal variation and improved patient experience for people with congenital heart disease;
- to analyse the demand for specialist inpatient congenital heart disease care, now and in the future;
- to make recommendations about the function, form and capacity of services needed to meet that demand and meet quality standards, taking account of accessibility and health impact;
- to make recommendations on the commissioning and change management approach including an assessment of workforce and training needs;
- to establish a system for the provision of information about the performance of congenital heart disease services to inform the commissioning of these services and patient choice; and
- to improve antenatal and neonatal detection rates.

Current work and next steps

The review team is currently finalising draft national standards and specifications for use in the national commissioning of congenital heart disease services for children and adults (Objective 1). The approach (based on the advice received from a range of people including

patients, public, clinicians and providers at the outset) has been to start from the basis of developing national CHD service standards and specifications. And to this end, the review team has had invaluable input from experts in this work.

In line with NHS England's standard practice, the standards and associated service specifications will be subject to full public consultation, with launch envisaged for September 2014. Following analysis of the responses, NHS England will ask the review's Clinical Advisory Panel to advise on whether, as a result of what has been heard, any of the standards need to be amended, or any extra standards need to be added.

At the same time, the new review team is conducting a fresh assessment of future capacity requirements based on latest data and projections (Objective 2); and taking forward work with partner organisations to improve antenatal detection rates (Objective 6).

The work on standards and specifications together with work on analysis of demand, and that on antenatal and neonatal detection rates will inform discussions in relation to Objectives 3, 4 and 5 above.

Once completed, the review team will be able to make recommendations to the NHS England Board.

It is expected that by the end of the 2014/15 financial year this work will cease to be a dedicated "task and finish" project, and implementation will be mainstreamed as part of NHS England's wider commissioning of specialised services.

Useful information and links

As part of the reviews' commitment to openness and transparency, all meeting agendas, papers and notes are published on the NHS England website and can be found here: http://www.england.nhs.uk/ourwork/qual-clin-lead/chd/meetings/

John Holden, Director of System Policy at NHS England produced a bi-weekly blog post to update stakeholder on progress of the new CHD review – all blog posts can be found here: http://www.england.nhs.uk/category/publications/blogs/john-holden/

Contact the new CHD review team at: england.congenitalheart@nhs.net or on **0113 82 48232**

1 August 2014

Issue covered in Chief Executive's monthly Report to Trust Board 31.7.14

To:	**Trust Board**
From:	Director of Strategy
Date:	31st July 2014
CQC regulation:	

Title:	Future provision of paediatric Congenital Cardiac Surgery at the University Hospitals of Leicester (UHL)

Author/Responsible Director:
Kate Shields

Purpose of the Report:
The purpose of this paper is to seek agreement on the next steps regarding the provision of Paediatric Congenital Cardiac Surgery at UHL, in light of the recent iteration of the draft Cardiac Review specifications

The Report is provided to the Board for:

Decision	X	Discussion	X
Assurance		Endorsement	

Summary / Key Points: This report updates the Board on the latest review developments and proposes action in response.

Recommendations:

The Board is asked to:

- Support the commissioning of an urgent assessment of the potential to alter our current reconfiguration plan to achieve co-location, including timelines and costs,
- Support the Director of Strategy pursuing the existing dialogue with BCH with a view to agreeing a network approach as soon as possible
- Agree a paper coming to a future meeting that sets out the implications of meeting the emerging standards and the implications of not meeting them (i.e. the future strategy for the service)
- Support a communication being issued to staff immediately explaining the approach being taken and decision-making timescales

Previously considered at another corporate UHL Committee?
Executive Team

Board Assurance Framework: Responsive Services, Research	**Performance KPIs year to date:**

Resource Implications (eg Financial, HR): Yes, TBC	
Assurance Implications:	
Patient and Public Involvement (PPI) Implications: Active engagement with support groups required	
Stakeholder Engagement Implications: National and local	
Equality Impact: Potential re accessibility	
Information exempt from Disclosure:	
Requirement for further review? Yes	

Future provision of paediatric Congenital Cardiac Surgery at the

University Hospitals of Leicester (UHL)

Purpose:

1. The purpose of this paper is to seek agreement on the next steps regarding the provision of Paediatric Congenital Cardiac Surgery at UHL, in light of the recent iteration of the draft Cardiac Review specifications

Background

2. The NHS England New Congenital Heart Disease Review has produced draft standards highlighting key requirements expected of Specialist Surgical Centres within the Congenital Heart Network. Whilst it is yet to be agreed when these will be published for public consultation, it is expected that consultation will be more about how to implement the recommendations, rather than what the standards are.

3. Following the challenge to the Safe and Sustainable process, this review has demonstrated significant governance and involvement of necessary stakeholders, and as such the outcome of the review is likely to be upheld

4. The latest iteration has highlighted two key points that impact UHL

   4.1 Surgical teams require a minimum of 4 surgeons each delivering a minimum of 125 cases and a total of 500 cases per annum. This is based on clinical evidence that indicates such activity over a period of 3 years provides the necessary level of clinical quality needed to provide the service.

   4.2 All paediatric services need to be co-located on one site and not as previously indicated within 30 minutes contact time.

5. Current Cardiac surgery case load is 273 and predictions in activity growth from demographic and network expansion shows that 375 cases can be achieved within a 3 year period

6. The predications for reaching 500 cases show this will be more challenging requiring a minimum of 12 years to achieve

7. The review committee have indicated that there is some latitude in reaching the 500 caseload and they are not adverse to network partnerships. Early discussions with Birmingham indicate an appetite for UHL working with Birmingham Children's Hospital (BCH) to achieve this.

8. The review committee have also indicated that there are other opportunities on how specialist commissioned services are provided and there is an appetite for creativity and innovation in commissioning and contracting. This supports the partnerships conversations already in place with BCH.

9. With Congenital Cardiac Surgery currently delivered at Glenfield Hospital we do not meet the proposed standard in respect to co- location. **The Review Committee has made it clear that there is no latitude in respect to this standard.** Without co-located paediatric services, the Paediatric Congenital Cardiac service would no longer be viable.

10. The loss of Paediatric Congenital Cardiac Surgery would still require UHL to retain other elements of the pathway such as fetal screening and interventional cardiology. To note this would also need to be co-located with paediatric services.

Recommendations

The Board is asked to:

- Support the commissioning of an urgent assessment of the potential to alter our current reconfiguration plan to achieve co-location, including timelines and costs,

- Support the Director of Strategy pursuing the existing dialogue with BCH with a view to agreeing a network approach as soon as possible

- Agree a paper coming to a future meeting that sets out the implications of meeting the emerging standards and the implications of not meeting them

- Support a communication being issued to staff immediately explaining the approach being taken and timescales

CONGENITAL HEART DISEASE REVIEW

COMMENTS AND OBSERVATIONS RECEIVED FROM INTERESTED PARTIES

E-MAIL TO STAKEHOLDERS FOLLOWING THE STAKEHOLDERS MEETING AT GLENFIELD HOSPITAL IN JUNE.

"Thanks to those who were invited and went along to the event hosted by NHS England for patients and families a couple of weeks ago.

For those who didn't attend, NHS England (NHSE) visited the East Midlands Congenital Heart Centre (EMCHC) at Glenfield on Friday 30 May. As part of the review, the NHSE team has been visiting all centres in England that provide this specialist service.

These visits have been an opportunity for NHS England to:

- update the clinical teams and patients and parents about the review,
- hear from the Trust's perspective of their Unit functions, what they are proud of and how they are facing their challenges; and
- listen to staff and patients as they describe what a good service looks like, to ensure that the standards reflect what we are being told.

The visit went well and was good opportunity to meet the key people leading the review for NHSE.

By now, I am sure you are all aware of the recent announcement made by health minister, Jane Ellison about the delay to the consultation period of the review.

