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City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Agenda for a meeting of the Health and Social Care Overview and Scrutiny Committee to be held on Thursday, 22 March 2018 at 4.30 pm in the Ernest Saville Room - City Hall, Bradford

Members of the Committee – Councillors

CONSERVATIVE	LABOUR	LIBERAL DEMOCRAT AND INDEPENDENT
Gibbons Rickard	Greenwood A Ahmed Akhtar Johnson Shabbir	N Pollard

Alternates:

CONSERVATIVE	LABOUR	LIBERAL DEMOCRAT AND INDEPENDENT
Barker Poulsen	Berry I Hussain S Hussain Iqbal H Khan	Griffiths

NON VOTING CO-OPTED MEMBERS

Susan Crowe	Strategic Disability Partnership
Trevor Ramsay	Strategic Disability Partnership
G Sam Samociuk	Former Mental Health Nursing Lecturer
Jenny Scott	Older People's Partnership

Notes:

- This agenda can be made available in Braille, large print or tape format on request by contacting the Agenda contact shown below.
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- If any further information is required about any item on this agenda, please contact the officer named at the foot of that agenda item.

From:

Michael Bowness
Interim City Solicitor
Agenda Contact: Claire Tomenson
Phone: 01274 432457
E-Mail: claire.tomenson@bradford.gov.uk

To:

A. PROCEDURAL ITEMS

1. ALTERNATE MEMBERS (Standing Order 34)

The City Solicitor will report the names of alternate Members who are attending the meeting in place of appointed Members.

2. DISCLOSURES OF INTEREST

(Members Code of Conduct - Part 4A of the Constitution)

To receive disclosures of interests from members and co-opted members on matters to be considered at the meeting. The disclosure must include the nature of the interest.

An interest must also be disclosed in the meeting when it becomes apparent to the member during the meeting.

Notes:

(1) Members may remain in the meeting and take part fully in discussion and voting unless the interest is a disclosable pecuniary interest or an interest which the Member feels would call into question their compliance with the wider principles set out in the Code of Conduct. Disclosable pecuniary interests relate to the Member concerned or their spouse/partner.

(2) Members in arrears of Council Tax by more than two months must not vote in decisions on, or which might affect, budget calculations, and must disclose at the meeting that this restriction applies to them. A failure to comply with these requirements is a criminal offence under section 106 of the Local Government Finance Act 1992.

(3) Members are also welcome to disclose interests which are not disclosable pecuniary interests but which they consider should be made in the interest of clarity.

(4) Officers must disclose interests in accordance with Council Standing Order 44.

3. MINUTES

Recommended –

That the minutes of the meeting held on 8 February 2018 be signed as a correct record (previously circulated).

(Claire Tomenson – 01274 432457)

4. INSPECTION OF REPORTS AND BACKGROUND PAPERS

(Access to Information Procedure Rules – Part 3B of the Constitution)

Reports and background papers for agenda items may be inspected by contacting the person shown after each agenda item. Certain reports and background papers may be restricted.

Any request to remove the restriction on a report or background paper should be made to the relevant Strategic Director or Assistant Director whose name is shown on the front page of the report.

If that request is refused, there is a right of appeal to this meeting.

Please contact the officer shown below in advance of the meeting if you wish to appeal.

(Claire Tomenson - 01274 432457)

5. REFERRALS TO THE OVERVIEW AND SCRUTINY COMMITTEE

Any referrals that have been made to this Committee up to and including the date of publication of this agenda will be reported at the meeting.

B. OVERVIEW AND SCRUTINY ACTIVITIES

6. CARE QUALITY COMMISSION INSPECTION REPORT ON BRADFORD DISTRICT CARE NHS FOUNDATION TRUST 1 - 72

The Care Quality Commission (CQC) carried out an inspection of Bradford District Care NHS Foundation Trust in October and November 2017. Nine complete core services were inspected (out of 14 provided by the Trust) and the Trust was rated as Requires Improvement.

The CQC will submit **Document "AE"** containing the inspection report.

Recommended –

That the report be noted.

(Caroline Coombes – 01274 432313)

7. RESPONSE FROM BRADFORD DISTRICT CARE NHS FOUNDATION TRUST TO THE CARE QUALITY COMMISSION INSPECTION REPORT 73 - 102

Bradford District Care NHS Foundation Trust will submit **Document "AF"** which provides an action plan to address the areas for improvement in response to the Care Quality Commission's inspection report undertaken in October and November 2017

Recommended –

That the findings of the recent Care Quality Commission inspection and the actions that are being taken by Bradford District Care NHS Foundation Trust to correct all areas of concern, in a timely and sustainable manner, be noted.

(Dr Andy McElligott – 01274 228293)

8. AIREDALE NHS FOUNDATION TRUST'S WHOLLY OWNED SUBSIDIARY FOR ESTATES, FACILITIES AND PROCUREMENT SERVICES 103 - 176

On the 25 October 2017 Airedale NHS Foundation Trust Board gave approval to proceed with the formation of a wholly owned subsidiary for Estates, Facilities and Procurement Services. The subsidiary is named AGH Solutions Limited and went live on 1 March 2018 with the transfer of 319 staff.

Airedale NHS Foundation Trust will submit **Document "AG"** which outlines the reasons for this decision and includes a redacted business case.

Recommended –

(1) That the reasons why Airedale NHS Foundation Trust agreed to form the wholly owned subsidiary, AGH Solutions, be noted.

(2) That the ambitions of AGH Solutions, including employing more people from the local community and using more local community businesses in the supply chain, be noted.

(David Moss – 01535 294826)

9. BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST POSITION STATEMENT - CREATION OF AN ALTERNATIVE DELIVERY MODEL FOR ESTATES AND FACILITIES SERVICES 177 - 178

Bradford Teaching Hospitals NHS Foundation Trust will submit **Document "AH"** which informs Members of an evaluation it is undertaking to explore the option to safely create an Alternative Delivery Model (ADM) to deliver Estates and Facilities Services.

Recommended –

That Bradford Teaching Hospitals NHS Foundation Trust's intention to complete a full evaluation and present a comprehensive business case to its Board of Directors in July 2018, where a definitive decision will be taken, be noted.

(Donna Thompson – 01274 364841)

City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the Care Quality Commission to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 22 March 2018

AE

Subject: CARE QUALITY COMMISSION INSPECTION REPORT ON BRADFORD DISTRICT CARE NHS FOUNDATION TRUST

Summary statement:

The Care Quality Commission carried out an inspection of Bradford District Care NHS Foundation Trust in October and November 2017.

Nine complete core services were inspected (out of 14 provided by the Trust):

- Acute wards for adults of working age and psychiatric intensive care units
- Long stay/rehabilitation mental health wards for working age adults
- Wards for older people with mental health problems.
- Wards for people with learning disability or autism
- Community-based mental health services for adults of working age
- Mental health crisis services and health-based places of safety
- Community mental health services for people with learning disability or autism
- Community health services for adults
- Community dental services

The overall rating of the Trust went down. It has been rated as Requires Improvement.

Kate Gorse-Brightmore
Inspection Manager
Care Quality Commission

Portfolio:

Health and Wellbeing

Report Contact: Caroline Coombes
Phone: (01274) 432313
E-mail:
caroline.coombes@bradford.gov.uk

1. Summary

The Care Quality Commission carried out an inspection of Bradford District Care NHS Foundation Trust in October and November 2017.

Nine complete core services were inspected (out of 14 provided by the Trust):

- Acute wards for adults of working age and psychiatric intensive care units
- Long stay/rehabilitation mental health wards for working age adults
- Wards for older people with mental health problems.
- Wards for people with learning disability or autism
- Community-based mental health services for adults of working age
- Mental health crisis services and health-based places of safety
- Community mental health services for people with learning disability or autism
- Community health services for adults
- Community dental services

The overall rating of the Trust went down. It has been rated as Requires Improvement.

2. Report issues

2.1 The Inspection Report: Bradford District Care NHS Foundation Trust was published on 12 February 2018. The Inspection Manager, Hospitals Directorate, will present the report.

3. Recommendations

3.1 That the report be noted

4. Appendices

4.1 Appendix A – Care Quality Commission Inspection Report: Bradford District NHS Foundation Trust (February 2018)

Bradford District Care NHS Foundation Trust

Inspection report

SBS New Mill
Victoria Road, Saltaire
Shipley
West Yorkshire
BD18 3LD
Tel: 01274228300
www.bdct.nhs.uk

Date of inspection visit: October 4th - November 8th
Date of publication: 12/02/2018

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Requires improvement**

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Summary of findings

Background to the trust

Bradford District Care NHS Foundation Trust is a provider of mental health, community health and specialist learning disability services. They support people of all ages who live in the Bradford, Airedale, Craven area and children (aged 0-19 years) in the Wakefield area. They also work with people from other areas when needed. There are over 3,000 staff working with at the trust. The trust was first registered with CQC on 17 June 2010 and has 15 active locations.

The trust serves a population of over 580,000 people. The population is amongst the most diverse in the country with over 100 languages. The trust's catchment area includes areas of high deprivation and higher than expected demand for health services.

The trust was established in 2002. Community health services were transferred to the trust in 2011 from Bradford and Airedale Community Health Services which was the provider arm of the former primary care trust NHS Bradford and Airedale. The trust was authorised as a foundation trust in 2015.

The trust has 206 beds for mental health inpatient services which are based at two sites; Lynfield Mount Hospital and the Airedale Centre for Mental Health. The trust headquarters are based at New Mill, Saltaire. Community mental health and community nursing services are registered to New Mill.

Trust locations include:

- BDCT Headquarters, New Mill
- Airedale Centre for Mental Health
- Lynfield Mount Hospital
- Keighley Health Centre
- Wrose Health Centre
- Bradford Royal Infirmary
- Barkerend Health Centre
- Holmewood Health Centre
- Horton Park Medical Centre
- Kensington Street Health Centre
- Royds Healthy Living Centre
- Shipley Health Centre
- Waddiloves Health Centre
- Westbourne Green Community Health Care Centre
- Airedale General Hospital

The trust provides the following core services:

- Acute wards for adults of working age and psychiatric intensive care units
- Long stay/rehabilitation mental health wards for working age adults
- Forensic inpatient/secure wards

Summary of findings

- Wards for older people with mental health problems.
- Wards for people with learning disability or autism
- Community-based mental health services for adults of working age
- Mental health crisis services and health-based places of safety
- Community mental health services for older people
- Specialist community-based mental health services for children and young people
- Community mental health services for people with learning disability or autism
- Community health services for adults
- Community services for children, young people and families
- Community end of life care
- Community dental services

Overall summary

Our rating of this trust went down since our last inspection. We rated it as Requires improvement 

What this trust does

Bradford District Care NHS Foundation Trust is a provider of mental health, community health and specialist learning disability services.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We inspected nine complete core services in total out of 14 core services provided by the trust.

These were:

- Acute wards for adults of working age and psychiatric intensive care units
- Long stay/rehabilitation mental health wards for working age adults

Summary of findings

- Wards for older people with mental health problems.
- Wards for people with learning disability or autism
- Community-based mental health services for adults of working age
- Mental health crisis services and health-based places of safety
- Community mental health services for people with learning disability or autism
- Community health services for adults
- Community dental services

These core services were either selected due to their previous inspection ratings or our ongoing monitoring identified that an inspection at this time was appropriate to understand the quality of the service provided.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question at the trust level. Our findings are in the section headed 'Is this organisation well-led?'

What we found

Overall trust

Our rating of the trust went down. We rated it as requires improvement because:

Our decisions on overall ratings take into account factors including the relative size of services and we use our professional judgement to reach a fair and balanced rating.

- We rated six of the 14 core services provided by the trust as requires improvement overall. This takes account of the ratings of core services that we did not inspect this time.
- We rated safe, effective and well-led as requires improvement for the trust overall. Our rating for the trust took into account the current ratings of services not inspected this time.
- We rated well-led at the trust level as requires improvement. The trust's senior leadership team did not have effective oversight of staff training, staff supervision and of restrictive interventions in inpatient services. The trust had not ensured that all staff had checks with the disclosure and barring service in line with trust policy. The trust had not ensured that documentation was maintained in line with the fit and proper persons requirements. There was an inconsistent approach to audits in relation to the use of the Mental Health Act and Mental Capacity Act. The trust had not updated all active policies to reflect the changes to the Mental Health Act Code of Practice in 2015. The trust had not ensured that all serious incidents were reviewed in line with the requirements of the duty of candour and that serious incidents were investigated appropriately and effectively.
- Services were not consistently managing risks safely. Risk assessments were not always completed or reviewed regularly. Staff were not consistently trained in line with the trust's requirements. Services had high sickness, vacancy and turnover rates and some relied on agency and bank staff to maintain safe staffing levels. Staff were not consistently recognising and reporting safeguarding concerns to external agencies. Staff had a mixed understanding of the duty of candour.
- Services were not consistently providing effective care. Care records in some services contained information that was incomplete or had not been reviewed for some time. Not all care plans were holistic and centred on the individual needs of the patient. Not all staff were regularly receiving supervision in line with the trust policy. Staff had a mixed understanding of the Mental Health Act and Mental Capacity Act.

Summary of findings

However

- The staff showed a caring attitude to those who used the trust services. Feedback from people using services and their relatives and carers was highly positive. Staff in all services were kind, compassionate, respectful and supportive. People who used services were appropriately involved in making decisions about their care.
- The trust had ensured that services were responsive to meet the needs of people. Services were planned so that local people could access services when they needed them. There was a systematic approach to managing access to services which was based on individual needs. The trust had ensured there was a clear pathway so that people were transferred appropriately between services.

Are services safe?

Our rating of safe went down. We took into account the ratings of services not inspected this time. We rated safe as requires improvement because:

- We rated eight of the 14 core services as requires improvement for safe. This includes the core services that we did not inspect at this time.
- Not all services assessed and managed patient risks safely. Risk assessments were missing or incomplete within patient records in a number of core services. Staff on some wards could not demonstrate that they had undertaken a meaningful assessment of risks in the environment; for example fire risks or risks from potential ligature anchor points.
- Staff in some services had not undertaken the training necessary for them to fulfil their role. Not all staff whose roles required training in breakaway techniques, basic life support, immediate life support and safeguarding had received training.
- Sickness, vacancy and turnover rates were high across the trust. Inpatient services in particular heavily relied on the use of bank and agency staff to maintain safe staffing levels.
- Blanket restrictions were in place in the trust's acute mental health wards for working adults, wards for people with a learning disability and wards for older people with mental health problems. The trust did not have an effective system to identify and review restrictions implemented in inpatient services.
- Staff working in the trust's acute mental health wards for working age adults and the wards for people with a learning disability and/or autism had not identified and reported safeguarding concerns to the trust's or the local authority's safeguarding team.
- The majority of staff working in both inpatient and community services could not recognise or explain the concept of the duty of candour.
- However:
- Within the trust's inpatient services staff had introduced safety huddles. Safety huddles were quick meetings which included all clinical and non-clinical staff. The purpose of the meeting was to ensure that all staff working on the wards had a clear understanding of the immediate risks.
- All inpatient and community services were clean and well-maintained. Staff were aware of and adhered to infection control procedures. Clinic rooms in inpatient services were maintained appropriately and staff could access appropriate equipment to carry out their roles.
- Compliance rates for the four modules regarded by the trust as mandatory training were consistently high in each core service inspected.

Summary of findings

Are services effective?

Our rating of effective went down. We took into account the ratings of services not inspected this time. We rated effective as requires improvement because:

- We rated five of the 14 core services as requires improvement for effective. This takes account of the core services that we did not inspect at this time.
- The quality of care records was inconsistent between the core services. In some services care records did not contain up to date information, were incomplete or could not be located by staff. Staff were not reviewing care records consistently. Not all bank staff and none of the agency staff could access patient records.
- Not all staff received regular supervision in line with the trust policy. Staff told us this was because of pressures caused by staffing levels and patient acuity. Managers did not have systems in place to monitor staff supervision.
- Patients had limited access to psychological therapies in both inpatient and community mental health services.
- Training in the Mental Health Act and Mental Capacity Act was not mandatory for staff. Compliance with role-specific required training in the Mental Health Act and Mental Capacity Act was inconsistent between core services. Staff demonstrated varying knowledge and understanding of the Mental Health Act and Mental Capacity Act. Not all staff working with patients were trained in the Mental Health Act and Mental Capacity Act.
- Staff in inpatient services were not consistently recording in care records that patients had received an explanation of their rights under the Mental Health Act.

However:

- Within mental health services there was a strong focus on caring for the physical health of patients. Staff undertook regular physical observations of patients prescribed high dose medication and those with long term enduring physical health conditions.
- Staff had embedded the use of national guidance to support effective patient care within community dental services and community health services for adults.
- Within a number of services there was a strong focus on multidisciplinary and inter-agency working. Services included staff from a range of professional disciplines which provided a holistic approach to patient care.

Are services caring?

Our rating of caring stayed the same. We rated it as good because: We took into account the ratings of services not inspected this time. We rated caring as good because:

- We rated all 13 of the 14 core services as good for caring. We rated one core service as outstanding for caring. This takes account of the core services we did not inspect at this time.
- We consistently received positive feedback from people using services and their relatives and carers. Staff ensured that patients and carers were involved in making decisions about their care.
- Staff in all services were kind, compassionate, respectful and supportive. Feedback from patient surveys indicated high patient satisfaction with staff attitudes.
- All services demonstrated that they were patient focussed. The community health services for adults in particular demonstrated a holistic approach to patient care in which the needs and preferences of individual patients were incorporated fully into the delivery of care.

Summary of findings

- The trust had implemented 'carer's hubs' in two locations and had plans to open a third. Carer's hubs were services provided in partnership with three third sector voluntary organisations providing a range of health and wellbeing activities for carers.

Are services responsive?

Our rating of responsive stayed the same. We took into account the ratings of services not inspected this time. We rated responsive as good because:

- We rated 12 of the 14 core services as good for responsive. We rated one core service as outstanding for responsive. This takes account of the core services we did not inspect at this time.
- The trust had ensured that services were organised so that people could access services when they needed them. There was a coordinated pathway for available for people experiencing mental health crisis from initial contact with services to inpatient admission through to discharge into the community mental health services. Community mental health and physical health services were planned to meet the needs of the local community.
- Inpatient services including wards for people with a learning disability and/or autism had a clear approach to discharge planning which ensured that discharges were safe and that people did not spend more time in hospital than they needed to.
- Services had a clear approach to triaging referrals which meant that people with higher risks or needs were not waiting longer than they should do.
- Ward environments had a range of rooms, equipment and facilities available to promote recovery.

However:

- There was limited evidence of discharge planning in community mental health services.

Ratings tables

The ratings tables in our full report show the ratings overall and for each key question, for each service, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account, for example, the relative size of services and we used our professional judgement to reach fair and balanced ratings

Outstanding practice

We found several examples of outstanding practice during the core service inspections.

In community dental services:

- The service had developed an anxiety care pathway which looked at other options, short of intravenous sedation, with a view to helping the patient to not need the service in the future. The service had a cognitive behavioural nurse and could arrange other therapies such as acupuncture and hypnosis. All patients being considered for intravenous sedation had to undergo a mandatory taster session for cognitive behavioural therapy.

In community health services for adults

- The trust had developed a spreadsheet for recording and monitoring pressure ulcers. Details of all pressure ulcers were entered and this allowed the ability for trends and themes to be easily identified and acted on.
- The continence service had recently expanded its remit to undertake all first continence pad and follow up continence assessments. This reduced the workload falling to the district nursing service and allowed patients to be assessed by specialist continence team members.

Summary of findings

- The tissue viability service used a vascular assessment outcome tool to track the outcome and cost of care provided. This data was then used to drive improvements in the service, such as the development of a chronic wound pathway which was presented to an international conference

In the mental health crisis services and health based places of safety:

- The redesign of the trust's mental health crisis services' pathway had ensured that no patient had needed to be admitted to an out of area placement in the previous two years. The intensive home treatment team ensured that more people could be cared for in the community without requiring an inpatient admission.
- The service worked closely in partnership with voluntary and community sector organisations to provide a comprehensive multi-level approach for people in crisis, based on presenting risks. The voluntary and community sector organisations provided people with safe spaces and peer support which reduced admissions to accident and emergency departments.

In community mental health services for people with a learning disability and/or autism:

- The service ran 10 training sessions in the last year to local support providers around active support and behavioural monitoring. The service also had positive and proactive champions and communication champions networks that shared best practice around the use of positive behaviour support and communication methods for people with a learning disability.
- The service was working with local police services to improve engagement with people living with learning disabilities by providing them with advice and guidance on the various types of conditions and associated issues and behaviours.
- The service had been involved in an NHS improvement programme around criteria led discharges, which included examining how discharge times could be reduced where appropriate.

Areas for improvement

Areas for improvement

We found areas for improvement including breaches of legal requirements that the trust must put right.

We found things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information see the Areas for Improvement sections in each core service of this report.

Action we have taken

We issued requirement notices to the trust. That meant the trust had to send us a report saying what action it would take to meet these requirements.

Our action related to breaches of legal requirements in six core services.

For more information on action we have taken, see the sections on Areas for Improvement in each core service and Regulatory Action at the end of this report.

What happens next

We will make sure that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Summary of findings

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in the future, or to improve services.

Action the trust MUST take to improve

- The trust must ensure that effective governance systems are in place to assess, monitor and improve the quality and safety of the services.
- The trust must ensure that ensure that checks are completed for all its executive and non-executive directors, and that accurate records of these checks are maintained in line with the Fit and Proper Person Requirement regulation and the trust's policy.
- The trust must ensure that all staff are checked by the Disclosure and Barring Service in line with trust policy.
- The trust must ensure that serious incidents are reviewed and thoroughly investigated within appropriate timescales, and monitored to make sure that action is taken to remedy the situation, prevent further occurrences and make sure that improvements are made as a result.
- The trust must put a system in place to ensure that there is effective oversight of the use of restrictive interventions in inpatient services.
- The trust must put a system in place to ensure that there is effective oversight of role-specific required training for all staff.
- The trust must update all active policies to reflect the changes to the Mental Health Act Code of Practice introduced in 2015.
- The trust must review role-specific required training to ensure that staff are appropriately trained in the Mental Health Act and Mental Capacity Act.
- The trust must put a system in place to ensure that there is effective oversight of compliance rates for staff supervision.
- The trust must ensure that there is a clear and effective approach to audit within services. Audits must be used to improve quality within services.
- The trust must ensure that it effectively audits the use of the Mental Health Act and the Mental Capacity Act.

Action the trust SHOULD take to improve

- The trust should ensure that all staff have access to the electronic systems required to complete their role and to ensure records are accurate and contemporaneous to keep patients safe.
- The trust should review its approach to accreditation from national organisations.
- The trust should ensure there is a systematic and standardised approach to quality improvement, and that staff are trained in the identified improvement methodology.

Summary of findings

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

This was our first review of well led under our next phase methodology. We rated well led as requires improvement because:

- The trust did not have effective oversight of staff supervision. Not all staff regularly received supervision. Systems were not in place to record and monitor supervision or to identify to senior managers the services which had low compliance.
- The trust did not have effective oversight of staff training. The trust distinguished between training which was mandatory for all staff and training which was required for staff working in specific roles or disciplines. The trust's senior leadership did not have effective oversight of role-specific required training. Our inspection of the trust's core services found a number of examples of low compliance with required training.
- The senior leadership team did not have effective oversight of restraint, prone restraint and the use of rapid tranquilisation. The trust's dashboards provided senior leaders with data which did fully represent the use of restrictive interventions in inpatient services.
- Managers had not undertaken a check with the Disclosure and Barring Service on all staff working at the trust at the time of inspection. This was not in line with the trust's policy.
- There were a number of policies in use at the trust which had not been updated to reflect the changes to the Mental Health Act Code of Practice which was introduced in 2015.
- There was not a clear, systematic approach to clinical and managerial audit to improve quality and safety within services. Audits in relation to the use of the Mental Health Act were not consistently completed. The trust did not audit the use of the Mental Capacity Act. Within local services, audits had not effectively identified the concerns we found during inspection in relation to the quality of patients' risk assessments, care plans and incident reports.
- Not all serious incidents were reviewed in line with the requirements of the duty of candour and the trust had not investigated all serious incidents effectively and within an appropriate timescale.
- The trust had not maintained a record of checks in line with the Fit and Proper Persons' Regulation. Personnel files for non-executive directors did not contain the documentation required to evidence that the trust had consistently and routinely checked to ensure that the non-executive directors were fit and proper persons in line with the requirements of the regulation.

However:

- The vision and values were prominent throughout the trust. Staff consistently demonstrated awareness and commitment to the trust's vision and values. The significant majority of staff we spoke to were positive about working at the trust.
- The board of directors were committed, competent and capable in their roles. Both executive and non-executive directors brought a range of skills and experience to the trust's senior management team. The trust's board was relatively stable and had benefited from effective succession planning.

Summary of findings

- There was a clear strategy which was aligned to the wider health and social care economy. The trust was an active participant in the West Yorkshire and Harrogate Health and Care Partnership. The trust had clear strategic objectives, corporate objectives and quality goals.
- The trust had worked to engage voluntary sector organisations to provide new and innovative models of care. Voluntary sector organisations were incorporated into the trust's governance structures to ensure appropriate oversight of performance, quality and safety.
- The trust had used a number of approaches to engagement. Patients, relatives and carers and staff were able to feedback to the trust on the care and treatment provided. The trust scored highly in patient feedback as a provider to receive care from. The trust had also worked to improve engagement with commissioners, local authorities and other agencies.
- Governance structures were well-embedded and were familiar to staff at all levels working within the trust. The trust board sub-committees were well established and were chaired by non-executive directors. The trust's council of governors had an active and diverse membership which was reflective of the trust's catchment area.
- The trust had a clear approach to managing risk using a board assurance framework and risk registers at team, service, business unit and corporate level. Staff were aware of how to use risk registers to escalate risks to senior managers. Staff concerns matched concerns identified on the trust's risk registers. The trust had a clear approach to identify and learn from patient deaths.
- There was a well-established programme which recognised good practice and achievement within staff teams. The trust had an annual awards ceremony and a number of other celebration events which included staff from a variety of disciplines. The trust itself had been recognised for a number of awards from a range of national organisations.

Ratings tables

Key to tables					
Ratings	**Not rated**	**Inadequate**	**Requires improvement**	**Good**	**Outstanding**
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔🡐	🡅	🡅🡅	🡇	🡇🡇
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement 🡇 Nov 2017	Requires improvement 🡇 Nov 2017	Good ➔🡐 Nov 2017	Good ➔🡐 Nov 2017	Requires improvement 🡇 Nov 2017	Requires improvement 🡇 Nov 2017

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community	Good ➔🡐 Nov 2017	Good 🡅 Nov 2017	Good ➔🡐 Nov 2017	Good 🡅 Nov 2017	Good ➔🡐 Nov 2017	Good 🡅 Nov 2017
Mental health	Requires improvement 🡇 Nov 2017	Requires improvement 🡇 Nov 2017	Good ➔🡐 Nov 2017	Good ➔🡐 Nov 2017	Requires improvement 🡇 Nov 2017	Requires improvement 🡇 Nov 2017
Overall trust	Requires improvement 🡇 Nov 2017	Requires improvement 🡇 Nov 2017	Good ➔🡐 Nov 2017	Good ➔🡐 Nov 2017	Requires improvement 🡇 Nov 2017	Requires improvement 🡇 Nov 2017

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good ➔➔ Nov 2017	Good ↑ Nov 2017	Outstanding ↑ Nov 2017	Good ↑ Nov 2017	Good ➔➔ Nov 2017	Good ↑ Nov 2017
Community health services for children and young people	Good Jun 2014	Good Jun 2014	Good Jun 2014	Requires improvement Jun 2014	Good Jun 2014	Good Jun 2014
Community end of life care	Good Jun 2014	Good Jun 2014	Good Jun 2014	Outstanding Jun 2014	Good Jun 2014	Good Jun 2014
Community dental services	Good Jun 2014	Good Jun 2014	Good Jun 2014	Good Jun 2014	Good Jun 2014	Good Jun 2014
Overall*	Good ➔➔ Nov 2017	Good ↑ Nov 2017	Good ➔➔ Nov 2017	Good ↑ Nov 2017	Good ➔➔ Nov 2017	Good ↑ Nov 2017

*Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement ↓ Nov 2017	Requires improvement ↓ Nov 2017	Good →← Nov 2017	Good →← Nov 2017	Requires improvement ↓ Nov 2017	Requires improvement ↓ Nov 2017
Long-stay or rehabilitation mental health wards for working age adults	Requires improvement Nov 2017	Requires improvement Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017	Requires improvement Nov 2017
Forensic inpatient or secure wards	Good Jun 2014	Good Jun 2014	Good Jun 2014	Good Jun 2014	Good Jun 2014	Good Jun 2014
Wards for older people with mental health problems	Requires improvement Nov 2017	Requires improvement Nov 2017	Good Nov 2017	Good Nov 2017	Requires improvement Nov 2017	Requires improvement Nov 2017
Wards for people with a learning disability or autism	Requires improvement Nov 2017	Requires improvement Nov 2017	Good Nov 2017	Good Nov 2017	Requires improvement Nov 2017	Requires improvement Nov 2017
Community-based mental health services for adults of working age	Requires improvement ↓ Nov 2017	Requires improvement ↓ Nov 2017	Good →← Nov 2017	Good →← Nov 2017	Requires improvement ↓ Nov 2017	Requires improvement ↓ Nov 2017
Mental health crisis services and health-based places of safety	Requires improvement ↓ Nov 2017	Good →← Nov 2017	Good →← Nov 2017	Good →← Nov 2017	Requires improvement ↓ Nov 2017	Requires improvement ↓ Nov 2017
Specialist community mental health services for children and young people	Requires improvement Jun 2014	Good Jun 2014	Good Jun 2014	Good Jun 2014	Good Jun 2014	Good Jun 2014
Community-based mental health services for older people	Good Jun 2014	Good Jun 2014	Good Jun 2014	Good Jun 2014	Good Jun 2014	Good Jun 2014
Community mental health services for people with a learning disability or autism	Requires improvement Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017
Overall	Requires improvement ↓↓ Nov 2017	Requires improvement ↓ Nov 2017	Good →← Nov 2017	Good →← Nov 2017	Requires improvement ↓ Nov 2017	Requires improvement ↓ Nov 2017

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Community health services

Background to community health services

The trust provides the following community health services:

- Community health services for adults
- Community services for children, young people and families
- Community end of life care
- Community dental services

We inspected two complete community health core services out of four provided by the trust.

These were:

- Community health services for adults
- Community dental services

Summary of community health services

Good

Our rating for these services improved. We rated them as good because:

- Our rating for community health services for adults improved. We rated this service as good.
- We rated community dental services as good.

Community health services for adults

Good ↑

Key facts and figures

Bradford District Care Trust provides a range of community health services for adults across the areas of Bradford, Airedale, Wharfedale and Craven. The trust serves a population of over 580,000 people.

The services are provided in people's homes, GP Practices, clinics and care homes. The trust had organised their community nursing services into 37 community nursing teams based around GP practice population and geographical location. The district nurse services provide over 330,000 face to face contacts each year.

Podiatry clinics are held at over 40 locations within the area and speech and language therapy is provided at several locations across Bradford. Continence services are also provided at four locations.

Our inspection was announced at short notice to enable us to observe routine activity. It took place between 4 and 6 October 2017.

During our inspection we visited 12 locations. We spoke with 62 staff, from community nursing services or integrated care teams, including district nursing, community matrons and specialist nursing services. We also spoke with community therapy services.

We spoke with 14 patients, three relatives and reviewed 10 patient records. We observed practice in a podiatry clinic, leg ulcer clinic and on several home visits with the district nursing teams.

At the previous inspection in 2014, CQC rated community adults services as requires improvement overall with the effective and responsive key questions rated as requires improvement. Safe, caring and well led were rated as good. During this inspection we looked at all five key questions.

Summary of this service

Our overall rating of this service improved. We rated it as good because:

- The service provided safe care and treatment to patients. Staff were competent in reporting and learning from incidents and safeguarding concerns. Staff were also supported to develop competencies and their professional practice.
- Multidisciplinary teams delivered evidence based care and treatment across the service. Services were planned and delivered to meet the needs of patients, including tailored services for patients with specific needs.
- Staff delivered outstanding care to patients. This was supported by comments and feedback received from patients, observations of caring interactions, and examples of where staff were able to go 'over and above' to deliver person centred care.
- There was a positive, patient centred culture within the service where staff felt supported by leaders to deliver good quality patient care.

However:

- Governance processes did not always provide assurance about performance or practice within the service. Examples of this included management and clinical supervision not being consistently practiced or documented. Other examples of this included incomplete data being provided around role specific training for staff.

Community health services for adults

Is the service safe?

Good 

Our rating of safe stayed the same. We rated it as good because:

- Staff reported incidents and near misses and this was encouraged. Most staff reported getting feedback from incidents, although wider learning from specific incidents was not always shared.
- Staff demonstrated a good knowledge of safeguarding and could provide examples where they had escalated and managed concerns.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service had the appropriate equipment to provide the care and treatment for their patients.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.
- Patient risk assessments were in place and we saw evidence of reassessment. Appropriate policies and procedures were in place for lone working and the management of deteriorating patients.
- The majority of services had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- The service planned for emergencies and staff understood their roles if one should happen.

However:

- Staff told us that they were up to date with mandatory training, but data provided by the trust was limited to four mandatory modules and did not provide assurance about the wider compliance rate with role specific training modules.

Is the service effective?

Good 

Our rating of effective improved. We rated it as good because:

- Staff provided evidence based care and treatment to patients.
- There was a strong focus on support for staff of all levels to improve and extend the scope of their practice.
- There were strong and positive local arrangements for multidisciplinary team working within various community teams.
- Staff we spoke with had a good understanding of consent and mental capacity issues. We saw that concerns in relation to a patient's capacity were appropriately documented and escalated when required.

However:

- There was an inconsistent approach to conducting and documenting clinical and management supervision across the service.

Community health services for adults

Is the service caring?

Outstanding ☆ ↑

Our rating of caring improved. We rated it as outstanding because:

- We observed excellent care being delivered by highly motivated staff and were provided with examples of staff going above and beyond in caring for patients.
- We received continually positive feedback from patients and their relatives.
- There was a strong patient-centred focus. People's individual preferences and needs were reflected in care delivery. We saw holistic patient care that took into account religion, ethnicity and personal preferences. This was supported by the care plans we reviewed.
- All staff were clearly committed to working in partnership with patients and their families.
- We observed staff offering emotional support and the importance of this was recognised by all staff. Patients' emotional and social needs were integrated into their care and treatment. Staff could access specialist support for patients when this was needed.
- We observed on our visits, and found from discussions with staff, that patients' independence was promoted. Staff worked with patients and their families to enable care to be delivered at home.
- Patients spoke about and we observed strong relationships with staff from the services, which meant there could be open discussions during visits.

Is the service responsive?

Good ● ↑

Our rating of responsive improved. We rated it as good because:

- Service planning was delivered to meet the needs of the local community offering flexibility, choice and continuity of care.
- Access to care was timely and focused on the needs of the individual patient.
- Community matrons and complex care teams were in place to manage the care of patients with long term conditions or complex physical health needs.
- The service was responsive to individual needs and worked flexibly to meet the needs of patients in vulnerable circumstances.

Is the service well-led?

Good ● →←

Our rating of well-led stayed the same. We rated it as good because:

- We saw that local and senior leadership was supportive and accessible to staff.

- Staff reported a good culture and feeling motivated in their roles. Staff felt supported and valued in adult community services and that the trust cared about the well-being of the staff.
- There was a focus on the delivery of person centred care and staff who were committed to the delivery of high quality patient care.
- Staff told us they knew how to raise concerns and felt conformable to do this.

However:

- There was no consistent approach to monitoring and auditing the quality of the service, outcome measures for patients to improve the quality of the service or clinical and management supervision.
- Governance systems were in place; however we did not see that senior staff were assured of compliance in all areas.
- We were not provided with data relating to all areas of mandatory and role specific training and rates of clinical supervision.

Outstanding practice

- The trust had developed a spreadsheet for recording and monitoring pressure ulcers. Using this information and looking at key indicators enabled the trust to extract lots of different information to improve care. For example trends and themes could easily be identified. This document had been shared with NHS England as an example of good practice.
- The continence service had recently expanded its remit to undertake all first continence pad and follow up continence assessments. This reduced the workload falling to the district nursing service and allowed patients to be assessed by specialist continence team members.
- The tissue viability service used a vascular assessment outcome tool to track the outcome and cost of care provided. This data was then used to drive improvements in the service, such as the development of a chronic wound pathway which was presented to an international conference.
- Mental health colleagues attended the quality and safety meeting and district nurses forum and adult community services could access mental health support from colleagues within the trust.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in the future, or to improve services.

