Quality and Safety Dashboard
Calderdale Clinical Commissioning Group

Report as of 16/02/2015

Calderdale Clinical Commissioning Group	E-Coli		MSSA		No of Complaints	
	No target set					
	Month	YTD	Month	YTD	Qtr	YTD
	Jan-15	2014-15	Nov-14	2014-15	Q3 2014-15	2014-15
	13	125	4	36	3	21

NHS Outcomes Framwork Domains:	Preventing Premature Death	Enhancing quality of life for people with LTCs		Helping people to recover from episodes of ill health or following injury		Ensuring people have a positive experience of care	Treating & caring for people in a safe environment & protecting from avoidable harm			
Indicator type (local / national)	National indicators									
Calderdale Clinical Commissioning Group Quality Premium Indicators:	Potential years of life lost from causes considered amenable to healthcare: adults, children and young people	Unplanned hospitalisation for chronic ambulatory care sensitve conditions (adults)	Unplanned hospitalisation for asthma, diabetes & epilepsy in under 19s	Emergency admissions for acute conditions that should not usually require hospital admission	Emergency admissions for children with Lower Respiratory Tract Infections (LRTI)	Friends & Family Test	MRSA		C Diff	
Indicator Target:	Reported through Finance and Performance Committee					Response rate targets for quarter 1: 15% for A&E 25% for inpatients	0		47	
Results period:						Q1 2014-15	Feb-15	YTD	Feb	YTD
Indicator results:						28.24%	0	2	3	36

Overall % of Quality Indicators in the Matrix that have achieved Green, Amber or Red

Provider				Change from previous month	No of indicators
Calderdale & Huddersfield Foundation Trust	55% (11)	30% (6)	15% (3)	↓	23
SWYPFT	75% (15)		25% (5)	↓	20

Back to Menu

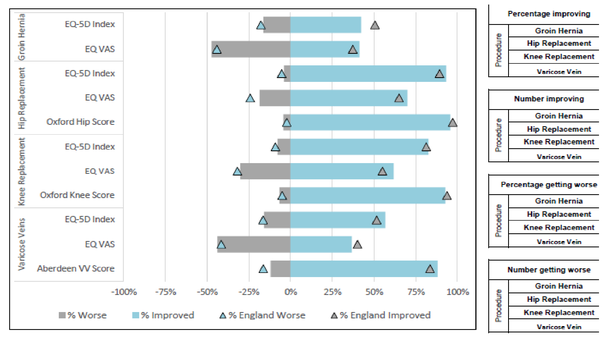
Quality and Safety Dashboard
Calderdale & Huddersfield Foundation Trust