In light of this, I have been liaising with members of the service to set up a date for our next meeting so we can proceed with our plans for expansion. This meeting is likely to take place towards the end of July/early August and will be an opportunity to discuss our estate options for the unit at Glenfield.

I will be in touch with you shortly once a date has been agreed."

COMMENTS FROM ERIC CHARLESWORTH

Dear Michael,

I understand the above meeting is due to be held tomorrow. In view of the significant role & continuing interest you showed in Glenfield Hospitals role in providing Paediatric Congenital heart surgery (now encompassing adult cc as well,) I thought it appropriate to share a concern raised with me, which may be worthy of clarification should you feel it appropriate.

The recent visit by NHS England, I thought was very positive & a refreshing change to the previous debacle of Safe & Sustainable. Video conferences with John Holden NHS E lead have supported a fresh & balanced review. Clearly however, the current health economy position has significance on the BETTER CARE TOGETHER Board proposals, endorsed by all 3 LA's & both Trusts.

Whilst the proposed direction of travel has endorsed the creation of a Women's hospital, there is NO reference to a similar commitment to a Children's Hospital. This would include the future of the paediatric Congenital care unit. The issue of having all services on 1 site may remain key in the final decision. Without such a reference in the planning proposals, fears are growing that this may influence NSH E's recommendations re the future of Glenfield as a key provider.It may be that the Trust are awaiting the Reviews recommendations , but this could be addressed by having a positional statement made about the future of a Children's hospital.

Should you not feel it appropriate to raise at OSC, the mere fact that we are sharing information seems vital, as it will be coming for public consultation in the months ahead.

Sent from my iPad

Regards

Eric Charlesworth

Chair Leicester Mercury Patients Panel

& Healthwatch member

22 JULY 2014

COPY OF E-MAIL FROM CONGENITAL HEART DISEASE REVIEW TEAM NHS ENGLAND

Dear colleagues

This week we are submitting **draft versions of our key consultation documents** to the NHS England new congenital heart disease review Programme Board for their review.

These documents include the:

- **draft financial impact assessment** (**attached**);
- **draft equality analysis** (**attached**); and
- **draft consultation document** (**to follow**).

All of these documents are currently being reviewed and **do not represent the final documents we will issue for public consultation**. We are still working on the consultation document, and it will be submitted to the Programme Board as a late paper, expected by close of business tomorrow.

As key stakeholders in the review we thought that you would be interested to see the current versions of these documents and to be aware that they will be published as part of the full set of Programme Board papers, as usual, on the NHS England website in advance of the meeting.

We have attached those that have been submitted so far and as soon as we have it available, we will provide you with a copy of the latest draft of the consultation document.

The Programme Board members will be submitting any comments they have relating to these documents in writing in advance of the meeting, or at the meeting on Monday 28 July 2014, in order to ensure the review team have sufficient time to consider and implement these comments prior to the final versions being approved for use in the public consultation.

We are not requesting you to review and comment on these documents at this stage but if you did have a comment to make please ensure it reaches us by Monday 28th July 2014.

For your information we have also attached a copy of the **draft minutes of the most recent meeting of the Clinical Advisory Panel (18 June 2014)**, where what we heard about the standards pre-consultation was considered, and changes to the standards were agreed. The papers issued for this meeting can be found here: http://www.england.nhs.uk/wp-content/uploads/2014/06/chd-26-cap-agend-papers-180614.pdf

Many thanks

Kind regards

New congenital heart disease review team

NHS England

Tel: 0113 8248232

Email: england.congenitalheart@nhs.net

4 AUGUST 2014

COPY OF E-MAIL SENT BY JOHN ADLER, CHIEF EXECUTIVE UHL TO STAFF AND LATER CIRCULATED TO FRIENDS OF THE EAST MIDLANDS CONGENITAL HEART CENTRE,

Dear colleagues,

I thought it would be helpful to share with you some very recent developments in the NHS England New Congenital Heart Disease Review because of the profile of this service and because the developments affect the plans of the Trust as a whole.

The Review has produced draft standards highlighting key requirements expected of Specialist Surgical Centres within the Congenital Heart Network. Whilst it is yet to be agreed when these will be published for public consultation, it is expected that consultation will be more about how to implement the recommendations, rather than what the standards are. This is because there has been a great deal of involvement in their production (including from UHL).

The latest iteration has highlighted two key points that impact our service:

- Surgical teams require a minimum of 4 surgeons each delivering a minimum of 125 cases and a total of 500 cases per annum. This is based on clinical evidence that indicates such activity provides the necessary level of clinical quality needed to provide the service. It is clear that there will be some flexibility in the timescales allowed to meet these numbers, with an initial milestone at 375 cases, probably within 3 years.

- All paediatric services need to be co-located on one site and not as previously indicated within 30 minutes contact time.

In the light of this, a paper regarding the provision of the service was submitted to our Trust Board for discussion on Thursday 31 July. The following actions were agreed:

- *Supporting the commissioning of an urgent assessment of the potential to alter our current reconfiguration plan to achieve co-location, including timelines and costs.* In order to be consistent with our recently published 5 Year Plan, we will be looking to co-locate all children's services at the LRI (i.e. move children's heart surgery from Glenfield to the LRI). This would have the added benefit of resolving our split-site children's services, which we all agree is less than ideal. It is worth mentioning that our investment plans already include spending on new children's and children's heart surgery facilities – we would simply spend this money in a different way.

- *Supporting the Director of Strategy pursuing the existing dialogue with Birmingham's Children's Hospital with a view to agreeing a network approach as soon as possible*. Although our projections show that we should be able to able to get to 375 cases, we will struggle to reach 500 because our catchment population is not big enough. The solution is to network with Birmingham Children's Hospital, something which we have been discussing with colleagues there for some time. This will allow the respective strengths of both centres to be brought together to the benefit of patients.

- *Agreed to a paper coming to a future meeting that sets out the implications of meeting the emerging standards and the implications of not meeting them.* The Board was clearly of the view that we should aim to meet the emerging standards in the way described above. This was felt to be the best way of securing the future of the children's heart service in Leicester and also potentially derive significant benefits for our children's services as a whole.

I hope that this update is helpful.

Kind regards,

John Adler

Chief Executive

Children's heart ops could be moved to Leicester Royal Infirmary

By Leicester Mercury | Posted: August 05, 2014

By Cathy Buss

Children's heart operations could be moved in a bid to protect the long-term future of the surgical unit.

NHS England, which is reviewing provision nationwide, is expected to insist all children's services are on one site if hospital trusts want to carry on as a surgical centre for youngsters born with heart problems.

At the moment, children's heart surgery is at Glenfield Hospital while all other paediatric services, including the neo-natal unit, are at Leicester Royal Infirmary.

There has been concern among medics at University Hospitals of Leicester NHS Trust that unless all the services are brought together, Leicester could miss out on heart surgery centre status in the future.

In a message to staff and campaigners yesterday, John Adler, chief executive of the trust, said there would be "an urgent assessment", including of the time and costs of moving children's heart facilities.

He said: "This would have the added benefit of resolving our split-site children's service, which we all agree is less than ideal."

Directors have also given the go-ahead for talks with Birmingham Children's Hospital to make sure the Leicester trust can meet a requirement – still in draft form – that each centre has four surgeons, all performing 125 operations a year.

Mr Adler said: "The trust board was clearly of the view that we should aim to meet the emerging standards.

"This was felt to be the best way of securing the future of children's heart services in Leicester and also, potentially, to derive the significant benefits for our children's services as a whole."

Adam Tansey, from Burbage, whose son Albert was born with half a heart, was on the panel which helped to draw up the standards.

He said: "This review recognises the need for the best national service.

"Naturally there is concern that the ethos changes if you move the service but we are constantly dealing with changes in our lives and everyone at Glenfield has shown their ability to move with the times."

The Leicestershire charity Heart Link cautiously welcomed a possible move.