Action the trust SHOULD take to improve:

- The trust should ensure there is a consistent approach to monitoring and auditing the quality of the service, outcome measures for patients to improve the quality of the service and clinical and management supervision.
- The trust should ensure that clinical supervision is recorded appropriately.
- The trust should ensure that management supervision is recorded appropriately.
- The trust should ensure that all mandatory and role specific training is completed by staff.
- The trust should ensure that patient group directives are appropriately completed and stored.
- The trust should ensure regular team meetings are held across all services.

Community dental services

Good

Key facts and figures

Community dental services sit within the Specialist Inpatient Administrative Services and Dental directorate of the Bradford District Care NHS Foundation Trust ('the trust'). On 10 to 12 October 2017 we inspected whether the service was safe; effective; caring; responsive; and well-led. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. This was the first time the service had been inspected and so there were no previous ratings.

Staff told us the Bradford and Airedale area has one of highest rates for missing decayed and filled teeth in the Yorkshire area. Further, they told us there is a shortage of NHS dentists in the area and so the local population often do not have a general dental practitioner. The service operates in this context.

The service operates out of eight community based locations based around Bradford, and in Shipley and Keighley. In addition, there is a mobile dental unit that offers services to hard to reach patient groups, such as homeless people. A range of specialised dental health clinics are offered including community dental care, unscheduled dental care and oral health promotion.

Community dental care supports people who have needs that cannot be met by a high street dentist (for example people who are housebound, have anxiety or severe physical disabilities) and people are referred to the service by a dentist, doctor or other healthcare professional. The service provides general dental treatment such as fillings, x-rays, cleaning and extractions. For those patients with additional needs, it can also offer treatment with sedation (inhalation sedation or intravenous sedation) or in hospital under general anaesthetic. In addition to the clinics within the community locations, the service, subject to strict acceptance criteria, can support people in their homes, following an assessment. The service has specialist equipment such as adapted dental chairs, hoists and transfer aids to support people who have mobility issues to receive the dental care they need.

Unscheduled dental care supports people during an emergency when urgent dental care is needed and is a referral based service accessed through the NHS 111 service and run as a contract by the community dental service. In the event the problem cannot be resolved on the day another appointment or referral to a different service for example, treatment in hospital, will be arranged.

Oral health improvement is supported by a dedicated oral health improvement team committed to improving the oral health of the local communities. The team works together with a wide range of health professionals, external partners (such as Mosques), and voluntary and community groups, to offer training and support about improving oral health particularly to key groups such as children, vulnerable adults and older people. The team also works in partnership with national campaigns such as national smile month to deliver key oral health messages and has a range of oral health education resources available free of charge to loan.

The service had 100 staff members with vacancies for one dental nurse and two dentists.

In the period 1 April 2017 to October 2017, the service had undertaken 11382 units of dental activity.

During this inspection, we visited the mobile dental clinic and observed a home visit, and we visited six out of the eight community dental service locations listed below:

- Keighley Health Centre
- Shipley Health Centre

Community dental services

- Westbourne Green
- Waddiloves Health Centre
- Holmewood Dental Clinic
- Horton Park Dental Practice

We did not inspect the dental training unit based at the Westbourne Green location because, although the unit is subject to the community dental service's governance framework, the unit does not see or treat patients from the community dental service.

We spoke with 41 staff (including the deputy director of the directorate, the clinical lead, the business manager, consultants, senior dentists, senior dental nurses and dental nurses), 19 patients and/or their carers or relatives (or observed the care received) and reviewed 16 patient records. We reviewed data about the community dental service supplied to us by the trust.

Summary of this service

We rated community dental services as good because:

- The service provided a welcoming and clean community dental service that was well regarded by the patients we spoke with.
- A range of clinics were offered including: clinics for emergency dental care, clinics for those patients who were unable to leave the house, dental care for patients who, because of their particular needs, could not be seen by a general dental practitioner, and mobile care for hard to reach groups, such as the homeless.
- Staff appeared motivated and had systems and processes in place to support them, including access to equipment they needed, and enough time, to enable them to see and treat patients safely.
- The service was well-led by a team of senior leaders who ensured there were adequate governance, risk and quality management systems in place to ensure safe care of patients and that the service continually strived to meet the needs of its local population.

Is the service safe?

Good

We rated safe as good because:

- We did not identify any safety concerns with the performance of the service and there were systems and processes in place to report incidents, and learn from them and improve.
- Adults and children using the service were protected from abuse because staff had received training in safeguarding and knew how to report any issues. Medicines were stored and managed safely. The environment was clean and supported access for those with mobility issues. All patient records seen were clear, legible, detailed and stored safely.
- Staffing numbers allowed the service to provide safe care to patients. The service was able to respond to medical emergencies, and individual risks to patients were assessed when receiving treatment.

Community dental services

- The service had a plan in place to help it deal effectively with risks to the service in terms of loss of staff or issues with information technology. Senior staff regularly discussed how they would respond to a major incident.

Is the service effective?

Good

We rated effective as good because:

- The service used relevant national guidelines to provide effective care to its patients, helped patients manage their pain, gave advice on good oral health care, and where relevant, such as for patients receiving a general anaesthetic, gave advice about fasting.
- Patient outcomes were monitored by the service by taking part in national audits in order to collect data to help commissioners plan the service and by running a series of local audits to make sure that the service was achieving the outcomes expected of best practice.
- Staff had the required skills and knowledge to do their roles and many had qualifications over and above their mandatory training, such as in dementia, to help them provide care to their patients.
- We saw that the service worked as part of a wider multi-disciplinary team with patient care at its centre, and had clear processes in place to accept patients into the service, or refer or discharge them, and all staff had ready access to computers to support them in finding information they needed.
- Staff understood the importance of gaining consent to treat patients and knew how to support those patients who were unable to consent by following the training they had received in mental capacity act training, such as, by arranging best interest meetings.

Is the service caring?

Good

We rated caring as good because:

- Staff were compassionate with children and adult patients and used a variety of techniques to support patients to accept treatment. To support patient confidentiality treatment was provided behind closed doors, unless patients' care plans specified an alternative.
- The service worked with the trust's learning disability service to understand the needs of and involve the patient, families and carers so that patients could be in a position to accept the dental treatment they needed.
- Emotional support was provided, for example, using detailed storybooks to support the patient through their journey into and out of the service. Staff worked as part of a multi-disciplinary team for as long as was required to support the emotional needs of their patients designing the care around the patients ability to accept treatment.
- Friends and Family survey results showed overall that 98.1% of patients would recommend the service. All patients we spoke with were positive about the service.

Community dental services

Is the service responsive?

Good

We rated responsive as good because:

- The service met with its commissioners to understand what the local population needed and tried to address the needs by offering the clinics that it did, such as the emergency clinic and the mobile clinic.
- The service embraced equality and diversity. This was visible in staff attitudes (as recognised by the award of dementia friend status) and by its use of interpreting services, which responded to the many asylum seekers who used the service.
- While access to the service was in demand, with an average waiting time of 30 weeks, emergency care was available through the NHS 111 service; the service had an action plan in place to try to reduce waiting times.
- The service encouraged feedback from its patients, whether by complaint or compliment, and carried out detailed investigations into complaints with a view to learning from them. The service made changes to its system and processes where necessary and appropriate.

Is the service well-led?

Good

We rated well-led as good because:

- A local vision existed which was discussed throughout the service during team meetings. Staff could describe the vision. The strategy was still in development as the services were due to be re-procured by NHS England.
- Systems and processes were in place to provide governance, risk management and quality assurance. These included appointing senior dental nurses at each location, having regular staff meetings, and regular quality/safety and business meetings where risk was monitored and action plans approved and monitored.
- The local leadership were experienced practitioners, and were respected by staff. They were visible and approachable and appeared to work well together. Staff described the culture of the service in a positive way.
- The service took active steps to engage with the staff and public alike in order to improve the service and act on any feedback.
- We were told about innovations the service was proud about and noted the service was committed to improve and was in discussions with commissioners to make the service sustainable.

Outstanding practice

The service had developed an anxiety care pathway, which looked at options to prevent intravenous sedation and eliminating the need to return to the service in the future. The service had a cognitive behavioural nurse and could arrange other therapies such as acupuncture and hypnosis. All patients being considered for intravenous sedation had to undergo a mandatory taster session for cognitive behavioural therapy.

Mental health services

Background to mental health services

The trust provides the following core services:

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

We inspected seven complete mental health core services in total out of nine mental health core services provided by the trust.

These were:

- Acute wards for adults of working age and psychiatric intensive care units
- Long stay/rehabilitation mental health wards for working age adults
- Wards for older people with mental health problems.
- Wards for people with learning disability or autism
- Community-based mental health services for adults of working age
- Mental health crisis services and health-based places of safety
- Community mental health services for people with learning disability or autism

Summary of mental health services

Requires improvement 

Our rating of these services went down. We rated them as requires improvement because:

- Following this inspection, six of the nine core services were rated as requires improvement overall.

Summary of findings

- For three of these nine core services, we changed the rating from good to requires improvement following this most recent inspection.

However:

- We rated community mental health services for people with a learning disability and autism as good.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement 

Key facts and figures

Bradford District Care NHS Foundation Trust provides one mental health rehabilitation and recovery ward. The ward is called Step Forward and it is based at Lynfield Mount Hospital in Bradford. Step Forward has 12 beds and can provide care and treatment to male or female patients aged between 18 and 65 years.

Step Forward is an open rehabilitation ward. This means that it is for patients that require less restrictive care and the doors are not locked. It aims to provide a specialised and person centred mental health rehabilitation and recovery programme. The service promotes techniques that facilitate mental health recovery and increase social functioning.

We last inspected long stay rehabilitation services for adults of working age in June 2014 with forensic secure inpatient services. At the last inspection, we rated those services as 'good' overall. We rated safe as 'requires improvement', we rated effective, caring, responsive and well led as 'good'. At this inspection, we inspected all of our key questions.

Our inspection was short notice announced by 30 minutes prior to the inspection, which enabled us to observe routine activity.

During our inspection, we:

- visited Step Forward, completed a tour of the care environment and observed how staff were caring for patients
- interviewed the ward manager
- interviewed seven other staff that included: one consultant psychiatrist, one occupational therapist, two registered nurses, one health care assistant, one occupational therapy assistant and a psychologist
- spoke with seven patients using the service
- spoke with three carers and relatives of patients using the service
- reviewed six patients' care and treatment records
- completed four observations of staff and patients completing activities
- observed three multi-disciplinary meetings
- observed a staff handover
- reviewed a range of documents relating to the running of the service.

Summary of this service

We rated long-stay or rehabilitation wards for working age adults as requires improvement because:

- The service did not always have enough staff. The trust reported that 80 shifts were not filled in the 12 month period between 01 July 2016 and 30 June 2017. Between 01 January 2017 and 31 July 2017 56 shifts fell below the safe minimum staffing levels and three shifts did not have a registered nurse on duty. Staff told us that registered nurses could not always have dedicated time with patients.

Long stay or rehabilitation mental health wards for working age adults

- Half of the patients' care plans reviewed did not contain information about interventions and support required to meet patients' needs. None of the records reviewed contained care plans with evidence of patient involvement or completed outcome measures. Staff had not ensured that they informed two patients of their rights under the Mental Health Act regularly. Training rates for Mental Health Act were low at 41%. Training in the Mental Capacity Act had not been consistent and although this was at 94% at the time of inspection, it had been 65% prior to our inspection.
- The clinic room was cluttered and this could impact on how quickly emergency equipment could be accessed when needed. A bottle of alcohol was stored with controlled drugs in the clinic room.
- The service did not have an allocated member of staff to complete patient observations each shift. When patients were on leave and missed physical health monitoring, staff did not always record whether they offered these checks again when patients' returned.
- The therapy kitchen was not fully accessible for disabled people because no areas of the kitchen had lowered worktops. Staff did not always respect patients' privacy; two patients told us they did not knock on their bedroom doors before opening and entering.

However:

- The ward was open access and had the appropriate restrictions expected for a rehabilitation ward. Patients had open access to a therapy kitchen and could make their own meals and drinks at any time. The service had facilities, activities and encouraged access to work to promote mental health rehabilitation and recovery. The service was clean, had good furnishings and was well maintained.
- Feedback from patients and observations showed that staff knew patients and their needs well. Staff were polite, respectful and supportive. They involved patients and their families, carers, advocates and care co-ordinators in multi-disciplinary meetings well.
- Staff managed and mitigated risks well. Patients risk assessments contained detailed information on risks and staff understood regular risk assessments of the care environment. Staff used de-escalation techniques and the service reported only three incidents of physical restraint in a 12-month period.
- The service reported no delayed discharges, serious incidents or safeguarding referrals and complaints in a 12-month period.
- Senior leaders were visible in the service and understood the services. Staff had opportunities for leadership development and they felt supported and valued.
- The trust provided opportunities for staff to participate in seminars on research, conferences and specialised learning events.

Is the service safe?

Requires improvement 

We rated safe as requires improvement because:

- In a six-month period, 80 shifts were not filled. Fifty six shifts fell below the minimum safe staffing level and three shifts did not have a registered nurse on duty. Staff told us that registered nurses could not always have dedicated time with patients due to their other responsibilities.
- The clinic room was cluttered and this could prevent staff from accessing emergency equipment quickly when needed. A bottle of alcohol was stored with controlled drugs.

- The ward did not have allocated staff to complete patient observations. This meant that there was a risk that observations to check patients' well-being could be missed.
- Records showed patients sometimes missed physical health checks when off the ward and there was no evidence that staff offered to complete this when they returned.

However:

- Staff ensured that all ward areas were clean, had good furnishings and were well maintained. They completed regular risk assessments of the care environment and managed ligature risks that they could not remove.
- Patient records contained detailed information on current and historical risks. They contained information on managing the risk of specific issues where appropriate such as, falls and skin integrity. Four out of six patient records contained detailed risk management plans to address identified risks.
- Records contained evidence that staff use de-escalation techniques prior to the use of restraint. In a 12-month period, there had been three incidents of physical restraint. Staff had not used rapid tranquilisation, seclusion or long-term segregation.
- Staff understood their responsibilities in safeguarding adults and children at risk of significant harm. They knew how to identify potential signs of abuse and neglect and how to report these.
- The service managed medicines in a safe way. A pharmacist reviewed medication and re-stocked the clinic room. They completed regular audits. Staff escalated issues with fridge temperatures outside of the normal range appropriately and replaced a faulty fridge.

Is the service effective?

Requires improvement 

We rated effective as requires improvement because:

- Three out of six care plans did not record what interventions and support staff should provide to meet the patient's needs.
- Out of the records reviewed, staff should have informed two patients of their rights under the Mental Health Act. One patient record did not show evidence that staff had informed them of their rights since their admission. The other patient record showed staff had not informed of their rights for three months.
- Staff training in the Mental Health Act was low. Only 41% of staff had completed training in the Mental Health Act. Training in the Mental Capacity Act had increased to 94% of staff. Prior to our inspection only 65% of staff had received this training.
- Staff did not always use outcome measures to evidence progress in treatment.

However:

- Staff invited patients' care co-ordinators and advocacy to attend multi-disciplinary meetings about their care and treatment. Multi-disciplinary meetings discussed a range of information relating to the progress of care and treatment for patients. Advocates visited the ward regularly.
- Staff completed prompt and comprehensive assessments of patients prior to and on admission to the ward.
- The multi-disciplinary team provided a range of suitable care and treatment interventions for rehabilitation and recovery. Patients could access medication, activities on the ward and in the community to support their recovery.

- Staff ensured that the right specialists were involved to meet patients' physical health needs.
- Managers ensured that staff received regular supervision and appraisals of their performance. Staff had access to attend additional training to support their professional development.

Is the service caring?

Good 

We rated caring as good because:

- Feedback from patients and observations of interactions showed that staff demonstrated positive attitudes and behaviours towards patients. Staff were polite, respectful and supportive. They understood patients and their needs well.
- Staff involved patients in their care and treatment. They ensured patients shared their views during multi-disciplinary meetings about their care. Patients' notes showed staff worked with them to create patient led Wellness Recovery Action Plans.
- Staff involved carers and relatives appropriately. They invited them to meetings planned and shared information with the patient's consent.
- The service scored 93% in the Patient Led Assessment of Care Environments for privacy, dignity and well-being.
- Patients and carers responded positively to the Friends and Family Test survey. This had a score of 91%.

However:

- Care plans did not reflect the patient involvement or show that patients had received a copy of their care plans.
- Two patients told us that staff did not always knock on their bedroom doors before entering.

Is the service responsive?

Good 

We rated responsive as good because:

- The quality and choice of food was good. Staff encouraged and supported patients to prepare their own meals. The trust provided money for patients to buy their own ingredients for meals. The service also provided a flexible menu that met different cultural dietary requirements.
- Staff ensured that patients had access to work, educational and recreational activities. They supported patients to maintain and develop relationships in the wider community and with those important to them.
- Staff used patients' individual communication systems where appropriate to support patients with additional communication needs.
- Patients could personalise their rooms and had their own bedroom keys to ensure their belongings were safe. They had open access to outdoor space.
- The service received no complaints four compliments in a 12-month period. Five out of seven patients knew how to make a complaint.

- There were no delayed discharges in a 12-month period.

However:

- Despite the service being mostly accessible for disabled people, the therapy kitchen did not have any lowered worktops so that disabled people could access the facilities.

Is the service well-led?

Good 

We rated well-led as good because:

- Senior leaders were visible in the service. They understood the services they managed and communicated the trust vision and values to staff.
- Systems and processes ensured that staff received all mandatory training and most required training elements the ward was clean and well maintained.
- The service received no complaints and reported no serious incidents or safeguarding referrals in a 12-month period.
- Staff could access training and hold champion roles to develop their professional development and leadership skills. Staff received regular appraisals of their performance.
- Staff felt respected and supported. They felt confident about raising concerns if they needed to.
- The service had clear frameworks on what information staff should discuss at team meetings. There was clear escalation of issues and cascading of information from senior leaders to the ward and back.
- The trust provided translating research into practice seminars for staff to attend. The trust had developed relationships with an international university in research for the effectiveness of Group Schema Therapy.

However:

- The service had a sickness rate of 10%. Despite absence management and the use of bank and agency staff, there continued to be shifts left unfilled and this meant that some shifts fell below the safe staffing level for the ward.
- The service did not audit the application of the Mental Health Act and Mental Capacity Act. We identified two patients who had not been informed of their section 132 rights at regular intervals.
- Although the service had ward champions for nursing audit and service user involvement, we identified issues with care plans. They did not evidence patient involvement and three out of six care plans did not show evidence of interventions and support patients required to meet their needs.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in the future, or to improve services.

Action the trust MUST take to improve:

- The trust must ensure that there are sufficient staff deployed to meet the minimum safe staffing levels.

Long stay or rehabilitation mental health wards for working age adults

- The trust must ensure that staff assess and design care plans in collaboration with patients and ensure these meet patients' assessed needs.
- The trust must ensure that staff receive training in the Mental Health Act.
- The trust must ensure that staff inform the relevant patients for their rights under section 132 of the Mental Health Act at regular intervals.

Action the trust SHOULD take to improve:

- The trust should ensure that emergency equipment is available quickly when needed.
- The trust should ensure that patients have access to one to one time with their named nurses.
- The trust should ensure that it is clear which member of staff is responsible to complete patient observations.
- The trust should ensure that medicines are not stored with other items.
- The trust should ensure that staff complete physical health monitoring they determine is required.
- The trust should ensure that staff receive training in the Mental Capacity Act consistently.
- The trust should ensure that staff document patients' involvement in their care plans.
- The trust should ensure that all staff maintain privacy of patients.
- The trust should consider using outcomes measures to measure patients' progress in treatment.
- The trust should consider making reasonable adjustments to ensure that disabled people can access the facilities of the therapy kitchen.

Wards for older people with mental health problems

Requires improvement

Key facts and figures

Bradford District Care NHS Foundation trust provides inpatient care for older people across two wards. The Dementia Assessment and Bracken ward.

The Dementia Assessment unit provides 24-hour care and support to people presenting with behavioural and psychological symptoms associated with dementia. A multidisciplinary team comprising consultant psychiatrists, nurses, physiotherapists and occupational therapists provides assessment and treatment.

The dementia assessment unit moved to a purpose built unit at Lynfield Mount Hospital in August 2015 and was awarded a national gold award by the Dementia Services Development Centre at Stirling University.

Bracken ward provides care for anyone over the age of 65 who is experiencing acute mental health issues.

Bracken ward offers assessment and treatment service to support people with the symptoms associated with acute mental health. A multi-disciplinary team including registered mental health nurses, healthcare support workers and occupational therapists provides assessment and treatment.

Both wards have 22 beds for both men and women.

The Care Quality Commission completed a comprehensive inspection of the services provided by Bradford District Care NHS Foundation trust in June 2014. During that inspection services for older people including inpatient and community services were inspected as a whole and were rated Good overall.

We completed this inspection of the inpatient mental health services for older people on the 24 and 25 October 2017. Our inspection was announced 30 minutes prior to the start of the inspection. This short notice announcement enabled us to observe routine activity.

During our inspection, we:

- Visited both wards, completed a tour of the care environment and observed how staff were caring for patients.
- Interviewed the ward managers.
- Interviewed 23 other staff including: consultant psychiatrists, junior doctors, occupational therapists, registered nurses, health care assistants and occupational therapy assistants.
- Interviewed the senior managers including the service manager, clinical manager and assistant director for each ward.
- Spoke with six patients using the service.
- Spoke with six carers or relatives of patients using the service.
- Reviewed eight patients' care and treatment records and their medication records.
- Completed one short observational framework for inspectors (SOFI) observation.
- Observed two multi-disciplinary meetings.
- Observed a staff handover.
- Reviewed a range of documents relating to the running of the service.

Wards for older people with mental health problems

Summary of this service

We rated wards for older people with a mental health problem as requires improvement because:

- Required training compliance rates were low with a compliance rate of 39.5% for clinical risk training and 53.5% for medication management.
- Training compliance rates for the Mental Health Act and Mental Capacity Act were low and staff understanding of the Acts was inconsistent.
- Staff received management and clinical supervision infrequently.
- Safeguarding processes had not identified where patients could have been placed at risk through a potential breach in professional boundaries.
- Incident recording lacked detail of the type and duration of restraints used and process did not demonstrate if safeguarding referrals had been considered following incidents of patient on patient assault.
- Blanket restrictions were in place on Bracken ward including daily room searches and searching patients following section 17 leave.
- Patients had limited access to psychology whilst in hospital with patients being referred to the community psychologist for support.

However:

- The service had effective medication systems in place and completed regular medication audits including regular checks by the pharmacist.
- Clinic rooms provided appropriate facilities and equipment to meet patient needs and were clean and well maintained.
- Patients' assessments were comprehensive, evidence based and contained a detailed physical health assessment for all patients. Care plans and risk assessments were holistic and reflected individual patient need.
- Staff were seen to interact with patients in a way which demonstrated kindness, dignity and respect. Staff demonstrated a genuine knowledge and awareness of the individual needs of patients.
- Ward environments reflected the needs of the patients, they were accessible to patients with a disability or difficulties with mobility. Handrails were available in communal areas and in bathrooms. There was a range of facilities available to patients including activity space, outdoor space, computers, electronic tablet devices and empathy dolls and pets.
- Managers had a good oversight of the needs of the wards and had an effective governance framework in place to highlight the wards performance. Action plans were in place to address the areas that the framework identified as an issue.

Is the service safe?

Requires improvement

We rated safe as requires improvement because:

- The compliance rate for required training for the service was at 72% overall, with clinical risk compliance rate of 39.5% and medication management compliance rate of 53.5%.

Wards for older people with mental health problems

- Blanket restrictions were utilised on Bracken ward with daily room searches and all patients searched following section 17 leave irrespective of individual risk.
- Recording of incidents involving restraint in patients' bedrooms lacked detail of time scales, type of restraint and de-escalation techniques utilised.
- Safeguarding processes did not demonstrate if safeguarding was considered or if an alert was raised following incidents.
- Safeguarding processes had not highlighted where potential breaches in professional boundaries could have placed patients at risk of abuse.

However:

- The service completed annual environmental audits and ligature assessments.
- Wards had separate male and female bedroom corridors and bathrooms. Separate female only lounges were available and there had been no mixed sex accommodation breaches.
- Clinic rooms were clean and well maintained. Appropriate equipment was available and regularly maintained and calibrated.
- Effective medication systems were in place including appropriate recording and storage of medication and regular medication audits.
- Patients' risk assessments were detailed and personalised to reflect individual risks.

Is the service effective?

Requires improvement 

We rated effective as requires improvement because:

- Management and clinical supervision for staff was infrequent with staff on average receiving one to three supervisions between January and October 2017.
- Provision of psychology was limited with patients being referred to psychologists within the community mental health teams.
- Training in the Mental Health Act and Mental Capacity Act was not mandatory and the compliance rate for these courses was low.

However:

- Patients initial assessments were comprehensive and utilised a range of evidence based tools to identify individual needs.
- The service completed a detailed physical health assessment for all patients and regularly monitored patients' physical health throughout their admission.
- Care plans were holistic and patient centred, identifying individual support needs and goals.
- All relevant Mental Health Act paperwork was available in patient records including evidence of consent to treatment and patients' leave. All patients had their rights under the Mental Health Act explained to them regularly.
- Staff appraisal rates were high with 93% of staff having received an appraisal.

Wards for older people with mental health problems

Is the service caring?

Good

We rated caring as good because:

- All the feedback received from patients and carers was positive.
- We observed staff interacting with patients in a way, which demonstrated kindness, dignity and respect whilst meeting individual patients' needs.
- Patient and carer involvement was evidenced within care plans.

Is the service responsive?

Good

We rated responsive as good because:

- The environment of the Dementia Assessment unit was specifically designed to meet the needs of the patients.
- Wards were accessible to patients with a disability and handrails were available in communal areas for patients with mobility difficulties.
- Patients had access to a range of facilities including activity space, occupational therapy kitchens, outdoor space and computers.

However:

- There were no formal timescales set for the resolution of complaints.

Is the service well-led?

Requires improvement

We rated well-led as requires improvement because:

- Systems and processes did not operate effectively to enable the trust to assesses, monitor, and improve the quality and safety of the service provided.
- Senior managers and ward managers did not have oversight of compliance rates for mandatory and required training, supervision and appraisal.
- Audits completed had not recognised all of the concerns we found during the inspection including issues with blanket restrictions, identifying and reporting safeguarding concerns and recording details about restraint.

However:

- Senior managers demonstrated an understanding of the service; they were aware of the challenges and could outline the areas for development and their plans to address these.
- There was a governance framework within the service, including access to information dashboards for managers, monthly quality and safety meetings, and regular staff meetings.

- Staff were positive about working for the trust and were passionate about providing high quality care.
- Staff could discuss opportunities for improvement and innovations in team meetings and were supported to develop these.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in the future, or to improve services.

Action the trust MUST take to improve:

- The trust must ensure safeguarding processes are in place to demonstrate that safeguarding is considered as part of the incident recording process and that safeguarding alerts are raised where necessary.
- The trust must ensure that systems are in place and operating effectively to ensure required training and supervision is completed, and that audits are effective to ensure patients are safe.
- The trust must ensure staff maintain professional boundaries so that patients are not at risk of abuse.
- The trust must ensure patient and room searches are based on risk and do not form a blanket restriction.
- The trust must ensure records of incidents involving restraint are detailed and any instances, which may qualify as seclusion, receive protections outlined in the Mental Health Act Code of Practice.
- The trust must ensure staff receive the training they require to enable them to carry out their duties.
- The trust must ensure staff receive regular clinical and management supervision and a record of the supervision is maintained.

Action the trust SHOULD take to improve:

- The trust should consider providing access to a psychologist for patients detained on the ward.
- The trust should ensure staff receive training in the Mental Health Act and Mental Capacity Act and staff are able to understand the application of the Acts in relation to their role and patient groups.

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement 

Key facts and figures

Bradford District NHS Foundation Trust provides acute inpatient services for men and women aged 18 and over. Services are provided at The Airedale Centre for Mental Health and Lynfield Mount Hospital in Bradford.

The Airedale centre for Mental Health provides two acute inpatient wards. These are:

- Fern Ward a 15 bed male acute admission ward
- Heather Ward a 19 bed female acute admission ward

Lynfield Mount Hospital in Bradford provides four acute inpatient wards. These are:

- Ashbrook Ward a 26 bed female admission ward
- Oakburn Ward a 22 bed male admission ward
- Maplebeck Ward a 21 bed male admission ward
- Clover Ward a 10 bed psychiatric intensive care unit

Lynfield Mount Hospital and The Airedale Centre for Mental Health have been registered with the Care Quality Commission since 2010 to carry out the following regulated activities:

- assessment and treatment for persons detained under the Mental Health Act 1983
- treatment of disease, disorder or injury
- accommodation for persons who require treatment for substance misuse
- accommodation for persons who require nursing and personal care
- diagnostic and screening procedures.

The service was able to admit patients who were detained for treatment under the Mental Health Act (1983), those with deprivation of liberty safeguards in place and informal patients. The majority of patients were detained under the Mental Health Act at the time our inspection, there were no patients with deprivation of liberty safeguards in place.

We have carried out three Mental Health Act monitoring visits across the service between January 2017 and June 2017. Following these visits, the trust provided an action statement telling us how they would improve the service and improve adherence to the Mental Health Act and Mental Health Act Code of Practice.

We previously inspected the acute and psychiatric intensive care unit services between 17 June and 19 June 2014. The inspection report was published 15 September 2014 and we found some areas for improvement. We rated the service as requires improvement in one key question (responsive) and rated the service as 'good' in safe, caring, effective and well led. We undertook a further inspection in January 2016 specifically relating to the responsive key question and found the service had improved. Following the inspection in January 2016 the service was rated as good overall.

This inspection was undertaken between 09 October 2017 and 11 October 2017. This inspection was announced 30 minutes prior to attending for the inspection and we inspected all key lines of enquiry in the five domains (safe, effective, caring, responsive and well-led).

Acute wards for adults of working age and psychiatric intensive care units

Before the inspection visit, we reviewed information that we held about these services and requested information from the trust.

During the inspection visit, the inspection team:

- visited all six wards, looked at the quality of the environments and observed how staff were caring for patients
- spoke with 17 patients who were using the service, and reviewed their comments on eight feedback cards
- spoke with three carers of patients who were using the service
- spoke with the deputy director, service manager, clinical managers, six ward managers, responsible clinicians and junior doctors
- spoke with 28 other staff members including nurses, healthcare support workers, pharmacists, physiotherapist, occupational therapists, occupational therapy assistants, activity workers, psychologist and the Mental Health Act Officer
- looked at the care and treatment records of 28 patients
- reviewed medication management including the medication administration records of 61 patients
- attended and observed six meetings including three safety huddles, two bed management meetings, and a multi-disciplinary meeting
- looked at policies, procedures and other documents relating to the running of the service.

Summary of this service

Our overall rating of this service went down. We rated it as requires improvement because:

- The service was not entirely safe for patients. Staff vacancies were high and there was a reliance on bank and agency staff to maintain safer staffing levels. Demand on staff time, acuity and staffing levels remained a constant challenge. Patient risk assessments were not always completed and environmental risk assessments were not available to staff. Not all incidents of abuse were reported and staff did not always seek support from specialist advisors.
- Patients did not always receive care that was effective. The quality of care plans were poor, did not reflect individual preferences and were not reviewed regularly. Staff were not sufficiently trained and supervision was not monitored across the service. Compliance for required training was low and this meant staff did not have the required skills for ensuring patient care was effective. Audit activity was not regular or effective.
- The service was not always well led. The service did not have effective systems and processes to monitor and assess performance. Audit activity was inconsistent and oversight of outcomes minimal. Not all ward managers were able to access and effectively use these systems.

However:

- The trust was committed to improving the service and took a proactive approach to achieving this using safety huddles and the introduction of the carers' hub.
- The service undertook comprehensive assessment of a patients' mental health and physical needs upon admission to hospital.
- Patients and carers were mostly positive about the service. Engagement by the trust was key to supporting patients and carers in recovery.

- The service promoted a culture that supported and valued all members of staff.

Is the service safe?

Requires improvement

Our rating of safe went down. We rated it as requires improvement because:

- Environmental risk assessments across the service were not accessible to staff. This meant staff were not aware of any identified risk or the action required to mitigate these.
- Staff vacancies were high and there was a reliance on bank and agency staff to maintain safer staffing levels. Demand on staff time, acuity and staffing levels remained a constant challenge to delivering consistent treatment and care.
- Staff did not always appropriately identify signs of abuse. Although systems were in place and staff had completed training, they did not report all incidents of abuse and use these systems. This meant safeguarding systems were not fully embedded and there were missed opportunities to seek specialist guidance.
- Staff did not always recognise and discuss when an incident may meet the trust threshold for duty of candour, and apply the duty of regulation as required by the regulation.
- Not all staff had completed the trusts required training modules and compliance was below 75% for a number of training courses including, immediate life support, medication management, rapid tranquilisation and physical interventions that are essential for ensuring patients are safe.
- Staff did not consistently complete and review risk assessments for all patients.
- The trust applied a blanket restriction to the use of bathrooms; all patients were required to be supervised whilst using a bathroom and this was not individually risk assessed.
- Staff did not carry out and record the necessary observations and reviews of patients in seclusion as outlined in the trust policy and the Mental Health Act Code of Practice.
- Policies and procedures were not followed in line with trust policies and the Code of Practice in relation to restraint, seclusion and rapid tranquilisation. Staff did not always record if a debrief was provided following an incident or the use of restrictive interventions such as restraint. Care records did not always accurately record episodes of rapid tranquilisation.

However:

- Safety huddles on each ward were introduced to support staff in understanding the immediate risks and issues at the beginning of each shift.
- All wards had access to fully equipped and organised clinic rooms.
- There was access to appropriate alarms and nurse call systems on each of the six wards.
- All wards complied with the Department of Health's national guidance on eliminating same-sex accommodation.

Is the service effective?

Requires improvement

Our rating of effective went down. We rated it as requires improvement because:

- Care plans were poor in relation to content and quality and were not regularly reviewed. One patient did not have a care plan for 10 days following their admission to hospital.
- Staff did not complete audits regularly. We reviewed audits including care records and controlled drugs and identified a series of gaps across the service in these audits.
- The recording of individual supervision was inconsistent and managers' did not have oversight of when supervision was happening.
- Compliance in a number of required training modules was low, ranging between 49% and 71% compliance. These included basic life support (69%), immediate life support (60%), rapid tranquilisation (55%) and physical intervention (49%)

However:

- All patients received a comprehensive assessment of both their mental and physical health needs when they were admitted to hospital.
- The service demonstrated how it was improving access to physical healthcare for patients; we saw regular monitoring of patients on high dose medication and those with long term conditions such as asthma and diabetes.
- The service was committed to quality improvement initiatives including a project to reduce the average length of stay for patients and an electronic rota system for staff to respond to the staffing needs of the ward.
- The service had sufficiently trained staff in the use of the Mental Health Act and Code of Practice. The service had skilled staff to administrate Mental Health Act documentation and provide specialist guidance.
- Staff completed capacity assessments when required. These were time and decision specific and were clearly documented.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

- Patients consistently gave positive feedback about the service; they felt cared for by staff and that the service was responsive to their needs.
- Patients told us staff were approachable, genuine and treated them with mutual respect.
- Patients were involved in meetings about their care and were supported to actively participate.
- Patients were able to give feedback about the service through a number of ways including ward community meetings, speaking with volunteers and completing the friends and family test.
- Carers had access to dedicated monthly carers meetings and the carers' hubs provided a range of health and wellbeing activities and support for carers.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good because:

Acute wards for adults of working age and psychiatric intensive care units

- The service had a co-ordinated and effective care pathway that provided a consistent approach to managing a patients care from admission and through to discharge into the community.
- The service maintained oversight of the bed state across the service through an effective daily bed management meeting.
- Patients were supported to maintain contact with their local community and community organisations.
- Patients knew how to complain and information was available to support this process. The service managed complaints effectively and staff received feedback on the outcome of investigations of complaints.
- All wards had a range of facilities such as activity rooms, occupational assessment kitchens, quiet rooms and communal areas. Patients had access to outside space and had keys to their bedrooms.

Is the service well-led?