Quality & Safety Committee
Quality Dashboard Report March 2015
12.03.2015

Quality Domain	Indicator	Reporting Frequency	CHFT Period Target	CHFT Month/ Period	CHFT YTD 2014-15	CHFT Month/ Period/Year data from	Trend information: Direction of Travel – Previous Month/Period	Direction of Travel – Corresponding month 2013/14	2013-14 D	2013-14 J	2013-14 F	2013-14 M	2014-15 A	2014-15 M	2014-15 J	2014-15 J	2014-15 A	2014-15 S	2014-15 O	2014-15 N	2014-15 D	2014-15 J	2014-15 F	2014-15 M
P.E.	EMSA	Monthly	0	0	7	Feb-15	↓	↔	0	0	0	0	0	0	0	0	0	0	7	0	0	0	0	
Patient Safety	C Diff	Monthly	Max 18 for the year	4	26	Feb-15	↑	↓	1	1	1	0	3	4	1	4	2	0	2	3	0	3	4	
	E Coli	Monthly	n/a	7	27	Feb-15	↔	↔	2	2	1	4	4	0	1	1	0	1	6	2	2	3	7	
	MRSA	Monthly	0	0	1	Feb-15	↔	↓	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	
	MSSA	Monthly	n/a	0	9	Feb-15	↔	↑	0	4	1	not avail	0	1	0	1	0	0	1	1	3	2	0	
	Never Events	Monthly	0	0	0	Feb-15	↔	↔	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Serious Incidents	Monthly	n/a	18	94	Feb-15	↑	↑	4	3	4	4	4	5	3	9	4	4	10	10	13	14	18	
	Safety Thermometer - % of harm free care	Monthly	n/a	94.00%	-	Feb-15	↑	↑	93.11%	92.77%	92.01%	94.63%	94.71%	95.17%	91.86%	94.68%	92.99%	93.77%	94.48%	93.93%	93.60%	93.47%	94%	
	Staffing levels - average fill rate - registered nurses/midwives % (day)	Monthly	n/a	81.2%	-	Feb-15	↓	n/a							88.0.%	84.25%	79.40%	79.43%	80.51%	82.30%	81.90%	84%	81%	
	Staffing levels - average fill rate - care staff % (day)	Monthly	n/a	91.5%	-	Feb-15	↔	n/a							106.0%	93.9%	93.40%	93.57%	92.67%	92.20%	92.40%	92%	92%	
	Staffing levels - average fill rate - registered nurses/midwives % (night)	Monthly	n/a	91.4%	-	Feb-15	↑	n/a							83.0%	84.5%	82.20%	82.14%	85.90%	82.80%	85.90%	89%	91%	
	Staffing levels - average fill rate - care staff % (night)	Monthly	n/a	116.7%	-	Feb-15	↓	n/a							132.0%	113.9%	118.10%	118.21%	121.09	130.9%	119.70%	117%	116%	

PROMs

(November 2014 release)



	Quality Domain	Indicator			Data collected
Patient Experience		CQC Conditions/Warnings		Follow up visit February 2014 - now fully compliant	Mar-14
		CQC Intelligent Monitoring Report	Band 5	2 Risks / 2 Elevated Risk	Quarterly - last updated Dec 2014 (draft)
		CQC Inpatient Survey - involved satisfactorily in decisions about care & treatment	7.3	About the same	Annually - updated April 2014
		CQC Inpatient Survey - overall level of respect & dignity	8.7	About the same	Annually - updated April 2014
		Staff Survey - satisfied with quality of work & patient care able to deliver	77%	Below average	Annually - updated March 2014
		Staff Survey - staff rec of trust as a place to work or receive treatment	3.74	Better than Average	Annually - updated March 2014
Patient Safety		NPSA NRLS - Incidents reported per 100 admissions	6.93	RAG rated as red - in lowest 25% of reporters. Median 6.93/100 admissions	6 monthly - Oct 13 - March 14. Next update due for release end of March 2015.
		NPSA Safety Alerts - CAS	96.66%	96.66% (58 of 60) of safety alerts completed within deadline Sep 14 - Feb 15	Monthly - Feb 15
		Patient-led Assessment of the Care Environment (PLACE)	98.54%	Cleanliness	Annually - last updated Sept 14 (end of August publication)
			83.41%	Food & Hydration	
			93.07%	Privacy, Dignity & Wellbeing	
			91.61%	Condition, Appearance & Maintenance	
		Overall HSMR	106.2	Year to Oct 14 (Provisional)	Quarterly - updated Jan 15
		SHMI	106.3	Q4 01/12/2014	Quarterly - updated January 15
		Mortality by weekend data	104.1	Year to Oct 14 (Provisional)	Quarterly - updated Jan 15
Clinical Effectiveness		Monitor Governance		Under review - Monitor is investigating financial risks and sustainability concerns at the trust, triggered by a deterioration in the trust's financial position	Quarterly (Q2 - July - Sept 2014) - updated Jan 15
		CQUINs	92%	92% achieved Q3 2014/15	Quarterly

Safety Thermometer March 2015
(February 2014 - February 2015)