Spokesman Richard French said: "Obviously, we would like the service to remain in Leicester, ideally at Glenfield, but if it has to transfer to the infirmary then so be it.

"Our priority is the children and parents who have to use the service. If it is relocated then all facilities and provisions we have supplied via our fund-raising over 33 years will be replicated on a new site."

Eric Charlesworth, chairman of the Leicester Mercury Patients' Panel, said: "I am delighted at these next steps.

"Now is the opportunity to begin to remove any issues that might hinder the continuation of this world-leading service."

Zuffar Haq, also a member of the Leicester Mercury Patients' Panel, said he would prefer a new children's hospital at Glenfield.

He said: "The move to the infirmary looks like a short-term fix."

Last year, a review, Safe and Sustainable, recommended cutting the number of children's heart surgery centres nationally from 11 to seven.

It was subsequently suspended after a High Court ruling that it was flawed.

However, Glenfield Hospital was one of the centres earmarked for closure.

Read more: http://www.leicestermercury.co.uk/Children-s-heart-ops-moved-infirmary/story-22073999-detail/story.html#ixzz39bfEYKEA

Draft paper – 6th August 2014

QUALITY ACCOUNTS – A PROCESS FOR HEALTH & WELLBEING SCRUTINY COMMISSION

1. Purpose

1.1 The Health & Wellbeing Scrutiny Commission is required to consider a more robust process to receive and comment on future draft Quality Accounts of local healthcare providers.

1.2 The Health & Wellbeing Scrutiny Commission is invited to comment annually on the draft Quality Accounts of local organisations providing NHS services, such as:

- University Hospitals of Leicester NHS Trust (UHL)
- Leicestershire Partnership NHS Trust (LPT)
- East Midlands Ambulance Trust (EMAS)
- LOROs Hospice, Leicester

1.3 Healthwatch Leicester use Quality Accounts to support discussions about NHS healthcare matters in the local area and they also provide the opportunity for healthcare providers to engage with stakeholders representing their patients and service users.

2. Recommendations

2.1 Commission members to consider and agree a process (at section 4) for receiving and commenting on future draft Quality Accounts of the above local healthcare providers (1.2).

2.2 Commission members to consider and agree the most appropriate way forward for providing comments on any other draft Quality Account they might receive, that is produced by a local healthcare provider.

3. Background – What is a Quality Account?

3.1 All providers of NHS healthcare services in England are required to publish an annual Quality Account – which are essentially annual reports to the public about the quality of services they provide. This includes independent and charitable organisations, unless they are classed as 'small providers'.

3.2 Providers are asked to consider three aspects of quality – patient experience, safety and clinical effectiveness. The Quality Account is a document aimed at a local, public readership. This both reinforces transparency and helps persuade stakeholders that the organisation is committed to quality and improvement.

4. Role of Health & Wellbeing Scrutiny Commission

4.1 Overview and Scrutiny Committees, in this case the Health & Wellbeing Scrutiny Commission, along with commissioners and local Healthwatch, are given the opportunity to comment on a provider's Quality Account before it is published, as it is recognised that they have a role in the scrutiny of local health services, including the ongoing operation of and planning of services.

4.2 The Health & Wellbeing Scrutiny Commission is ideally placed to ensure that a provider's Quality Account reflects the local priorities and concerns voiced by their constituents.

4.3 If an important local healthcare issue is missing form a provider's Quality Account then the Health & Wellbeing Scrutiny Commission can use the opportunity in the form of a statement to be included in their comments.

4.4 Quality Account aim to encourage local quality improvements and Health & Wellbeing Scrutiny Commission can add to the process and provide further assurance by providing comments on the issues they are involved in locally.

4.5 Quality Accounts should provide a summary of quality performance for the previous year and enable patients and the public to understand:

- What the organisation is doing well
- What improvements in service quality are required
- What the priorities for improvement are for the forthcoming year
- How the provider has involved service users, staff and others with an interest in the organisation in determining the priorities for improvement

4.6 Given the support for Quality Accounts expressed by Robert Francis in his report on Mid Staffordshire NHS Foundation Trust, the chair of Health & Wellbeing Scrutiny Commission is keen that comments should be provided, where possible. However, if for any reason this is not possible, the commission will provide an explanation for the lack of comment and this should not be seen as a reflection on the provider.

4.7 The Health & Wellbeing Scrutiny Commission should not feel that they have to comment on areas of the Quality Account where they do not have relevant knowledge e.g. clinical information.

4.8 Providers are required to report on activities on an annual basis submitting their Quality Account to the Secretary of State and on the website NHS Choices by 30th June each year. For this purpose, the Health & Wellbeing Scrutiny Commission expects to receive draft Quality Accounts during (April / May? tbc) to allow a reasonable timescale to provide their comments. Quality Accounts to be added to the work programme accordingly.

4.9 An example of good practice is ATT re: 'Comments from Health & Wellbeing Scrutiny Commission for University Hospitals Leicester NHS Trust 'Quality Accounts 2012/2013'.

5. Background Papers:

5.1 NHS Choices Website, Quality Accounts:
http://www.nhs.uk/aboutNHSChoices/professionals/healthandcareprofessionals/quality-accounts/Pages/about-quality-accounts.aspx

5.2 NHS England guidance requirements 2013/2014:

http://www.england.nhs.uk/wp-content/uploads/2014/01/qual-accs-rep-lett.pdf

6. Report by:

Councillor Michael Cooke, Chair of Health & Wellbeing Scrutiny Commission,

EXAMPLE LETTER OF GOOD PRACTICE

7th June 2013

To:
Sharon Hotson, Director of Clinical Quality
John Adler, Chief Executive
University Hospitals of Leicester (UHL)

RE: COMMENTS OF THE HEALTH SCRUTINY COMMISSION ON THE UNIVERSITY HOSPITALS LEICESTER TRUST (UHL) - DRAFT QUALITY ACCOUNT 2012-13

Thank you for attending our Health and Well-being Scrutiny Commission meeting at Leicester City Council, on 28th May 2013 to present the University Hospitals of Leicester Trust report on its Draft Annual Quality Account 2012/13. We welcomed your presentation and also the attendance of John Adler, Chief Executive, who presented the UHL Strategic Direction report.

Please accept the following minute extract to form the comments of the Health and Wellbeing Scrutiny Commission:

Members made the following observations on the draft Quality Account Report:-

- It was pleasing to see improvements of some of the local indicators even if these were still no so good compared to the national average. The direction of travel in improvement was welcomed.
- Additional support facilities, including parking, should be provided for family and relatives as part of 'End of Life Care.'
- The low level of staff (55%) who would recommend the provider to friends or family needing care was disappointing when compared to the national average (64%).
- A breakdown and better understanding of the differing groups involved and how they inter-play with each other would be useful, together with an understanding of proposals to target hard to reach groups.

In response, it was stated that:-

- The improvement in mortality rates was pleasing but the Trust wished to continue this improvement so that it was in the national top 25 quartile.
- The issue of staff recommending the provider to friends and family would be addressed through the Listening Into Action and Quality Care initiatives. It was however, pleasing that the equivalent rate for patient recommendations had risen from 51% in 2012 to 64% in 2013.
- An open invitation was extended to any member of the Commission to visit the hospital to see how services were provided.

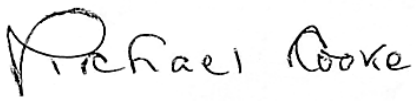
The Healthwatch representative expressed appreciation to the 20 LINk members in the City and County who had been involved in consultations on the Quality Account and for Health watch to be involved in the future.

RESOLVED:

that the draft Quality Accounts 2013/16 be received and the invitation for Members of the Commission to visit the hospital to see how services are provided be welcomed.

The commission found the quality accounts 2012/13 report format to be easily accessible and reader friendly. The Health and Wellbeing Scrutiny Commission at Leicester City Council, welcomes the opportunity to continue to provide their comments each year.