Requires improvement 

Our rating of well-led went down. We rated it as requires improvement because:

- The service did not have effective systems and processes to monitor and assess performance. Senior managers and ward managers did not have oversight of compliance rates for mandatory and required training, supervision and appraisal.
- Not all ward managers could access performance dashboards for their teams, team information was incorrect and confidence in the use of the dashboards was variable.
- The service did not have systems sufficiently embedded to monitor, assess and improve the quality and safety of the service.
- Oversight of the frequency of audit completion, outcomes and required actions was inconsistent.

However:

- Managers at all levels promoted a culture that supported and valued staff.
- Leaders within the service were visible and supportive, clinical managers and advanced nurse practitioners were noted to be key individuals.
- The service was committed to continuous learning, improvement and innovation, including leadership development, service improvement through safety huddles, and innovations through pilot projects.
- The service maintained a live risk register and issues raised by staff and identified within this inspection featured on the current risk register.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in the future, or to improve services.

Action the trust MUST take to improve:

- The trust must ensure that there are sufficient staff numbers to consistently provide all aspects of patient care.

Acute wards for adults of working age and psychiatric intensive care units

- The trust must ensure that all patients have a care plan in place that is reviewed regularly and is produced collaboratively with patients to ensure they are personalised, and reflect individual choice and preferences.
- The trust must ensure that all assessment of risk for patients and the environment are completed fully, accurately and are accessible; and action is taken to mitigate risk.
- The trust must ensure that they safeguard patients against abuse and improper treatment by ensuring staff know how to identify signs of abuse and how to report safeguarding concerns.
- The trust must ensure that restrictive practices, when required, should be planned, lawful, in the patient's best interest, proportionate and dignified. They should be individual in response to identified risk.
- The trust must ensure that systems are in place and operating effectively to ensure required training and supervision is completed, and that audits are effective to ensure patients are safe.
- The trust must ensure that all staff on all wards have received up to date required training, as determined by the trust.
- The trust must ensure that systems and processes are effective to monitor, assess and improve the quality and safety of the services.
- The trust must ensure that staff consistently monitor and record patient care during periods of seclusion and following rapid tranquilisation.
- The trust must ensure that staff record whether a debrief was provided to patients following an incident or restrictive intervention such as restraint.
- The trust must ensure that staff recognise and discuss when an incident may meet the trust threshold for duty of candour, and apply the duty of regulation as required by the regulation.

Action the trust SHOULD take to improve:

- The trust should ensure that agency staff have direct access to care records and incident reporting system.

Community-based mental health services of adults of working age

Requires improvement 

Key facts and figures

Bradford District Care NHS Foundation Trust provides community mental health services for adults aged 16 to 65 years with complex and enduring mental health problems who require specialist support. Patients who are registered with a GP in Bradford, Airedale, Wharfedale or Craven can ask their GP to be referred through a Single Point of Access. They may then be referred to one of five community mental health teams based across the district. All bases have bookable clinic space for appointments, but where appropriate staff see patients in community settings and/or in their own home.

The community mental health teams are made up of a range of mental health experts working together to provide care. The community mental health teams provide the following services;

- assessment and treatment for adults experiencing a range of complex mental health problems
- assertive outreach services
- early intervention psychosis services
- improving access to psychological therapies services
- employment support for patients
- access to diversionary activities
- occupational therapy
- support for carers and families
- support and advice to primary care and signposting to voluntary sector organisations and other services

At the last inspection, we rated the core service as 'good' overall. We inspected this core service on 19 to 20 October 2017. At this inspection, we inspected all of the key questions. Our inspection was announced 24 hours prior to the start of the inspection to ensure that we could speak with staff and patients during the inspection.

Before the inspection visit, we reviewed information that we held about these services and requested information from the trust.

During the inspection visit, the inspection team;

- toured the care environments at two service locations; Horton Park Medical Centre and Meridian House and observed how staff were caring for patients
- completed observations which included consultants clinics, home based treatment appointments, multidisciplinary meetings for two of the teams
- interviewed the director and the assistant director and the service manager of the community mental health services
- interviewed three team leaders for the community mental health teams and two team leaders from the early intervention psychosis services

Community-based mental health services of adults of working age

- spoke with 22 other staff members including consultant psychiatrists, advanced nurse practitioners, community mental health nurses, care coordinators, associate nurse practitioners, support workers, social workers, occupational therapists and psychologists
- spoke with 10 patients using the community mental health services
- spoke with 4 carers
- reviewed feedback left by 14 patients using comment cards
- reviewed 14 records of patients who had used the community mental health services
- reviewed a range of documents relating to the running of the service

Summary of this service

Our overall rating of this service went down. We rated it as requires improvement because:

- The service could not evidence they had carried out fire risk assessments or health and safety assessments at two of the locations we inspected where they saw patients.
- Half of the patients' records we looked at did not contain up-to-date risk assessments and some did not have a crisis plan documented for patients. Staff did not monitor physical health needs for all the patients in their care.
- The service did not carry out medication audits so could not ensure medicines were always managed appropriately. Some medication records had not been reviewed in line with trust policy.
- Some patients did not have up-to-date assessments of their needs and some did not have a personalised care plan. The service did not monitor outcomes for patients and none of the records we looked at had discharge plans in place for patients.
- Managers could not provide assurance that all staff had access to regular supervision in line with trust policy.
- Not all staff knew about the application of the Mental Capacity Act or about the trust's responsibilities regarding duty of candour. Not all staff were up-to-date with their required training and managers did not provide training for staff in the Mental Health Act.
- The service did not monitor waiting times for patients in the community mental health service and did not always respond effectively when audits highlighted gaps in care records.

However:

- The overall appearance of the patient areas in both the locations we inspected were clean, well maintained and had furnishings which were in good order.
- Staff were good at responding when patients became mentally unwell. Generally patients had good access to a psychiatrist when needed. Staff met regularly and frequently to discuss patients and share information with the wider care team. They knew how to identify potential signs of abuse and neglect and how to report these.
- Patients had access to a skilled multidisciplinary staff team with access to healthier lifestyle advice, employment support and activities aimed at promoting recovery.

Community-based mental health services of adults of working age

- Feedback from patients and observations of interactions showed that staff demonstrated a caring and compassionate approach. Staff treated them with respect, listened to their concerns, and showed genuine empathy. Staff had good links with carer's support and signposted patients' families and carers.
- Staff provided assertive outreach visits for patients and referred them to a rapid response service when they needed support out-of-hours.
- The service had an accessible complaints procedure and patients found staff approachable and willing to resolve concerns.
- Senior leaders understood the services they managed and communicated the trust vision and values to staff. Staff felt valued by their immediate managers and could raise concerns when needed.
- Staff met to discuss learning from incidents and where needed, they made changes to systems and procedures.

Is the service safe?

Requires improvement 

Our rating of safe went down. We rated it as requires improvement because:

- The service could not evidence they had conducted recent fire risk assessments or health and safety assessments for either of the locations we inspected where they saw patients.
- Staff compliance with training, which was required for their role was below the trust's target of 80% in all but one of the 14 role specific training programmes.
- Half of the patient records we looked at did not contain an up-to-date risk assessment and three did not have a crisis plan documented for patients.
- The trust did not carry out medication audits in the service so staff had not identified that thirteen medication records had not been reviewed in line with the trust timescales.

However:

- The overall appearance of the patient areas in both the locations we inspected were clean, well maintained and had furnishings which were in good order.
- Staff were good at responding when patients became mentally unwell and generally, patients had good access to a psychiatrist.
- Staff knew how to report incidents. They shared lessons learned and made changes in response to recommendations from incidents
- Staff understood their responsibilities in safeguarding adults and children at risk of significant harm. They knew how to identify potential signs of abuse and neglect and how to report these.

Is the service effective?

Requires improvement 

Our rating of effective went down. We rated it as requires improvement because:

Community-based mental health services of adults of working age

- Eight out of 14 records did not contain an up-to-date comprehensive assessment of patients' needs and eight did not have an up-to-date personalised care plan. None of the patients' records reviewed contained evidence of discharge planning.
- We found mixed levels of staff knowledge about how they would apply the Mental Capacity Act to their practice.
- Managers did not provide training for staff about the Mental Health Act or the Mental Health Act Code of Practice. Not all staff were up-to-date with their required training.
- Staff did not monitor or record physical health needs for all the patients under their care

However:

- Staff offered patients access to healthier lifestyle advice and activities aimed at promoting recovery, for example, football and creative activity groups. Patients had access to employment support including job hunting skills and benefits advice.
- The teams had effective arrangements in place to coordinate care when patients moved between teams or went into hospital.
- Managers ensured that most staff received an appraisal of their performance. Staff had access to attend additional training to support their professional development.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good because:

- Feedback from patients and observations of interactions showed that staff demonstrated a caring and compassionate approach. Staff treated them with respect, listened to their concerns, and showed genuine empathy.
- Staff supported patients to manage their condition and access other appropriate services.
- Staff provided support to carers and relatives appropriately. They had links with a carers' hub where carers could meet and get relevant advice and support.
- Ninety percent of patients and carers said they would recommend the service to their families and friends.

However,

- Care plans did not always show evidence of the patient involvement and collaboration, or that patients had received a copy of their care plans.

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good because:

- Staff told us patients did not have to wait for an assessment of their needs by a care coordinator. Staff said they saw patients within ten working days of referral and in some cases sooner.
- Patients had access to educational and recreational activities.

- Staff provided assertive outreach visits for patients and referred them to a rapid response service when they needed support out-of-hours.
- Patients knew how to make a complaint and found staff approachable and willing to resolve concerns.

However:

- The service did not set a target for how long patients should wait to see a psychiatrist or a psychologist and some patients told us they had waited a long time to see them.
- The walls between consulting rooms in Meridian House did not have adequate soundproofing so patients could be overheard and patient clinics were interrupted to access essential supplies. The trust had a refurbishment plan to address these concerns.

Is the service well-led?

Requires improvement 

Our rating of well-led went down. We rated it as requires improvement because:

- Some of the audits carried out by managers identified deficiencies in care records but they did not always rectify these in a timely manner.
- Managers had not kept an accurate record of staff supervision and so could not evidence that they provided regular supervision to all staff in line with trust policy.
- The service did not monitor waiting times, for example, how long patients in community mental health services waited to see a psychiatrist or a psychologist.
- Not all staff were aware of that the trust had a duty of candour and what this meant.

However,

- Senior leaders understood the services they managed and communicated the trust vision and values to staff. In their work with patients, staff demonstrated the trust's values of openness, respect, and working together.
- Staff felt supported by their immediate line managers and were confident about raising concerns and who to report these to.
- Staff worked well together to provide an integrated service for patients. They met frequently to discuss and learn from incidents. They used the information to make improvements.
- Patients and carers had opportunities to provide feedback on the service through surveys and a complaints process.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in the future, or to improve services.

Action the trust MUST take to improve:

- The trust must ensure that all premises used to treat patients have up-to-date health and safety risk assessments in place including fire risk assessments.

Community-based mental health services of adults of working age

- The trust must ensure that medication being prescribed for patients is reviewed in line with the relevant trust policy.
- The trust must ensure that staff complete and update regular assessments of need, risk assessments and crisis plans for all patients in line with trust policy.
- The trust must ensure that all patients have an up-to-date personalised care plan and discharge plan.
- The trust must ensure that systems are in place and operating effectively to ensure required training and supervision is completed, and that audits are effective to ensure patients are safe.

Action the trust SHOULD take to improve:

- The trust should ensure that staff use personal protective equipment when carrying out clinical procedures.
- The trust should ensure that staff maintain the privacy of patients during consultations.
- The trust should ensure that staff document whether carers have been offered an assessment of their needs.
- The trust should consider using outcomes measures to measure all patients' progress in treatment.
- The trust should ensure that managers provide feedback to staff on the outcome of patient complaints.
- The trust should ensure that staff are aware of the trust's duty of candour responsibilities.
- The trust should ensure that patients are routinely offered a copy of their care plan and this is documented in their care record.
- The trust should ensure that managers document the frequency of supervision provided to individual staff in line with trust policy.
- The trust should consider providing documented evidence that staff employed by the local authority are suitably qualified and trained for their roles within the integrated teams.
- The trust should ensure the business continuity plan for community mental health services is reviewed in line with the relevant timescales.

Community mental health services for people with a learning disability or autism

Good

Key facts and figures

Bradford District Care NHS Foundation Trust's community mental health services for people with a learning disability or autism service works across Bradford and Airedale. Care and treatment is delivered at The Waddiloves Health Centre in Bradford. There is a second site called The Oaks in Keighley, which is used for agile working, and when there are difficulties with Wi-Fi connections at The Waddiloves Health Centre; no care and treatment is delivered at The Oaks.

The service provides specialist health support for adults who have learning disabilities and who cannot access mainstream health services, even when reasonable adjustments have been made. The team provides a variety of clinics including dental services, podiatry, audiology, ophthalmology and psychiatry.

The team comprises speech and language therapists, occupational therapists, physiotherapists, nurses, dietitians, psychologists and health care support workers. The service works with people aged from 16 upwards both at the service building and in people's own homes, providing transition support for young adults with complex health needs and helping patients to access mainstream services to ensure that their health needs are met and that any reasonable adjustments are put in place for them.

The service was last inspected in June 2014 jointly with the trust's learning disabilities inpatient services. The trust's learning disabilities inpatient and community services at that inspection were rated together as requires improvement overall; good in safe, requires improvement in effective, good in caring, good in responsive, and requires improvement in well-led. The areas for improvement identified included:

- staff needed more training in the Mental Health and Mental Capacity Acts
- mental capacity assessments not being undertaken for every decision made about patients' care and treatment
- information not being available in a format that each person who uses the service can understand
- the service's intensive support team needing to be developed so it met people's needs
- the service was not always responding to the current need to close the assessment and treatment unit to admissions
- staff did not have clear leadership and objectives
- administrative staff were being moved to hub offices which left the community team alone and at risk of harm

We inspected this core service on the 12 – 13 October 2017. At this inspection, we inspected all of the key questions. Our inspection was announced 24 hours prior to the start of the inspection to ensure that we could speak with staff and patients during the inspection.

During the inspection we:

- checked the service environment for health, safety and cleanliness
- looked at six patient care records
- accompanied staff during visits to patients' homes
- spoke with the deputy director and interim head of service acute and community mental health services and service manager

Community mental health services for people with a learning disability or autism

- spoke with 12 other members of staff including nurses, administrators, health care support workers, a psychologist, speech and language therapist, physiotherapist
- spoke with nine patients and carers and looked at feedback received
- looked at information about staff supervision, appraisals and mandatory training and,
- attended a multidisciplinary meeting and a hydrotherapy session.

Summary of this service

Our rating of this core service improved . We rated the service as good because:

- The service building was clean and tidy and all necessary testing in relation to health and safety such as fire, electrical wiring and gas safety had been completed.
- There were contingency plans in place in the event of the service building or electronic systems being unavailable.
- The people who used the service that spoke with us told us staff were kind, caring and were aware of their needs and that they were involved in decisions about their care and treatment.
- The people who used the service were able to given feedback via surveys and user groups.
- Two patients worked as volunteers at the service.
- Staff made efforts to engage with patients who had not attended appointments or were reluctant to engage with mental health services.
- The trust had policies and procedures in place to protect people from discrimination, unfair treatment, harassment and bullying.
- Staff assessed and monitored patients' physical health and encouraged them to attend appointments with other services such as GP appointments.
- Staff encouraged patients to live healthier lifestyles by taking exercise, eating healthily and smoking cessation and there were posters and leaflets in the waiting area giving advice on a wide range of health conditions such as cancer and diabetes. The service provided breast screening in conjunction with another external organisation.
- Staff were knowledgeable about safeguarding, knew how to report incidents and received information about learned lessons from incidents, complaints and patient feedback to improve practice within the service.
- The trust reported there were no serious incidents in the 12 months prior to our inspection.
- Staff knew what their responsibilities were under the duty of candour in relation to being open, honest and transparent with people when things go wrong.
- Staff received training in equality and diversity and the trust had policies to protect people from discrimination, unfair treatment, bullying and harassment
- There were sufficient numbers of staff to meet the needs of the patients, there was no freeze on staff recruitment, and sickness absence figures were at 2.12% which was better than the trust's target of keeping levels down to 4%.
- The multidisciplinary team comprised a wide range of professionals and there were effective meetings and handover arrangements within the team.

Community mental health services for people with a learning disability or autism

- Staff were experienced and qualified to do their job.
- Staff had access to specialist training for their role and managers identified their training and development needs.
- The service's medicines management arrangements were effective and were in line with the National Institute for Care and Health Excellence, Royal College of Psychiatrists, Faculty of Intellectual Disabilities and Stopping the Over-Medication of People with Learning Disability and Autism guidance.
- The service had an effective lone working process to ensure staff were safe when they were working in the community.
- Pathways used by the service included mental health, behaviour, maternity, ophthalmology, respiratory and dementia.
- Patient care records were holistic, person-centred and recovery orientated.
- The service used positive behaviour support plans for patients, which were tailored to meet patients' individual needs and centred around reducing their behaviours that challenged.
- Staff received mandatory training in the Mental Capacity Act and had a good knowledge of the Act.
- The service made effective and appropriate use of best interests decisions and capacity assessments and supported patients to make their own decisions.
- Staff were appraised and agreed with the trust's visions and values.
- The numbers, experience and role mix of staff meant the service could meet patients' needs.
- Staff morale and job satisfaction were positive, there was a good level of support from peers and managers, staff felt proud to work for the trust.
- The trust recognised staff's success and staff within the team had won awards from the trust and a member of staff had won a national learning disability award.
- Staff could add items to the service and trust risk registers and knew where to access the trust's whistleblowing policy.
- The service worked with the local police to raise awareness of issues associated with learning disabilities, a health care support worker supported the service and trust with the delivery of learning disabilities awareness training for first year student nurses and a speech and language therapist led a quarterly communications champions' network forum and ran consultancy clinics during which staff could discuss patient cases.
- The service worked with external care providers and services to promote the use of information technology to older people to enable them access to various forms of online support. It also delivered learning disability awareness sessions to acute hospitals.
- The service had run training sessions to local support providers around active support and behavioural monitoring and had positive and proactive champions and communication champions networks that shared best practice around the use of positive behaviour support and communication methods for people with a learning disability.
- The service participated in one of the Commissioning for Quality and Innovation's national audits in relation to ensuring patients were able to access national physical health checks.

However

- Staff compliance rates for required training in level three safeguarding children and adults, managing violence and aggression – breakaway and basic life support were below 75%.

- The garden area that was situated at the top of a grassy bank with a steep incline with insufficient protection to prevent people falling.
- Mental Health Act training was not a mandatory training requirement for staff at the service.
- The service were unable to provide accurate data in relation to the number of cancelled appointments, numbers of patients subject to community treatment orders and numbers of complaints.
- The service had insufficient monitoring arrangements in place to ensure mandatory training was within the trust's 80% compliance target, clinical supervision was taking place, all care plans and risk assessments were reviewed at least every six months in line with the service's policy and all initial risk assessments were included in care records. The trust did not monitor compliance with staff supervision.

Is the service safe?

Requires improvement

Our rating of safe went down. We rated it as requires improvement because:

- Staff compliance rates for required training in level three safeguarding children and adults, managing violence and aggression – breakaway and basic life support were below 75%.
- The garden area used by people who use the service was situated at the top of a grassy bank with a steep incline with a fence that ran along it which offered inadequate protection to prevent people falling over the edge and coming to serious harm.
- Risk assessments were not always reviewed at least every six months in line with the trust policy.

However:

- The service building was clean and tidy and all necessary testing in relation to health and safety such as fire, electrical wiring and gas safety had been completed.
- There were sufficient numbers of staff to meet the needs of the patients. Urgent referrals were dealt with as a priority.
- The service had an effective lone working process to ensure staff were safe when they were working in the community, however, staff sometimes felt unsafe because they did not carry personal alarms.
- Staff were knowledgeable about safeguarding and knew how to report incidents and received information about learned lessons from incidents, which were used to improve practice at the service.
- The trust reported there were no serious incidents in relation to the service in the 12 months prior to our inspection.
- Staff knew what their responsibilities were under the duty of candour in relation to being open, honest and transparent with people when things go wrong.
- The service's medicines management arrangements were effective and were in line with the National Institute for Care and Health Excellence, Royal College of Psychiatrists, Faculty of Intellectual Disabilities and Stopping the Over-Medication of People with Learning Disability and Autism guidance.

Is the service effective?

Good

Community mental health services for people with a learning disability or autism

Our rating of effective improved. We rated it as good because:

- Patient care records were holistic, person-centred and recovery orientated.
- The service used positive behaviour support plans for patients, which were tailored to meet patients' individual needs and centred around reducing their behaviours that challenged.
- Staff assessed and monitored patients' physical health and encouraged them to attend appointments with other services such as GP appointments.
- Staff encouraged patients to live healthier lifestyles by taking exercise, eating healthily and smoking cessation and there were posters and leaflets in the waiting area giving advice on a wide range of health conditions such as cancer and diabetes. The service provided a breast screening service in conjunction with an external organisation.
- Staff received mandatory training in the Mental Capacity Act and had a good knowledge of the Act.
- The service made effective and appropriate use of best interests decisions and capacity assessments and supported patients to make their own decisions.
- The multidisciplinary team comprised a wide range of professionals and there were effective meetings and handover arrangements within the team. Staff were experienced and qualified to do their job. Staff had access to specialist training for their role and managers identified their training and development needs.

However:

- Mental Health Act training was not a mandatory training requirement for staff at the service. Staff told us the service would benefit from additional training in the Act.
- Not all care plans were reviewed at least every six months in line with the service's policy.

Is the service caring?

Good

We rated caring as good because:

- The people who used the service that spoke with us told us staff were kind, caring and were aware of their needs and that they were involved in decisions about their care and treatment.
- People who used the service were able to given feedback via surveys and user groups.
- Staff used the most appropriate communication method to help patients understand and be properly involved in their care and treatment.
- Staff supported patients in making advance decisions such as refusing certain treatments and do not attempt cardiopulmonary resuscitation orders.
- Two patients worked as volunteers at the service, one of whom spoke with us and said they enjoyed their role.

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good because:

Community mental health services for people with a learning disability or autism

- Staff made efforts to engage with patients who did not attend appointments or were reluctant to engage with mental health services.
- The service dealt with urgent referrals as a priority and there were systems in place to ensure waiting lists were regularly monitored.
- Pathways used by the service included mental health, behaviour, maternity, ophthalmology, respiratory and dementia.
- Staff supported patients in accessing education and work opportunities if they requested help. Information was available in an easy read format.
- Patients had access to signers, interpreters and advocacy services.
- Complaints were handled appropriately and were used to improve practice within the service.

Is the service well-led?

Good

Our rating of well-led improved. We rated it as good because:

- Staff were appraised and agreed with the trust's visions and values.
- The numbers, experience and role mix of staff meant the service could meet patients' needs.
- Staff morale and job satisfaction were positive, staff felt proud to work for the trust and there was a good level of support from peers and managers.
- The trust recognised staff's success and staff within the team had won awards from the trust and a member of staff had won a national learning disability award.
- Staff understood the need to be open, honest and transparent with people when things went wrong.
- Staff knew how to report incidents and lessons learned from investigating incidents and complaints were shared with patients and staff and used to improve practice within the service.
- Staff could add items to the service and trust risk registers and knew where to access the trust's whistleblowing policy. Staff were trained in safeguarding and knew how to recognise possible signs of abuse.
- The trust had policies and procedures in place to protect people from discrimination, unfair treatment, harassment and bullying.
- The service had a business continuity plan, which included contingency plans to be implemented in the event of potential disruptions leading to normal service delivery being below predefined levels.
- The service and wider trust provided a variety of ways for people to provide feedback on the service including surveys, user group forums and participating in friends and family tests.
- The service was working with the local police to raise awareness of issues associated with learning disabilities, a health care support worker supported the service and trust with the delivery of learning disabilities awareness training for first year student nurses and a speech and language therapist led a quarterly communications champions' network forum and ran consultancy clinics during which staff could discuss patient cases.
- The service worked with external care providers and services to promote the use of information technology to older people to enable them access to various forms of online support.

- The service had run training sessions to local support providers around active support and behavioural monitoring and also had positive and proactive champions and communication champions networks that shared best practice around the use of positive behaviour support and communication methods for people with a learning disability.
- The service participated in one of the Commissioning for Quality and Innovation's national audits in relation to ensuring patients were able to access national physical health checks.

However

- The service had insufficient monitoring arrangements in place to ensure mandatory training was within the trust's 80% compliance target, all care plans and risk assessments were reviewed at least every six months in line with the service's policy and all initial risk assessments were included in care records.
- Three staff members did not know what the role of the trust's freedom to speak up guardian entailed.

Outstanding practice

- The service run 10 training sessions in the last year to local support providers around active support and behavioural monitoring. The service also had positive and proactive champions and communication champions networks that shared best practice around the use of positive behaviour support and communication methods for people with a learning disability.
- The service was working with local police constables to improve engagement with people living with learning disabilities by providing them with advice and guidance on the various types of conditions and associated issues and behaviours.
- The service had been involved in an NHS improvement programme around criteria led discharges, which included examining how discharge times could be reduced where appropriate.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in the future, or to improve services.

Action the provider MUST take to improve

- The provider must ensure that systems are in place to ensure all staff are compliant with required training.

Action the provider SHOULD take to improve

- The provider should review the safety of the layout of the garden area to ensure it is sufficiently safe to prevent serious injury or fatalities.
- The provider should ensure that systems are in place to ensure all staff are compliant with the Mental Health and Mental Capacity Acts.
- The provider should ensure that care records and risk assessments are reviewed in line with the service's policy and that audits are effective in identifying issues within care records.
- The provider should ensure that all staff are made aware of who the trust's Freedom to Speak Up Guardian is and what their role entails.

Mental health crisis services and health-based places of safety

Requires improvement 

Key facts and figures

The crisis service of Bradford District Care NHS Trust was made up of two intensive home treatment teams, two health based places of safety suites and a 'First Response' team that spanned the whole service.

Bradford District NHS Foundation Trust Crisis Service mental health crisis services and health-based places of safety are based across two sites, one at Lynfield Mount hospital in Bradford and the other at the Airedale Centre for Mental Health in Keighley.

Lynfield Mount Hospital and the Airedale Centre for Mental Health have been registered with the Care Quality Commission since 2010 to carry out the following regulated activities:

- assessment and treatment for persons detained under the Mental Health Act 1983
- treatment of disease, disorder or injury
- accommodation for persons who require treatment for substance misuse
- accommodation for persons who require nursing and personal care
- diagnostic and screening procedures.

We first inspected the service in June 2014. We rated the service was requires improvement in the safe key question and rated the service as good in effective, caring, responsive and well-led key questions. We inspected the service again in January 2016 and we rated the service as good in the safe key question.

This inspection was completed on 16 - 18 October 2017. It was announced 48 hours prior to the inspection and we inspected all key lines of enquiry in the five domains (safe, effective, caring, responsive and well-led).

Before the inspection visit, we reviewed information that we held about these services and requested information from the trust.

During the inspection visit, the inspection team:

- looked at the quality of the environments
- observed how staff were caring for patients
- spoke with five patients who were using the service
- spoke with four carers of patients who were using the service
- spoke with two service managers and three clinical managers
- spoke with 23 other staff members including nurses, a healthcare support worker, a social worker, domestic staff, telecoaches and triage staff
- looked at the care and treatment records of 24 patients
- reviewed medication management including the medication administration records of 12 patients
- attended and observed two safety huddles, three handovers, a conference call and an Advanced Nurse Practitioner meeting

Mental health crisis services and health-based places of safety

- looked at six policies, procedures, team meeting minutes and other documents relating to the running of the service
- pathway tracked three patients in depth
- attended four home visits
- facilitated a focus group for four staff at The Haven

Summary of this service

Our overall rating of this service went down. We rated it as requires improvement because:

- The service was not entirely safe for patients. Not all staff were trained in life support techniques which meant that not everyone could respond to patients in a medical emergency. Not all staff were trained in breakaway techniques to maintain their own safety. The physical environments of both health based places of safety required improvement to maintain the safety, privacy and dignity of service users.
- The service was not always well-led. Managers had not maintained proper records to show that all staff received regular supervision. Managers had not ensured that all staff received the required training for their role and appraisal rates varied between teams in the service. Audits had not identified areas of concern in relation to the physical environment or in records related to the use of the Mental Health Act. The service did not audit the use of the Mental Capacity Act.

However:

- The service was providing care which was effective. Patients received a care plan which was designed specifically to meet their needs. Staff used recognised rating scales to monitor patient's outcomes. The service was multi-disciplinary as teams brought together skilled staff from a range of professional disciplines. The service worked in close partnership with a number of other agencies to deliver effective care.
- The staff working in the service were caring. Staff offered practical, professional support for patients and demonstrated an approach which was kind and compassionate. Patients and carers were positive about the service and the staff. Staff were adaptive to the needs of patients and had a number of routes for people who used the service and their relatives to provide feedback.
- The service was responsive to the needs of people using the service. People could access the service at any time and there was a clear pathway for patients based on their individual needs. Staff worked proactively to engage people who had difficulty engaging with services. There were examples of the service using patient complaints to improve the service.

Is the service safe?

Requires improvement 

Our rating of safe went down. We rated it as requires improvement because:

Mental health crisis services and health-based places of safety

- The service had low compliance rates for role specific required training. The average compliance rate for required training was 65%. Less than half of the staff (49%) were trained in basic life support. Only 335 of staff were trained in intermediate life support. The compliance rate for breakaway training was 54%. The compliance rate for conflict resolution training was 64%.
- Staff in the intensive home treatment teams told us that they were required to provide duty nurse cover for the trust's acute mental health wards for working age adults. Some staff felt that they did not have the required expertise and competence to fulfil this role safely.
- Airedale Health Based Place of Safety had a sharp edged mirror in the bathroom, which was a risk to patients. In addition, the corridor windows leading to the health based place of safety at Lynfield Mount Hospital compromised patients' privacy and dignity.

However:

- The service had a clear approach to assessing, triaging and managing patient risks and recorded risks appropriately. Records showed that risk assessments were updated regularly, including after any incident.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most staff had training on how to recognise and report abuse and they knew how to apply it.
- The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.
- Staff understood that they should be open and honest with patients and their families if something went wrong during their care and treatment, although not all staff understood that this was referred to as 'duty of candour'.

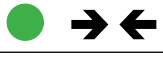
Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good because:

- The majority of care plans were comprehensive and patient centred. Care records showed that staff assessed the mental health of each patient on an ongoing basis. Care plans were updated and adapted to meet the changing needs of patients experiencing a mental health crisis. There was a process in place to respond to the physical health needs of people using the service.
- Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. There was an electronic records system that all staff could update.
- The service had a well-established pathway for patients to deliver effective care which was based on presenting risks and individual needs.
- The service was both multi-disciplinary and multi-agency. Staff came from a range of professional disciplines. The service combined staff from the trust, the local authority and a number of voluntary sector organisations to deliver a model of care which was effective and coordinated.

Is the service caring?

Good 

Mental health crisis services and health-based places of safety

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Staff actively sought feedback from patients and those close to them and used feedback to improve the service.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good because:

- People could access the service when they needed it. The First Response team could see patients within four hours of the referral being made at any time of day. Nine out of ten calls to the service were answered within two minutes.
- The service worked closely in partnership with voluntary and community sector organisations to provide a comprehensive multi-level approach for people in crisis, based on presenting risks. The voluntary and community sector organisations provided people with safe spaces and peer support, which reduced admissions to accident and emergency departments.
- Staff actively tried to engage patients who were difficult to engage with services using a variety of methods.
- Both health based places of safety were furnished and equipped to a high standard. Staff met patients with mobility difficulties at either their own homes or other suitable premises.
- Staff in the service reflected some of the diversity of the local population, which meant that staff could easily care for patients who first language was not English. They also had good access to interpreters, including phone interpreters.

Is the service well-led?

Requires improvement 

Our rating of well-led went down. We rated it as requires improvement because:

- We found that although staff said they took part in supervision, records of supervision were incomplete or unavailable in the intensive home treatment team - Bradford, and not all teams achieved the trust compliance rate for appraisal rates.
- Managers had not ensured that all staff had completed the required training to fulfil their roles. Not all staff had received training in the Mental Health Act.
- Environmental assessments had not identified safety concerns in relation to the health based place of safety at the Airedale Centre for Mental Health or concerns in relation to the privacy and dignity of service users at the health based place of safety at Lynfield Mount.
- The service's audits of the Mental Health Act had not identified that information was missing in relation to patients receiving an explanation of their rights whilst they were admitted under Section 136 of the Mental Health Act. The service did not audit the application of the Mental Capacity Act.

However,

- The service had managers at all levels with the right skills and abilities to run a service.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff were provided with opportunities for development at all levels. All staff we spoke with either spoke positively or very positively about their job and what they offered to patients.
- The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. Senior managers were developing new performance dashboards to allow them to have more effective oversight of key performance indicators in the service.

Outstanding practice

The redesign of the trust's mental health crisis services' pathway had ensured that no patient had needed to be admitted to an out of area placement in the previous two years. The intensive home treatment team ensured that more people could be cared for in the community without requiring an inpatient admission. The service worked closely in partnership with voluntary and community sector organisations to provide a comprehensive multi-level approach for people in crisis, based on presenting risks. The voluntary and community sector organisations provided people with safe spaces and peer support, which reduced admissions to accident and emergency departments.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in the future, or to improve services.

Action the trust MUST take to improve:

- The trust must ensure that systems are in place and operating effectively to ensure required training and supervision is completed, and that audits are effective to ensure patients are safe.
- The trust must ensure that the corridor windows leading to the health based place of safety at Lynfield Mount Hospital do not compromise patients' privacy and dignity.
- The trust must ensure that the mirrors in the health based place of safety in the Airedale Centre for Mental Health do not pose a risk to patient safety.
- The trust must ensure that all staff mental health crisis services receive regular supervision and this is documented.
- The trust must ensure that the use of the Mental Health Act and Mental Capacity Act is audited effectively.

Action the trust should take to improve:

- The trust should review the current arrangements for duty nurse cover on the trust's acute mental health wards for working age adults to ensure that staff are working within their competencies.
- The trust should ensure that all staff receive training in the Mental Health Act and that compliance rates are recorded accurately and monitored.
- The trust should ensure that all patients are aware of and receive copies of their care plans.
- The trust should maintain a record that evidences that staff provide information to patients on their rights when detained under Section 136 of the Mental Health Act.

Wards for people with a learning disability or autism

Requires improvement

Key facts and figures

Bradford District NHS Foundation Trust provide one inpatient ward for people with a learning disability or autism. The ward is located at Lynfield Mount hospital in Bradford.

Lynfield Mount hospital has been registered with the Care Quality Commission since 2010 to carry out the following regulated activities:

- assessment and treatment for persons detained under the Mental Health Act 1983
- treatment of disease, disorder or injury
- accommodation for persons who require treatment for substance misuse
- accommodation for persons who require nursing and personal care
- diagnostic and screening procedures.

The Highfields assessment and treatment ward is a purpose built inpatient service, which is able to provide care to a maximum of six male or female patients.

The ward was able to admit patients who were detained for treatment under the Mental Health Act (1983), or those with deprivation of liberty safeguards in place. There were no informal patients admitted to the ward at the time our inspection, all patients were detained under the Mental Health Act.

We carried out a Mental Health Act monitoring visit at the Highfields assessment and treatment ward in March 2016. Following this visit, the trust provided an action statement telling us how they would improve the service and improve adherence to the Mental Health Act and Mental Health Act Code of Practice.

We last inspected the inpatient wards for people with a learning disability or autism together with the community learning disability service in June 2014. We rated these services together as 'requires improvement' overall with ratings of 'good' in the safe, caring and responsive key questions, and requires improvement in effective and well-led. This inspection was the first time we have inspected wards for people with learning disabilities and autism as a service in its own right.

This inspection was completed on 09 October 2017. It was announced 30 minutes prior to the inspection and we inspected all key lines of enquiry in the five domains (safe, effective, caring, responsive and well-led).

Before the inspection visit, we reviewed information that we held about these services and requested information from the trust.

During the inspection visit, the inspection team:

- visited the ward, looked at the quality of the environments and observed how staff were caring for patients
- spoke with four patients who were using the service, and reviewed their comments on two feedback cards
- spoke with three carers of patients who were using the service
- spoke with the deputy director, service manager, clinical manager, ward manager and responsible clinician
- spoke with eight other staff members including nurses, healthcare support workers, an occupational therapist and occupational therapy assistant.

Wards for people with a learning disability or autism

- looked at the care and treatment records of all six patients
- reviewed medication management including the medication administration records of all six patients
- attended and observed two meetings including a ward handover, and a multi-disciplinary meeting
- looked at policies, procedures and other documents relating to the running of the service.
- carried out an observation using the short observational framework for inspection.