Back to Menu

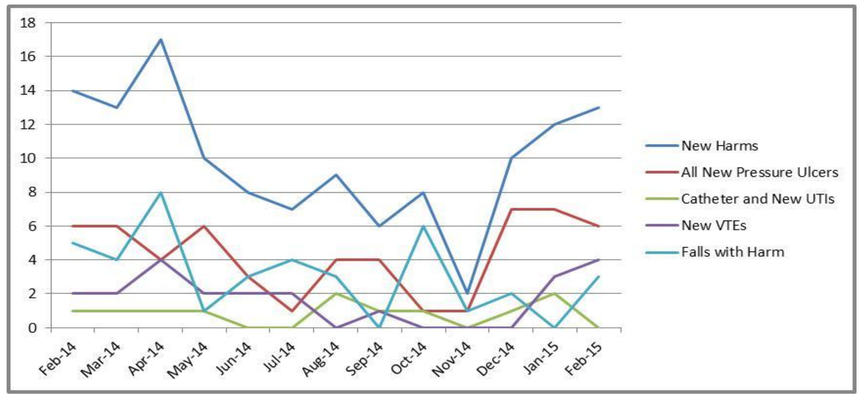
Quality and Safety Dashboard
South West Yorkshire Partnership Foundation Trust

Quality & Safety Committee
Quality Dashboard Report March 2015
11.3.15

Quality Domain	Indicator	Reporting Frequency	SWYPFT Period Target	SWYPFT Month/ Period	SWYPFT YTD 2014-15	SWYPFT Month/ Period/Year data from	Direction of Travel: Previous Month/Period	Direction of Travel: Corresponding month 2013/14	Trend information														
												2014-15											
									J	F	M	A	M	J	J	A	S	O	N	D	J	F
Patient Experience	EMSA	Monthly	n/a	0	0	Jan-15	↔	↔	0	0	0	0	0	0	0	0	0	0	0	0	0	-
	CQUIN Service User Survey - inpatient survey	Quarterly	100%	Q3 85.71%	87% (2014-15)	Q3 2014-15	↓	↓	88.9%			88%			88%			85.71%			-	-
	CQUIN Service User Survey - community survey			Q3 92.8%	90% (2014-15)	Q3 2014-15	↑	↓	88.9%			95%			85%			92.8%			-	-
	% Complaints incl staff attitude as an issue	Quarterly	<25%	Q3 15%	Not avail	Q3 2014/15	↑	↓	11.6%			14.63%			13%			15%			-	-
Patient Safety	Never Events	Monthly	0	0	0	Feb-15	↔	↔	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Serious Incidents	Monthly	n/a	10	104	Feb-15	↑	↓	6	14	6	10	18	9	10	8	7	11	9	8	4	10
	Safety Thermometer - % of harm free care	Monthly	n/a	96.44%	-	Feb-15	↔	↑	97.22%	95.55%	96.12%	96.43%	96.56%	96.57%	97.29%	97.33%	96.72%	97.67%	98.40%	97.36%	96.05%	96.44%
	Staffing levels - average fill rate - registered nurses/midwives (day)	Monthly	n/a	94.0%	-	Jan-15	↓	-						109.0%	91.9%	91.5%	91.0%	95.0%	97.9%	92.7%	94.0%	
	Staffing levels - average fill rate - care staff (day)	Monthly	n/a	106.1%	-	Jan-15	↑	-						102.0%	108.9%	111.9%	110.7%	108.7%	106.2%	103.8%	106.1%	
	Staffing levels - average fill rate - registered nurses/midwives (night)	Monthly	n/a	92.5%	-	Jan-15	↓	-						100.0%	96.1%	93.8%	94.1%	93.7%	94.1%	93.8%	92.5%	
	Staffing levels - average fill rate - care staff (night)	Monthly	n/a	116.8%	-	Jan-15	↑	-						110.0%	122.4%	126.4%	120.5%	117.5%	117.1%	112.2%	116.8%	
Clinical Effectiveness	% Service users on CPA followed up within 7 days from inpatient care	Quarterly	95%	Q3 96.33%	96.45% (14-15)	Q3 2014-15	↑	↓	96.72%			96.84%			95.36%			96.33%			-	-
	% Service users on CPA having formal review within 12 months	Quarterly	95%	Q3 98.64%	97.73% (14-15)	Q3 2014-15	↑	↑	98.64%			96.50%			98.06%			98.64%			-	-
	Delayed Transfers of Care	Quarterly	≤ 7.5%	Q3 4.56%	4.23% (14-15)	Q3 2014-15	↑	↑	2.60%			4%			4.13%			4.56%			-	-