Many thanks,



Councillor Michael Cooke
Chair of Health and Wellbeing Scrutiny Commission
LEICESTER CITY COUNCIL.

Public Health England

Leicester

Unitary Authority

This profile was produced on 8 July 2014

Health Profile 2014

Health in summary
The health of people in Leicester is varied compared with the England average. Deprivation is higher than average and about 30.0% (21,000) children live in poverty. Life expectancy for both men and women is lower than the England average.

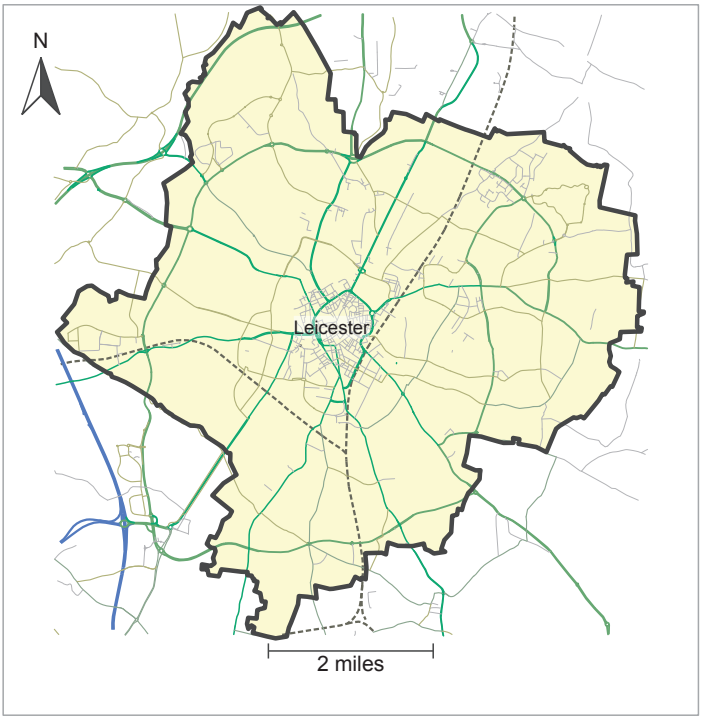
Living longer
Life expectancy is 6.8 years lower for men and 4.5 years lower for women in the most deprived areas of Leicester than in the least deprived areas.

Child health
In Year 6, 21.1% (713) of children are classified as obese, worse than the average for England. The rate of alcohol-specific hospital stays among those under 18 was 25.7*, better than the average for England. This represents 20 stays per year. Levels of teenage pregnancy, GCSE attainment and smoking at time of delivery are worse than the England average.

Adult health
In 2012, 19.6% of adults are classified as obese. The rate of alcohol related harm hospital stays was 717*, worse than the average for England. This represents 1,988 stays per year. The rate of self-harm hospital stays was 137.4*, better than the average for England. This represents 488 stays per year. The rate of smoking related deaths was 293*. This represents 366 deaths per year. Estimated levels of adult physical activity are worse than the England average. Estimated levels of adult excess weight are better than the England average. Rates of sexually transmitted infections and TB are worse than average. The rate of people killed and seriously injured on roads is better than average.

Local priorities
Priorities include young people, premature deaths, supporting independence, mental health and the wider determinants of health. For more information see www.leicester.gov.uk

* rate per 100,000 population



Population: 332,000
Mid-2012 population estimate. Source: Office for National Statistics.

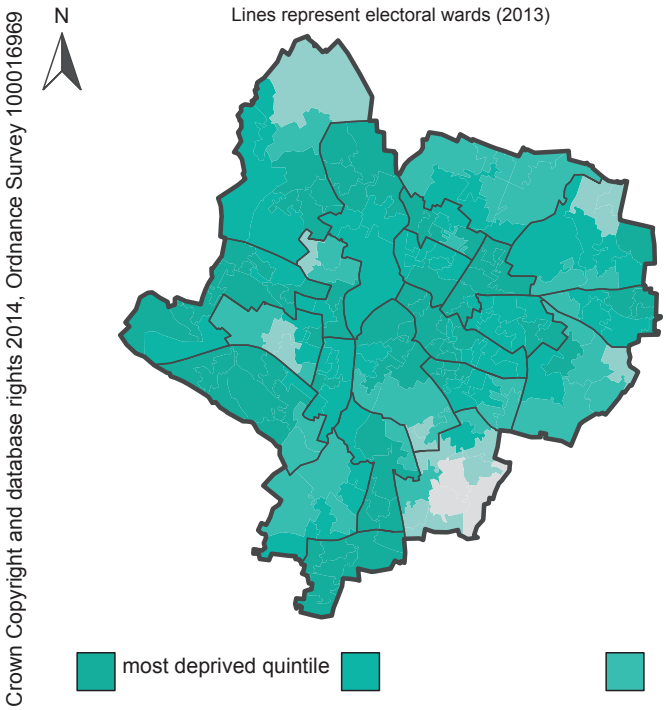
This profile gives a picture of people's health in Leicester. It is designed to help local government and health services understand their community's needs, so that they can work to improve people's health and reduce health inequalities.

Visit www.healthprofiles.info
or scan this Quick Response code: for more profiles, more information and interactive maps and tools.

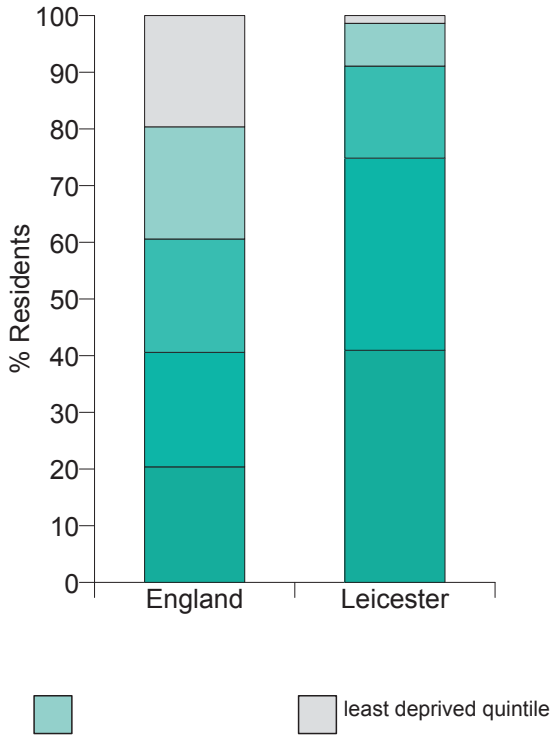
Follow @healthprofiles on Twitter

Deprivation: a national view

The map shows differences in deprivation levels in this area based on national quintiles (fifths) of the Index of Multiple Deprivation 2010 by Lower Super Output Area. The darkest coloured areas are some of the most deprived areas in England.



This chart shows the percentage of the population in England and this area who live in each of these quintiles.

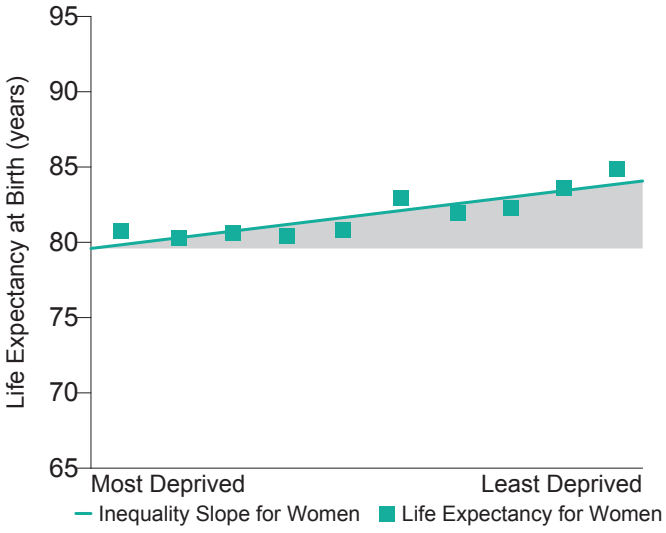


Life Expectancy: inequalities in this local authority

The charts below show life expectancy for men and women in this local authority for 2010-2012. Each chart is divided into deciles (tenths) by deprivation, from the most deprived decile on the left of the chart to the least deprived decile on the right. The steepness of the slope represents the inequality in life expectancy that is related to deprivation in this local area. If there were no inequality in life expectancy as a result of deprivation, the line would be horizontal.