Summary of this service

We rated wards for people with a learning disability and autism as requires improvement because:

- The service was not entirely safe for patients because staff had not taken into account all of the risks to patients and assessed and recorded them appropriately, such as; ligature points, blanket restrictions, incidents, the use of restrictive interventions and safeguarding concerns. Staff did not always recognise and discuss when an incident may meet the trust threshold for duty of candour.
- The service did not always provide effective care and treatment because staff did not receive specialist training in meeting the needs of patients with complex needs and did not always provide care in line with national best practice guidance. Staff undertook some audits to measure the quality of care but did not always make improvements following these audits or take action in a timely way. The trust did not audit the wards compliance with the Mental Health Act and Mental Capacity Act Codes of Practice.
- There was a disconnect between the risks, issues and challenges presented at ward level and how these were fed into leaders above ward manager level. The monitoring systems in place did not always provide detailed assurance about quality and safety of care. The senior leaders had not recognised the concerns we highlighted during the inspection.

However:

- Patients felt safe and well supported and described staff who were caring and compassionate, and carers told us that they did not have concerns about the safety of the ward. Patients had thorough risk assessments, which staff updated regularly. There were sufficient nursing staff available to meet the needs of patients. Staff monitored and assessed patient's physical health needs.
- Patients had comprehensive assessments of their needs and staff regularly updated them. Staff had completed capacity assessments and best interests discussions when patients lacked capacity to make specific decisions.
- The service had a good admission and discharge processes, which meant that the service could meet the needs of the local population and that there was an embedded system of discharge in line with the transforming care agenda. Patients were aware of their rights and understood the reasons for the treatment. Staff encouraged patients to visit their local community and to maintain relationships with people who were important to them.
- The trust had a clear vision underpinned by values, which the senior leadership team championed and which were known by the staff working on the ward. Staff felt supported and senior leaders were open, engaging and encouraging feedback and contact with staff. The service celebrated staff success and encouraged staff to achieve high quality care.

Wards for people with a learning disability or autism

Is the service safe?

Requires improvement

We rated safe as requires improvement because:

- We identified ligature risks on the ward that were not included in the service's ligature risk assessments. This was also a concern at our previous inspection of the ward in June 2014. These were in patient communal bathrooms and in the sensory room.
- The fire risk assessment for the ward was out of date and not all required equipment had been electrically tested to ensure safety.
- Not all staff had undertaken required and mandatory training. Training was below 75% compliance in the Mental Health Act (72%), suicide prevention awareness (74%) care programme approach awareness (3%). None of the staff team had undertaken required training in relation to care planning and the roles and responsibilities of a care co-ordinator.
- The service had not identified and eliminated blanket restrictions on patient's freedom. Patients all used plastic crockery and cups and had no access to hot drinks and snacks between meals without the support of staff. This was not individually risk assessed.
- Staff used restrictive interventions and did not always record how they did so in line with Mental Health Act Code of Practice guidelines for restraint. This was because they did not record whether restraint had been used as a last resort, why it was ongoing for a long period of time and did not record whether they had offered a debrief to the patient involved. This may mean that patients were not protected from improper treatment or potential abuse.
- Although systems were in place and staff had completed training they did not accurately record and report signs of abuse. When reviewing incidents we saw that staff had observed or been notified of suspected abuse and they had not reported it to the internal or local authority safeguarding teams. This meant that the service had not fully embedded the systems and not understood and there were shortfalls in the system in engaging with internal and external safeguarding teams.
- Staff did not consistently identify safety concerns where incidents had caused harm to patients. Although systems were in place, and used by staff to report incidents the service did not review these in detail that meant that when things went wrong staff could not always learn from these events to improve the quality of care.
- Staff had not always recognised and escalated concerns about incidents to senior leaders to allow them to make changes. For example, to comply with same sex accommodation guidance staff had caused distress to a patient by moving their bedroom. This was managed at ward level but not escalated to the senior leadership team to ensure they could drive and implement changes in practice.
- Staff did not always recognise and discuss when an incident may meet the trust threshold for duty of candour, and apply the duty of regulation as required by the regulation.

However:

- All patients told us that they felt safe and that their possessions were safe. Carers were not concerned about the safety of their relative.
- The ward was clean, staff were managing and risk of infection and the ward complied with guidance on eliminating same sex accommodation.

Wards for people with a learning disability or autism

- The ward had a clinic room which staff maintained in good order and contained all the equipment required to support patients with their physical health needs. The storage and administration of medication was in order.
- The service planned and reviewed nurse staffing levels and staff responded quickly and adequately to shortages. The ward met optimum staffing levels the majority of the time. Patients and carers told us that there was enough staff to meet their needs. Patients had access to medical support throughout the day and night.
- Patients had thorough risk assessments, which staff updated regularly and after any change in risk level. Risk assessments identified specific risk issues such as falls, choking and long term health conditions. Staff were undertaking regular observations of patients to reduce risk and discussed these observation levels in staff handover meetings and in multi-disciplinary team meetings.
- Staff had access to relevant information regarding the care of patients and they kept this securely.

Is the service effective?

Requires improvement

We rated effective as requires improvement because:

- The service had not ensured that staff were skilled and knowledgeable about treating patients with specialist needs, as they had not trained all staff in learning disability and autism.
- The use of positive behaviour support planning was variable between staff members and this had a negative impact on patients.
- There was limited access to psychological, and occupational therapies and therapy based activities for patients.
- Staff collated information about people's care and treatment and their outcomes via audits and assessments. However, staff did not always robustly assess the outcomes of these audits and make the changes effectively to improve quality.
- The service did not monitor or audit practice in relation to the Mental Health Act and Mental Capacity Act. This meant that the service did not have assurance that staff were meeting patient's needs in line with legal requirements. However, we did not find concerns in relation to practice under either legislation at the time of the inspection.

However:

- Staff ensured that all patients had comprehensive assessments of their needs, which were holistic and included details of their physical and mental health needs alongside health action plans. Staff initiated assessments within 24 hours of admission and staff regularly updated them. Staff collated information about patient's historical information to inform care planning.
- Staff had completed capacity assessments and undertaken best interests discussions when patients did not have capacity to make specific decisions about their care and treatment.
- The multi-disciplinary team worked together to produce detailed care plans and specialist assessments to support patients.

Is the service caring?

Good

Wards for people with a learning disability or autism

We rated caring as good because:

- Patients, and their relatives and carers spoke positively about the care staff provided. The service had received a number of compliments about their care and practice.
- We observed that staff working at the service were caring, kind and compassionate. One staff member had received an award for compassionate care.
- Patients were encouraged to give feedback about the service and advocates supported them to ensure they felt listened too.
- The service supported carers to become active partners in care and staff supported them by providing carers assessments. The service had a member of staff who was a carer's champion.
- Staff provided information to patients in a way that they could understand using easy read accessible information in care planning and supporting patients to understand their rights. This meant that patients' understood their conditions and the plans for their care and treatment. However, the voice of the patient was not always clear in the care plans stored on the trust electronic system.
- Staff respected patient's confidentiality, dignity and privacy by ensuring that they kept information securely.

Is the service responsive?

Good

We rated responsive as good because:

- The service managed bed availability in a way that ensured the service was available to local people. The service had measured available beds against the complex needs of the patient group.
- Staff ensured that they embedded discharge planning from admission to the service. Patients had clear discharge plans with actions they needed to achieve during their stay on the ward. Staff planned transitions to new services in advance to ensure that discharges were safe and appropriate and this reduced the need for patients to return to hospital and to remain in hospital for unnecessary periods of time in line with the transforming care agenda.
- The ward environment took into account the individual needs of patients, it was accessible to people with mobility difficulties and signs were provided in English and Urdu in order to meet the needs of the local population.
- Patients had access to a full range of facilities including; activity rooms, visitor's rooms, quiet areas and communal spaces. Patients had access to outside space. Patients were able to personalise their bedrooms and staff offered them bedroom keys.
- Staff ensured that patients were able to access the local community with or without staff support. Staff encouraged patients to do this and to maintain contact with people who were important to them.
- Patients had access to information about their rights, treatment, local services, how to contact the Care Quality Commission and how to complain.
- The ward manager listened and acted on complaints. They had made adjustments to visiting times following a concern raised by a carer.

Wards for people with a learning disability or autism

Is the service well-led?

Requires improvement

We rated well-led as requires improvement because:

- Systems and processes did not operate effectively to enable the trust to assesses, monitor, and improve the quality and safety of the service provided. Audits completed had not recognised all of the concerns we found during the inspection including issues with blanket restrictions, recording restraint, reporting and classifications of incidents and safeguarding, identifying all ligatures risks, and record keeping. This meant that leaders were not always aware if the risks, issues and challenges in the service.
- There was insufficient oversight of required training and supervision, and systems were not effective to monitor and ensure that required training was being completed or that staff had the specialist skills and knowledge required to work with a complex patient group such as learning disability and autism training.
- The sickness and absence levels for the service were higher than the trust average at 10% and this was not entered on the service risk register
- Where audits were taking place at ward level there was not a process in place to ensure action plans were completed in a timely manner or reviewed.
- The service was not involved in research or accreditation schemes to raise the quality of the service.

However:

- The senior leadership team had the skills, knowledge and experience to lead the service. They were responsive and actively sought out feedback from staff and patients. They visited the ward regularly and made themselves visible to patients and staff.
- There was a clear statement of vision and values. The senior leadership team promoted a culture of positivity that made staff feel supported and valued. Staff were aware of the trust values. Staff felt able to raise concerns without fear of victimisation and spoke of working in supportive teams.
- At service and provider level, the team recognised and celebrated staff success via staff awards and encouragement to achieve excellence.
- The service had continuity plans in place for emergencies such as adverse weather or outbreaks of infection and managers had regularly updated them.
- Where cost improvements had taken place the senior leadership team had ensured that these did not impact on patient care.
- The service was engaging with patients, carers and the local of community via a variety of methods in order to obtain feedback about the quality of care and the needs of the local population.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in the future, or to improve services.

Action the trust MUST take to improve:

Wards for people with a learning disability or autism

- The trust must ensure that staff undertake patients' care and treatment in a person centred manner. This includes ensuring that staff provide all patients with positive behaviour support plans and that these are followed.
- The trust must ensure that patients have access to psychological and occupational therapies.
- The trust must ensure that where patients have preferences for their care to be undertaken away from others, this is clear in patient care plans and the trust undertake continual reviews of whether this type of care and treatment amounts to long term segregation.
- The trust must ensure that systems and processes operate effectively to enable them to assesses, monitor and improve the quality and safety of the service provided. This includes ensuring that audits are effective and the outcomes acted on in a timely way, and ensuring that there is sufficient oversight of ligature risks, training, supervision and appraisal to assure themselves staff are skilled, competent, and supported to complete their role.
- The trust must ensure that they safeguard patients against abuse and improper treatment. This includes ensuring that staff report safeguarding concerns and take appropriate action and that there is sufficient oversight from managers and that staff record restraint appropriately including reasons for the length of time the patient is restrained.
- The trust must ensure that staff recognise and discuss when an incident may meet the trust threshold for duty of candour, and apply the duty of candour regulation as required by the regulation.
- The trust must ensure that blanket restrictions are reviewed and ensure that all restrictions are individually risk assessed.

Action the trust SHOULD take to improve:

- The trust should ensure that all patients have communication plans and that staff provide all information in an accessible format.
- The trust should ensure that when staff keep documentation in more than one place this documentation is the same.
- The trust should ensure all the risks for the service are entered on the service risk register.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Our inspection team

Jenny Wilkes, Head of Hospitals Inspection led this inspection. An executive reviewer, a Director of Nursing and Quality, supported our inspection of well-led for the trust overall.

The team included one inspection manager, 14 inspectors, one Mental Health Act Reviewer, one inspection planner, two executive reviewers, 27 specialist advisers, two observers and four experts by experience..

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.

City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of Bradford District Care NHS Foundation Trust to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 22nd March 2018

AF

Subject:

CQC Inspection: outcome and response

Summary statement:

Following an inspection of nine, out of fourteen, core services the CQC has published an updated report on Bradford District Care NHS Foundation Trust

The Trust has been rated as 'Requires Improvement' overall which is a deterioration from the previous rating of 'Good'

Community services have been rated as 'Good' with some aspects of care rated 'Outstanding'.

Mental health services have been rated as 'Requires Improvement'.

An action plan has been developed in response to the CQC's findings and actions are already underway to address the areas for improvement.

The Improving Quality Programme Board, chaired by the Medical Director, will oversee delivery of the action plan and will report to the Executive Management Team.

The Trust is committed to the introduction of a formal Quality Improvement methodology in order to bring about long term, sustainable, staff-led improvements to the quality of its services.

Portfolio:

Health and Wellbeing

Report Contact: Dr Andy McElligott
Phone: (01274) 228293
E-mail: andy.mcelligott@bdct.nhs.uk

1. Summary

Following an inspection of nine, out of fourteen, core services the CQC has published an updated report on Bradford District Care NHS Foundation Trust

The Trust has been rated as 'Requires Improvement' overall which is a deterioration from the previous rating of 'Good'

Community services have been rated as 'Good' with some aspects of care rated 'Outstanding'.

Mental health services have been rated as 'Requires Improvement'.

An action plan has been developed in response to the CQC's findings and actions are already underway to address the areas for improvement.

It is important to note that the CQC findings in respect of organisational culture, the care that staff provide and the responsiveness of Trust services was uniformly positive and that all service users who were spoken to confirmed this to be the case. The failures identified are typically failures of internal process and, whilst in no way attempting to underplay their importance, these are issues which should be amenable to relatively rapid resolution. Deep-rooted cultural, or attitudinal concerns, would have been more troubling.

The Trust is considering the introduction of a formal Quality Improvement methodology in order to bring about long term, sustainable, staff-led improvements to the quality of its services.

2. Background

In October 2017, the Care Quality Commission (CQC) undertook an inspection of nine complete core services in total out of 14 core services provided by the Trust. These were:

- Acute wards for adults of working age and psychiatric intensive care units
- Long stay/rehabilitation mental health wards for working age adults
- Wards for older people with mental health problems.
- Wards for people with learning disability or autism
- Community-based mental health services for adults of working age
- Mental health crisis services and health-based places of safety
- Community mental health services for people with learning disability or autism
- Community health services for adults
- Community dental services

These core services were either selected due to their previous inspection ratings or because CQC's ongoing monitoring identified that an inspection at this time was appropriate to understand the quality of the service provided.

The inspection also included an assessment of the well-led key question at the Trust level

The final report was published on 12th February 2018 and, whilst it contained many positive findings, the overall rating for the Trust and a number of individual service ratings had deteriorated to 'Requires Improvement'.

The full report can be accessed here:

http://www.cqc.org.uk/sites/default/files/new_reports/AAAH0101.pdf

3. Report issues

The CQC found several examples of **outstanding practice** during the core service inspections.

In community dental services:

The service had developed an anxiety care pathway which looked at other options, short of intravenous sedation, with a view to helping the patient to not need the service in the future. The service had a cognitive behavioural nurse and could arrange other therapies such as acupuncture and hypnosis. All patients being considered for intravenous sedation had to undergo a mandatory taster session for cognitive behavioural therapy.

In community health services for adults:
The trust had developed a spreadsheet for recording and monitoring pressure ulcers. Details of all pressure ulcers were entered and this allowed the ability for trends and themes to be easily identified and acted on.

The continence service had recently expanded its remit to undertake all first continence pad and follow up continence assessments. This reduced the workload falling to the district nursing service and allowed patients to be assessed by specialist continence team members.

The tissue viability service used a vascular assessment outcome tool to track the outcome and cost of care provided. This data was then used to drive improvements in the service, such as the development of a chronic wound pathway which was presented to an international conference.

In the mental health crisis services and health based places of safety:

The redesign of the trust's mental health crisis services' pathway had ensured that no patient had needed to be admitted to an out of area placement in the previous two years. The intensive home treatment team ensured that more people could be cared for in the community without requiring an inpatient admission.

The service worked closely in partnership with voluntary and community sector organisations to provide a comprehensive multi-level approach for people in crisis, based on presenting risks. The voluntary and community sector organisations provided people with safe spaces and peer support which reduced admissions to accident and emergency departments.

In community mental health services for people with a learning disability and/or autism:

The service ran 10 training sessions in the last year to local support providers around active support and behavioural monitoring. The service also had positive and proactive champions and communication champions networks that shared best practice around the

use of positive behaviour support and communication methods for people with a learning disability.

The service was working with local police services to improve engagement with people living with learning disabilities by providing them with advice and guidance on the various types of conditions and associated issues and behaviours.

The service had been involved in an NHS improvement programme around criteria led discharges, which included examining how discharge times could be reduced where appropriate.

The CQC also found numerous examples of **positive practice** and stated:

The vision and values were prominent throughout the trust. Staff consistently demonstrated awareness and commitment to the trust's vision and values. The significant majority of staff the CQC spoke to were positive about working at the trust.

The board of directors were committed, competent and capable in their roles. Both executive and non-executive directors brought a range of skills and experience to the trust's senior management team. The trust's board was relatively stable and had benefited from effective succession planning.

There was a clear strategy which was aligned to the wider health and social care economy. The trust was an active participant in the West Yorkshire and Harrogate Health and Care Partnership. The trust had clear strategic objectives, corporate objectives and quality goals.

The trust had worked to engage voluntary sector organisations to provide new and innovative models of care. Voluntary sector organisations were incorporated into the trust's governance structures to ensure appropriate oversight of performance, quality and safety.

The trust had used a number of approaches to engagement. Patients, relatives and carers and staff were able to feedback to the trust on the care and treatment provided. The trust scored highly in patient feedback as a provider to receive care from. The trust had also worked to improve engagement with commissioners, local authorities and other agencies.

Governance structures were well-embedded and were familiar to staff at all levels working within the trust. The trust board sub-committees were well established and were chaired by non-executive directors. The trust's council of governors had an active and diverse membership which was reflective of the trust's catchment area.

The trust had a clear approach to managing risk using a board assurance framework and risk registers at team, service, business unit and corporate level. Staff were aware of how to use risk registers to escalate risks to senior managers. Staff concerns matched concerns identified on the trust's risk registers. The trust had a clear approach to identify and learn from patient deaths.

There was a well-established programme which recognised good practice and achievement within staff teams. The trust had an annual awards ceremony and a number of other celebration events which included staff from a variety of disciplines. The trust itself had been recognised for a number of awards from a range of national organisations.

The staff showed a caring attitude to those who used the trust services. Feedback from people using services and their relatives and carers was highly positive. Staff in all services were kind, compassionate, respectful and supportive. People who used services were appropriately involved in making decisions about their care.

The trust had ensured that services were responsive to meet the needs of people. Services were planned so that local people could access services when they needed them. There was a systematic approach to managing access to services which was based on individual needs. The trust had ensured there was a clear pathway so that people were transferred appropriately between services.
Within the trust's inpatient services staff had introduced safety huddles; safety huddles are quick meetings which include all clinical and non-clinical staff. The purpose of the meetings is to ensure that all staff working on the wards have a clear understanding of the immediate risks.

All inpatient and community services were clean and well-maintained. Staff were aware of and adhered to infection control procedures. Clinic rooms in inpatient services were maintained appropriately and staff could access appropriate equipment to carry out their roles.

Compliance rates for the four modules regarded by the trust as mandatory training were consistently high in each core service inspected.

Within mental health services there was a strong focus on caring for the physical health of patients. Staff undertook regular physical observations of patients prescribed high dose medication and those with long term enduring physical health conditions.

Staff had embedded the use of national guidance to support effective patient care within community dental services and community health services for adults.

Within a number of services there was a strong focus on multidisciplinary and inter-agency working. Services included staff from a range of professional disciplines which provided a holistic approach to patient care.

The CQC consistently received positive feedback from people using services and their relatives and carers. Staff ensured that patients and carers were involved in making decisions about their care.

All services demonstrated that they were patient focused. The community health services for adults in particular demonstrated a holistic approach to patient care in which the needs and preferences of individual patients were incorporated fully into the delivery of care.

The trust had implemented 'carers' hubs' in two locations and had plans to open a third. Carers' hubs are services provided in partnership with three third sector voluntary organisations providing a range of health and wellbeing activities for carers.

The trust had ensured that services were organised so that people could access services when they needed them.

There was a coordinated pathway for available for people experiencing mental health crisis from initial contact with services to inpatient admission through to discharge into the

community mental health services. Community mental health and physical health services were planned to meet the needs of the local community.

Inpatient services including wards for people with a learning disability and/or autism had a clear approach to discharge planning which ensured that discharges were safe and that people did not spend more time in hospital than they needed to.

Services had a clear approach to triaging referrals which meant that people with higher risks or needs were not waiting longer than they should do.

Ward environments had a range of rooms, equipment and facilities available to promote recovery.

Despite this extensive array of good and outstanding practice our overall ratings fell short of our aspiration; although community health services were all rated 'good', most mental health services were rated 'requires improvement'. These results are displayed below in a tabular format for ease of understanding:

Overall

SAFE	EFFECTIVE	CARING	RESPONSIVE	WELL LED	OVERALL

Community Health Services

	SAFE	EFFECTIVE	CARING	RESPONSIVE	WELL LED	OVERALL
Adults						
Children						
End of Life						
Dental						
Overall						

Mental Health Services

	SAFE	EFFECTIVE	CARING	RESPONSIVE	WELL LED	OVERALL
Adult Wards and PICU						
Rehab Ward						
Low Secure Wards						
Older People's Wards						
Learning Disability Ward						
Adult Community Mental Health						
Crisis Services						
Child and Adolescent Mental Health						
Older People's Community Mental Health						

Community Learning Disability Services						
Overall						

Outstanding

Good

Requires Improvement

The most important thing now is to ensure that we correct all of the areas for improvement, which CQC has identified, and that we do this in a way which ensures changes are sustainable so that similar concerns are not flagged up in future inspections.

BDCFT has a history of responding positively to regulatory change and the Executive Team is confident that the issues identified by the CQC can be effectively addressed.

After alerting staff to the report and its conclusions, the executive team has held a number of face-to-face staff briefing sessions; the primary purpose of these sessions was to assure our staff that we are proud of them (particularly in relation to the consistently good caring and responsive findings), to emphasize the positive aspects of the report and to get their views on the areas for improvement. Initial feedback was positive, with a determination to take the necessary actions to improve our services; in addition, the Chief Executive has received some extremely supportive e-mails from staff through the chat2nicola portal.

Similarly, the Council of Governors has received a face-to-face briefing and, again, initial responses were of disappointment at the overall outcome but recognition of the extremely positive comments about organizational culture and staff attitudes and behaviours.

The report identifies 51 ‘must do’ requirements and a number of ‘should do’ requirements..

The actions have been scrutinized and condensed into 14 key themes as follows:

- Governance
- Fit & Proper Person
- DBS
- Serious Incidents
- Restrictive Practices
- Required Training
- Policies
- Supervision
- Audit
- Care Records
- Safeguarding
- Duty of candour
- Safer Staffing
- Health & Safety

An executive director has been assigned responsibility for overseeing every single 'must do' as per the action plan which accompanies this paper.

In addition, each 'must do' has been allocated to either Trust Board or the relevant Committee for continuing oversight to completion. Each one has a review date and all actions relevant to core services have also been allocated a business unit lead with responsibility for ensuring implementation.

The trust submitted a report to the CQC on 9th March setting out the actions we will take to meet all relevant regulations and legislation.

The 'Outstanding Care Programme Board' which had already been established, prior to the inspection, will now have detailed oversight of progress against the full action plan. This group is chaired by the Medical Director and will provide regular updates to the Executive Management Team.

The Medical Director has spoken with his counterpart at a Trust which moved from 'Requires Improvement' to 'Outstanding' to gain insight of how they tracked the implementation of post-inspection actions and how they ensured sustainable improvement culminating in an 'outstanding' rating.

A number of actions have already been taken, including:

i) immediate environmental improvements to the Section 136 Suite at Lynfield Mount Hospital
ii) every Director having a repeat DBS check
iii) required training figures submitted to Quality and Safety Committee
iv) clinical supervision policy updated
v) serious incident policy updated

Quarterly updates will be provided to Board on progress against the action plan until it is complete.

4. Implications

When taken together, the various areas for improvement amount to a number of regulatory breaches. The following is a list of the legal requirements which the Trust was not meeting. As mentioned, above, we sent a report to the CQC on 9th March, stating what actions we are taking to meet these requirements.

Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors

Regulation 9 HSCA (RA) Regulations 2014 Person-centred Care

Regulation 10 HSCA (RA) Regulations 2014 Dignity and Respect

Regulation 12 HSCA (RA) Regulations 2014 Safe care and Treatment

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulation 17 HSCA (RA) Regulations 2014 Good Governance

Regulation 18 HSCA (RA) Regulations 2014 Staffing

5. Longer term action planning: Quality Improvement

The challenge for all healthcare organisations is to develop and implement an approach that will enable improvements to the quality of healthcare to happen while confronting the operational and financial challenges of today.

Quality Improvement (QI) encompasses a range of evidence-based approaches which have been used by several, high-performing NHS organisations to meet this challenge.

Tees, Esk & Wear Valley Foundation Trust (TEWV) and East London Foundation Trust (ELFT) are two Trusts providing similar services to our own which have been using QI for years and have achieved some very impressive results in terms of better services and better staff engagement. Some of the central tenets of any QI methodology are having a clear rationale, ensuring staff are ready, allocating adequate time and resources for front-line teams to develop solutions and fidelity to the chosen methodology.

The Trust is committed to developing a QI methodology which works for us so, in December, the whole Board undertook a training session facilitated by NHS Improvement which proved extremely useful and thought provoking.

On the back of that session we have had conversations and visits to TEWV and ELFT and are arranging further visits to both Trusts for larger groups of staff to see different QI methodologies in action. It is hoped that some of these individuals will form the first cohort of BDCFT QI Champions.

The objectives of the session were:

- Why an organisational improvement approach is needed?
- What do we mean by quality improvement?

- Organisational improvement approaches in practice

and it allowed a protected space for a ‘good quality conversation’ about improvement, allowed us to learn about different improvement approaches, helped us all to understand the importance of leadership for improvement and allowed reflection on our current improvement work and how this might be enhanced.

We recognise that the lack of a formal QI methodology has probably hindered our progress, towards the ‘outstanding’ status we all aspire to, and, hopefully, these next few months will see us beginning that journey of continuous and sustainable quality improvement.

6. Recommendations

Recommended -

That the committee notes the findings of the recent CQC inspection and the actions that are being taken by Bradford District Care NHS Foundation Trust to correct all areas of concern in a timely and sustainable manner.

7. Appendices

7.1 Appendix 1 - BDCFT CQC Action Plan

8. Not for publication documents

None

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Appendix 1

Bradford District Care NHS Foundation Trust November 2017 CQC Inspection Must Dos Action Plan – 09/03/2018 Version

Core Service	Page Number	Must Do Ref	MUST DO'S	Business Unit Lead	Exec Lead	Board for Reporting	Date for Progress Review at Committee	Action Status	Expected Completion Date	Evidence/ Assurance check undertaken by and date	Position as of 05/03/2018
Well Led	**9**	MD01	The trust must ensure that effective governance systems are in place to assess, monitor and improve the quality and safety of the services.	Margaret Waugh	EMT	Trust Board	29/03/2018	Ongoing	Short terms actions by 30/06/2018 but development of QI methodology will continue to evolve thereafter		The trust has commissioned Humber Foundation Trust to undertake a review of the effectiveness of the Mental Health Legislation Committee and how it interacts / overlaps with the Quality and Safety Committee. Implementation of the 'CQC action plan' will be subject to rigorous oversight at a number of levels including the Improving Quality Steering Group (Deputy Director of Quality Improvement chair), Improving Quality Programme Board (Medical Director chair), Board subcommittees (NED chairs) and Board itself (quarterly until completion). In the longer term the trust is looking to introduce a formal Quality Improvement (QI) methodology to drive continuous improvement: Board has already piloted NHSI's 'Organising for Improvement' module and this was repeated with clinicians and managers on March 8th, in addition, visits (for clinicians and managers) are arranged to TEWV and ELFT to see their QI approach in practice and to attend the ELFT QI conference in April. The trust will seek to link our chosen QI methodology with the 'Clever Together' crowdsourcing platform we have recently procured, as has been done at Leeds Teaching Hospitals. As an FT, an independent review of the well-led framework will be discussed by the Board, with a view to commissioning this work in Quarter 1 of the new financial year. Cross links to MD 01 , 19, 37
Well Led	**9**	MD02	The trust must ensure that ensure that checks are completed for all its executive and non-executive directors, and that accurate records of these checks are maintained in line with the Fit and Proper Person Requirement regulation and the trust's policy.	Fiona Sherburn	Sandra Knight	Quality & Safety Committee	23/03/2018	Ongoing	30/04/2018		A full audit of all Non-Executive Directors and Executive Directors documents has taken place and additional documentation has been uploaded onto personnel files. The policy is being reviewed and will be updated by end March 2018 and approved by Executive Management Team by the end of April. A system is now in place for DBS checks for all executive and no-executive directors. A full validation exercise and paper will go to Board Nominations Committee in April 2018.
Well Led	**9**	MD03	The trust must ensure that all staff are checked by the Disclosure and Barring Service in line with trust policy.	Fiona Sherburn	Sandra Knight	Quality & Safety Committee	23/03/2018	Ongoing	31/12/2018		All records have been reviewed and all staff hold a DBS check who require one. All staff are now required to register with the DBS online service, which provides the Trust with alerts to any non-matches for those registered with the Update Service. Likewise, if any check shows a change in status e.g. additional conviction which would affect their ability to work within regulated activity, we will also be notified. There is an action plan in place to bring all DBS revalidation checks up to date in line with the policy by the end of 2018.

Core Service	Page Number	Must Do Ref	MUST DO'S	Business Unit Lead	Exec Lead	Board for Reporting	Date for Progress Review at Committee	Action Status	Expected Completion Date	Evidence/ Assurance check undertaken by and date	Position as of 05/03/2018
Well Led	**9**	MD04	The trust must ensure that serious incidents are reviewed and thoroughly investigated within appropriate timescales, and monitored to make sure that action is taken to remedy the situation, prevent further occurrences and make sure that improvements are made as a result.	Sharon Lumb	Andy McElligott	Quality & Safety Committee	23/03/2018	Ongoing	30/06/2018		Updated Serious Incident policy ratified at Quality and Safety Committee February '18. A new Serious Incident investigator has been appointed which will improve timeliness of reports. The Quality and Safety Committee has agreed a new assurance process whereby quarterly SI reporting will include much more narrative, provided by services, about how learning has been translated into sustainable change. The Trust will review its existing action plan template as the current version does not easily lend itself to showing how services will reduce the risk of similar incidents happening in the future. All future action plans will contain information on how services plan to ensure that the risk of repeated incidents is reduced.
Well Led	**9**	MD05	The trust must put a system in place to ensure that there is effective oversight of the use of restrictive interventions in inpatient services.	Simon Long	Andy McElligott	Mental Health Legislation Committee	19/04/2018	Ongoing	31/07/2018		All local practices around blanket restrictions are under review against CQC guidance around the appropriate use of Blanket Restrictions (2017). Any required changes to current practice will be implemented thereafter. Mental Health Legislation Committee external review commissioned. MDT practice introduced on Assessment and Treatment Unit and process will be shared across all wards. Cross links to MD 5, 30,40
Well Led	**9**	MD06	The trust must put a system in place to ensure that there is effective oversight of role-specific required training for all staff.	Joanne Somers	Sandra Knight	Quality & Safety Committee	23/03/2018	Ongoing	30/09/2018		Executive team has reviewed the mandatory and required training matrix and agreed a broader range of mandatory training for all staff. In addition they have agreed that board will have oversight of compliance for all additional mandatory training areas. A new PowerPoint slide has been developed for the Board Dashboard which has been placed in the Professions section of the Board performance report. The Q&S committee will also receive quarterly reports. The first report to the Q&S meeting was received on the 9th February 2018 and will go quarterly thereafter. Cross links to MD6, 18, 32, 51
Well Led	**9**	MD07	The trust must update all active policies to reflect the changes to the Mental Health Act Code of Practice introduced in 2015.	Simon Binns	Andy McElligott	Mental Health Legislation Committee	19/04/2018	Ongoing	30/06/2018		Mental Health Act team has undertaken a review of the following policies: • Blanket locked door policy / management of entry and exit policy; this policy is currently with Professions Council for approval • Search policy has been amended to reflect the code of practice but is due for review anyway so will be submitted to Professions Council for approval once other changes have been made • Admission of young person onto adult mental health ward has been amended • Provider policy on the use of enhanced observations is currently being reviewed to ensure it reflects the requirements of chapter 11 of the code of practice and will be submitted to Professions Council for approval as soon as the necessary changes are made• The Mental Health Act policy and procedures (issued 25/1/16) have been updated to include reference to exceptions to certificate requirements (section 62, 64b, 64c and 64e); they have been submitted to the Mental Health Legislation Forum for final comment, on 14 March, and after that, will be submitted to Professions Council for approval and ratification at Executive Management Team.