				Data collected
Patient Experience	CQC Conditions/Warnings		December 2013 - some standards not met	As and when
	CQC Intelligent Monitoring Report	Band 4	1 Risk / 0 Elevated Risk	Nov 14 - published quarterly
	Staff Survey - satisfied with quality of work & patient care are able to deliver	84%	Best performing trusts	Annually - updated March 2015
	Staff Survey - staff rec of trust as a place to work or receive treatment	3.60	Staff experience deteriorated since 2013 survey - was 3.75	Annually - updated March 2015
Patient Safety	NPSA NRLS - Incidents reported per 1000 bed days	26.71	RAG rated as amber - in middle 50% of reporters. Median 26.71/1000 bed days	6 monthly - Oct 13 - March 14. Next update due for release end of March 2015.
	NPSA Safety Alerts - CAS	92.3%	92.3% (60 of 65) of safety alerts completed within deadline Sept 14 - Feb 15	Monthly - March 2015
	Patient-led Assessment of the Care Environment (PLACE)	99.98%	Cleanliness	Annually - last updated Sept 14 (end of August publication)
		97.26%	Food & Hydration	
		90.48%	Privacy, Dignity & Wellbeing	
		99.49%	Condtion, Appearance & Maintenance	
Clinical Effectiveness	Monitor Governance		Remains Green - no evident concerns	Quarterly (Q3 - Oct - Nov 2014) - updated Dec 2014
	CQUINs	95%	95% achieved Q3 2014-15	Quarterly

Safety Thermometer March 2015
(February 14 - February 15)

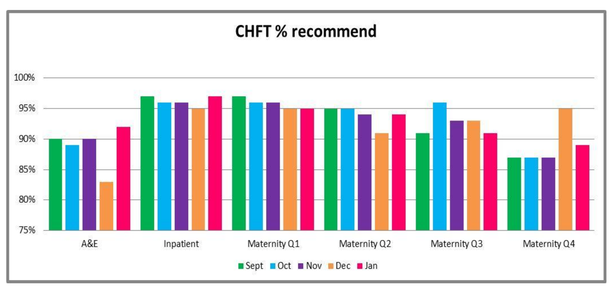


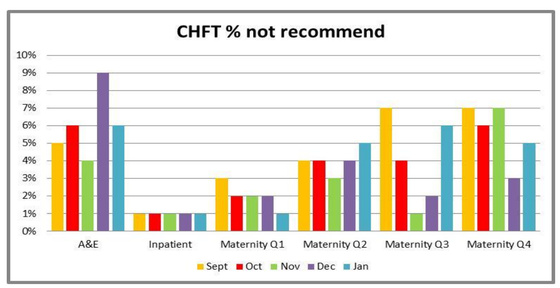
Back to Menu

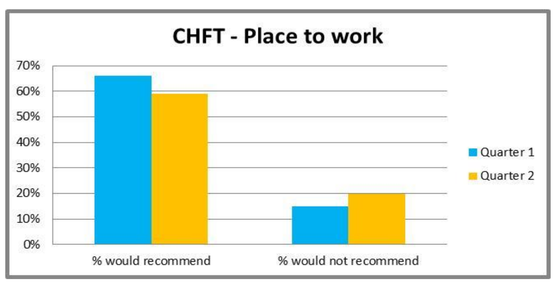
Quality and Safety Dashboard
Friends and Family Test

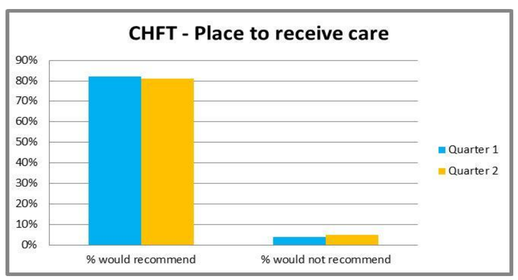
Quality & Safety Committee
Quality Dashboard Report March 2015