Life Expectancy Gap for Men: 6.8 years

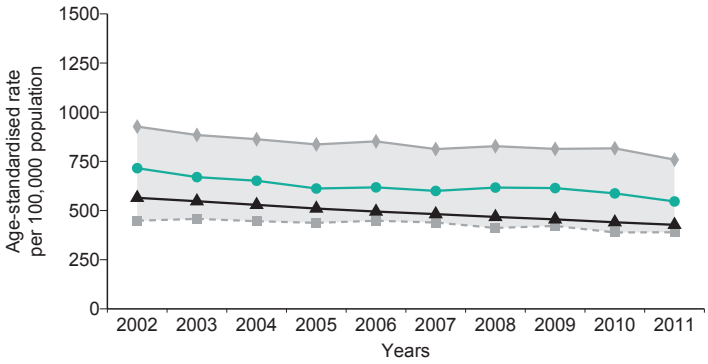
Life Expectancy Gap for Women: 4.5 years



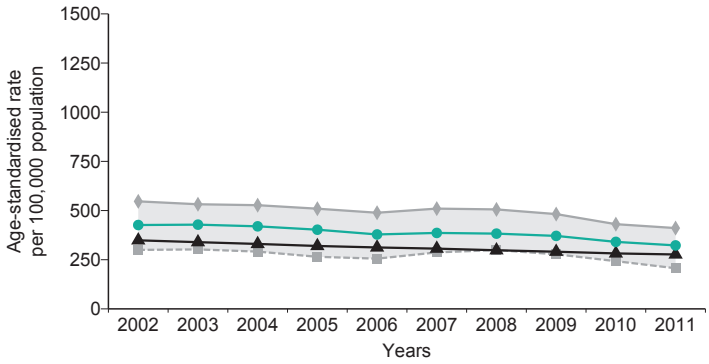
Health inequalities: changes over time

These charts provide a comparison of the changes in early death rates (in people under 75) between this area and all of England. Early deaths from all causes also show the differences between the most and least deprived quintile in this area. (Data points are the midpoints of 3 year averages of annual rates, for example 2005 represents the period 2004 to 2006).

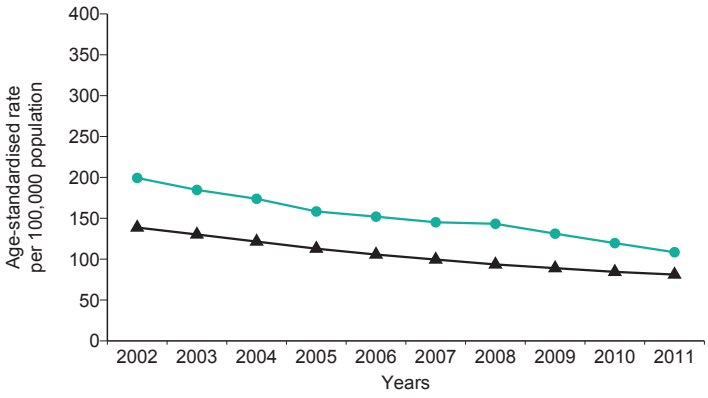
Early deaths from all causes: MEN



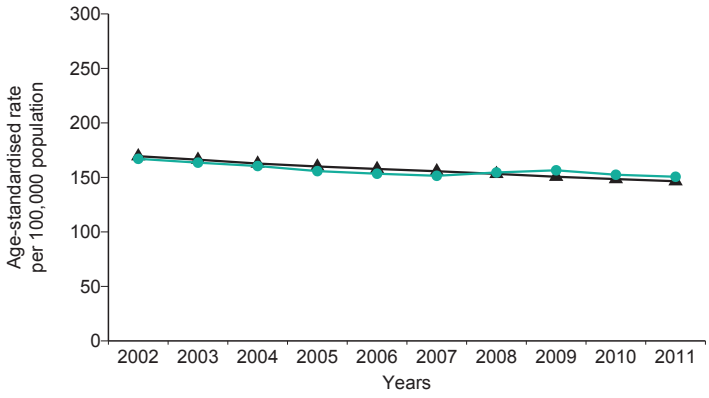
Early deaths from all causes: WOMEN



Early deaths from heart disease and stroke



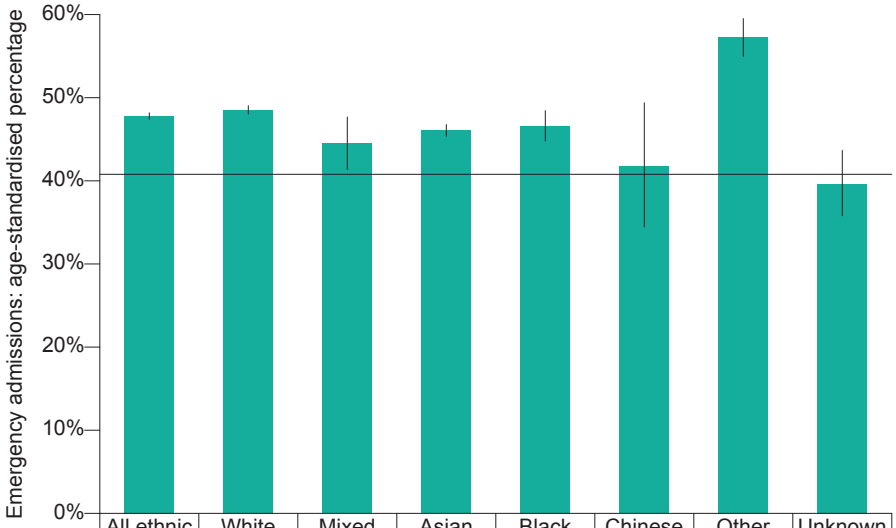
Early deaths from cancer



England average | Local average | Local least deprived | Local most deprived | Local inequality

Health inequalities: ethnicity

Percentage of hospital admissions that were emergencies, by ethnic group



This chart shows the percentage of hospital admissions in 2012/13 that were emergencies for each ethnic group in this area. A high percentage of emergency admissions may reflect some patients not accessing or receiving the care most suited to managing their conditions. By comparing the percentage in each ethnic group in this area with that of the whole population of England (represented by the horizontal line) possible inequalities can be identified.

Leicester

England average (all ethnic groups)

95% confidence interval

Figures based on small numbers of admissions have been suppressed to avoid any potential disclosure of information about individuals.