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											Cross links to MD 7, 11, 15, 26
Well Led	**9**	MD08	The trust must review role-specific required training to ensure that staff are appropriately trained in the Mental Health Act and Mental Capacity Act.	Joanne Somers	Sandra Knight	Quality & Safety Committee	23/03/2018	Ongoing	30/04/2018		Cleansing complete on role requirements final sign-off by Mental Health Act lead. Reports will be produced from this for the Mental Health Legislation Committee meeting on the 19th April. This work will also be undertaken for all required training. A review of the required/ mandatory and training matrix has been completed and agreed by Executive team on 6th March 2018. Performance on compliance will be monitored by the board and appropriate sub committees. Cross link to MD 8, 25.
Well Led	**9**	MD09	The trust must put a system in place to ensure that there is effective oversight of compliance rates for staff supervision.	Rebecca Bentley	Debra Gilderdale	Quality & Safety Committee	23/03/2018	Ongoing	30/09/2018		System and process redesign underway to record training, supervision and audit activity. Performance reporting around same will follow, reported via Business Unit, Quality and Safety and Operational performance meetings. Any subsequent underperformance to be managed locally. The following actions have been completed - Connect page in place for Clinical Supervision - Clinical Supervision policy revised in December 2017 in light of new compliance monitoring approach. Amends made to draft following Professions Council and Executive team review. - E learning live for all staff at point of induction - Face to face workshops in place for those wishing to become supervisors or attend for a 3 year update. This is delivered by service appointed Supervision Training Champions whose contacts are on the Connect page and sessions delivered across the calendar year as per demand. - Live register of Clinical Supervisors on Clinical Supervision Connect Page - Supervision database live for all staff to record their supervision activity (compliance has increased from 47 entries in January to 390 to date). Meeting arranged for 29/3 with IT/Business support/HR and the Nursing Development team to further develop robust reporting from this database linked to live nominal role data. This will afford assurance and intelligence to Service Managers/DDs around staff specific non-compliance to enable timely action planning. - E learning package to be developed by QHIL/Project Support Officer in Nursing Development Team for launch in April to provide an overview of expectations of staff and supervisors' Supervision engagement and details of how and what to log on the database. Compliance reporting will also be included. Cross links to MD 9,33,49

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Well Led	**9**	MD10	The trust must ensure that there is a clear and effective approach to audit within services. Audits must be used to improve quality within services.	Simon Long	Debra Gilderdale	Mental Health Legislation Committee	19/04/2018	Ongoing	30/06/2018		Current weekly ward level audit processes to be reviewed and redesigned to enhance standardisation to provide assurance of a robust audit process. Following redesign an escalated reporting process will be agreed to ensure reporting to Business Unit Level Q&S (Quarterly) and Trustwide MHLC (bi-annually) . Mental Health Legislation Committee external review commissioned Quality and Safety Committee to undertake a deep dive into local ward audits . Cross links to none
Well Led	**9**	MD11	The trust must ensure that it effectively audits the use of the Mental Health Act and the Mental Capacity Act.	Simon Long	Debra Gilderdale	Mental Health Legislation Committee	19/04/2018	Ongoing	30/06/2018		Current weekly ward level audit processes are being reviewed and redesigned to enhance standardisation to provide assurance of a robust audit process. Following redesign an escalated reporting process will be agreed to ensure reporting to Business Unit Level , Quality and Safety (Quarterly) and Trustwide Mental Health Legislation Committee (bi-annually). Mental Health Legislation Committee external review commissioned. Quality and Safety Committee to undertake a deep dive into local ward audits . Cross links to MD 11, 50
Acute wards for adults of working age and psychiatric intensive care units	**41**	MD12	The trust must ensure that there are sufficient staff numbers to consistently provide all aspects of patient care.	Simon Long	Debra Gilderdale	Quality & Safety Committee	23/03/2018	Ongoing	31/08/2018		The National Quality Board (NQB) recommends that a thorough strategic clinical team establishment review should be undertaken annually. The acting head of nursing has led a review across 13 ward areas meeting on a face to face basis with a review team and the clinical ward team to formally discuss key areas for supporting and underpinning staffing level decisions. The review team have considered all data relating to team activity utilising the NQB check list RAG rating to support this process and to provide assurance that the team is cross checking data using evidence based guidance and presenting a rounded view of staffing requirements to support professional judgements about delivering high quality safe care to patients . All wards have been reviewed, and the report on completion in mid March will be presented to the Director of Nursing. This detail will also be included in the Safer Staffing Report in June. Following this Deputy Director, heads of service, service managers and clinical managers will further develop a workforce strategy and local plan. A weekly eRoster meeting has been established and reviews whether or not adequate staffing is planned to ensure safe levels of staff. The Trust Escalation plan has been shared with the whole inpatient services to ensure that protocol is followed when staffing falls below required numbers in order that the problem can be remedied. Staffing Incidents are monitored monthly through Safer Staffing meetings and incidents actioned, this is chaired by the Director of Operations and Nursing. Safer staffing is reported monthly to the Trust Board. A tracker will be developed to establish themes and trends to review monthly at safer staffing steering group. This is included in the safer staffing report which goes to board on a monthly basis including reporting of incidents. A six monthly report is an in-depth analysis of safer staffing monitoring which is reported to the board. Cross links to MD 12 ,23,35

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Acute wards for adults of working age and psychiatric intensive care units	**42**	MD13	The trust must ensure that all patients have a care plan in place that is reviewed regularly and is produced collaboratively with patients to ensure they are personalised, and reflect individual choice and preferences.	Simon Long	Debra Gilderdale	Quality & Safety Committee	23/03/2018	Ongoing	31/08/2018		Service Manager, Clinical Managers and Advanced Nurse Practitioners offer clinical consultation and advice regarding the development of care plans and risk assessments with ward staff. This will be at least weekly taking place on each ward supporting staff in reviewing care plans and risk assessment to guide learning and improve quality. Current weekly ward level audit processes to be reviewed and redesigned to enhance standardisation. Outcomes of audits will be reported through Quality and Safety processes to provide assurance of a robust audit process. With the onset of the new clinical system (SystmOne), a new care plan has been devised identifying involvement with service users in creating a collaborative care plan to complete by August 2018. Cross links to MD 13, 24 34, 43, 44
Acute wards for adults of working age and psychiatric intensive care units	**42**	MD14	The trust must ensure that all assessment of risk for patients and the environment are completed fully, accurately and are accessible; and action is taken to mitigate risk.	Simon Long	Debra Gilderdale	Quality & Safety Committee	23/03/2018	Completed	05/03/2018	To be reviewed and signed off by Executive Management Team on 27/03/2018.	All fire, ligature and health and safety assessments are available within a dedicated folder within each ward. Ligature assessments are implemented on an annual basis, when environmental changes are made or new guidance issued. . A Ligature Safety Group has been established with full Clinical, Estates & Facilities involvement. Cross links to MD 14, 41, 47, 48
Acute wards for adults of working age and psychiatric intensive care units	**42**	MD15	The trust must ensure that they safeguard patients against abuse and improper treatment by ensuring staff know how to identify signs of abuse and how to report safeguarding concerns.	Simon Long	Debra Gilderdale	Quality & Safety Committee	23/03/2018	Ongoing	30/09/2018		Training compliance rates for all wards across the units is being closely monitored, identifying and managing any underperformance. All training compliance is being monitored within quality and safety meetings. Access to safeguarding supervision is available on a monthly basis across all hospital sites from the safeguarding team. Each ward has a safeguarding champion identified. • Organisational safeguarding leads now receiving all incident reports that are service user to service user abuse (SU-SU) • Additional guide to be developed for staff to support safeguarding decision making in SU-SU incidents. • Additional safeguarding training to be provided to all assistant and ward managers. • Monthly SU-SU alleged and actual incidents report to be sent to organisational safeguarding leads, for themes and trends oversight. • Assurance to be provided on a bi-monthly safeguarding forum chaired by the Director of Nursing and Operations who will feed back to Quality and Safety Committee. • Employee relations meetings to be held monthly with safeguarding and HR to review staff Cross links to MD 15, 27, 29, 38

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Acute wards for adults of working age and psychiatric intensive care units	**42**	MD16	The trust must ensure that restrictive practices, when required, should be planned, lawful, in the patient's best interest, proportionate and dignified. They should be individual in response to identified risk.	Simon Long	Andy McElligott	Quality & Safety Committee	23/03/2018	Ongoing	30/06/2018		All local practices around blanket restrictions are under review against CQC guidance. Recirculate CQC guidance table to all Inpatient wards relating to Blanket Restrictions for their ward areas around the appropriate use of Blanket Restrictions (2017). For all patients on wards, assure that there are no restrictions in place which have not been individually risk assessed. to be completed by end of June 2018 Cross links to MD 16, 20, 21,31, 36
Acute wards for adults of working age and psychiatric intensive care units	**42**	MD17	The trust must ensure that systems are in place and operating effectively to ensure required training and supervision is completed, and that audits are effective to ensure patients are safe.	Simon Long	Debra Gilderdale	Quality & Safety Committee	23/03/2018	Ongoing	30/09/2018		System and process redesign underway to record training, supervision and audit activity. Performance reporting around same will follow, reported via Business Unit, Quality and Safety and Operational performance meetings. Any subsequent underperformance to be managed locally. Cross links to MD 17,28,46, 50
Acute wards for adults of working age and psychiatric intensive care units	**42**	MD18	The trust must ensure that all staff on all wards have received up to date required training, as determined by the trust.	Simon Long	Sandra Knight	Quality & Safety Committee	23/03/2018	Ongoing	30/09/2018		Current work underway to update all staff profiles around required training. Current work underway to produce performance reports around same. Performance will be monitored & managed on an ongoing basis via Operational meetings, Senior Management Team and Business Unit Performance Meetings chaired by the Chief Executive Officer.. Cross links to MD 6, 18, 32, 51
Acute wards for adults of working age and psychiatric intensive care units	**42**	MD19	The trust must ensure that systems and processes are effective to monitor, assess and improve the quality and safety of the services.	Simon Long	Andy McElligott	Quality & Safety Committee	23/03/2018	Ongoing	30/06/2018		Review initiated within the business unit how quality and safety is monitored, assessed and communicated across all levels. This includes, meeting structures, agendas, use of existing reports and data. Current weekly ward level audit processes are being reviewed and redesigned to enhance standardisation to provide assurance of a robust audit process these will be discussed at quality and safety meetings and reported to the Quality and Safety business unit meeting. All quality and safety issues that are discussed in ward meetings and safety huddles are escalated through the service quality and safety meeting. All chairs of the quality and safety meetings within the business unit attend and report to the business unit quality and safety report. If these issues are unable to be resolved locally these will be identified within the risk register, Business Unit Performance Meetings and Quality and Safety Committee. To be completed by June 2018. Cross links to MD 1, 19, 37

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Acute wards for adults of working age and psychiatric intensive care units	**42**	MD20	The trust must ensure that staff consistently monitor and record patient care during periods of seclusion and following rapid tranquilisation.	Simon Long	Andy McElligott	Mental Health Legislation Committee	19/04/2018	Ongoing	31/10/2018		A process is in place to ensure that staff consistently monitor and record patient care during periods of seclusion. A programme of education, support around use of seclusion and rapid tranquilisation and policy and practice relating to this, is being developed and will be rolled out by October 2018. This will ensure all teams have consistent understanding of policy and procedures. Both rapid tranquilisation and seclusion data is reported through the local quality and safety meetings and quality and safety business unit meetings. Cross links to MD 16, 20, 21,31, 36
Acute wards for adults of working age and psychiatric intensive care units	**42**	MD21	The trust must ensure that staff record whether a debrief was provided to patients following an incident or restrictive intervention such as restraint.	Simon Long	Andy McElligott	Mental Health Legislation Committee	19/04/2018	Completed	05/03/2018	To be reviewed and signed off by Executive Management Team on 27/03/2018.	All staff have been reminded that debriefs with patients must occur and that the details are recorded within the progress notes. All managers of incident forms will document that a debrief has either occurred or is planned and any reasons as to why a debrief has not occurred. Cross links to MD 16, 20, 21,31, 36
Acute wards for adults of working age and psychiatric intensive care units	**42**	MD22	The trust must ensure that staff recognise and discuss when an incident may meet the trust threshold for duty of candour, and apply the duty of regulation as required by the regulation.	Simon Long	Andy McElligott	Mental Health Legislation Committee	19/04/2018	Ongoing	31/05/2018		Duty of candour will be included in safeguarding training and also at trust induction. Central guidance to be issued. Services to be asked to review all incidents of moderate harm or above with specific question as to whether or not they meet the trust threshold for duty o candour. Ensure staff are supported when involved in duty of candour incidents. On Connect there are slides which will be shared with staff and included in service manager blog. This will be included on staff notice boards Cross links to MD 22, 39
Long stay or rehabilitation mental health wards for working age adults	**31**	MD23	The trust must ensure that there are sufficient staff deployed to meet the minimum safe staffing levels.	Allison Bingham	Debra Gilderdale	Quality & Safety Committee	23/03/2018	Ongoing	31/08/2018		The National Quality Board (NQB) recommends that a thorough strategic clinical team establishment review should be undertaken annually. The acting head of nursing has led a review across 13 ward areas meeting on a face to face basis with a review team and the clinical ward team to formally discuss key areas for supporting and underpinning staffing level decisions. The review team have considered all data relating to team activity utilising the NQB check list RAG rating to support this process and to provide assurance that the team is cross checking data using evidence based guidance and presenting a rounded view of staffing requirements to support professional judgements about delivering high quality safe care to patients . All wards have been reviewed, and the report on completion in mid March will be presented to the Director of Nursing. This detail will also be included in the Safer Staffing Report in June. Following this Deputy Director, heads of service, service managers and clinical managers will further develop a workforce strategy and local plan. A weekly eRoster meeting has been established and reviews whether or not adequate staffing is planned to ensure safe levels of staff. The Trust Escalation plan has been shared with the whole inpatient services to ensure that protocol is followed when staffing falls

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											below required numbers in order that the problem can be remedied. Staffing Incidents are monitored monthly through Safer Staffing meetings and incidents actioned, this is chaired by the Director of Operations and Nursing. Safer staffing is reported monthly to the Trust Board. A tracker will be developed to establish themes and trends to review monthly at safer staffing steering group. This is included in the safer staffing report which goes to board on a monthly basis including reporting of incidents. A six monthly report is an in-depth analysis of safer staffing monitoring which is reported to the board. Cross links to MD 12 ,23,35
Long stay or rehabilitation mental health wards for working age adults	**31**	MD24	The trust must ensure that staff assess and design care plans in collaboration with patients and ensure these meet patients' assessed needs.	Allison Bingham	Debra Gilderdale	Quality & Safety Committee	23/03/2018	Ongoing	31/08/2018		Ward Managers offer guidance regarding the ongoing development of care plans and risk assessments with ward staff. This will be at least weekly taking place on each ward supporting staff in reviewing care plans and risk assessment to guide learning and improve quality. Random audits will be undertaken. Outcomes of audits will be reported through Quality and Safety processes to provide assurance. With the onset of the new clinical system, a new care plan has been devised identifying involvement with service users in creating a collaborative care plan. Cross links to MD 13, 24 34, 43, 44
Long stay or rehabilitation mental health wards for working age adults	**31**	MD25	The trust must ensure that staff receive training in the Mental Health Act and the Mental Capacity Act.	Allison Bingham	Andy McElligott	Quality & Safety Committee	23/03/2018	Ongoing	30/04/2018		Cleansing complete on role requirements final sign-off by Mental Health Act lead. Reports will be produced from this for the Mental Health Legislation Committee meeting on the 19th April. This work will also be undertaken for all required training. A review of the required/ mandatory and training matrix has been completed and agreed by the executive team on 6th March 2018. Performance on compliance will be monitored by the board and appropriate sub committees. Cross links to MD 8,25
Long stay or rehabilitation mental health wards for working age adults	**31**	MD26	The trust must ensure that staff inform the relevant patients for their rights under section 132 of the Mental Health Act at regular intervals.	Allison Bingham	Andy McElligott	Mental Health Legislation Committee	19/04/2018	Ongoing	30/09/2018		The importance of reading rights has been reinforced to all staff and the Mental Health Act advisor will issue a reminder to all nursing staff regarding procedures of Section 132 rights by end of April 2018. We have identified a clinical system issue with the recording of the receiving of rights and are resolving this as part of the new clinical system implementation in May 2018 Cross links to MD 11, 26

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Wards for older people with mental health problems	**36**	MD27	The trust must ensure safeguarding processes are in place to demonstrate that safeguarding is considered as part of the incident recording process and that safeguarding alerts are raised where necessary.	Allison Bingham / Simon Long	Debra Gilderdale	Quality & Safety Committee	23/03/2018	Ongoing	30/09/2018		Training compliance rates for all wards across the units is being monitored, identifying and managing any underperformance. All training compliance is being monitored within quality and safety meetings. Access to safeguarding supervision is available on a monthly basis across all hospital sites from the safeguarding team. Each ward has a safeguarding champion identified. • Organisational safeguarding leads now receiving all incident reports that are service user to service user abuse (SU-SU) • Additional guide to be developed for staff to support safeguarding decision making in SU-SU incidents. • Additional safeguarding training to be provided to all assistant and ward managers. • Monthly SU-SU alleged and actual incidents report to be sent to organisational safeguarding leads, for themes and trends oversight. • Assurance to be provided on a bi-monthly safeguarding forum chaired by the Director of Nursing and Operations who will feed back to Quality and Safety Committee. • Employee relations meetings to be held monthly with safeguarding and HR to review staff Cross links to MD 15, 27, 29, 38
Wards for older people with mental health problems	**36**	MD28	The trust must ensure that systems are in place and operating effectively to ensure required training and supervision is completed, and that audits are effective to ensure patients are safe.	Allison Bingham / Simon Long	Debra Gilderdale	Quality & Safety Committee	23/03/2018	Ongoing	30/09/2018		System and process redesign underway to record training, supervision and audit activity. Performance reporting around same will follow, reported via Business Unit, Quality and Safety and Operational performance meetings. Any subsequent underperformance to be managed locally. The following actions have been completed - Connect page in place for Clinical Supervision - Clinical Supervision policy revised in December 2017 in light of new compliance monitoring approach. Amends made to draft following Professional Council and Executive team review – awaiting upload to Clinical Policy section of Connect. - E learning live for all staff at point of induction - Face to face workshops in place for those wishing to become supervisors or attend for a 3 year update. This is delivered by service appointed Supervision training Champions whose contacts are on the Connect page and sessions delivered across the calendar year as per demand. - Live register of Clinical Supervisors on Clinical Supervision Connect Page - Supervision database live for all staff to record their supervision activity (compliance has increased from 47 entries in January to 390 to date). Meeting arranged for 29/3 with IT/Business support/HR and the Nursing Development team to further develop robust reporting from this database linked to live nominal role data. This will afford assurance and intelligence to Service Managers/DDs around staff specific non-compliance to enable timely action planning. - E learning package to be developed by QHIL/Project Support Officer in Nursing Development Team for launch in April to provide an overview of expectations of staff and supervisors Supervision engagement and details of how and what to log on the database. Compliance reporting will also be included. Cross links to MD 17,28,46, 50

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Wards for older people with mental health problems	**36**	MD29	The trust must ensure staff maintain professional boundaries so that patients are not at risk of abuse.	Allison Bingham / Simon Long	Debra Gilderdale	Quality & Safety Committee	23/03/2018	Completed	05/03/2018	To be reviewed and signed off by Executive Management Team on 27/03/2018.	The Individual member of staff received feedback from the Service Manager regarding professional boundaries and learning was discussed within the setting. Cross links to MD 15, 27, 29, 38
Wards for older people with mental health problems	**36**	MD30	The trust must ensure patient and room searches are based on risk and do not form a blanket restriction.	Allison Bingham / Simon Long	Andy McElligott	Mental Health Legislation Committee	19/04/2018	Ongoing	30/06/2018		All local practices around blanket restrictions are under review against CQC guidance around the appropriate use of Blanket Restrictions (2017). Any required changes to current practice will be implemented thereafter. The search policy is currently being reviewed and will be amended to ensure that room searches can only be carried out as part of a legitimate search and not a blanket restriction. Cross links to MD 30,40
Wards for older people with mental health problems	**36**	MD31	The trust must ensure records of incidents involving restraint are detailed and any instances, which may qualify as seclusion, receive protections outlined in the Mental Health Act Code of Practice.	Allison Bingham / Simon Long	Andy McElligott	Quality & Safety Committee	23/03/2018	Ongoing	30/04/2018		A review of recording of incidents of restraint, identifying any deficits in the recording process. Redesign recording process in response to findings. This will be included within the restraint log and be explicit recording will take place. To be completed end of April 2018. Cross links to MD 16, 20, 21,31, 36
Wards for older people with mental health problems	**36**	MD32	The trust must ensure staff receive the training they require to enable them to carry out their duties.	Allison Bingham / Simon Long	Sandra Knight	Quality & Safety Committee	23/03/2018	Ongoing	31/10/2018		Executive team has reviewed the mandatory and required training matrix and agreed a broader range of mandatory training for all staff. In addition the team has agreed that board will have oversight of compliance for all additional mandatory training areas. A new PowerPoint point slide has been developed for the Board Dashboard which has been placed in the Professions section of the Board performance report. The Quality and Safety Committee will also receive quarterly reports. The first report to the Quality and Safety Committee was received on the 9th February 2018 and will go quarterly thereafter. Cross link to MD 6, 18, 32, 51

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Wards for older people with mental health problems	**36**	MD33	The trust must ensure staff receive regular clinical and management supervision and a record of the supervision is maintained.	Allison Bingham / Simon Long	Debra Gilderdale	Quality & Safety Committee	23/03/2018	Ongoing	30/09/2018		System and process redesign underway to record training, supervision and audit activity. Performance reporting around same will follow, reported via Business Unit, Quality and Safety and Operational performance meetings. Any subsequent underperformance to be managed locally. The following actions have been completed - Connect page in place for Clinical Supervision - Clinical Supervision policy revised in December 2017 in light of new compliance monitoring approach. Amends made to draft following Professions Council and Executive team review. - E learning live for all staff at point of induction - Face to face workshops in place for those wishing to become supervisors or attend for a 3 year update. This is delivered by service appointed Supervision Training Champions whose contacts are on the Connect page and sessions delivered across the calendar year as per demand. - Live register of Clinical Supervisors on Clinical Supervision Connect Page - Supervision database live for all staff to record their supervision activity (compliance has increased from 47 entries in January to 390 to date). Meeting arranged for 29/3 with IT/Business support/HR and the Nursing Development team to further develop robust reporting from this database linked to live nominal role data. This will afford assurance and intelligence to Service Managers/DDs around staff specific non-compliance to enable timely action planning. - E learning package to be developed by QHIL/Project Support Officer in Nursing Development Team for launch in April to provide an overview of expectations of staff and supervisors. Supervision engagement and details of how and what to log on the database. Compliance reporting will also be included. Cross links to MD 9,33,49
Wards for people with a learning disability or autism	**67**	MD34	The trust must ensure that staff undertake patients' care and treatment in a person centred manner. This includes ensuring that staff provide all patients with positive behaviour support plans and that these are followed.	Allison Bingham	Debra Gilderdale	Quality & Safety Committee	23/03/2018	Ongoing	31/03/2018		Continued use of the weekly activity plans both generic and specific for individual patients. Support agency / bank staff to ensure they are fully briefed in the individual positive behavioural support plans for patients. These will be discussed on induction of bank/agency staff, the process will be in place 16/03/2018. Cross links to MD 13, 24 34, 43, 44
Wards for people with a learning disability or autism	**67**	MD35	The trust must ensure that patients have access to psychological and occupational therapies.	Allison Bingham	Debra Gilderdale	Quality & Safety Committee	23/03/2018	Ongoing	31/07/2018		Recruitment is in progress for the psychological therapy post. In the meantime, work is ongoing in partnership with community learning disability services to provide psychological support. In regards to the Occupational Therapists, these individuals work on the ward and included in funded establishment. Cross links to MD 12 ,23,35

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Wards for people with a learning disability or autism	**67**	MD36	The trust must ensure that where patients have preferences for their care to be undertaken away from others, this is clear in patient care plans and the trust undertake continual reviews of whether this type of care and treatment amounts to long term segregation.	Allison Bingham	Debra Gilderdale	Quality & Safety Committee	23/03/2018	Ongoing	30/03/2018		The issue re segregation is resolved as this comment specifically relates to one individual who chose to self seclude from other patients. This was detailed in the care plan of the individual at the time of CQC's visit. However, the topic of segregation will be discussed with all staff who work on the ATU by the end of March 2018. Cross links to MD 16, 20, 21,31, 36
Wards for people with a learning disability or autism	**67**	MD37	The trust must ensure that systems and processes operate effectively to enable them to assesses, monitor and improve the quality and safety of the service provided. This includes ensuring that audits are effective and the outcomes acted on in a timely way, and ensuring that there is sufficient oversight of ligature risks, training, supervision and appraisal to assure themselves staff are skilled, competent, and supported to complete their role.	Allison Bingham	Debra Gilderdale	Quality & Safety Committee	23/03/2018	Ongoing	30/09/2018		System and process redesign underway to record training, supervision and audit activity. Performance reporting around same will follow, reported via Business Unit, Quality and Safety and Operational performance meetings. Any subsequent underperformance to be managed locally. The following actions have been completed - Connect page in place for Clinical Supervision - Clinical Supervision policy revised in December 2017 in light of new compliance monitoring approach. Amends made to draft following Professions Council and executive team review – awaiting upload to Clinical Policy section of Connect. - E learning live for all staff at point of induction - Face to face workshops in place for those wishing to become supervisors or attend for a 3 year update. This is delivered by service appointed Supervision training Champions whose contacts are on the Connect page and sessions delivered across the calendar year as per demand. - Live register of Clinical Supervisors on Clinical Supervision Connect Page - Supervision database live for all staff to record their supervision activity (compliance has increased from 47 entries in January to 390 to date). Meeting arranged for 29/3 with IT/Business support/HR and the Nursing Development team to further develop robust reporting from this database linked to live nominal role data. This will afford assurance and intelligence to Service Managers/Deputy Directors around staff specific non-compliance to enable timely action planning. - E learning package to be developed by QHIL/Project Support Officer in Nursing Development Team for launch in April to provide an overview of expectations of staff and supervisors Supervision engagement and details of how and what to log on the database. Compliance reporting will also be included. The action around ligature risks on the ward is complete as an assessment was conducted post CQC visit. The availability of the assessment of ligature risks will be made available on the ward for staff to refer to or to share when requested with regulators or others as required. All equipment has been risked assessed for ligature risk and stored in locked cupboards. All patients are supervised when using shower chairs and these have been added to the ligature risk assessment. Cross link to MD 1, 19, 37

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Wards for people with a learning disability or autism	**67**	MD38	The trust must ensure that they safeguard patients against abuse and improper treatment. This includes ensuring that staff report safeguarding concerns and take appropriate action and that there is sufficient oversight from managers and that staff record restraint appropriately including reasons for the length of time the patient is restrained.	Allison Bingham	Debra Gilderdale	Quality & Safety Committee	23/03/2018	Ongoing	30/09/2018		Training compliance rates for all wards across the units is being monitored, identifying and managing any underperformance. All training compliance is being monitored within quality and safety meetings. Access to safeguarding supervision is available on a monthly basis across all hospital sites from the safeguarding team. Each ward has a safeguarding champion identified. • Organisational safeguarding leads now receiving all incident reports that are service user to service user abuse (SU-SU) • Additional guide to be developed for staff to support safeguarding decision making in SU-SU incidents. • Additional safeguarding training to be provided to all assistant and ward managers. • Monthly SU-SU alleged and actual incidents report to be sent to organisational safeguarding leads, for themes and trends oversight. • Assurance to be provided on a bi-monthly safeguarding forum chaired by the Director of Nursing and Operations who will feed back to Quality and Safety Committee. • Employee relations meetings to be held monthly with safeguarding and HR to review staff Cross links to MD 15, 27, 29, 38
Wards for people with a learning disability or autism	**67**	MD39	The trust must ensure that staff recognise and discuss when an incident may meet the trust threshold for duty of candour, and apply the duty of regulation as required by the regulation.	Allison Bingham	Andy McElligott	Mental Health Legislation Committee	19/04/2018	Ongoing	31/05/2018		Duty of candour will be covered in safeguarding training and also at trust induction. Central guidance to be issued. Services to be asked to review all incidents of moderate harm or above with specific question as to whether or not they meet the trust threshold for duty of candour. Ensure staff are supported when involved in duty of candour incidents. On connect there are slides which will be shared with staff and included in service manager blog. This will be included on staff notice boards Cross links to MD 22, 39
Wards for people with a learning disability or autism	**67**	MD40	The trust must ensure that blanket restrictions are reviewed and ensure that all restrictions are individually risk assessed.	Allison Bingham	Andy McElligott	Mental Health Legislation Committee	19/04/2018	Ongoing	30/06/2018		Recirculate CQC guidance table to all Inpatients relating to Blanket Restrictions for their ward areas. For all patients on this ward, assure that there are no restrictions in place which have not been individually risk assessed. MDT practice to discuss blanket restrictions has been introduced on Assessment and Treatment Unit and the process will be shared across all wards. Cross links to MD 5, 30,40
Community-based mental health services for adults of working age	**47**	MD41	The trust must ensure that all premises used to treat patients have up-to-date health and safety risk assessments in place including fire risk assessments.	Andrew Morris	Liz Romaniak	Quality & Safety Committee	23/03/2018	Ongoing	31/03/2018		Work is ongoing to consolidate all environmental assessments. This will be actioned during March-18 targeting completion by 31st March-18. A Ligature Assessment Group has also been established and which is meeting fortnightly to ensure ligature assessments take place as per the Ligature Assessment Plan (Tracker), on an annual basis) and that assessment actions are delegated to Clinical and Estates leads appropriately. The Ligature Assessment Group will also monitor completion of actions from ligature assessments and escalate to HSG and QSC in the event of significant exceptions. Cross links to MD14, 41, 47, 48

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Community-based mental health services for adults of working age	**48**	MD42	The trust must ensure that medication being prescribed for patients is reviewed in line with the relevant trust policy.	Simon Long	Andy McElligott	Quality & Safety Committee	23/03/2018	Ongoing	30/04/2018		This specifically relates to depot prescriptions. All depot prescriptions have been updated The medicines audit that is currently in place within Community Mental Health Teams, on a monthly basis, now includes a review of depot prescriptions. This is monitored quarterly on the Community Mental Health Team quality and safety meeting agenda. Team leaders will be required to present their completed audits at this meeting. Minutes of quality and safety meetings will be the audit trail that provides assurance to the business unit Quality and Safety Meeting Cross links to none
Community-based mental health services for adults of working age	**48**	MD43	The trust must ensure that staff complete and update regular assessments of need, risk assessments and crisis plans for all patients in line with trust policy.	Simon Long	Debra Gilderdale	Mental Health Legislation Committee	19/04/2018	Ongoing	30/05/2018		Informatics to run reports to assist Team Leaders and Care Co-ordinators to identify any out of date assessments. Weekly performance meetings to be held to focus on individual action plans and progress towards the 100% target. Any issues can be addressed in a timely fashion with either individuals or processes. Reports run weekly and support offered by senior managers. To complete by end of May 2018 Cross links to MD 13, 24 34, 43, 44
Community-based mental health services for adults of working age	**48**	MD44	The trust must ensure that all patients have an up-to-date personalised care plan and discharge plan.	Simon Long	Debra Gilderdale	Mental Health Legislation Committee	19/04/2018	Ongoing	30/05/2018		Informatics to run reports to assist Team Leaders and Care Co-ordinators to identify any out of date assessments. Weekly performance meetings to be held to focus on individual action plans and progress towards the 100% target. Any issues can be addressed in a timely fashion with either individuals or processes. Reports run weekly and support offered by senior managers. To complete by end of May 2018 Cross links to MD 13, 24 34, 43, 44
Community-based mental health services for adults of working age	**48**	MD45	The trust must ensure that systems are in place and operating effectively to ensure required training and supervision is completed, and that audits are effective to ensure patients are safe.	Simon Long	Debra Gilderdale	Quality & Safety Committee	23/03/2018	Ongoing	30/09/2018		System and process redesign underway to record training, supervision and audit activity. Performance reporting around same will follow, reported via Business Unit, Quality and Safety and Operational performance meetings. Any subsequent underperformance to be managed locally. The following actions have been completed - Connect page in place for Clinical Supervision - Clinical Supervision policy revised in December 2017 in light of new compliance monitoring approach. Amends made to draft following Professions Council and Executive team review – awaiting upload to Clinical Policy section of Connect. - E learning live for all staff at point of induction - Face to face workshops in place for those wishing to become supervisors or attend for a 3 year update. This is delivered by service appointed Supervision training Champions whose contacts are on the Connect page and sessions delivered across the calendar year as per demand. - Live register of Clinical Supervisors on Clinical Supervision Connect Page - Supervision database live for all staff to record their supervision activity (compliance has increased from 47 entries in January to 390 to date). Meeting arranged for 29/3 with IT/Business support/HR and the Nursing Development team to

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											further develop robust reporting from this database linked to live nominal role data. This will afford assurance and intelligence to Service Managers/DDs around staff specific non-compliance to enable timely action planning. - E learning package to be developed by QHIL/Project Support Officer in Nursing Development Team for launch in April to provide an overview of expectations of staff and supervisors Supervision engagement and details of how and what to log on the database. Compliance reporting will also be included. See MD51 detailing actions for required training. Cross links with MD 17,28,46, 50
Mental health crisis services and health-based places of safety	**60**	MD46	The trust must ensure that systems are in place and operating effectively to ensure required training and supervision is completed, and that audits are effective to ensure patients are safe.	Simon Long	Debra Gilderdale	Quality & Safety Committee	23/03/2018	Ongoing	30/09/2018		System and process redesign underway to record training, supervision and audit activity. Performance reporting around same will follow, reported via Business Unit, Quality and Safety and Operational performance meetings. Any subsequent underperformance to be managed locally. The following actions have been completed - Connect page in place for Clinical Supervision - Clinical Supervision policy revised in December 2017 in light of new compliance monitoring approach. Amends made to draft following Professions Council and Executive team review – awaiting upload to Clinical Policy section of Connect. - E learning live for all staff at point of induction - Face to face workshops in place for those wishing to become supervisors or attend for a 3 year update. This is delivered by service appointed Supervision training Champions whose contacts are on the Connect page and sessions delivered across the calendar year as per demand. - Live register of Clinical Supervisors on Clinical Supervision Connect Page - Supervision database live for all staff to record their supervision activity (compliance has increased from 47 entries in January to 390 to date). Meeting arranged for 29/3 with IT/Business support/HR and the Nursing Development team to further develop robust reporting from this database linked to live nominal role data. This will afford assurance and intelligence to Service Managers/DDs around staff specific non-compliance to enable timely action planning. - E learning package to be developed by QHIL/Project Support Officer in Nursing Development Team for launch in April to provide an overview of expectations of staff and supervisors Supervision engagement and details of how and what to log on the database. Compliance reporting will also be included. See MD51 detailing actions for required training. Cross links with MD 17,28,46, 50
Mental health crisis services and health-based places of safety	**60**	MD47	The trust must ensure that the corridor windows leading to the health based place of safety at Lynfield Mount Hospital do not compromise patients' privacy and dignity.	Andrew Morris	Liz Romaniak	Quality & Safety Committee	23/03/2018	Completed	31/10/2017	Andrew Armitage, Project & Compliance Manager, assured completion by walkabout To be reviewed and signed off by Executive Management Team on 27/03/2018.	Works completed in Oct-17 while the CQC were present. Cross links to MD14, 41, 47, 48

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Mental health crisis services and health-based places of safety	**60**	MD48	The trust must ensure that the mirrors in the health based place of safety in the Airedale Centre for Mental Health do not pose a risk to patient safety.	Andrew Morris	Liz Romaniak	Quality & Safety Committee	23/03/2018	Completed	31/10/2017	Andrew Armitage, Project & Compliance Manager, assured completion by walkabout To be reviewed and signed off by Executive Management Team on 27/03/2018.	Works completed in Oct-17 while the CQC were present. Cross links to MD14, 41, 47, 48
Mental health crisis services and health-based places of safety	**60**	MD49	The trust must ensure that all staff mental health crisis services receive regular supervision and this is documented.	Simon Long	Debra Gilderdale	Quality & Safety Committee	23/03/2018	Ongoing	30/06/2018		System and process redesign underway to record training, supervision and audit activity. Performance reporting around same will follow, reported via Business Unit, Quality and Safety and Operational performance meetings. Any subsequent underperformance to be managed locally. The following actions have been completed - Connect page in place for Clinical Supervision - Clinical Supervision policy revised in December 2017 in light of new compliance monitoring approach. Amends made to draft following Professions Council and Executive team review. - E learning live for all staff at point of induction - Face to face workshops in place for those wishing to become supervisors or attend for a 3 year update. This is delivered by service appointed Supervision Training Champions whose contacts are on the Connect page and sessions delivered across the calendar year as per demand. - Live register of Clinical Supervisors on Clinical Supervision Connect Page - Supervision database live for all staff to record their supervision activity (compliance has increased from 47 entries in January to 390 to date). Meeting arranged for 29/3 with IT/Business support/HR and the Nursing Development team to further develop robust reporting from this database linked to live nominal role data. This will afford assurance and intelligence to Service Managers/DDs around staff specific non-compliance to enable timely action planning. - E learning package to be developed by QHIL/Project Support Officer in Nursing Development Team for launch in April to provide an overview of expectations of staff and supervisors' Supervision engagement and details of how and what to log on the database. Compliance reporting will also be included. Cross links to MD 9,33,49
Mental health crisis services and health-based places of safety	**60**	MD50	The trust must ensure that the use of the Mental Health Act and Mental Capacity Act is audited effectively.	Simon Long	Andy McElligott	Mental Health Legislation Committee	19/04/2018	Ongoing	30/06/2018		Current weekly ward level audit processes to be reviewed and redesigned to enhance standardisation to provide assurance of a robust audit process. Following redesign an escalated reporting process will be agreed to ensure reporting to Business Unit Level Quality and Safety (Quarterly) and Trustwide Mental Health Legislation Committee (bi-annually) Cross links to MD 11, 50

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Community Mental Health Services for People With A Learning Disability Or Autism	**78**	MD51	The provider must ensure that systems are in place to ensure all staff are compliant with required training.	Simon Long	Debra Gilderdale	Quality & Safety Committee	23/03/2018	Ongoing	30/09/2018		Executive team has reviewed the mandatory and required training matrix and agreed a broader range of mandatory training for all staff. In addition they have agreed that board will have oversight of compliance for all mandatory training. A new PowerPoint slide has been developed for the Board Dashboard which has been placed in the Professions section of the Board performance report. The Q&S committee will also receive quarterly reports. The first report to the Q&S meeting was received on the 9th February 2018 and will go quarterly thereafter. Cross links to MD6, 18, 32, 51

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City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of Airedale NHS Foundation Trust to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 22nd March 2018

AG

Subject:

Airedale NHS Foundation Trust's wholly owned subsidiary for Estates, Facilities and Procurement Services

Summary statement:

On the 25th October 2017 Airedale NHS Foundation Trust Board gave approval to proceed with the formation of a wholly owned subsidiary for Estates, Facilities and Procurement Services. The subsidiary is named AGH Solutions Limited and went live on 1st March 2018 with the TUPE (Transfer of Undertakings (Protection of Employment)), transfer of 319 staff to the subsidiary.

This is aligned to the Trust's drive for continual improvement in the quality of services provided to the local population and a reflection of the need to change our approach to continue to thrive and be sustainable going forward.

It reflects the national picture across the NHS, driven by the financial challenge and coupled with the need to sustain high quality and safe services, where organisations are coming together to work in different ways to ensure delivery of the population health, quality of care and better use of resources.

The Trust has listened to the staff transferring to the new subsidiary and has agreed that their terms and conditions will be protected for the life of the 25 year contract. Staff will also retain their terms and conditions upon promotion and the subsidiary will at least match the Agenda for Change annual award for cost of living. In addition the Trust has transferred any eligible bank staff on to Agenda for change contracts prior to the subsidiary going live.