All ethnic groups	White	Mixed	Asian	Black	Chinese	Other	Unknown	
30,693	18,845	485	8,606	1,361	72	1,084	240	Local number of emergency admissions
47.8	48.5	44.5	46.1	46.6	41.7	57.3	39.7	Local value
40.8	41.3	40.8	45.4	45.0	37.0	46.5	30.3	England value

Health Summary for Leicester

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average

Domain		Indicator	Local No Per Year	Local value	Eng value	Eng worst	England Range (Regional average^ / England Average; England Worst / England Best; 25th Percentile / 75th Percentile)	Eng best
Our communities	1	Deprivation	135,783	40.9	20.4	83.8		0.0
	2	Children in poverty (under 16s)	20,955	30.0	20.6	43.6		6.4
	3	Statutory homelessness	69	0.5	2.4	33.2		0.0
	4	GCSE achieved (5A*-C inc. Eng & Maths)	1,905	54.8	60.8	38.1		81.9
	5	Violent crime (violence offences)	5,222	15.8	10.6	27.1		3.3
	6	Long term unemployment	3,753	16.8	9.9	32.6		1.3
Children's and young people's health	7	Smoking status at time of delivery	715	14.2	12.7	30.8		2.3
	8	Breastfeeding initiation	3,731	74.1	73.9	40.8		94.7
	9	Obese children (Year 6)	713	21.1	18.9	27.3		10.1
	10	Alcohol-specific hospital stays (under 18)	20	25.7	44.9	126.7		11.9
	11	Under 18 conceptions	198	32.9	27.7	52.0		8.8
Adults' health and lifestyle	12	Smoking prevalence	n/a	20.5	19.5	30.1		8.4
	13	Percentage of physically active adults	n/a	50.0	56.0	43.8		68.5
	14	Obese adults	n/a	19.6	23.0	35.2		11.2
	15	Excess weight in adults	470	57.0	63.8	75.9		45.9
Disease and poor health	16	Incidence of malignant melanoma	24	8.8	14.8	31.8		3.6
	17	Hospital stays for self-harm	488	137.4	188.0	596.0		50.4
	18	Hospital stays for alcohol related harm	1,988	717	637	1,121		365
	19	Drug misuse	2,704	12.1	8.6	26.3		0.8
	20	Recorded diabetes	24,551	8.4	6.0	8.7		3.5
	21	Incidence of TB	64	57.9	15.1	112.3		0.0
	22	Acute sexually transmitted infections	3,016	915	804	3,210		162
	23	Hip fractures in people aged 65 and over	218	513	568	828		403
Life expectancy and causes of death	24	Excess winter deaths (three year)	115	15.2	16.5	32.1		-3.0
	25	Life expectancy at birth (Male)	n/a	77.0	79.2	74.0		82.9
	26	Life expectancy at birth (Female)	n/a	81.8	83.0	79.5		86.6
	27	Infant mortality	34	6.4	4.1	7.5		0.7
	28	Smoking related deaths	366	293	292	480		172
	29	Suicide rate	32	10.3	8.5			
	30	Under 75 mortality rate: cardiovascular	208	108.5	81.1	144.7		37.4
	31	Under 75 mortality rate: cancer	293	151	146	213		106
	32	Killed and seriously injured on roads	90	27.3	40.5	116.3		11.3

Indicator Notes

1 % people in this area living in 20% most deprived areas in England, 2010 2 % children (under 16) in families receiving means-tested benefits & low income, 2011 3 Crude rate per 1,000 households, 2012/13 4 % key stage 4, 2012/13 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2012/13 6 Crude rate per 1,000 population aged 16-64, 2013 7 % of women who smoke at time of delivery, 2012/13 8 % of all mothers who breastfeed their babies in the first 48hrs after delivery, 2012/13 9 % school children in Year 6 (age 10-11), 2012/13 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2010/11 to 2012/13 (pooled) 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2012 12 % adults aged 18 and over, 2012 13 % adults achieving at least 150 mins physical activity per week, 2012 14 % adults classified as obese, Active People Survey 2012 15 % adults classified as overweight or obese, Active People Survey 2012 16 Directly age standardised rate per 100,000 population, aged under 75, 2009-2011 17 Directly age sex standardised rate per 100,000 population, 2012/13 18 The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause, directly age standardised rate per 100,000 population, 2012/13 19 Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2010/11 20 % people on GP registers with a recorded diagnosis of diabetes 2012/13 21 Crude rate per 100,000 population, 2010-2012 22 Crude rate per 100,000 population, 2012 (chlamydia screening coverage may influence rate) 23 Directly age and sex standardised rate of emergency admissions, per 100,000 population aged 65 and over, 2012/13 24 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.09-31.07.12 25 At birth, 2010-2012 26 At birth, 2010-2012 27 Rate per 1,000 live births, 2010-2012 28 Directly age standardised rate per 100,000 population aged 35 and over, 2010-2012 29 Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population, 2010-2012 30 Directly age standardised rate per 100,000 population aged under 75, 2010-2012 31 Directly age standardised rate per 100,000 population aged under 75, 2010-2012 32 Rate per 100,000 population, 2010-2012 ^ "Regional" refers to the former government regions.

More information is available at www.healthprofiles.info Please send any enquiries to healthprofiles@phe.gov.uk

East Leicestershire and Rutland Clinical Commissioning Group
Leicester City Clinical Commissioning Group
Leicestershire Partnership NHS Trust
NHS England (Leicestershire & Lincolnshire Area)
University Hospitals of Leicester NHS Trust
West Leicestershire Clinical Commissioning Group

Learning Lessons to Improve Care

A joint review of the quality of care delivered to patients who died in Leicester, Leicestershire and Rutland (LLR) in 2012-13

Summary Document

July 2014

1. Executive Summary

The Summary Hospital-Level Mortality Indicator (SHMI) of University Hospitals of Leicester (UHL) NHS Trust has been at or slightly above 1.05 since 2010/11. Although a SHMI of 1.05 (compared to a national average of 1.0) is within the expected range of NHS hospitals, local NHS organisations chose to request a joint primary and secondary care case records review of patients who died during the year of 2012/13, to ensure the care provided locally was of an acceptable standard.

In order to identify areas where the care delivered in Leicester, Leicestershire and Rutland (LLR) could be improved, local doctors and nurses reviewed the case records of a focused sample of patients who died in hospital or within 30 days of discharge following an emergency admission to UHL NHS Trust.

Reviewers found significant lessons to learn for all healthcare partners in 208 (55%) of the 381 cases reviewed, which included 89 cases (23%) where care was considered to be below an acceptable standard.

Comments made by reviewers as to how and where issues occurred in the 208 cases identified as having significant lessons to learn were grouped into themes. 47 themes were identified overall, which were ranked according to how many cases were affected.

The issues identified were wide-ranging and 99 of the 208 cases (48%) with significant lessons to learn involved more than one theme.

Furthermore, 23 of the 89 cases (26%) where care was considered to be below an acceptable standard involved services delivered in two or more local health and social care organisations. These data reflected how dependent the different organisations which make up the health and social care system in LLR are on each other and led reviewers to the conclusion that care quality must be improved not by addressing the issues individually, but by looking at the healthcare system as a whole.

'Issues, Challenges and Next Steps', which the LLR healthcare community would need to address in order to improve patient care, were identified following the review. These next steps included:

- Convincing People that the Problem is Theirs
- Getting Data Collection and Monitoring Systems Right
- Shifting Organisational Context and Culture
- Maintaining Momentum
- Convincing People that by Working Together a Solution can be Found
- Making Changes that are Achievable and Sustainable
- Leadership, Oversight and Co-ordination
- Considering the Side Effects of Change

A vision document entitled 'Reflection from the Future' was completed which recommended the development of a LLR-wide healthcare 'co-operation association' through which all health and social care would be planned and delivered jointly by local organisations, with a focus on patient need and care quality and with input from patients and practitioners.

2. Background for the Review

The quality of healthcare services is assessed using a number of different quality measures. One measurement of the standard of care provided in hospitals used nationally is the Summary Hospital-Level Mortality Indicator (SHMI)[1].

Since the publication of the SHMI for NHS Trusts in England in March 2011, University Hospitals of Leicester (UHL) NHS Trust's SHMI has been at or slightly above 1.05. Although a SHMI above 1.00 does not mean that UHL NHS Trust is providing poor care, it is recommended that further investigation into the hospital's performance is undertaken to ensure that the care provided is at an acceptable standard[2].

NHS England, on behalf of the Clinical Commissioning Groups for Leicester, Leicestershire and Rutland (LLR), Leicestershire Partnership NHS Trust (LPT) and UHL NHS Trust, requested the University of Leicester undertake a retrospective (historic) case record review to better understand whether there were common clinical issues and/or errors in the care received by patients who had died within the LLR healthcare system. It was understood that, should no common clinical issues and/or errors be identified, that further investigation into the data submitted by UHL to calculate the SHMI may be required.