This report includes extracts from the redacted business case which is attached as an appendix.

Portfolio:

Health and Wellbeing

Report Contact: David Moss
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E-mail: david.moss@anhst.nhs.uk

1. Summary

It was considered that the establishment of a wholly owned subsidiary company for Estates, Facilities and Procurement services, at Airedale NHS Foundation Trust, will:-

- Enable the Trust and its subsidiary company to have greater focus on the specific core functions of these services and also enable the subsidiary to develop an increased commercial focus. This will enhance the opportunity to improve the quality of the services provided to Airedale NHS Foundation Trust and give greater potential to realise additional income which will be necessary to keep pace with the investments needed to ensure services can be sustained.

- Provide an improved focus and transparency of performance against standards as part of a continued drive for improvement and efficiencies needed to respond to the rising demand for services the Trust provides.

- Provide a model which gives the subsidiary company greater flexibility to recruit and retain key staff, helping to address workforce pressures now and in the future.

- Gives an excellent opportunity to discharge our role in the wider community in respect of providing additional employment for local people at competitive rates of pay, the subsidiary will look to develop and train these people and provide opportunities to have a long and prosperous career. This will support the local authority's ambition of making Bradford a great place to live given the links between good employment and the health and wellbeing of the local population.

- Look to take up the opportunity of reviewing the potential of increasing the opportunities for local Small and Medium Enterprise (SME) to do business with the Subsidiary. The current SFI rules use the NHS criteria for doing business with SME's which are extremely strict and in most cases it makes it challenging for SME's to tender for business. This gives an opportunity to provide a huge boost to the local economy as well as providing potential growth in employment for other local businesses.

- Provide a significant contribution to the Trust's financial sustainability plan, quickly and with more certainty than other options.

- Provide a governance system which reserves control on key issues to the Trust, as the parent organisation, whilst also providing the company with delegated freedoms and flexibility to develop its services and its staff.

- Provide a service model which is more in accord with Trust values than other possible options, including valuing the Trust staff concerned and recognising their contribution. The governance arrangements would also require the subsidiary company to carry out its activities in accordance with the vision and values of the Trust.

- Research undertaken with other NHS Trusts who have progressed with this model has been positive in respect of improvements they are able to demonstrate with service and quality metrics, staff satisfaction, efficiencies delivered and growth.

2. Background

The NHS is facing increasing financial challenges linked to a number of factors - an ageing population giving rise to increased demand for the Trust's services, increased drug costs, rising public expectation, increasing regulatory requirements and workforce shortages that are creating competing demands for scarce financial resources.

In our local patch, the demographic challenge is complicated by the diversity of the communities we serve, significant areas of deprivation, and the rurality of our catchment area.

The Trust has through its positive financial position been able to manage local financial pressures but now recognises the need to do things differently to ensure that the organisation has a sustainable future. Externally, this involves working with partners across health and social care locally and regionally, in order to address the triple aim set out in the Five Year Forward View, i.e. population health, quality of care, and cost control. Internally, this has led to the recognition that the way the Trust runs its support functions needs to change to enable innovative solutions, to become more fleet of foot, to be able to work differently with our local community, and to create both savings and an income stream that will be available to support the Trust's financial position.

The creation of the SPV with its focus on delivering a high quality service managed through stretching contracts and KPIs, and its commercial freedoms to grow its business and develop innovative solutions and services will provide a better support for the Trust than maintaining the status quo.

In line with the overall focus on productivity across the NHS, the SPV will be required to deliver on operational efficiencies through standardisation and rationalisation of products. This will be achieved through establishing a managed equipment and consumables service which will enable a more collaborative approach between the estates and facilities and procurement services.

It is the Trust's genuinely held belief that this proposal provides our existing staff with greater protection and support when compared with other possible consolidation options that are being considered at a regional level, and it enables them to continue to work closely with the Trust, and be part of the Trust's delivery of the Right Care strategy to our population.

There are currently nine other NHS Estates, Facilities and Procurement subsidiaries with over 100 staff.

3. Report issues

The Trust's strategy is centred on providing high quality, accessible care for the local population in a context where there are significant financial constraints and increasing demand .The Trust will not be able to meet these challenges and sustain services without implementing new models of care and new models for delivering the business. The Trust believe that creating a subsidiary for estates, facilities and procurement will enable those services to be sustained at a high quality and prevent the need to cut costs that impact upon the quality of the services provided and or the wellbeing of the staff .

The reasons can be summarised as follows:

- **People: -** A subsidiary will deliver the benefits of having private sector freedoms with public sector values, including greater flexibility to allow staff incentives and rewards for excellent performance. This will ensure that staff and experience can be retained at the organisation and more specialist staff can be attracted to the organisation. The culture of the new organisation can be become more focused on performance, excellent customer service and be more agile and innovative. The subsidiary will target growth in the local community by providing local employment and continuous improvement.

- **Financial: -** The subsidiary will be managed as a separate financial unit which will be closely linked to performance metrics and patient focused objectives. NHS SFIs are rigid and restrict the opportunity to work creatively and flexibly with SMEs in the local community. Working through an SPV removes these issues and will enable the SPV to participate in and win more tenders/contracts for new business. The subsidiary will benefit from greater flexibility and more efficient processes, obtaining commercial regulatory advantages. Upon expansion there will be further advantage from the economies of scale that will be created through new contracts that the subsidiary wins. In the longer term it will be able to access funding, grants and other external investment. These benefits will ultimately be reflected in the Trust financial position.

- **Management: -** In forming a subsidiary the Trust will be able to maintain a level of control, rather than outsourcing and ensure a strong governance framework through the management of service level agreements. The trust will be able to focus on delivering its core services and risks.

- **Service: -** The subsidiary will ensure the delivery of improved services for the Trust which will improve patient care and patient experience.

- **Growth:** - The subsidiary will develop a separate identity and brand to enable it to bid for other work to increase in size and diversify its services into areas not available to the NHS.

Forming a subsidiary will enable a number of benefits to be realised for the Trust. These will include:

- Establishing a company to provide cost effective and quality support services, which focuses on this and this alone, enabling the Trust to focus on its core services.

- Helping to improve quality through detailed service specifications and KPIs as part of the Operated Healthcare Facility Contract and Service Level Agreements.

- Providing greater flexibility and freedoms for the Trust's subsidiary company, enabling it to build upon the expertise of its staff and systems and develop a more commercial focus, capitalising on working outside the restrictions on NHS SFIs, with the aim of being better able to seize opportunities to generate additional income, for the benefit of the Airedale NHS Foundation Trust.

- Enabling the company to change the culture and develop new ways of working more effectively (which would be more difficult to achieve within directly managed Trust departments) whilst the company would still share the Trust's values, ethics and aspirations.

- Transferring performance risks relating to these services from the Trust to the company, with clear accountability arrangements.

- Delivering a significant and tangible contribution to the Trust's financial delivery plan, supporting Airedale NHS Foundation Trust to continue to deliver sustainable, high quality and safe services.

- Allowing more flexibility to recruit and retain staff to provide these support services, addressing workforce pressures and risks.

- Offering more security to Airedale NHS Foundation Trust support services staff, compared to other possible options, as the Trust would retain specified reserved powers over the company.

- Providing an efficient, effective and quality managed equipment and consumables service which will deliver operational efficiencies from the standardisation and rationalisation of products, including a more joined up approach between estates and facilities and procurement services.

- Further improvements to sustainability, whilst the Trust has made a significant reduction in the energy consumed by the hospital (a reduction of 30% over the last 4 years), it can be seen in the graph in the business case that energy use is only a small proportion of the Trust's Carbon footprint. A policy of more local procurement by the subsidiary and an improved use of electric vehicles will lead to a further reduction in Carbon emissions in the future.

Airedale NHS Foundation Trust contracted QEF (Gatehead) to assist setting up their wholly owned subsidiary. QEF were one of the first subsidiaries established and underwent significant scrutiny by HMRC. This model was approved by HMRC and the same model has been adopted by Airedale NHS Foundation Trust.

4. **Options**

The options considered by Airedale NHS Foundation Trust can be viewed in 3.2 of the redacted business case attached to this paper.

5. **Contribution to corporate priorities**

The Trust's '*Right Care'* strategy over the previous few years of 'putting the patient and their care at the centre of everything we do' has been about improving the patient experience and maintaining high quality care, working in partnership across health and social care.

The Trust's strong financial position in recent years has supported delivery of this strategy however, the NHS is facing increasing financial challenges and the Trust recognises the need to do things differently to ensure that the organisation has a sustainable future.

The creation of the wholly owned subsidiary with its focus on delivering a high quality service managed through stretching contracts and KPIs, and its commercial freedoms to grow its business and develop innovative solutions and services will provide a better support for the Trust than maintaining the status quo. This will be achieved by providing a significant contribution to the Trust's financial sustainability plan, quickly and with more certainty than other options.

Specifically, the wholly owned subsidiary will give an excellent opportunity to discharge the Trust's role in the wider community, in respect of providing additional employment for local people at competitive rates of pay.

The case for change and benefits of change shown in section 3.0, 3.1 and 3.2.1 respectively, of the redacted business case attached to this paper give further detail.

6. Recommendations

6.1 It is asked that the Health and Social Care Overview & Scrutiny Committee note the reasons why Airedale NHS Foundation Trust agreed to form the wholly owned subsidiary, AGH Solutions.

6.2 It is asked that the Health and Social Care Overview & Scrutiny Committee note the ambitions of AGH Solutions, including employing more people from the local community and using more local community businesses in the supply chain.

7. Background documents

None

8. Not for publication documents

None.

9. Appendices

9.1 Appendix 1 - Full Business Case for a wholly owned subsidiary delivering Estates, Facilities and Procurement Services with confidential appendices redacted.

Airedale
NHS Foundation Trust

Airedale NHS Foundation Trust Wholly Owned Subsidiary

Full Business Case for a wholly owned subsidiary delivering Estates, Facilities and Procurement Services

CONTENTS

1.0 Executive Summary

The business case details the reasons for proposing the creation of a Wholly Owned Subsidiary for the delivery estates, facilities and procurement services. This is aligned to the Trusts drive for continual improvement in the quality of services provided to the local population and a reflection of the need to change our approach to continue to thrive and be sustainable going forward.

It reflects the national picture across the NHS, driven by the financial challenge, where organisations are coming together to work in different ways to ensure delivery of the population health, quality of care and better use of resources.

It is considered that the establishment of a wholly owned subsidiary company for Estates, Facilities and Procurement services, as described in this Business Case, will:-

- Enable the Trust and its subsidiary company to have greater focus on the specific core functions of these services and also enable the subsidiary to develop an increased commercial focus. This will enhance the opportunity to improve the quality of the services provided to Airedale NHS Foundation Trust and give greater potential to realise additional income which will be necessary to keep pace with the investments needed to ensure services can be sustained.

- Provide an improved focus and transparency of performance against standards as part a continued drive for improvement and efficiencies needed to respond to the rising demand for services the Trust provides.

- Provide a model which gives the subsidiary company greater flexibility to recruit and retain key staff, helping to address workforce pressures now and in the future.

- Gives an excellent opportunity to discharge our role in the wider community in respect of providing additional employment for local people at competitive rates of pay, the subsidiary will look to develop and train these people and provide opportunities to have a long and prosperous career. This will support the local authority's ambition of making Bradford a great place to live given the links between good employment and the health and wellbeing of the local population.

- Look to take up the opportunity of reviewing the potential of increasing the opportunities for local Small and Medium Enterprise (SME) to do business with the Subsidiary. The current SFI rules use the NHS criteria for doing business with SME's which are extremely strict and in most cases it makes it challenging for SME's to tender for business. This gives an opportunity to provide a huge boost to the local economy as well as providing potential growth in employment for other local businesses.

- Provide a significant contribution to the Trust's financial sustainability plan, quickly and with more certainty than other options.

- Provide a governance system which reserves control on key issues to the Trust, as the parent organisation, whilst also providing the company with delegated freedoms and flexibility to develop its services and its staff.

- Provide a service model which is more in accord with Trust values than other possible options, including valuing the Trust staff concerned and recognising their contribution. The governance arrangements would also require the subsidiary company to carry out its activities in accordance with the vision and values of the Trust.

- Research undertaken with other NHS Trusts who have progressed with this model has been positive in respect of improvements they are able to demonstrate with service and quality metrics, staff satisfaction, efficiencies delivered and growth.

- There is a significant risk that the Trade Unions will trigger formal dispute procedures with the Trust if this business case is supported.

The majority of the Trust's assets will be transferred to the subsidiary, this will include buildings, infrastructure, fixtures and fittings and consumables. These will constitute the managed service provided by the subsidiary as an Operated Healthcare Facility (OHF).

The Board should note that if this business case is approved it will not trigger a significant transaction in respect of the Foundation Trust Licence. However, NHS Improvement has requested that the business case is sent to them following Board consideration, at which stage they will confirm their agreement to proceed. NHSI have dealt with the creation of similar arrangements in other FTs, and has signalled that it does not regard this proposal as contentious.

It is acknowledged that this is a significant change for the Trust and for a large number of Trust staff and there are a number of risks associated with the proposal. These risks are summarised at section 6.2, and the Risk Log included as an appendix to this business case. However, as the case details it will deliver substantial benefits and it is therefore recommended that the proposal is considered and approved by the Board.

2.0 Background and alignment to Trust Strategy

The Trust focus over the previous few years has been setting out our Right Care ambition for our population; putting the patient and their care at the centre of everything that we do. The Right Care programme has had a relentless focus on improving the patient experience and maintaining high quality care, working in partnership across health and social care. The Trust's strong financial position in recent years has supported delivery of the strategy, and allowed capital investment in the estate including the new emergency department, new endoscopy suite, upgrade to the outpatients department, a number of ward refurbishments, and the keenly awaited AAU which will open in Spring 2018.

The NHS is facing increasing financial challenges linked to a number of factors - an ageing population giving rise to increased demand for the Trust's services, increased drug costs, rising public expectation, increasing regulatory requirements and workforce shortages that are creating competing demands for scarce financial resources.

In our local patch, the demographic challenge is complicated by the diversity of the communities we serve, significant areas of deprivation, and the rurality of our catchment area.

The Trust has through its positive financial position been able to manage local financial pressures but now recognises the need to do things differently to ensure that the organisation has a sustainable future. Externally, this involves working with partners across health and social care locally and regionally, in order to address the triple aim set out in the Five Year Forward View, i.e. population health, quality of care, and cost control. Internally, this has led to the recognition that the way the Trust runs its support functions needs to change to enable innovative solutions, to become more fleet of foot, to be able to work differently with our local community, and to create both savings and an income stream that will be available to support the Trust's financial position.

The creation of the SPV with its focus on delivering a high quality service managed through stretching contracts and KPIs, and its commercial freedoms to grow its business and develop innovative solutions and services will provide a better support for the Trust than maintaining the status quo.

In line with the overall focus on productivity across the NHS, the SPV will be required to deliver on operational efficiencies through standardisation and rationalisation of products. This will be achieved through establishing a managed equipment and consumables service which will enable a more collaborative approach between the estates and facilities and procurement services.

It is the Trust's genuinely held belief that this proposal provides our existing staff with greater protection and support when compared with other possible consolidation

options that are being considered at a regional level, and it enables them to continue to work closely with the Trust, and be part of the Trust's delivery of the Right Care strategy to our population.

2.1 NHSI Position

If the Board approve proceeding with the SPV then NHSI approval will also be required. NHSI have requested that the Board paper is sent to them following Board consideration, at which stage they will confirm their agreement to proceed. At this stage they have not signalled that this will be contentious.

2.2 Significant Transaction

The Trust's FT Constitution includes a section to the effect that *'in considering any significant transaction, the directors shall have regard to the views of the Council of Governors'.* The term 'significant transaction' is defined as meaning a transaction meeting any one of the tests shown below:

- The fixed asset test; or
- The turnover test; or
- The gross capital test.
- The fixed asset test is met if the assets which are the subject of the transaction exceed 25% of the fixed assets of the Trust.
- The turnover test is met if, following completion of the transaction, the gross income of the Trust will increase, or decrease by more than 25%.
- The gross capital test is met if the gross capital of the company or business being acquired or divested represents more than 25% of the capital of the Trust following completion.

For the purpose of this section, a 'transaction' is any agreement entered in to by the Trust in respect of the acquisition of a business or services or the disposal of a business or service.

The Board is assured that the arrangements for transferring estates, facilities and procurement services to the wholly owned subsidiary will not trigger a significant transaction.

2.3 Trust reasons for proposing an SPV model

As set out in the Executive Summary the Trust's strategy is centred on providing high quality, accessible care for the local population in a context where there are significant financial constraints and increasing demand .The Trust will not be able to meet these challenges and sustain services without implementing new models of care and new models for delivering the business. The Trust believe that creating a subsidiary for estates, facilities and procurement will enable those services to be sustained at a high quality and prevent the need to cut costs that impact upon the quality of the services provided and or the wellbeing of the staff .

The reasons can be summarised as follows:

- **People: -** A subsidiary will deliver the benefits of having private sector freedoms with public sector values, including greater flexibility to allow staff incentives and rewards for excellent performance. This will ensure that staff and experience can be retained at the organisation and more specialist staff can be attracted to the organisation. The culture of the new organisation can be become more focused on performance, excellent customer service and be more agile and innovative. The subsidiary will target growth in the local community by providing local employment and continuous improvement.

- **Financial: -** The subsidiary will be managed as a separate financial unit which will be closely linked to performance metrics and patient focused objectives. NHS SFIs are rigid and restrict the opportunity to work creatively and flexibly with SMEs in the local community. Working through an SPV removes these issues and will enable the SPV to participate in and win more tenders/contracts for new business. The subsidiary will benefit from greater flexibility and more efficient processes, obtaining commercial regulatory advantages. Upon expansion there will be further advantage from the economies of scale that will be created through new contracts that the subsidiary wins. In the longer term it will be able to access funding, grants and other external investment. These benefits will ultimately be reflected in the Trust financial position.

- **Management: -** In forming a subsidiary the Trust will be able to maintain a level of control, rather than outsourcing and ensure a strong governance framework through the management of service level agreements. The trust will be able to focus on delivering its core services and risks.

- **Service: -** The subsidiary will ensure the delivery of improved services for the Trust which will improve patient care and patient experience.

- **Growth:** - The subsidiary will develop a separate identity and brand to enable it to bid for other work to increase in size and diversify its services into areas not available to the NHS.

In June 2017, the Board of Directors gave approval to proceed with the early stages of work to progress the proposal to set up a subsidiary company to provide estates, facilities and procurement services so that a detailed proposal could be considered

A Project Board and a Project Team were set up to take this forward, including the appointment of QE Facilities (Gateshead) to provide advisory services. An Interim Managing Director and Interim Finance Director have been appointed. This has enabled work to progress to further develop the proposal, as described in this Full Business Case.

Further detail is available in the outline business case, submitted to June board and the supplementary paper on quality benefits for the Trust, the benefits for staff, the

vision and the non-financial benefits the subsidiary which was submitted to the board in September.

2.4 Scope of the Proposal

The support services being considered in this business case are shown in the table below. This business case relates only to the services identified; this does not preclude future consideration of this model for other non-clinical services at a future stage.

In scope	
1.	Procurement
2.	Stores (inc.receipt and distribution and the BDCFT service)
3.	Estate management
4.	Capital developments
5.	Domestic services
6.	Catering (via contract)
7.	Portering (including Radiology, pharmacy, ED and theatres)
8.	In hospital patient transfer
9.	Ward Hostessing
10.	Housekeeping
11.	Security (via contract) & Fire
12.	Car parking
13.	Linen services
14.	Estates and facilities admin
15.	Property management
16.	Medical Engineering
17	Gardening
18.	Other contract management
19	Health and Safety management
20.	Transport (via contract)
21.	Sterile Services Department
22.	Interpreting services
23.	Telecoms
24.	Volunteer Services management team **(this does not refer to volunteers per se)**

In establishing the company, there would need to be a transfer of assets to enable it to provide the Operated Healthcare Facility and enable the Trust to focus on its core activities of healthcare delivery. This would be facilitated using a non-cash transaction, although any loan repayments would be made by the subsidiary as cash payments over the agreed period. Any loan would need to be agreed through a Loan

Agreement and would be repaid by the subsidiary to the FT over an agreed period at an agreed commercial interest rate.

All of the Trust's assets will be transferred to the subsidiary, this will include buildings, infrastructure, fixtures and fittings and consumables. These will constitute the managed service provided by the subsidiary

3.0 Case for change and the benefits

The case for change can be summarised briefly as:

- Current staff surveys indicate that the people in Estates, Facilities and Procurement feel that they are a small part of a big organisation and a service function. The formation of the subsidiary will enable these people to be at the centre of their own organisation, therefore improving staff morale and culture. Evidence from more mature subsidiaries support that this is achievable.

- There is an opportunity to better use the expertise of staff in Estates, Facilities and Procurement to identify commercial opportunities.

- There is a strategic national direction through the Carter Report and STPs to review and transform how support services are provided;

- The quality of the support services being provided to the Trust could be further improved, as evidenced by the recent PLACE scores;

- There is a requirement for the Trust to make significant financial savings, part of which will need to be delivered by Estates, Facilities and Procurement services, so there is a case for considering how these services could be provided in different more cost effective ways, helping to enable the Trust to continue to provide sustainable and safe clinical services;

- Our staff are our greatest asset and without them we could not provide and sustain our excellent care to those who need it. We place importance on the Trust values relating to our staff and are committed to ensuring staff are recruited, retained, developed and engaged throughout their careers. Therefore, within the context of change already happening strategically in how support services are provided in the NHS, there is a case for considering how the Trust can best manage this for its services and support services staff;

- The Trust has also identified workforce pressures and risks in its People Plan and the need to consider flexibility in its workforce and reward systems to address these pressures, meet service needs and continue to deliver high quality services

3.1 Benefits of Change

Forming a subsidiary will enable a number of benefits to be realised for the Trust. These will include:

- Establishing a company to provide cost effective and quality support services, which focuses on this and this alone, enabling the Trust to focus on its core services.

- Helping to improve quality through detailed service specifications and KPIs as part of the Operated Healthcare Facility Contract and Service Level Agreements. Examples of this are in appendices 2-3.

- Providing greater flexibility and freedoms for the Trust's subsidiary company, enabling it to build upon the expertise of its staff and systems and develop a more commercial focus, capitalising on working outside the restrictions on NHS SFIs, with the aim of being better able to seize opportunities to generate additional income, for the benefit of the Airedale NHS Foundation Trust.

- Enabling the company to change the culture and develop new ways of working more effectively (which would be more difficult to achieve within directly managed Trust departments) whilst the company would still share the Trust's values, ethics and aspirations.

- Transferring performance risks relating to these services from the Trust to the company, with clear accountability arrangements.

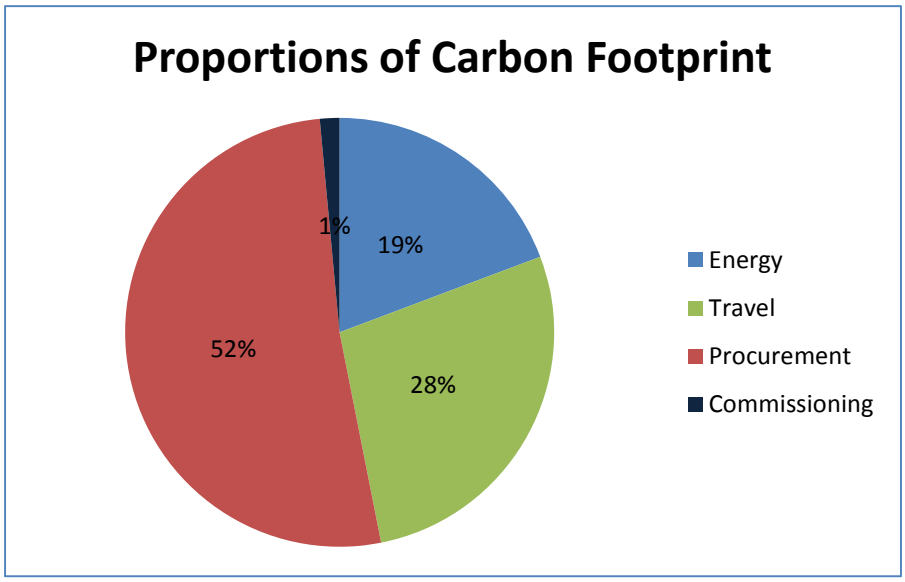
- Delivering a significant and tangible contribution to the Trust's financial delivery plan, supporting Airedale NHS Foundation Trust to continue to deliver sustainable, high quality and safe services.

- Allowing more flexibility to recruit and retain staff to provide these support services, addressing workforce pressures and risks.

- Offering more security to Airedale NHS Foundation Trust support services staff, compared to other possible options, as the Trust would retain specified reserved powers over the company.

- Providing an efficient, effective and quality managed equipment and consumables service which will deliver operational efficiencies from the standardisation and rationalisation of products, including a more joined up approach between estates and facilities and procurement services.

- Further improvements to sustainability, whilst the Trust has made a significant reduction in the energy consumed by the hospital (a reduction of 30% over the last 4 years), it can be seen in the graph below that energy use is only a small proportion of the Trust's Carbon footprint. A policy of more local procurement by the subsidiary and an improved use of electric vehicles will lead to a further reduction in Carbon emissions in the future.



3.2 Options Appraisal

This section describes the option appraisal, including the benefit criteria to be used in evaluating the options (derived from the objectives which the Trust wants to achieve); it identifies the possible options and the appraisal of these options to identify the preferred option.

The Board noted that the "do nothing" and outsourcing options had been excluded at an earlier stage by the management team. This happened at both an Airedale NHS Foundation Trust level and in a Case for Change Paper submitted to the West Yorkshire Association of Acute Trusts (WYAAT) Committee in Common in April 17. This is because a wholly owned subsidiary offered more significant benefits.

The Assistant Director of Estate and Facilities shared the options with the Executive Team via the Divisional Assurance Groups in spring 2017 and it was agreed at this level to seek support from the Board of Directors to pursue a Wholly Owned Subsidiary Company (WOS) for estates, facilities and procurement services.
The Board of Directors considered and received an Outline Proposal for a WOS at its meeting in June 2017 and supported the recommendation to develop a full business case for a WOS to consider in October 2017.

Whilst the Trust Board agreed the wholly owned subsidiary case in October 2017, for completeness the Board asked for a brief paper outlining this alongside 2 other options – **Do Nothing and Outsourcing**. The Board discussed these options as part of their deliberations and noted that the business case made reference to them and felt it would be useful to see them set out. The Board agree that this would not deter the decision to progress with a wholly owned subsidiary.

3.2.1 Case for Change and Benefit Criteria

The case for change for the proposal, set out in Section 3.0 has been used to derive the following benefit criteria to evaluate the options.

Quality of Support Services - the extent to which the options would improve the quality of Estate, Facilities and Procurement services provided to the Trust's clinical departments. This includes the potential for improvement through more transparent management and reporting against key performance indicators; and consideration of the nature of the working relationship between the Trust and the service provider e.g. the level of flexibility which the Trust would have in how services are delivered and responsiveness to requested contract changes from the Trust.

Staff Considerations - the extent to which the options would impact on staff, including staff security, recruitment, terms and conditions of service, and opportunities for existing Airedale staff. It takes into account consideration of the Trust's commitment to its staff in line with the People Strategy, including the Trust values relating to its staff.

Cost Savings – the extent to which the options would deliver a contribution to the Trust's financial delivery plan and financial stability and reduce the risk of cost cutting impacting upon the quality of services and or the staff experience.

Sustainability and Deliverability - how sustainable would each option be going forward and the impact on sustaining Trust services due to differing timescales involved in establishing each option and delivering financial savings and or opportunities. This would also include any benchmarking /research information available from other trusts that have either outsourced and or formed a wholly owned subsidiary.

Potential for Income Generation - the extent to which the considered options could generate additional income for the Trust through selling services to other organisations or diversification into new commercial activity.

Minimising disruption to services - this criterion has been added to those above, which were directly derived from the case for change for the proposal, recognising that any major change has a risk of causing disruption to services.

3.2.2 Identification of Options

The following options were agreed with the Board in October 2017 in order to compare the wholly owned subsidiary proposal with other possible ways of achieving the same objectives.

Do Nothing- This option would involve retaining direct management of the services as they currently exist. However this option would deliver no significant efficiency savings and place higher risks sustaining the quality and standard of services offered to the local population. This option also leaves a situation whereby the current workforce are highly likely to continue to report the impact of doing more with less negatively in respect of their staff experience and health and well- being .

Subsidiary Company- This option is the proposed solution that is agreed and detailed in the full business case. It would involve the transfer of all Estates, Facilities and Procurement staff and budgets to the subsidiary company and the transfer, where feasible, of Trust buildings to the company (through a 25 year lease); This would enable the subsidiary company to deliver a fully managed Operated Healthcare Facility service to those buildings that are leased to the company - this service would be provided through a detailed contract based on commercial terms. The Trust has also specified that approval from the NHS Pensions Scheme for access to their schemes for staff transferred to the subsidiary company would be necessary. The subsidiary would be part of Airedale NHS Foundation Trust group of companies, with the Trust reserving agreed powers.

Outsourcing-This option, commonly used in business and increasingly in recent years within central government and the public sector more widely, would involve the contracting out of the services in this business case to a private company outside of the NHS. It is a practice that is commonly used to reduce support services costs. Local examples include our own Trust outsourcing catering services to Sodexo or NHSPS outsourcing maintenance work for our community services buildings to Mitie (a national strategic outsourcing company).

3.2.3 Option Appraisal

Each of the shortlisted options above, were considered and appraised against the benefit criteria. This was undertaken by the Assistant Director of Estates and Facilities, the Head of Procurement, the Deputy Director of Finance, HR business partner with relevant departmental heads of service and agreed by the Chief Operating Officer.

The scoring methodology numerically assesses the various options to represent relative strength of each proposal against each benefit criteria in a range from -5 (detrimental effect) to 0 (neutral) to 5 (being the greatest possible benefit).

	Do Nothing	Subsidiary Company	Outsourcing
Quality of Support Services	0	4	2
Staff considerations	5	3	-5
Cost Savings	-4	5	3
Sustainability and delivery	-2	4	4
Potential for Income generation	1	4	1
Minimising disruption to services	5	3	3
Net score	**5**	**23**	**8**

Quality of Service. It was considered that a subsidiary company would be able to deliver an improved quality of service based upon both it and the Trust being able to

focus on their “core business”, with better performance management arrangements in place. It was felt that whilst this was also applicable to the outsourcing option, disadvantages would be the typically tighter management of contract changes and ad hoc jobs requested by the Trust, and less flexibility in how services are provided. It was also taken into account that the Trust’s clinical services would release their staff’s time with a subsidiary model, e.g. on removing management of some equipment and support service staff. The Trust Board would retain less control and influence over key decisions in respect of strategy and direction with outsourcing as compared to a wholly owned subsidiary.
The Do Nothing Option is not realistic given the current performance and quality metrics in the services being considered. It is clear that in estates and facilities there is not sufficient potential to reduce costs further without impacting upon the quality of the services offered. In respect of procurement whilst the team is high performing and benchmarks exceptionally well when compared to other Trusts as demonstrated in the Lord Carter reports, there are significant further opportunities associated with a wholly owned subsidiary.

Staff Considerations. In comparing the options, it was considered that the advantages of the do nothing and subsidiary company options score highly in relation to staff, given the added commitment by the Trust to protect Agenda for Change terms and conditions for the life of the contract. However, there are concerns about the future sustainability of the do nothing option relating to staffing considerations, this is reflected in the sustainability and deliverability criteria below. For the outsourcing option there would be additional factors relating to risks around longer term protection of NHS terms and conditions for transferred staff and on-going level of commitment to the values of Airedale NHS Foundation Trust. Recent examples whereby Airedale staff at Skipton transferred to OCS have raised concerns about how staff are treated in outsourced contracts.

Cost Savings. Significant cost savings are identified from establishing a subsidiary company as identified within the business case. It was considered that although an outsourcing company could realise similar operating savings, the typical outsourcing company profit margin, plus central overhead costs would reduce the savings passed back to the Trust, ultimately to a much lower point than could be achieved with a subsidiary. The outsourcing option was therefore marked lower. Further financial savings under the current model would be very limited; the Lord Carter dashboard indicates that the Trust is already operating at a very efficient level.

Sustainability and Deliverability. The subsidiary company option was assessed as being a more sustainable solution for future years than the “do nothing” option. The do nothing and outsourcing options were given lower values reflecting the need to make significant financial savings in the near future and the timescales involved in the outsourcing option delivering savings, as well as a longer period of uncertainty for the staff concerned.

Potential for Income Generation. The appraisal against this criterion was based upon the ability of a subsidiary company to be able to respond quickly and be able to develop commercial opportunities to generate income for the Trust, compared to the

other options. An outsourcing company would retain any new income generated rather than consolidate it back to the Trust.

Minimising Disruption to Services. It was considered that all the options would involve greater disruption than the "do nothing" option. However it was assessed that the level of short term disruption to the Trust and its services around implementing the subsidiary company option, which essentially involves Airedale staff working together, would be less than the disruption in implementing the outsourcing option, involving developing a working relationship with a third party.

3.2.4 Identification of Preferred Option

The analysis above identifies the proposal to establish a subsidiary company as the best scoring option.

All options have risks and therefore it should also be considered whether this option presents any risks which are considered significant enough in comparison to the other options to prevent it being selected as the preferred option.
As the Board are aware the risks associated with establishing a wholly owned subsidiary were considered in detail in section 6.2 of the full business case.
On the basis of the subsidiary company proposal scoring best against the benefit criteria and after the consideration of relative risks, the wholly owned subsidiary company full business case is presented to the Board as the preferred option.

4.0 Current Service Provision

4.1 Staff Numbers

The staff numbers transferring to the proposed subsidiary are detailed below. Whilst, there are 230 WTE's identified, the number of people transferring, including bank staff is between 380 and 390. These numbers include all staff currently in the Estates, Facilities and Procurement departments. In addition, the ward hostesses, radiology porters, 1.7 WTE pharmacy porters and 1 health and safety coordinator post will be transferring to the subsidiary.

***The Board should note that the 300 plus volunteers that currently support the Trust do not form part of this proposal. The volunteer management roles that work in support of the volunteers that will transfer into the subsidiary will ensure that the support for the volunteers is not disrupted at any point in this process**.

4.2 Interim appointments

As the board are aware the Trust have appointed a Managing Director and a part time Finance Director on an interim basis. This was required as it was necessary to establish a separate company in order to apply for the pensions order for the staff

that will transfer into the subsidiary. The interim posts are being undertaken by existing staff from the Trust.

4.3 Proposed Management Structure

It is proposed that the subsidiary board will consist of the following posts:

- 1 x Managing Director
- Part-time Finance Director
- 1 x NED

HR support will be delivered through a reverse HR SLA. The professional support for this role will be provided by the Director of HR and Workforce Development for Trust through the HR SLA. It is recognised that there will be a high demand for HR support for the subsidiary in years 1 and 2 in respect of supporting TUPE processes as well OD and training for the teams as they are establishing themselves.

Further support is proposed in respect of the transfer of the senior management member from the procurement service into the subsidiary and 3 members of staff from the Trusts finance team who currently provide support to these services. All members of the management structure are existing staff employed by the Trust, thus limiting additional management costs in forming the subsidiary.

4.4 Service Performance

The national PLACE assessments provide a snapshot of how providers are performing against a range of non-clinical activities which impact on the patient experience of care, including cleanliness; the quality and availability of food and beverages and the environment The Trust is currently behind national averages in some areas.

Airedale Criteria	Airedale Results 2016	Airedale Results 2017	Airedale Difference from 2016	National Average (NA) Results 2016	Airedale Results 2017 vs National Average (NA) Results 2016
Cleanliness	95.59%	97.21%	+1.62%	98.06%	-0.85%
Condition, Appearance and Maintenance	87.70%	89.39%	+1.69%	93.37%	-3.98%
Privacy, Dignity and Wellbeing	74.07%	78.35%	+4.28%	84.16%	-5.81%
Food overall	87%	90.76%	+3.76%	88.24%	+2.52%
Organisational Food	88.26%	84.17%	-4.09%	87.01%	-2.83%
Ward Food	86.54%	92.31%	+5.77%	88.96%	+3.35%
Dementia	65.22%	74.91%	+9.69%	75.28%	-0.37%
Disability	68.63%	86.48%	+17.85%	78.84%	+7.64%

The subsidiary, through its service level agreements and key performance indicators will allow the Trust to increase its PLACE scores, and Carter metrics to national averages and therefore improve standards.

5.0 Staff and the People Strategy

This section describes the people strategy; the impact on staff; new terms and conditions for subsidiary staff and union engagement.

NHS
Airedale
NHS Foundation Trust

AGH Solutions People Strategy

Empowering individuals to create our future

When the Trust Board agreed to progress to a Full Business Case to consider whether or not to set up a subsidiary it was agreed that a key part of the considerations would relate to the subsidiaries culture and approach. This is not only the TUPE transfer of existing staff into the new company , but having a clear understanding of the approach to people management and development on an ongoing basis.
In response to this the Interim Directors and key management leads for the development of the business case were asked to detail this. The following information is

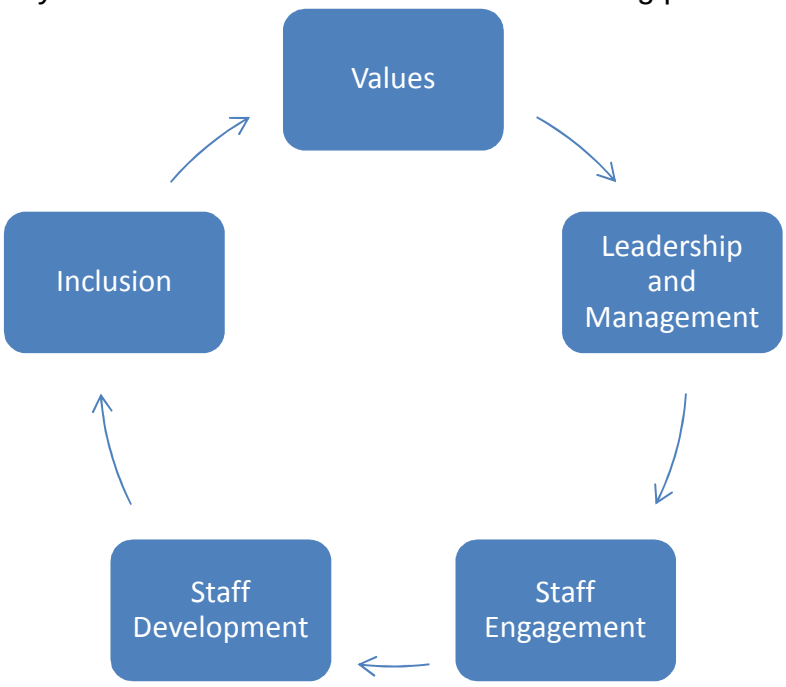
their initial response accepting that if the business case is approved the subsidiary board and management teams would want to develop this further with their staff.

5.1 AGH Solutions People Strategy

AGH Solutions will be a business in its infancy, our business is our people and without our hard working staff AGH Solutions would not exist. We will therefore aspire to be an employer of choice and through our people we will deliver a service that is efficient, effective, patient and customer focused. The People Strategy outlines our vision for how we will support, manage, lead and develop our workforce over the next 3-5 years. It recognises that the majority of staff that will be being TUPE transferred into the organisation are in departments that have had the highest levels of staff sickness absence, the lowest staff survey results and low staff morale. In contrast the Procurement Department is a department with one of the best staff survey results. This People Strategy sets out the vision for how we will transform the way we support our people to make AGH Solutions an employer of choice and a brand that our staff and the local community are proud of.

Our Ethos

AGH Solutions will deliver a staffing model which encourages hard work and good performance. We will reward staff for adhering to our values, displaying the behaviours we expect and for good performance. As a socially responsible employer we will offer employment opportunities for our local communities through recruiting apprentices which will give individuals opportunities to earn as they learn providing employment for our local communities where unemployment levels are higher than the national average. We will offer flexible working opportunities which will offer individuals opportunities to work where they may not be able to under conventional working patterns.



Our Vision

We will develop a vision that supports the Trust's Right Care Values and Behaviours, and focuses on delivering quality in a socially responsible and ethical manner. It will be important the values and behaviours that underpin the subsidiary's vision are aligned with the Trusts' values and behaviours, to support the staff from the subsidiary and the Trust as they work alongside each other to deliver services for our population. This work will be undertaken through a planned engagement process with the staff to ensure that the vision will be owned by everyone who works for AGH solutions, and staff will be able to articulate the core vision of the organisation and demonstrate the values and behaviours that underpin it.

We will reward individuals who display behaviours that represent our vision and those that work hard and perform well by offering incentives linked specifically to our vision and performance. We aspire to being an employer of choice.

Our Leaders and Managers

Our leaders will model our values. They will support our staff to be able to perform at their best and create a culture of openness and innovation. We will manage staff through fair performance and appraisal processes and provide support for our staff when they need it. Our leaders will reward performance with development and training so that our staff can develop to be able to perform to their best and progress their careers where they wish to. Our management of staff will be fair, consistent and even handed valuing individual and team contribution.

We will train our leaders and managers to ensure they are aware of their duties, know how to manage, lead and support staff and ensure they are aware of how performance management appraisals should be carried out. We will have policies and procedures in place which will provide structure and guidance in line with ACAS best practice guidance; this will provide a structure for our managers in managing and supporting our workforce. Strong line management support will be the key to our staff feeling valued, supported and engaged.

We will access the leadership and management training and development offer provided by the Trust through a Service Level Agreement. However, in order to enhance this offer and tailor development for both our staff and management a bespoke internal training and development offer will be devised to meet the needs of AGH Solutions.

Managers in areas with better staff engagement will work with their peers and share good practice.

Engagement and Staff Voice

This People Strategy aims to significantly improve staff experience in these areas with the belief that those carrying out work on the front line are the experts that should be encouraged and rewarded for making improvements in their work. We will increase staff engagement to create a culture of continuous improvement and an organisation that our

staff are proud to be a part of.

We will establish a staff forum/voice which will be a mechanism for us to understand staff concerns, how we can support staff better and where we need to improve. This forum will also provide a mechanism for us to provide feedback to staff and determine how best to communicate with our staff, for example, 66% of staff in the Estates and Facilities Department did not feel they were given feedback about changes made in response to errors.

Staff will be encouraged to raise concerns. We will recruit a staff Freedom to Speak Up Guardian who will be our champion on the front line raising awareness and encouraging their colleagues to bring forward areas where we can improve. In turn we will offer incentives for individuals who take on this important role.

We will establish constructive and effective relations with our union colleagues with the joint aim of supporting our staff.

On recruitment every new starter will undertake an induction programme tailored specifically for AGH Solutions and focussed on the vision and values of the business.
We will seek staff feedback by having a regular staff survey and staff opinions will help us in improving how we lead, manage and support our staff. Our leaders will be visible, approachable and will communicate with our staff ensuring staff have opportunities to provide feedback. The staff survey results for 2016 tell us that in the Estates and Facilities Department 59% of staff did not feel they were involved in deciding changes that affected their work and 64% did not believe they could make improvements happen in their area. Our challenge In contrast, the Procurement Department had 73% of staff stating they were involved in deciding changes that affected their work and 91% reported that they were able to make improvements happen in their area.

Staff Development

AGH Solutions will identify talent within our workforce and support individuals to develop and enrich their roles. Individuals that wish to progress their career further and are high performing will be offered opportunities which will enhance their learning and development. A programme will be development which will offer opportunities for our best performers to have accelerated development which in turn will provide the organisation with a talent pool to support our succession planning.

We are committed to recruiting apprentices as a way of giving back to the community in an area where our nearest local authority has one of the lowest levels of academic attainment in the country. Our apprenticeship scheme will offer opportunities to individuals who may not otherwise be able to find a route into employment. We will utilise the training and development opportunities on offer by Airedale NHS Foundation Trust through a service level agreement to support those wanting to progress their careers. The apprenticeship scheme will help the organisation to develop a future workforce offering a true career path from Apprentice through to qualified skilled positions.

All senior managers will undertake a coaching course/qualification in order for the organisation to be able to work with our line managers to coach them towards having an open and consultative approach towards the management of their staff. All staff will have set training which will be mandatory. Job specific training will be provided where required to support staff.

We will support our staff develop within their roles and increase their knowledge base recognising that a successful business needs experienced staff who can be role models in sharing their knowledge. Our long serving staff will play a key role in the development of new staff.

AGH Solutions will develop an in house NVQ based assessment centre by skilling managers to become NVQ Assessors and establishing links with college and education providers, this will offer staff the opportunity to undertake qualifications in their field of work. Providing job enrichment and a more skilled workforce.

Inclusion

AGH Solutions will aim to be an organisation that truly reflects the makeup of our community and will aspire to achieve this by 2022. This will offer the organisation a rich mix of individuals with different experience to help us develop as an inclusive employer and service provider. Through recruitment we will aim to reflect the diversity of our community, with a particular emphasis on attracting and recruiting applicants from groups currently under represented in the workforce. We will do this through outreach and by utilising different approaches to recruitment. We will offer a range of work patterns that will attract individuals who are unable to work within the traditional working patterns offered. Our values will focus on respect and acceptance of our differences. We will develop and create an inclusion network that is focused on supporting the organisation to become a truly inclusive employer.

5.2 Staff – TUPE arrangements

The key points relating to staff in this proposal are:

- All staff employed in Estates, Facilities and Procurement and other staff identified at the date of the company becoming operational will be transferred to the company under the terms of the “Transfer of Undertakings (Protection of Employment) Regulations 2006” as amended by the “Collective Redundancies and Transfer of Undertakings (Protection of Employment) (Amendment) Regulations 2014”. These regulations are known as TUPE and apply to all organisations of all sizes and protect employees’ rights when the organisation or service they work for transfers to a new employer. In effect this means that staff would transfer with their current terms and conditions of service being retained. This covers for example basic pay, holidays, overtime rate, sick pay entitlements and enhancements such as for on-call, working weekends, bank holidays, unsociable hours etc.

- On the 18 September 2017 an application was made to the NHS Business Services Authority, which administers the NHS Pensions Scheme, to request that all staff who

transfer under TUPE regulations continue to be able to access their NHS Pension Scheme. Under new procedures, final approval is only received following the transfer of staff to the new company. The Trust is expecting a "letter of comfort" from the NHS Business Services Authority confirming that if HMT's fair deal policy requirements are met, a direction order will be granted. Should approval not be received for the pension order, this would be considered a material change and the Board will be asked to reconsider their decision on whether to proceed with the subsidiary, based on the updated pension information.

- New pension arrangements for new staff joining the company will be established, as they would not be able to access the NHS Pension Scheme. This would be provided under "NEST", the new workplace pension scheme set up by the Government.

- Any future changes to terms and conditions for staff under TUPE would be the subject of due consultation with those involved and their representatives. It is not the intention of the subsidiary company to make any such changes.

- Any changes in job descriptions e.g. to reflect future service developments, will be discussed with the individuals concerned, with formal consultation where required, in line with best practice.

- Staff will continue to work in their current departments but, as currently within the Trust, things could change with any future service developments. Any changes would be discussed with the individuals concerned and their representatives with formal consultation where required.

- The new company would establish its own terms and conditions of employment for new staff joining the company. These are outlined in section 5.3. These aims to enable the company to be an employer of choice and support the key aims of the proposed People Strategy, creating a flexible workforce that can deliver a high quality service and be responsive to commercial opportunities that may arise. The terms and conditions will also enable the company to attract staff in areas where there are recruitment difficulties by offering a more flexible, person centred reward package in line with local market conditions. It will be possible to bring services that are contracted out back to within the subsidiary.

- Staff in the new company would remain eligible for the relevant salary sacrifice schemes.

- The company will recognise and value Union colleagues and place great importance on partnership working throughout this change process and in the future. The new company will set up a forum to enable it to meaningfully involve, engage and inform its staff. Any negotiation or consultation on employment matters will follow similar arrangements to the Trust with staff side and Trade Unions, in a separate company forum.

- The Health and Wellbeing of the workforce moving into the subsidiary company is important. This has been taken into account throughout the process thus far and will

continue into the operation of the subsidiary company. Support will be available for staff and managers to guide them through the transition.

- The subsidiary company would commit to training and education by continuing to educate and equip staff with the necessary knowledge and skills to do their jobs and develop their potential.

- The company will ensure that the Trust values are intrinsic in its operations and people management.

5.3 Terms and Conditions for New Staff

AGH Solutions proposes to set terms and conditions for new starters that are competitive with the local employment market and that will attract talented individuals to the organisation. Examples of what this might mean are set out below:

- A minimum starting salary of £8.00/hour. This is above the government's national living wage of £7.50/hour and higher than the Trust starting salary of £7.88/hour.
- The opportunity for staff to earn a £500 non-consolidated annual bonus subject to meeting performance standards.
- Standard rates of pay for 'in hours' and 'out of hours', with enhancements for work on bank holidays.
- Cost of living increases determined by the subsidiary on an annual basis related to company performance.
- Initial periods of absence being unpaid with increased sick pay entitlement being earned over the years. The company will ensure its approach does not result in staff attending work when they are unwell.

- Bereavement, compassionate and special leave.

- Holiday entitlement in line with the private sector, but with extra days as reward for achieving performance standards.

- Maternity and paternity provision above statutory requirements.

Equal Pay

It is recognised that over time through natural turnover and as AGH Solutions expands as a business, new staff will be recruited on new terms and conditions outside of Agenda for Change. This will mean that there will be two separate sets of terms and conditions for staff employed by AGH Solutions. Whilst this is not uncommon within the private sector it does present a risk in relation to future equal pay claims. The advice received from QEF which reflects what they have done is this is mitigated by role design and by TUPE being seen as a material defence. The company will take legal advice on how best to mitigate future risks as it determines the new terms and conditions to ensure the approach taken is robust.

The SPV will use an objective job evaluation tool for new job roles to ensure equal pay

for work of equal value.

6.0 Governance Arrangements

6.1 Governance

AGH Solutions Limited was registered at Companies House on 1 September 2017. The sole shareholder is Airedale NHS Foundation Trust and the directors are David Moss and Amy Whitaker.

Model Articles of Association have been adopted. The Articles of Association will be reviewed and finalised as part of the legal work-stream work that will commence once approval for the transfer of estates, facilities and procurement to the subsidiary company has been given.

For the purpose of providing assurance to the Board, the review of the Articles of Association will consider further the following subject matters:

- Directors' - powers and responsibilities, decision-making, appointments*
- Shares and distributions e.g. dividends
- Decision-making by the shareholder
- Administrative arrangements
- Director's indemnity and insurance

*The Board of Directors have signalled that a Non-Executive Chair will be appointed at a later stage.

The Trust as sole shareholder will be required to approve any changes to the Articles of Association.

The Trust and the subsidiary will need to ensure that appropriate governance arrangements are put in place so that the Trust, as sole shareholder of the subsidiary, can set and oversee the strategic direction of the subsidiary whilst allowing the directors of the subsidiary discretion to carry out the operational managements effectively, efficiently and with clear targets and milestones. This will require a clear decision making framework to ensure the Trust as shareholder makes

the appropriate decisions reserved for them and at the same time, give sufficient authority to the subsidiary directors to make decisions in relation to the day to day activities of the subsidiary.

Appendix 5a is provided as an illustration of how this could work in practice using the Key Performance Indicators in respect of people management and leadership as an example. This would work alongside the annual planning process whereby the Trust Board would publish its strategic direction and objectives for the year and agree the relevant specifics with the subsidiary.

Governance arrangements must ensure accountability whilst not hindering operational activity, however an agreement is required to regulate, amongst other matters how the subsidiary is to be governed. This will be a key document as it will capture how the Trust as sole shareholder will exercise its control over the subsidiary. This will be shared with the Trust Board when the work has been done and it is complete.

In creating the subsidiary the following obligations will be considered either through the Articles of Association or through a controlling governing document i.e. shareholders agreement or standing orders.

- Define how important decisions are to be made (decisions reserved for shareholder approval)
- Running the company – including process for appointing, removing and remuneration of directors; audit arrangements (internal and external), approval of strategy, budget/business plan and annual report and accounts, Insurance arrangements
- Reporting arrangements to the shareholder
- Financial controls including banking arrangements
- Role descriptions for key senior manager positions including the Trust's Nominated Representative
- Dispute resolutions procedures including exit strategy

The following schedule shows the main matters reserved for the subsidiary board and those matters requiring shareholder approval (the list is not exhaustive).

Matters reserved for Subsidiary Board	Shareholder approval?
1. Strategy and Management	
1.1 Responsibility for the overall leadership of the Company and setting the Company's values and standards.	
1.2 Approval of the Company's strategic aims and objectives.	YES
1.3 Approvals of the annual operating and capital expenditure budget.	YES
1.4 Material changes to annual operating expenditure budget.	YES Where business plan limits exceeded by £xx
1.5 Material changes to annual capital expenditure budget.	YES Where business plan limits exceeded by £x

1.6 Oversight of the subsidiary's operations ensuring: o competent and prudent management; o sound planning; o maintenance of sound management and internal control systems; o adequate accounting and other records; and o compliance with statutory and regulatory obligations.	
1.7 Review of performance in the light of the subsidiary's strategic aims, objectives, business plans and budgets and ensuring that any necessary corrective action is taken.	
1.6 Extension of the subsidiary's activities into new business or geographic areas.	YES
1.7 Any decision to cease to operate all or any material part of the subsidiary's business.	YES
2. Structure and capital	
2.1 Changes relating to the subsidiary's capital structure.	BOTH
2.3 Changes to the subsidiary's management and control structure.	BOTH
3. Financial reporting and controls	
3.1 Approval of the annual report and accounts.	YES
3.2 Approval of the dividend policy.	YES
3.3 Recommendation of the dividend.	
3.4 Approval of any significant changes in accounting policies or practices	BOTH
3.5 Approval of treasury policies.	BOTH
3.6 Approval of material unbudgeted capital expenditure (in excess of Business Plan limits).	YES where >£x
3.7 Approval of material unbudgeted operating expenditures (in excess of Business Plan limits).	BOTH where >£x
4. Internal controls	
4.1 Ensuring maintenance of a sound system of internal control and risk management including: o Approving the subsidiary's risk appetite statements; o Receiving reports on, and reviewing the effectiveness of, the subsidiary's risk and control processes to support its strategy and objectives; o Approving procedures for the detection of fraud and the prevention of bribery; o Undertaking an annual assessment of these processes; and o Approving an appropriate statement for inclusion in the annual report.	YES (assurance via AFT Audit Committee)
5. Contracts	
5.1 Approval of procurement strategy for award of new contract by subsidiary where contract value (over the life of the contract) expected to be in excess of £x.	YES Where value is >£x
5.2 Disposal of land or rights over land to a third party.	YES
5.3 Disposal of obsolete or surplus items of plant, vehicles or equipment where the consideration is expected to be in excess of £x.	YES
5.4 Purchase of land/buildings, including leases.	YES
6. Board membership	
6.1 Ensuring adequate succession planning for the board and senior management to maintain an appropriate balance of skills and experience within the subsidiary and on the board.	
6.2 Appointment, removal or replacement of executive	BOTH

directors of the subsidiary.	
6.3 Appointment, removal or replacement of subsidiary Board Chair.	BOTH
6.4 Appointment, removal or replacement of any independent directors of the subsidiary.	BOTH
6.5 Appointment of members of Board Committees (including appointment of the Committee Chair).	BOTH
7. Remuneration	
7.1 Agreeing the remuneration of all executive directors of the subsidiary (including the Chief Executive Officer) within the constraints of the Remuneration Policy.	
7.2 Approving remuneration policy applicable to executive directors of the subsidiary and senior management (including the subsidiary's forward-looking policy on remuneration).	YES
7.3 Approving the implementation of the Remuneration Policy including approving the total pay received by each director during the year, including any bonuses payable.	YES
7.4 Determining the remuneration of the non-executive directors, subject to the articles of association and shareholder approval as appropriate.	YES
8. Delegation of authority	
8.1 Agreeing the division of responsibilities between the Chairman, the Chief Operating Officer and other executive directors.	
8.2 Establishing board committees and approving their terms of reference, and approving material changes.	BOTH
8.3 Receiving reports from board committees on their activities.	
9. Corporate governance matters	
9.1 Undertaking a formal and rigorous annual review of its own performance, its committees and individual directors, and the division of responsibilities.	
9.2 Determining the independence of non-executive directors in light of their character, judgment and relationships.	
9.3 Reviewing the subsidiary's overall corporate governance arrangements.	
9.4 Authorising conflicts of interest where permitted by the subsidiary's articles of association.	
9.5 Approval of the appointment of the auditors for the subsidiary.	YES
9.6 Prosecution, commencement, defence or settlement of litigation, or an alternative dispute resolution mechanism involving claims above £x or being otherwise material to the interests of the subsidiary.	YES (where claim is >£x
9.7 Approval of the overall levels of insurance for the subsidiary and the group up including directors' & officers' liability insurance.	YES
9.8 Changes to the subsidiary standing orders, SFI's and scheme of delegation.	YES
9.9 Approval of draft and final business plan.	BOTH
9.10 Approval of changes to the Articles of Association	BOTH
10. Policies	
10.1 Approval of material policies, including: o Code of Conduct; o Bribery prevention policy; and o Whistleblowing and reporting concerns policy.	
10.2 Approval of the subsidiary's Health and Safety Policy.	BOTH

This is work in progress which the Trust Board will be kept appraised of if the business case is approved. The Interim Directors of the subsidiary will be asked to produce a more detailed implementation plan which will provide the Trust Board with further opportunity to detail how this will work in practice.

It is proposed that once the subsidiary commences trading, the Trust's Audit Committee will provide assurance to the Trust that the governance arrangements are being applied in accordance with the governing documents. The assurance process will be set out in the governing documents.

The Trust Board of Director's will receive a quarterly report from the subsidiary's managing director setting out the subsidiary's performance against pre-determined KPI's. The proposed reporting format is attached in Appendix 5b.

Exit Strategy - as the proposed company would be a wholly owned subsidiary of the Trust, the Trust would have the power to dissolve the company, taking the assets of the company back into its ownership. In such an event, the staff employed by the company would be covered by TUPE regulations and the protection of terms and conditions of service that apply.

6.2 Risk

Subsidiary Risks

The current risk register for the project is in appendix 1.

There will be other risks with the formation of a wholly owned subsidiary, which are highlighted below:

- **Strategic Risks:** These include managing the speed of growth to ensure that the focus on core services is not diluted. The possibility of business failure and the implementation of implementing the exit strategy.

- **Reputational risks:** The strength of the relationship between the trust and the subsidiary is important and the balance between control and freedom must be appropriate.

- **Operational risks:** The governance arrangements for a new organisation of significant size must be managed from the offset.

- **Legislative Risks:** A change to taxation or legislation could affect the subsidiary although the specialist tax advice received by tax specialists at QEF suggests the model would be protected for the length of the contract (25 years). Market changes may also impact business direction.

Trust Risks

Reputational Risks

- The decision whether to link the brand of the NHS to the subsidiary must yet be decided. Any diversification by the subsidiary must be in areas that would not bring the Trust into disrepute and any risk managed by doing this in line with NHSE guidance.

- The Trust is meeting fortnightly with unions via the Airedale Partnership Group to discuss the subsidiary and to keep them updated with progress and developments. The relationship is good; an honest and open approach is being pursued. Despite this they are opposed to the NHS setting up these new business models and argue it is privatisation of the NHS. This gives rise to a risk of the Trade Unions triggering a dispute which could lead to Industrial Action.

- **Operational risks –** there is a risk that the Trust having transferred existing personnel with the technical expertise in estates, facilities and procurement services into the new subsidiary will be challenged in respect of oversight of the contract with the subsidiary. This will be mitigated via the detailed SLAs and the appointment of a contract manager for the Trust who has relevant experience and expertise to discharge this function.

7.0 Operational Working

The key features of the day to day operational working arrangements would include:

- Services will be provided by the company to agreed standards as set out in Service Level Agreements (SLAs) with associated key performance indicators (KPIs). These will include pricing of the service with agreed tolerances relating to levels of service, based on commercial terms. A list of SLAs is provided overleaf and examples of the detail of x 2 Service Level Agreement are provided at Appendix 2-3. This illustrates an example of one of the SLA proposed between the SPV and the Trust i.e. Domestic services and a reverse SLA between the Trust and the SPV i.e. payroll.

  There will be flexibility within the SLA's to allow for reasonable variances in demand for services to ensure that the Trust can avoid unnecessary from the subsidiary. There would not be additional charges for normal operational issues that we manage today, for example an outbreak of D&V, which requires a deep clean. Initially the transfer of services from the Trust to the subsidiary will be on a "status quo" basis, whereby the existing service will be matched and re-provided. Any significant changes will be managed through a variation to contract and separately costed. Where there are any performance issues in service delivery there will be a performance monitoring procedure and KPI remedial procedure which could ultimately result in service penalties should performance not improve.

The Trust intends to appoint a Senior Contract Manager, who will oversee the contract management on behalf of the Trust. This is a key part of the arrangements the Trust will have in place in respect of ensuring the SLAs are effectively managed on behalf of the Board.

- For a small number of services there will be SLAs for services provided by the Trust to the company. These are for services which are more effectively and efficiently provided by the Trust, for reasons of economies of scale. The "reverse SLA's" would cover HR, Finance, payroll, IT, IG, training, risk management, marketing and communications. The reverse SLA will work in much the same way as above in relation to performance issues but vice versa.

- There will be more regular and transparent reporting to the Trust of the performance of the services provided by the company. The Trust will ensure that it has the capability and capacity to monitor and review the company's performance – the "informed client" role. An experienced professional will be employed by the Trust to undertake this role for estates, facilities & procurement services and a Trust officer identified to do likewise for transactional services. It is likely that this post will be a senior role reporting to the Head of Planning and Performance.

- The company will have the necessary statutory policies in place covering the grievance procedure, disciplinary procedure and health and safety. Other non-statutory polices will also have to be developed and will be introduced. Where a policy is not in place on 1 April, the existing Trust policy would be used until such time as it is replaced with a separate company policy.

Services from AGH Solutions Ltd to Airedale NHS Foundation Trust	
000	Estates General
001	Estates Maintenance
002	Help desk
003	Property specialist service
004	Capital projects
005	Energy and utilities management
006	Waste management
007	Ground and Gardens maintenance
008	Domestic Services
009	Portering services
010	Linen services
011	Catering services
012	Switchboard
013	CSSD
014	Procurement
015	Security and Car Park
016	Telecoms
017	Facilities managed service
018	Voluntary services
019	Interpreter services
020	Accommodation services
021	Ward housekeeping
022	Non-Patient Transport
023	Ward hostess
024	Mobility services
025	EBME Managed equipment service

Service to third parties

AGHS 3P 001	Telemedicine
AGHS 3P 002	Pathology JV (AGH to ISL)
AGHS 3P 003	Bradford Healthcare

Estates Management Services Agreement (EMSA)

AGHS EMSA 00	Procurement (not in Managed service) specification for retained non clinical areas

AGHS EMSA 01	Procurement (not in Managed service) specification for retained non clinical areas

SLA's Service provider to trust	
AGHS 01	General service specification
	Risk management
	Business Continuity
	Legal
	Marketing/Comms
AGHS 02	HR
	Training
AGHS 03	Finance
AGHS 04	Payroll
AGHS 05	IT
AGHS 06	IG

8.0 Finance

The finance work stream meets on a weekly basis and reports to the Project Board on a monthly basis. QEF join the finance work stream on a monthly basis and separate conference calls take place when necessary. Current progress on the key areas of work is highlighted below:

8.1 Leasehold/ Freehold

The finance and estates team have completed their analysis of the risks associated with the different lease options and ranked based on each risk, what the best option would be for the Group against each of the risks. The options available are:

- Freehold
- Leasehold > 21 years
- Leasehold < 21 years

QEF facilities provided a document to use as a guide to determine the most suitable option. Officers of the parent company should assure themselves that they are happy with the ranking in relation to the risks, financially, operationally and regulatory. The risk weightings are shown in Appendix 6, with 5 being very high, 3 being high, 2 medium and 1 low.

The final summary results are shown at Appendix 6. As can be seen from this analysis the order of preference was as follows:

Lease Arrangement	Score
Freehold	77

Leasehold > 21 years	122
Leasehold < 21 years	95

AGH Solutions will therefore be proceeding under a leasehold agreement of 25 years.

8.2 Asset Transfer

A full list of all Trust Assets and their values has been quantified, reconciled to the Trust asset register, and verified by the Head of Estates and Facilities. As part of this exercise assets needed to be individually considered to understand which items would remain with the Trust and which assets would be part of the leasehold agreement with AGH Solutions Ltd. It is agreed that IT assets should remain with the Trust and as such all items classified as IT have been reviewed with the IT team, Estates and Finance are to determine which are true Trust IT assets and which should transfer, e.g. Telecomms.

As well as capital assets an exercise has also been completed for non-capital equipment, e.g. furniture, beds, etc. Based on an audit of equipment in each area of the Trust, and utilising average price, an inventory of all of these assets has been identified for transfer to AGH Solutions Ltd. QEF are now reviewing all of the non-building assets to determine a transfer value. This transfer value will form part of the lease agreement for non-building assets.

Building and land assets will form part of the revaluation which is to take place over the next few weeks to provide a value as of the 28th February 2018. This value will be the value of the assets that will transfer to the SPV and will make up the lease payment charge for building assets. Following this valuation QEF will work on behalf of the Trust to understand whether there are any backdated capital gains that may be applicable for those assets.

There remain a number of outstanding queries around this exercise as follows:

- Car Parking – income will continue to be received by the Trust but the SPV will provide a managed service for supporting the infrastructure. Need clarity on who should therefore have the asset;

- Assets that may be sold in the future – the Trust will want to hold onto assets that could be sold in the future , therefore these need to be identified and removed from the asset transfer list;

- Community Assets – leases for the community building will transfer to the SPV, we therefore need to identify the equipment that the Trust owns that are in these building to include in the overall equipment inventory;

- Pathology JV assets – as the Pathology JV is a business in its own right and the SPV is not providing a managed service for it, it is not considered appropriate that the SPV owns the equipment. The Pathology JV has been contacted to

ascertain whether these assets will remain with the Trust or be sold to the JV. It is suggested that the Trust and JV take their own advice on the options for these assets.

8.3 Leases

The finance team are working with our Auditors to establish whether the lease agreement will be considered finance or an operating lease. It is expected that it will be considered a finance lease but this has not been confirmed at this stage. Following this confirmation a calculation of the lease will take place for all buildings and equipment. This exercise is due to complete by 19th January 2018.

8.4 Asset valuation

The Trust is required to complete a full asset valuation based on Market Equivalent Asset (MEA) valuation. The Trust already performs this type of valuation, however there may be a change in value if the Trust wishes to review its asset lives as part of this exercise. The building valuation is required as at 28th February 2018 and needs to have been completed by 22nd December 2017. This valuation may have an impact on the Trusts future I&E position due to potential changes to the depreciation and PDC values.

The final asset valuation will be used to determine the building lease payment that the Trust will incur.

8.5 Costings & Unitary payments

Details of all costs related to the services that will be provided by AGH Solutions Ltd are being collated. The majority of these costs will be directly from Estates & Facilities and Procurement budgets; however there are also a number of other areas that require transfer. There are some posts in departmental budgets where an element of their role relates to jobs that will be delivered by the managed service. Due to this only being percentages of some roles this has not always enabled the transfer of staff and therefore has led to some duplication of costs.

Areas that are being included in the costs that are not in current Estates and Facilities or Procurement budgets are:

- The putting away of stock in departments that is not currently completed by Procurement staff;
- The transfer of patients by porters that are allocated to individual departments and are not part of the current porter pool;
- Health & Safety;
- Finance, including payroll;
- HR;
- IT;
- Legal;

- Non-pay that currently sits in department budgets for equipment, maintenance, consumables related to medical devices, calibration, cleaning/decontamination, replacement.

In order to prevent any duplication, where possible budget will be removed from the departments and pulled to a central budget to cover the cost of the unitary payment. However, there are some areas related to staff time where the saving will be efficiency rather than cost savings and therefore the centralisation of these budgets may not be possible. These costs are being built into the model and will have to be covered by the expected savings in the first instance.

The final unitary payment value and financial model will be completed by 5th February 2018. This model will show the expected service charges and costs for the following ten years and will have inflationary uplifts applied to the service charge based on the average RPI for the previous 10 years. This will be compared to the expected staffing costs to show future viability for the SPV.

Alongside the unitary payment, which is based on current service provision, the teams are calculating the value of each SLA that is being developed, both from the SPV to Trust and Trust to SPV. These SLAs will form the basis of the service that will be provided for the unitary payment. Any additional work will then need to be requested through a variation procedure for which there will be clear costs set out as part of the contract, or for ad hoc pieces of work will be calculated on application. There will be tolerances built into the contract before these prices will be applied. An example of the pricing schedule is included at Appendix 7.

On go-live the SPV will create mirrored budgets for the Trust in order that the Trust is able to continue to manage financial performance of the clinical areas and will be clear on potential variations to price due to increased activity within the Trust. These mirrored budgets will be able to be extracted from the SPV ledger and merged with the Trust budgets in order for the Trust to performance manage spend against the contract.

Each month the Trust will be required to provide a consolidated position to NHS Improvement (NHSI), therefore the financial position of the SPV will impact on the Trusts overall reported position.

8.6 Projected savings

The Trust has been presented with potential savings as part of the scoping report that was undertaken with QEF, as per the table below:

Revenue Savings	Year 1	Year 2	Year 3	Year 4	Year 5
Staffing Savings	110,000	177,000	272,000	362,000	447,000
Purchasing Savings (Assuming 3% annual increase)	880,000	906,400	933,592	961,600	990,448
Stock and Consumable Non Recurrent Saving (High Level Estimate)	300,000				
Capital Savings					
Capital Programme	1,011,340	247,280	318,000	357,170	351,860
Recent Investment Recovery	973,174				
Costs					
Implementation Costs	(409,822)				
Recurrent Running Costs (Assuming 3% annual increase)	(289,375)	(298,056)	(306,998)	(316,208)	(325,694)
Impact on Cash	**2,575,317**	**1,032,624**	**1,216,594**	**1,364,562**	**1,463,614**
Cumulative Impact	**2,575,317**	**3,607,941**	**4,824,535**	**6,189,097**	**7,652,710**

As the project develops and the commercial model is understood these costs continue to be refined.

Staffing savings based on the proposed terms and conditions included in this paper are summarised below:

Type of Saving	£	Assumption Used
Current Vacancy Saving	75,738	Based on vacancies as at September 2017. This figure will depend on actual vacancies as go-live. This is the difference between current costs and new costs. Cash saving would be dependent on whether vacancy is being covered.
Savings based on current annual turnover figures:		
Basic Pay	30,661	Assumes that all new staff do opt in to the pension due to reduced contributions. Assumes leavers at top of scale and calculated based on rates for the highest number of staff or lowest band if this was not clear
Bank holiday savings	842	Based on changing from enhancements to time and half/double time. Applying average turnover rates.
Enhancements	33,624	Based on total cost of enhancements in 1617 and applied currrent turnover rates
Maternity Leave	36,175	Based on total cost in 1617 and applying new terms
Sickness - need to know % short-term/long-term	38,432	Based on Sept 16 - August 17 data on sickness days lost. Saving made for days sickness not paid after average turnover rates have been applied. Used non pensionable costs to prevent saving being over estimated.
Less: Cost of Bonus	-67,410	Assumed all staff that are applicable receive the bonus therefore this is worst case
Total Potential Year One Staff Savings	**148,062**	
Potential Year on Year savings dependent on turnover rates and whether staff on old T&Cs or new T&Cs turnover	**72,324**	

These savings are based on current turnover rates, current sickness rates and the 16/17 costs related to enhancements and maternity leave. It is therefore important to recognise the savings as estimates.

Based on the current position, where a number of additional running costs remain estimates and a number of savings also require validation the below is a summary of estimated recurrent savings:

Type of Saving	£
Recurrent Savings related to Terms and Conditions	72,324
Increased Running Costs	(577,952)
Non-Pay Revenue Savings	1,191,622
Total Potential Gross Recurrent Savings	**685,994**
Corporation Tax	(130,339)
Total Potential Net Recurrent Savings	**555,655**

The application of 19% corporation tax to the savings assumes all savings lead to a final net profit therefore this is an illustrative figure only.