The retrospective case record review was undertaken not to challenge the reported excess in the number of deaths in patients who receive care from UHL NHS Trust, or any other organisation providing health or social care services in LLR; rather it was completed as best practice to identify any areas where care and patient experience may be improved.

3. Context for the Review

From the outset, it was agreed that the review would look at the care provided by all NHS organisations in Leicester, Leicestershire and Rutland (LLR) and that the findings would have implications for all of the organisations involved.

It was therefore decided that a joint primary and secondary care case records review would be undertaken in which doctors and nurses from primary care, community health services and hospitals review primary care, community health and hospital case records together.

This type of joint review of NHS healthcare records has not been attempted before and so it was difficult to anticipate the findings or compare the findings with other reviews. Where previous reviews have included random patient samples, been completed by doctors only and focussed on the care delivered/deaths in hospitals, this review looked at a specific patient group, the care delivered in both the community and hospital setting, included patients who died up to 30 days after discharge from hospital and used nurses and doctors to retrospectively assess the standard of care provided.

[1] SHMI average value for all NHS Trusts for England is 1.00. Values more than 1.00 suggest a higher than expected number of deaths (after consideration of relevant differences in the patients). Values less than 1.00 indicate fewer deaths than expected.

[2] Health and Social Care Information Centre. (2014) *Summary Hospital-level Mortality Indicator (SHMI) – Frequently Asked Questions (FAQs)* (available at http://www.hscic.gov.uk/media/9926/SHMI-FAQs/pdf/SHMI_FAQ.pdf).

4. Summary of the Review Process

49 doctors and nurses from local primary, community and secondary healthcare services reviewed 381 selected case records. The records were of patients admitted to UHL NHS Trust as an emergency and subsequently died in hospital, following an attempt at resuscitation or in the Intensive Therapy Unit, or within 30 days of discharge from hospital after changing their postcode or registered GP. The change of postcode was assumed to demonstrate a move by the patient from independent living to supported living (e.g. move into a care home). This approach was used to select the cases most likely to help reviewers identify issues and/or errors that may exist across local healthcare services.

Each case record was reviewed by a pair of local doctors, one from primary care and the other from secondary care, and then discussed with the medical co-ordinator of the review. Only those case records that the doctors agreed had no 'significant lessons to learn' were reviewed by a pair of local nurses, one from community healthcare and the other from secondary care, who then discussed their findings with the nursing co-ordinator of the review.

The data collected during the review was managed in two ways. Any numerical data was collated and analysed to help identify trends in the care provided. The comments made by reviewers about how and where the issues occurred in the delivery of care were examined to identify common areas or 'themes'.

5. Questions to be answered by the Review

The primary question was the proportion (percentage) of cases reviewed that had clinical care of at least an acceptable standard.

The secondary question was whether there were significant lessons that could be learnt from the clinical care provided.

5.1. Primary Question: Was the Clinical Care of at Least an Acceptable Standard?

'Clinical care' was defined as the processes of healthcare or social care services that affect a patient's experience and/or the probability of an outcome for a patient. When deciding whether care was of an acceptable standard or not, the reviewers considered the implications for the patient's experience or the probability of outcomes for the patient rather than whether the care would be considered as customary or usual practice.

The acceptable standard of care was considered as the absence of error. So, for care to be considered as not acceptable, an error had to be identified. The reviewers used the definition of error described by the Institute of Medicine's Committee on Quality of Health Care in America in its report *To err is human – building a safer health system* (page 54)[3]:

[3] Kohn LT, Corrigan JM, Donaldson MS (eds) on behalf of the Committee on Quality of Health Care in America, Institute of Medicine. *To err is human – building a safer health system.* Washington DC: National Academy Press; 2000.

"Error is defined as the failure of a [correctly] planned action to be completed as intended (i.e. error of execution) or the use of a wrong plan to achieve an aim (i.e. error of planning)."

Note that an action or inaction does not have to be linked with an adverse event for it to be considered an error. So, the reviewers were not looking for adverse events or serious untoward incidents, nor were they looking to attribute blame to any practitioner or organisation. However, they were looking for errors of action or inaction. The theory is that a pattern of repeated errors reflects shortcomings in the systems of care, even if a patient was not harmed in a particular case.

5.2. Secondary Question: What Significant Lessons can be Learnt from the Care?

Any significant lessons that could be learnt from a case were described by the reviewers under one or more of the following headings:

- **"Failure to Interpret"** refers to the initial assessment of the patient and the failure to realise that an adverse event had happened or could happen based on what would reasonably be expected to be ascertained in the situation.

- **"Failure to Investigate"** refers to the follow-up of the patient after the initial assessment. This includes observations to monitor the patient, as well as laboratory tests, imaging or referral.

- **"Failure in Instruction"** refers to the conveying of information for others to take action once it is realised that such actions are necessary. The features of good communication are accuracy, completeness, relevance, clarity and timeliness.

- **"Failure in Information"** refers to the conveying of information for others to take note rather than for action. The features of good communication are accuracy, completeness, relevance, clarity and timeliness.

- **"Failure to Implement"** refers to the actions that should take place based on appropriate instructions conveyed correctly.

From the comments made by reviewers, issue 'themes' were identified.

Further details of the methods used to complete the LLR Joint Mortality Review and examples of the reviewer comments which were used to identify system themes can be found in the 'Case Records Review' document.

6. Summary of the Results of the Review

6.1. Answers to Review Questions

Reviewers found significant lessons to learn in 208 (55%) of the 381 cases reviewed, which included 89 cases (23%) where care was considered to be below an acceptable standard.

Of the 208 cases identified as having significant lessons to learn, 175 involved UHL NHS Trust, 54 involved primary care and 37 involved community or social care. 48 of the 208 cases (23%) involved services delivered in two or more local health and social care organisations, showing how dependent the various organisations which make up the health and social care system in LLR are on each other.

Of the 89 cases where care was considered to be below an acceptable standard, 79 involved UHL NHS Trust, 25 involved primary care and 15 involved community or social care. 23 of the 89 cases (26%) involved services delivered in two or more local health and social care organisations, again showing how dependent the various organisations which make up the health and social care system in LLR are on each other.

It should be recognised that different healthcare organisations manage patients with different levels of risk. The risk of an error occurring during care delivery increases as: the complexity of the patient's condition or required intervention increases, the number of contacts with healthcare professionals increases and the number of clinicians involved in the delivery of care increases. It was therefore not surprising to find that the greatest number of errors/issues was identified in UHL NHS Trust.

6.2. Issues Identified

Comments made by reviewers as to how and where issues occurred in the 208 cases identified as having significant lessons to learn were analysed and grouped into themes. 47 themes were identified overall, which were ranked according to how many cases were affected. The 'Top Twelve' themes, reflecting the most common issues in health and social care delivery in LLR, were identified as:

System Theme	Number of cases with the theme
DNAR orders[4]	45
Clinical reasoning	41
Palliative care	30
Clinical management	24
Discharge summary	19
Fluid management	18
Unexpected deterioration	16
Discharge	14
Severity of illness	13
Early Warning Score	11
Antibiotics	11
Medication	11

However it is of note that 99 of the 208 cases (48%) with significant lessons to learn involved more than one theme, i.e. nearly half of the cases with significant lessons to learn involved more than one issue.

[4] DNAR (Do Not Attempt Resuscitation) orders are legal orders which tell a medical professional or team not to perform Cardiopulmonary Resuscitation (CPR) on a patient if their heart stops or if they stop breathing (further information is available at http://www.gmc-uk.org/guidance/ethical_guidance/end_of_life_DNACPR_decision.asp).