Using the QEF proposal numbers and adjusting for up-to-date figures where known the new forecast cash savings are as follows:

Revenue Savings	Year 1	Year 2	Year 3	Year 4	Year 5
Staffing Savings (assuming avg. 6% turnover on TUPE transfer staff)	148,062	220,385	288,370	352,015	411,320
Purchasing Savings (Assuming 3% annual increase)	1,191,622	1,227,370	1,264,192	1,302,117	1,341,181
Stock and Consumable Non Recurrent Saving (High Level Estimate)	300,000				
Capital Savings					
Capital Programme	1,011,340	247,280	318,000	357,170	351,860
Recent Investment Recovery	973,174				
Costs					
Implementation Costs	(409,822)				
Recurrent Running Costs (Assuming 3% annual increase)	(577,952)	(595,291)	(613,149)	(631,544)	(650,490)
Impact on Cash	**2,636,424**	**1,099,745**	**1,257,412**	**1,379,758**	**1,453,871**
Cumulative Impact	**2,636,424**	**3,736,169**	**4,993,581**	**6,373,339**	**7,827,210**
Of which is expected to be annual revenue savings	1,663,250	1,099,745	1,257,412	1,379,758	1,453,871

At this stage the figures for capital and stock savings, as well as implementation costs, remain at the same estimated levels that QEF provided. Further work is on-going with regards to validating these savings.

The Trust has received a letter from the Department of Health to reiterate its position on tax avoidance schemes as included at Appendix 8. The SPV project team has reviewed the letter because there are likely to be tax implications due to the creation of the SPV; however it still considers that there is no breach of guidance in this respect. The SPV is being created for the commercial reasons as set out in this paper and the efficiencies that will be enabled through operating as a commercial entity.

There remain a number of areas that still require working through to further validate the projected savings, which include:

- Insurance – the SPV will require its own insurance cover, as follows:
- Property Damage
- Combined Liability
- Motor Fleet
- Professional Indemnity
- Directors and Officers Liability

Quotes have not been received for all areas of Insurance, however current advice suggests this could be circa. £100k and therefore this value is included in the estimates above.

- Audit – an estimate has been made for Internal and External audit fees but these require further validation.

- Revaluation – depending on the revaluation figure the Trust may see further savings on depreciation and PDC which are not included in the savings presented.

8.7 Finance Ledger

One of the most significant risks on the finance work stream is the ability to have the finance systems in place for go-live. The Trust is currently updating all of its ledgers to the new NEP cloud system. At the same time a new ledger is required for the SPV. The service providers (NEP) have agreed to implement the new ledger at the same time as migrating the current ledgers, however delivery of the project overall relies on third party support (NEP) as well as internal delivery. The Trust has a project team set up purely on ledger migration to support this transition and set up and, if there are no issues, delivery should be complete by December. It is in NEPs interest to deliver as they are also ending their contract with their current service provider from April.

Although NEP has not signalled to the Trust that the go-live date could be delayed it is known that other providers have pulled out of the pilot due to reports not being ready within the system. NEP also contacted the most recent meeting with the Trust on implementation. The Trust has escalated their concerns to NEP and asked for further assurances around this. If this is not forthcoming Executive support may be required.

If this date slips and it impacts on the go-live date this could have serious cash flow implications related to the dates agreed with HMRC for payment of VAT, PAYE, etc. not correlating with the inwards cash flow from the Trust to the SPV.

8.8 SFIs, SOs and Scheme of Delegation

The Trust's SFIs, SOs and Scheme of Delegation will be reviewed and those areas pertaining to the formation of the wholly owned subsidiary will be amended to reflect the new governance arrangements. As described in section 6, a new set of SFI's and Scheme of Delegation will be required for the subsidiary. This work will be the responsibility of the legal work stream. . These changes will be recommended by the team working on the implementation of the SPV and then sent to the Trust for approval. Governance arrangements will need to be considered around the Audit Committee. Although there will be two separate Audit plans it may be considered sensible to continue with one Audit Committee through the parent company.

8.9 HMRC Registration

Systems required for HMRC, e.g. VAT, Corporation Tax returns, PAYE, CIS are all being set up and expected to be in place by end of October depending on certainty around the finance ledger being delivered within the agreed timetable.

8.10 Stock

The Procurement team run a materials management just in time system and are therefore aware of the levels of stock and the period of time that it lasts for each area (on average one week). Therefore, for all of these areas the team will stop purchasing stock for the Trust a week before (or whatever term is considered applicable) go-live of the SPV and start purchasing direct into the SPV at this time. This will enable transfer of the stock balance from the Trust to the SPV.

At the end of the first month trading this will be amended through the unitary payment and offset the reduced stock for the Trust. A full stock take as at 28 February 2018 will take place for ED, Theatres and Critical Care and the value of this stock be transferred based on that value.

9.0 Procurement

The Trust has obtained external legal advice to confirm that the process being undertaken to form a Subsidiary complies with EU Public Contracts Directive Regulations 2015.

The Subsidiary will look to take up the opportunity of reviewing the potential of increasing the opportunities for local Small and Medium Enterprise (SME) to do business with the Subsidiary. The current SFI rules use the NHS criteria for doing business with SME's which are extremely strict and in most cases it makes it impossible for SME's to tender for business.

Awarding competitive contracts to local SME's will provide a huge boost to the local health economy as well as providing potential growth in employment for the local business with our Health economy.

10.0 Appendices

10.1 Appendix 1 Risk Register

10.2 Appendix 2 Payroll Reverse Service Level Agreement

10.3 Appendix 3 – Domestics Service Level Agreement

10.4 Appendix 4 – Project Information Document (PID) .

1.5 Appendix 5a – Values Governance

Example of how the Board could detail the KPIs they want to retain input to and oversight of:

The Board of Directors will need to agree the key standards and performance indicators for the Estates and Facilities Subsidiary in line with Trust Strategy, Vision and Values. The Subsidiary will be responsible for putting in place people management strategies, approaches and plans to deliver these standards and KPIs.

The Board level KPIs will be monitored at the Trust Board of Directors meetings through scrutiny of the report presented by AGH Solutions Managing Director, which will include a people dashboard. The Board may delegate some of the lower level KPIs for people to an appropriate operational group.

Example standards and KPIs for People

Standard	Expectations	Key Performance Indicator
AGH People Strategy to be aligned to the NHS Constitution and Airedale NHS Foundation Trust's Right Care Values.	**Staff are able to explain how their work and management align with the NHS Constitution and Trust Values.**	**% of staff who say they understand the values of the organisation and how they relate to their work - Staff Survey**
People in AGH solutions are well led and managed	**AGH Solutions has a clear People Plan/ Strategy including arrangements to improve leadership and management across the service and develop inclusive, compassionate leadership.**	**Staff engagement index in comparison to parent trust; and best performing trusts.** **% of staff appraised in the last year (90%) and % improvement in quality of appraisals.** **% of staff satisfied with line management support – Staff Survey** **% of staff satisfied with communication between management and staff – Staff Survey.**
AGH Solutions invests in the development of its people	**AGH Solutions has an education and training plan to meet service needs and the needs of its workforce**	**% of staff accessing education and training** **% of staff saying that education and training**

Standard	Expectations	Key Performance Indicator
		helped them improve in their job
AGH solutions strives to be an inclusive employer of choice	AGH Solutions has recruitment and employee relations practices that reflect Trust values and are aligned to good employment practice (E.G ACAS Code)	Success rates of applicants at each stage of the recruitment process. BAME, disability, gender, age profile of workforce v wider Trust and local population Number of ER cases and ETs Number of Harassment and Bullying Cases. % of staff saying they have experienced harassment and bullying from colleagues or line managers.
AGH solutions takes care of the health and well-being of its employees	AGH Solutions has effective policies and practices to support the health and well- being of its employees and to manage attendance	Sickness rates – all service and by occupational group Number of stress related absences % of staff saying they have suffered with work related stress % of staff saying that have attended work when not well enough to do so.
AGH Solutions engages effectively with employee and their representatives	AGH Solutions has in place effective mechanisms for engaging with employees and their representatives.	Engagement index (year on year improvements) Number of industrial relations disputes and grievances

10.5 Appendix 5b – Example of the Subsidiary Quarterly Report

TEMPLATE FOR SUBSIDIARY MANAGING DIRECTOR'S REPORT

Section 1. Current Significant Issues - Overview

An overview of any significant current issues facing the company. These may continue on from the previous meeting of the Board or be a new issue. These current issues should not just be for information, but also to allow the Managing Director (MD) to obtain input and feedback from Directors.

Section 2. Matters for Approval

2.1 Any matters for which the MD is seeking the Board's approval and which are not covered elsewhere in the agenda.

2.2 There may also be some specific issues, often related to the MD, which may be better included at this point in the agenda.

Section 3. Update on Business Plan Implementation

3.1 Major reviews on progress on the business plan should be covered every quarter. The action oriented business plan should be included, with updates indicating progress since the last meeting.

3.2 In addition, it may be desirable to comment in greater detail on the performance of a particular business section at this point in the MD's report.

3.3 Either one or two business units or functions might be covered, with an update on initiatives and progress.

3.4 Over the course of the year each business or function should be addressed at least once.

Section 4. Major Key Performance Indicators

4.1 The business plan should have had a number of both financial and non-financial KPIs. Examples may be overall budgeted surplus/deficit, funding; various indicators of services provided; staffing numbers; client staff ratio etc.

4.2 The financial section of the performance report

Principle	**Good Practice**
Relevant	Focussed financial report. A good report will summarise the issues and highlight the overall position, making use of graphs and charts to replace lengthy tabular information where appropriate.
Integrated	Activity data linked to financial performance. Variances calculated and explained. The report should integrate non-financial and financial reporting.
In perspective	Abbreviated P&L account shows period and cumulative positions with highlighted variances against budget. Major variances adequately explained. Trend analysis included. Full-year projections updated.
Reliable	Every key issue identified with sufficient explanation
Comparable	Consistent style across reports. Performance indicators used to illustrate trends in liquidity, asset utilisation etc. Comparison with budget/previous year.
Clear	Appropriate use of graphs, colour-coding and clear chapter headings.

4.3 Key elements of the performance report

Principle	**Good Practice**
Executive summary	All key issues identified in an introductory summary with a synopsis of performance by key indicators. Supporting documentation and appendices clearly referenced.
Action plan	Corrective action specified with contingencies and sensitivity analysis showing best-case and worst-case scenarios.
Profit and loss	P&L account showing period and cumulative positions with highlighted variances against budget. Major variances highlighted and adequately explained. Trend analysis shown graphically. Full-year projections updated.
Projected outturn	Projected outturn recalculated on the basis of actual performance and action plans.
Cash flow	Profiled cash flow summarising actual and projected payments and balances on

	a regular basis to year end.
Capital Programme	Analysis of progress of capital schemes showing percentage completion, current and projected expenditure, completion cost and timescale.
Balance sheet	Indication of working capital position presented in tabular form or using performance indicators eg debtor and creditor days

4.4 Key elements of the clinical governance report

Principle	**Good Practice**
Executive summary	All key issues identified in an introductory summary with a synopsis of performance by key indicators. Supporting documentation and appendices clearly referenced.
Action plan	Corrective action specified with contingencies and sensitivity analysis showing best-case and worst-case scenarios.
Patient experience	Performance profiled against a number of relevant measures showing aggregate position, trend and variations. Analysis of major variances highlighted and adequately explained. Trend analysis shown graphically. Full-year projections updated. Examples of measures may include privacy and dignity, F&FT responses, food standards, complaints and compliments.
Patient safety	Performance profiled against a number of relevant measures showing aggregate position, trends and variations. Analysis of major variances highlighted and adequately explained. Trend analysis shown graphically. Full year projections updated. Examples of measures may include patient safety incidents, infection prevention.
Clinical effectiveness	Performance profiled against a number of relevant measures showing aggregate position, trends and variations. Measures chosen to demonstrate the safe, effective and efficient delivery of services for the purpose of improving the quality of care. Analysis of major variances highlighted and adequately explained. Trend analysis shown graphically. Full year projections updated. Examples of measures may include elements of the clinical audits, NICE compliance and other benchmarking data.

4.5 Key elements of the staff engagement and workforce development report

Principle	**Good Practice**
Executive summary	All key issues identified in an introductory summary with a synopsis of performance by key indicators. Supporting documentation and appendices clearly referenced.
Action plan	Corrective action specified with contingencies and sensitivity analysis showing best-case and worst-case scenarios.
Staff engagement	Performance profiled against a number of relevant measures showing aggregate position, trend and variations. Analysis of major variances highlighted and adequately explained. Trend analysis shown graphically. Full-year projections updated. Examples of measures may include sickness absence, freedom to speak up cases, staff survey results, annual appraisal rate.
Effective resourcing	Performance profiled against a number of relevant measures showing aggregate position, trends and variations. Analysis of major variances highlighted and adequately explained. Trend analysis shown graphically. Full year projections updated. Examples of measures may include turnover rate, vacancy rate, training compliance.

4.6 In this section, which should follow the same format from meeting to meeting, these KPIs will be reported, together with their target, possibly a “traffic light“ indicator to indicate whether performance is on or better than target (green); a little less than target, but not major concern (amber) or below target and of some concern (red).

4.7 A brief description of the reason and actions being taken for amber and red items should also be included. In this way the Board is constantly having its attention drawn to the outcomes expected under the strategic plan.
4.8 A good report will summarise the issues and highlight the overall position, making use of graphs and charts to replace lengthy tabular information where appropriate.

Section 5. Commercial Report
This section should describe ongoing and future potential commercial opportunities in the form of a tracker with percentage probability of success.

Section 6. Risk and Compliance Update
Depending on what actions management have taken between Board meetings this section may have two components:
6.1 Update on risk and compliance management
A brief update on any significant outcomes from the ongoing work on risk and compliance, including presentation of the corporate risk register.
6.2 Risk and Compliance Incidents
A brief outline of any incident or activity which has resulted in the occurrence of a risk or compliance event which is outside the agreed risk and compliance standards. Examples will include any health and safety incidents, any significant client or staff complaints, any environmental incidents, any legal action etc.

Section 7. Matters for noting/information
Any other issues which the MD wishes to bring to the Boards attention but which are unlikely to require discussion. This can include visitors to the organisation, significant meetings which have involved the MD and so on.

10.6 Appendix 6 – Lease/Freehold Assessment

10.7 Appendix 7 – Example of Pricing Service Level Agreements

10.8 Appendix 8 – Letter from DOH regarding Tax Avoidance

10.9 Appendix 9 – Frequently Asked Questions

Estates, facilities and procurement subsidiary - frequently asked questions July and August 2017

Jump to:

Terms and conditions

Q. What is TUPE?

A. TUPE stands for Transfer of Undertakings (Protection of Employment). In law, TUPE regulations mean that you transfer to the new organisation with your existing terms and conditions.

Q. How long are terms and conditions protected under TUPE?

A. TUPE is a complicated piece of employment law. Your terms and conditions are protected on transfer. Under the TUPE Regulations, existing terms and conditions transfer with staff to the new company and remain the same as they were with Airedale NHS Foundation Trust. Under TUPE, staff terms and conditions cannot be changed if the sole reason for the change is the transfer.

Changes to terms and conditions in future may be valid if the sole or main reason is an Economic, Technical or Organisational reason needing changes in the workforce and provided the subsidiary company and you agree the change.

Changes may also be valid if the terms of your contract would have allowed the subsidiary company to make the change anyway, or a new development arises. For example the subsidiary company wins an order from a new client and has to bring in change to meet the needs of the new client. However the subsidiary company should then consult and seek agreement about any changes.

Q. Does TUPE depend on how long you've worked for the Trust?

A. No, every employee is protected under TUPE.

Q. How long will TUPE protection of our terms and conditions last?

A. There's no time limit set out in law. Our trade unions have asked us whether employees could have a long period of protection and we are considering this.

Q. How will this affect agency staff?

A. It will be up to each service whether they retain the individual from the agency, but agency staff are not subject to TUPE.

Q. What happens to TUPE protected terms and conditions if I change my job within the new company? Will I still have the NHS pension?

A. This is to be confirmed. We are working with Unions and other staff side representatives on this.

Q. NHS employees get certain benefits and discounts. Would we continue to get the benefits if we're employed by the new company?

A. Benefits like these don't form part of the terms and conditions, so are not protected by TUPE. However, we expect that the new organisation would negotiate a similar range of benefits for its employees.

Q. I have a lease car via the NHS Fleet. Will I be able to keep it?

A. We don't know yet, this detail has got to be worked through. However if not, the company should be able to negotiate with NHS Fleet or another provider to get a similar scheme.

Q. What about other salary sacrifice benefits?

A. They are a benefit rather than terms and conditions, so this will be for the new company to negotiate.

Q. Where will we park if we're not NHS staff?

A. In the car park – we will organise a service level agreement between the Trust and the new company. The same goes for the nursery, for anyone who uses it.

Q. Will we still get the staff discount in the canteen?

A. Yes.

Q. Will we still have access to employee health services?

A. Yes you will.

Q. How will the new company set their own terms and conditions?

A. The new company will draft the terms and conditions and the Trust will have to be assured that they are appropriate and chime with our values.

Q. Do I have a choice about whether I transfer on my existing terms and conditions or can I move onto the terms and conditions of the new company?
A. You transfer under your existing terms and conditions but you can choose once you've transferred, in agreement with the new company.

Q. How this will affect recruitment? I imagine that the terms and conditions for new employees will be less favourable and would deter any potential candidates coming to work at Airedale.

A. We do not yet know what the terms and condition of any future employees will be as this will be determined by the new company. However from the experience of other Trusts that have done this there haven't been any recruitment difficulties and we are not envisaging that this will be a significant challenge.

Q. Will the managers be on better terms and conditions?

A. Any managers transferring from Airedale will be on the same terms and conditions as they are currently. Any managers joining the new company will be on new terms and conditions.

Q. Will new people be paid less than existing NHS employees?

A. The terms and conditions aren't set out yet, but it's unlikely there will be significant differences in pay. The main difference in terms and conditions is likely to be around the pension offer.

Q. Will the Trust change our terms and conditions before we move over?

A. No, there is no intention to do that.

Q. If you employ people on different terms and conditions, won't that lead to friction between staff?

A. It's possible, particularly if they are doing the same job. However we will follow QEF's example in transforming services, so there are likely to be new and different job roles.

Q. Are employees of the new company still counted as NHS employees?

A. No, you will be an employee of the new company. However, your parent company (i.e. Airedale NHS FT) is an NHS organisation, you will retain your NHS terms and conditions and pension (pension subject to ministerial approval) and you will still provide services to the NHS for the benefit of patient care.

Q. What happens if I don't want to transfer to the new organisation?

A. We will be providing you with an opportunity to have individual conversations, and if someone was very opposed we'd have to discuss options available. However, we hope people would generally support the move because we need your skills and capability to make a success of the new company.

Q. Will there be any redundancies?

A. There are no job losses planned.

Q. Could the new company consider redundancies after we've transferred?

A. They could, but they'd have to speak to the Trust as the parent company to explain why they felt they needed to take such a step.

Q. What happens if I fall pregnant between now and the date of transfer?

A. You'll be protected under the same terms and conditions, like everyone else.

Q. I'm about to go on maternity leave – will I be kept informed?

A. Yes, your line manager or service lead will keep you informed of developments, and we would encourage you to feedback your views and questions, as you would do if you were at work.

Q. Will the payment structure be the same in the new company – will we get our increments and pay rises?

A. Yes your increments are part of your terms and conditions. However, the strategy around discretionary annual pay rises will be up to the new company to decide.

Q. Who will decide the pay award for employees of the new company?

A. The directors of the new company will propose the pay award and share those proposals with the Airedale FT board.

Q. Who oversees remuneration for the directors of the new company?

A. Airedale FT board of directors will have oversight.

Q. Do we get the choice whether we can work to NHS policies or not?

A. The aspects of policies that form part of terms and conditions will transfer with you. Other more general aspects of policies will be for the new company to develop. This is a big piece of work that we will carry out and we will ensure we keep our staff side and union colleagues informed through our partnership working.

Q. Whose policy applies if an incident happens between a Trust employee and an employee of the new company?

A. Each employee will be managed in accordance with their organisation's policies.

Q. Where we have contracted staff who are employed by other companies, will they transfer over with us?

A. The staff fulfilling those contracts will still be employed by their original company but the contracts will novate (ie transfer), and the new company will manage them.

Q. I work for Sodexo – will I transfer to the new company?

A. No. The Sodexo contract will be novated (i.e. transferred) to the new company, who will then manage it, but people working for Sodexo will remain Sodexo employees.

Q. Will people still be doing their same job?

A. Yes when you transfer. However, teams and job roles change, much like they do now, so roles may change in the future.

Q. Could my job title change?

A. It won't change on transfer, and can't change subsequently without discussion/negotiation with you.

Q. What would have to happen for this to stop?

A. The full business case would have to not stack up so that the Board could not agree to it.

Q. What will happen if it isn't approved on 25 October?

A. Things will stay as they are.

Q. Will contracts change?

A. If you're a permanent employee your contract won't change as it's protected under TUPE. However, you will have a new employer named on your contract.

Q. Porters cover theatres and x-ray 7pm – 7am, how will this be agreed?

A. Like all other services, there will be a service level agreement in place for portering services.

Pensions

Q. Who will administer my NHS pension if I transfer under TUPE to the new company?

A. NHS pensions will be administered by the NHS pension scheme as they are now, not by Airedale NHSFT or by the new company. You will continue to pay your pension contributions and the new company will pay contributions on your behalf as Airedale NHS FT does now.

Q. Is there a time limit for getting the pensions direction order back from the Secretary of State?

A. No set time limit. However we will be making the application as soon as possible once the company is registered.

Q. How soon will we know whether we will be able to retain our NHS pensions?

A. The new company will apply for the pensions direction order as soon as possible and well in advance of 28 February 2018. To do this, we will need to set up a shadow management team who will be able to do this for us on behalf of the new company. It is very likely that the pension scheme will remain the same and the Trust is committed to ensuring that staff retain their current NHS pension scheme.

Q. Would we delay transfer without the pension letter?

A. That would be a Board decision. We want to protect pensions, they are top of the priority list.

Q. What happens if you're already taking the NHS pension (ie on retire and return) – will it continue to be paid after the transfer?

A. Yes, just the same as now. The NHS Pensions are administered by the Pensions Agency and they are the ones who pay it to you.

Q. If I'm working for the new company and I leave to work for another part of the NHS, will my pension transfer with me?

A. Yes.

Q. Will my existing NHS be frozen?

A. No it will carry on as normal.

Structure

Q. Is another company taking us over?

A. No, Airedale NHS Foundation Trust is setting up this company and will own 100% of the new company. The new company will be a subsidiary and will still remain under the control of Airedale NHS Foundation Trust.

Q. What will the new company be called?

A. AGH Solutions Ltd. The AGH as many of you will know stands for Airedale General Hospital, so the name links us to our roots.

Q. Will the board of the new company be accountable to the ANHSFT Board?

A. Yes. The new company will be an arm's length organisation from ANHSFT but Airedale Foundation Trust will own the new company and therefore will still oversee the new company, and ensure that it is operating within our values.

Q. Who will manage the new company?

We have appointed two interim directors: David Moss, interim managing director and Amy Whitaker, interim finance director. If the Board decide to go ahead with the new

company, a full recruitment process will take place to appoint the permanent managing director and finance director.

Q. What was the appointment process for the interim directors?

A. We took the decision that it would be an internal process. We tested the applicants through interview and appointed David and Amy.

Q. What will the appointment process be for the permanent directors?

A. It will go out to external advertisement and a full selection process will take place, with the Trust Board members involved. They have the final approval of the appointments.

Q. Will the permanent MD and FD have commercial experience?

A. We would hope to appoint someone with the right blend of skills to manage a commercial company that adheres to our values.

Q. Will the management of the new company be paid more?

A. We are clear that the management costs and the headcount of the new company cannot increase significantly.

Q. When will the management structure be published?

A. We hope to publish an outline structure of the company when the business case is completed.

Q. What would the new management team structure look like?

A. It's likely to at least consist of a managing director, and finance director, plus some commercial expertise. However, the company would also be able to access expertise from ANHSFT eg. IT, HR, finance, communications etc.

Q. Will the MD and FD recruit a commercial director?

A. We still haven't finalised what the structure will look like, so can't confirm whether there will be a commercial director or not at this stage. Any director posts will have to be proposed to and approved by the Trust Board.

Q. Is there likely to be a restructure?

A. That will be up to the new company, but we would hope that the first 12 months would be focused on bedding in the new arrangements and delivering services.

Q. Is the new company a limited company?

A. The legal entity for the new company has not yet been decided. However whatever legal entity is applied, the new company will be a wholly owned subsidiary of Airedale NHSFT.

Q. Is the list of services to transfer set in stone?

A. Not yet. We are working through this – we have a lot of analysis to do on job roles.

Q. How many staff are transferring?

A. We believe between 320 and 330, but it's not fixed yet as we are still working through the detail.

Q. When will there be clarity on which staff groups will be affected by the changes?

A. As the business case develops between now and October, it will become clear which groups will be included. These decisions will be communicated as we go along.

Queen Elizabeth Facilities (QEF)

QEF is the company formed out of Gateshead NHS Foundation Trust

Q. Are we able to talk to some of the QEF staff and find out how it felt for them?

A. We have been in discussion with them, and some members of our staff have met their counterparts at QEF. It will not be possible for our staff to meet with their staff in a large group as it disrupt day to day work, however, you can read testimonials from them on their website.

Q. Has QEF maintained the same levels of staff turnover since setting up the new company?

A. Staff turnover has remained about the same. Sickness absence rates are much better, and they haven't struggled to recruit to the new company.

Q. Did staff terms and conditions of employment change at QEF after year one for staff who transferred under TUPE?
A. No.
Q. Will we be working for QEF?

A. No, they're just helping us to understand how to set up the new company and helping us with the business case.

Q. Are we paying QEF as consultants?

A. Yes.

Q. Will you be taking advice from QEF about what will happen in individual departments?

A. No, we won't be looking at changing individual services significantly. QEF's advice is mainly around the set-up of the company.

Q. Apart from QEF, has anywhere else done this?

A. 11 Trusts across the country have done or are actively doing this. Our nearest is Bolton and Barnsley are also in the process of doing it. It's early days for some of the new companies, but all have been able to report success so far.

How the company will work

Q. Will the new company work to a contract?

A. Yes it will have a range of contracts or service level agreements with ANHSFT for the services it provides. It will also potentially have contracts for new business that it has won.

Q. How long will the contract with the new company be?

The length of the contract will be confirmed in the business case, but is likely to be in the range of 20-25 years.

Q. Will the new company automatically supply the hospital or would they have to bid for the work?

A. No, they won't have to bid. The contracting will be set up via service level agreements for the different services it will provide.

Q. Will the new company cut services?

A. The vision is to grow, not to cut services. The services transferring to the subsidiary are key services that enable the Trust to deliver good patient care so if they did decide to cut a service, they would have to bring it to the Trust to explain the rationale.

Q. Lots of hospitals contract these services out to private companies which can end up providing sub-standard services – how will this be any different?

A. We are not contracting our services out to a private company; instead we will wholly own it. This means that the standards the company provides will be within the Trust's control, and as a minimum the Trust will expect the level of service they currently receive.

Q. Why can't we get sufficient savings and efficiencies out of our services without moving them into a wholly owned subsidiary?

While we feel we are already efficient, we think that there are no more efficiencies and savings to come from the way we currently do things. We need to do things differently now in order to release further savings and to improve services further.

Q. Could other companies/new business decide to end their SLA with the new company?

A. Yes in theory, but they could do that to us now. This is why it's important to sustain the quality of the services you provide.

Q. What would happen if we failed?

A. We don't believe that will happen, but as part of the business case we have to work up an exit strategy.

Q. Will we have a set time frame in which we have to succeed?

A. Yes, but the length hasn't yet been decided. The new company will have regular performance reviews which should help it to stay on track.

Q. Could part of the exit strategy be to bring services back into Airedale?

A. Yes it's likely to be one of the options.

Q. If we are successful and make a profit, would the money have to go back into ANHSFT or could we use it to invest in our services?

A. It would be much the same as our various departments now. The overall budget for the Trust – including the arm's length company – would be reviewed and budgets allocated accordingly. So yes, it is likely, but the bulk would be invested in frontline services for our patients. One example is that Queen Elizabeth Facilities has set up a new transport service by reinvesting savings.

Q. What happens if some other company offers ANHSFT a better deal for providing our services in the future?

A. It's impossible to answer that at this stage, but it is not part of our current plan. If that did happen, the company taking over the services would have to take on the existing staff – ie you – under TUPE legislation.

Q. How will the new company be funded?

A. Budgets currently associated with the various lines of service to be transferred will be stepped down from the Airedale FT budget into the new company.

Q. Will private investors be involved?

A. No, the company would be wholly-owned by the NHS.

Q. Will there be shareholders?

A. Only one, and that is Airedale NHS Foundation Trust.

Q. Is there a business plan for the new company yet?

A. No. A business plan will follow from the fully worked up business case later in the year. We do have a view of business prospects for the new company based on experience from other NHS foundation trusts who are ahead of us in taking this action.

Q. Will the new company have its own HR department?

A. This is to be decided as part of the business case.

Q. Who will the new company's staff be paid by?

A. They will be paid by the new company via suitable payroll arrangements.

Q. Who will own assets such as equipment and buildings?

A. The trust currently operates a variety of arrangements for equipment, some managed contracts and some owned. The detail of assets to be transferred will form a part of the business case.

Q. Will there be a condition survey undertaken ahead of the transfer of assets?

A. This forms part of the work being done between now and October.

Q. Who decides which assets transfer?

A. The Trust Board oversees this.

Q. Could the new company borrow against its assets?

A. Yes in theory, but it would have to have agreement from the Trust Board.

Q. Will we be based in the same offices?

A. Yes, there are no plans to relocate services.

Q. Will the new company rent the offices from ANHSFT?

A. It depends on the financial model that is set up between the new company and ANHSFT – we're not at this stage yet.

Q. Will Airedale FT be putting all of its estate into the new company?

A. Yes, with provisions for repatriation if that became necessary.

Q. Will the new company have to charge more money to the Trust for its services to be able to make a profit?

A. The new company will charge a competitive rate for the services it provides. There will also be money made from procurement benefits ie being able to have more of a competitive edge on how we run procurement.

Q. Will the new company have a cost improvement programme?

A. Yes, it will be part of the Trust's agreement with the new company.

Q. How will the new company be more efficient if the same people are running it as now?

A. The new company will have more freedom outside of the NHS rules and regulations, so it will be able to bid for external work and grow the business in ways that the Trust currently can't.

Q. Will my department lose control of what I do?

A. No, because the Trust will set up a service level agreement (SLA) to set out what they want us to deliver.

Q. I'm worried that we will be treated differently by the wards.

A. It's a core part of our values and behaviours that we expect people to behave with respect towards each other. It would be extremely disappointing if Trust staff treated the new organisation's staff any differently – and vice versa – and anyone not treating people with respect would be dealt with in accordance with the policies of their respective organisation.

Q. Can you give any examples of the sort of growth planned or commercial work the company might bid for?

A. We have a number of ideas but they are commercial in confidence.

Q. How will we cope with growth? We're stretched now.

A. We will take on more people to service our new contracts.

Q. In procurement, we work to the Trust's Standing Financial Instructions (SFIs). Will the SFIs be changing in the new company?

A. They may – the new company's Board will make those decisions. But they won't be able to make significant change without speaking to the Trust first.

Q. If the company grows massively, could it move off site?
A. Possibly – it depends on the nature of the growth. e.g. if it expanded transport services and suddenly got loads of vehicles it may have to look for new premises. However there are no plans to move off site and the services provided to the Trust will have to remain in the Trust.

Q. Will badges and uniforms change?

A. Yes. This is all part of branding the new company.

Q. We will still use bank staff?

A. Yes it is likely that the new company will need to use bank staff in a similar way to how it is done now.

Q. What's to stop another company coming in and trying to take over the new company?

A. The contract with the Trust, and the fact that the organisation will be owned by the Trust.

Q. Just because it's worked at Gateshead doesn't mean it will work here.

A. We're not trying to completely copy what's done at Gateshead, it's not one size fits all. Our task is to make sure that whatever we set up will work for Airedale; that the culture and values will fit.

Q. In SSD, will there be reinvestment in new equipment? If you're going to grow the business you'll need machines to keep up with the extra work

A. Yes, we have a business case going to the capital board at the moment.

Q. Is this something we could do with Bradford Teaching Hospitals?

A. We originally looked at doing something like this across West Yorkshire. However the complexities of establishing a subsidiary meant it made more sense to do it at a local level.

Q. Will the new company stop weekend working?

A. No – your contract will transfer with you, so your job role will be the same as now. Weekend working/unsocial hours allowance will stay.

Mythbusting

Q. Is it true that only staff bands 1 – 4 will go into the new company?

A. No – all members of each service will transfer.

Q. I've heard QEF was a private company to begin with that changed its name?

A. No, they were formed by Gateshead NHS Trust around three years ago.

Q. I've heard that the new company will cut our holidays, is that true?

A. No it isn't. Your holiday entitlement is protected by TUPE, like all your terms and conditions.

Q. I have heard that in the new company we will be required to work 7 days a week but will only be paid for 5 days?

A. This is not true and will not be the case. You will transfer on the same terms and conditions as you have now and that includes your pay.

Q. This is just the same as Sodexo.

A. No, the catering contract went out to the open market, and Sodexo bid for it and won it. We don't own Sodexo, it is not a subsidiary of the Trust.

Q. I've heard that if you've worked here longer than 10 years, and you transfer, five years later you have to move onto new terms and conditions.

A. No, that is untrue.

Q. I've heard that the new company will be slashing sick pay.

A. New staff that join the company after Airedale staff have been transferred will be on different terms and conditions, which may include different sick pay arrangements. But existing staff will transfer with existing terms and conditions including current sick pay arrangements.

If you have any questions which are not covered here, please speak to your line manager or service lead, staffside representative or contact Faeem Lal in Human Resources on x4862 or Human.Resources@anhst.nhs.uk

City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 22 March 2018

AH

Subject: Bradford Teaching Hospitals NHS Foundation Trust Position Statement – Creation of an Alternative Delivery Model (ADM) for Estates and Facilities Services.

Summary statement:

Bradford Teaching Hospitals has a duty to evaluate all opportunities that could secure improvements in value for money and cost effectiveness whilst at the same time ensuring sustainable and high quality services for its patients. Bradford Teaching Hospitals NHS Foundation Trust has an ambitious clinical strategy that will need to be complemented by a sustainable financial plan.

In its endeavours to remain financially viable and to be able to continue to deliver high quality services, the Foundation Trust is exploring the option to safely create an Alternative Delivery Model (ADM) to deliver Estates and Facilities services. The evaluation to date has been undertaken in conjunction with the other West Yorkshire Association of Acute Trusts (WYAAT) (with the exception of Airedale Foundation Trust and Harrogate and District Foundation Trust who have progressed independently from WYAAT), with the initial case for change receiving chair and chief executive approval in 2017.

The Board of Directors for Bradford Teaching Hospitals NHS Foundation Trust received an update to the evaluation at its January 2018 meeting, where further information was requested to ensure the appropriate amount of due diligence can be evidenced to inform the right decision for Bradford Teaching Hospitals NHS Foundation Trust and the population it serves.

Portfolio:

Health and Wellbeing

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1. Background

1.1 In light of the economic challenge faced, and the drive to continuously improve the quality and safety of the services it provides, Bradford Teaching Hospitals NHS Foundation Trust (BTHFT), as part of the WYAAT grouping, is undertaking an evaluation to assess the feasibility/viability of creating an Alternative Delivery Model (ADM) to provide Estates and Facilities services to the Trust. The case for change produced by WYAAT emphasises the opportunity of future collaboration, with the aspiration being the creation of a joint West Yorkshire ADM with the preferred model being a Wholly Owned Subsidiary (WoS).

1.2 A number of ADMs either exist or are being created across the public sector, with around 40 already in place across the National Health Service. Each ADM aligns to the mission, vision, objectives and values of the originating organisation (which in this instance would be BTHFT) and as such the criteria for evaluating the feasibility will be unique to each instigating organisation.

2. Report issues

2.1 At its meeting on 8 March 2018, the Board of Directors of BTHFT discussed alternative delivery models for its estates and facilities services. The conclusion of this discussion was an agreement to work to develop a Full Business Case (FBC) for consideration at the Board's July 2018 meeting, but only on the basis that all suitable delivery models will be looked at.

2.2 The Board of Directors' meeting in July 2018 will be the point at which the Board makes a definitive decision, whether or not to move to a different delivery model from the current arrangements, and if the decision is to move to an ADM, the preferred model will be agreed.

2.3 When it considers the FBC in July 2018, the Board will need to understand the costs, risks, and benefits (financial and non-financial) of any proposed approach.

2.4 The Board has stated that it requires there to be meaningful engagement with staff side representatives which would inform the development of the FBC.

3. Recommendations

3.1 At this stage the members are asked to note that Bradford Teaching Hospitals NHS Foundation Trust intends to complete a full evaluation and present a comprehensive business case to its Board of Directors in July 2018 where a definitive decision will be taken.