From the data analysed it was clear that patients did not always receive the type of care they needed due to issues in the way the local healthcare system is organised. 70 (34%) of the 208 cases with significant lessons to learn received acute (emergency) care when the reviewers felt that palliative or end of life care would have been more appropriate. These data suggest that local healthcare services need to improve their ability to identify patient's health and social care needs and work together to ensure the system can provide the care required.

6.3. Review Conclusion

Reviewing cases identified issues and themes and it is of note that more than half of the cases with significant lessons to learn involved more than one issue. This suggested to reviewers that care quality must be improved not by addressing the issues individually, but by looking at the healthcare system as a whole.

The review therefore recommended that system-wide co-operation and collaboration was needed to identify solutions and make improvements to the care delivered across LLR. The solutions would need to take into account the more challenging aspects of healthcare delivery, such as organisational culture, and would need to be generated by those that work within and use the local health and social care system.

Full results and definitions of system themes from the LLR Joint Mortality Review can be found in the 'Case Records Review' document.

7. Summary of the Action Planning Process

Following completion of the review, NHS England requested that an action plan be developed to address the issues identified by the Leicester, Leicestershire and Rutland (LLR) Joint Mortality Review.

20 local doctors and nurses who participated in the original review returned to help the University of Leicester create an action plan based on data and comments collected during the review process. The reviewers were reminded of the issues which formed the Top Twelve themes and asked to identify the challenges the current healthcare system would need to overcome in order to improve care.

Further details on the action planning process, and for examples of reviewer comments and proposed solutions, please see the 'Issues, Challenges and Next Steps' document.

8. Summary of Review Recommendations: Issues, Challenges and Next Steps

The eight Challenges to Quality Improvement identified by the 20 reviewers who returned to create an action plan following the Leicester, Leicestershire and Rutland (LLR) Joint Mortality Review are outlined below.

A number of steps were identified to enable the healthcare organisations of LLR to overcome the challenges and provide quality health and social care to all:

Challenge[5]		Next Steps
Challenge 1:	Convincing People that the Problem is Theirs	a) Wide dissemination and discussion of implications of the LLR Joint Mortality Review. b) Mapping interdependencies of health and social care services from the perspectives of the people in LLR at a strategic (including financial) and operational level.
Challenge 2:	Convincing People that by Working Together a Solution can be Found	a) Wide dissemination and discussion of the 'Challenges for Quality Improvement' and 'Reflection from the Future'. b) Wide dissemination and discussion of health and social care interdependencies map.
Challenge 3:	Getting Data Collection and Monitoring Systems Right	a) Creation of cross-sectoral patient-based data collection and monitoring systems based on a single universal identifier such as NHS number. b) Training and development of all practitioners in Quality Improvement so that they can make sense of and use patient-based data.
Challenge 4:	Making Changes that are Achievable and Sustainable	a) Alignment of funding with data regarding health need and effectiveness of care. b) Involvement of public and patients in service development.
Challenge 5:	Shifting Organisational Context and Culture	a) Wide dissemination and discussion of the descriptions of significant lessons to learn identified in the LLR Joint Mortality Review. b) Creation of cross-sectoral fora for practitioners to develop integrated services.
Challenge 6:	Leadership, Oversight and Co-ordination	a) Training, development and support of all staff in Service Development. b) Creation of cross-sectoral 'co-operation associations'[6] for service providers to deliver consistent good quality care for all.
Challenge 7:	Maintaining Momentum	a) Development of mechanisms to encourage and disseminate effective innovation. b) Monitor progress by a LLR Joint Mortality Review of cases occurring in 2016/17.
Challenge 8:	Considering the Side Effects of Change	a) Adoption of an open culture in which deviation is reported early. b) Development of risk register to identify and address issues arising from change.

[5] Adapted from Dixon-Woods M, McNicol S, Martin G. (2012) *Overcoming challenges to improving quality. Lessons from the Health Foundation's improvement programme evaluations and relevant literature* (available at http://www.health.org.uk/public/cms/75/76/313/3357/overcoming%20challenges.pdf?realName=HGHuMk.pdf).

[6] 'Co-operation associations' (aka '*kyoryoku kai*') are from Japanese manufacturing industry in which multiple suppliers/providers work with each other and their purchaser/commissioner to deliver products/services to agreed specifications/goals sharing knowledge and expertise with joint learning and development.

9. Summary of Vision: Reflection from the Future

'Reflection from the Future' is a vision document written to illustrate how health and social care in Leicester, Leicestershire and Rutland (LLR) could be delivered if the recommendations outlined in the 'Issues, Challenges and Next Steps' document were accepted and actioned.

The document describes a LLR-wide health and social care 'co-operation association', through which health and social care is planned and delivered jointly, with a focus on patient need and quality of care. The vision outlines how discussions and decisions about health and social care in LLR should involve every level of staff and every organisation affected, directly or indirectly, by the care process – including patients.

In the document the 'co-operative association' employs a funding system which rewards innovation and an education system which shares best practice to allow all of the organisations which form the 'co-operation association' to benefit equally and for patient care to be improved.

The vision relies on working relationship based on trust, quality and dependence which allows the 'co-operative association' to develop health and social care services which are organised, innovative, effective and high quality.

10. Summary of LLR Healthcare Provider Response

In response to the review findings, and subsequent recommendations and vision documents, the Clinical Commissioning Groups for Leicester, Leicestershire and Rutland (LLR), Leicestershire Partnership NHS Trust (LPT) and UHL NHS Trust completed two exercises:

10.1. Joint LLR Quality Review Action Plan

The first exercise outlined six priority areas for healthcare improvement in LLR. The Joint LLR Quality Review Action Plan also identified current quality improvement initiatives anticipated to address the priority areas and gaps where further work would be required. Opportunities for collaborative working were highlighted and deadlines for action jointly agreed. The six priority areas jointly agreed were:

- Advance Care Planning co-ordination (including DNAR orders, palliative care and end of life care)
- Use of, and compliance with, best practice policies and guidelines
- Patient-centred care for the frail older person
- Ensuring ongoing learning and feedback
- Completion of Individual Organisation Action Plans (see 10.2)
- Development of joint long term action plan to reflect recommendations outlined in Issues, Challenges and Next Steps document

10.2. Individual Organisation Quality Review Action Plans

The second exercise was the completion of individual action plans by the LLR Clinical Commissioning Groups, LPT and UHL NHS Trust detailing their role in the review response and the specific actions required by them to realise the Joint LLR Quality Review Action Plan.

A commitment was also made by all of the healthcare organisations involved in the review to use the review findings for educational purposes and share the learning across all organisations to improve healthcare planning and delivery in LLR.

11. Acknowledgements

The 49 doctors and nurses who participated in the Leicester, Leicestershire and Rutland (LLR) Joint Mortality Review would like to express their gratitude to the patients whose case records were reviewed and analysed. Each of the reviewers was personally touched by the experiences, both good and bad, of the patients described in the case records and are committed to ensuring lessons are learned from the review and that health and social care across LLR is improved.

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12. Bibliography

This document is a summary of original review documents and action plans, namely:

1. Leicester, Leicestershire and Rutland (LLR) Joint Mortality Review: Case Records Review (24 July 2014)

2. LLR Joint Mortality Review: Critique and Comparison (18 March 2014)

3. LLR Joint Mortality Review: Issues, Challenges and Next Steps (24 July 2014)

4. LLR Joint Mortality Review: Reflection from the Future (18 March 2014)

The above documents are available on the following websites:

www.eastleicestershireandrutlandccg.nhs.uk

www.leicestercityccg.nhs.uk

www.leicestershospitals.nhs.uk

www.leicspart.nhs.uk

www.westleicestershireccg.nhs.uk

5. Joint LLR Quality Review Action Plan

6. Individual LLR Organisation Action Plans

The above documents are available from:

West Leicestershire Clinical Commissioning Group on 01509 567755 or

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