			CHFT			Trend information									
						Direction of Travel									
Quality Domain	Indicator	Reporting Frequency	Period Target	Month/ Period	Month/Period data from	Previous Month/Period	S	O	N	D	J	F	M	J	J
Patient Experience	Response Rate - A&E	Monthly	Q1-3 15% Q4 20%	12.9%	Feb-15	↑	20.3%	23.4%	19.2%	4.50%	12.9%				
	Response Rate - Inpatient	Monthly	Q1-3 25% Q4 30%	38.20%	Feb-15	↓	40.63%	46.70%	44.29%	40.97%	38.2%				
	Response Rate - Maternity question 2 - care during birth	Monthly	n/a	18.5%	Feb-15	↓	23%	23.2%	24%	19%	18.5%				
	Response rate - staff	Quarterly	n/a	6.59%	Q2 2014	↓	6.59%	-			n/a				

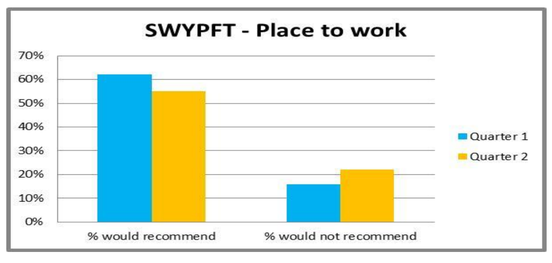


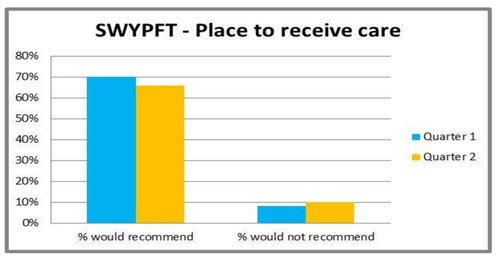






			SWYPFT			Trend information				
						Direction of Travel				
Quality Domain	Indicator	Reporting Frequency	Period Target	Month/ Period	Month/Period data from	Previous Month/Period	S	O	N	D
Pat. Exp.	Response rate - staff	Quarterly	n/a	14.4%	Q2 2014-15	↓	14.4%	-		





Back to Menu

Quality and Safety Dashboard
Yorkshire Ambulance Service

Quality & Safety Committee
Quality Dashboard Report January 2015
8.12.14

Quality Domain	Indicator	Reporting Frequency	YAS				Trend information																	
							Direction of Travel		2014-15															
			Period Target	Month/ Period	YTD 2014-15	Month/ Period/Year data from	Previous Month/ Period	Corresponding month 2013/14	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J
Patient Experience	Friends and Family Test Socre - Response rate and score (see and treat/hear and treat)	Quarterly	75%	61.73%	-	Q2 2014-15	↓	-	76.03%			61.73%												
	Number of Complaints	Quarterly	N/A	261	581	Q2 2014-15	↓	-	320			261												
	Re-contact rates: Hear and Treat (includes OOA) Re-contract rates: See & Treat (includes OOA)	Quarterly	tbc	5.1% 3.8%	Rank 2 Rank 1	Q2 2014-15	-	-	8.5% 3.74%			5.1% 3.8%												
Operational	999 operational vacancies (all grades)	Quarterly	WTE establishment target Oct 14 = 2164	46 WTE	-	Q2 2014-15	↓	-	77.6 WTE			46 WTE												
	Staff sickness rate (Trust)	Quarterly	5%	6.85%	-	Q2 2014-15	↑	-	6.54%			6.85%												
	Statutory and mandatory training - workbook compliance	Quarterly	85%	93.46%	-	Q2 2014-15	↔	-	94%			93.46%												
	PDRs for all of workforce within the last 12 months (all staff)	Quarterly	75%	72%	-	Q2 2014-15	↑	-	70%			71.78%												
	Staff FFT	Quarterly	tbc	not avail	-	Q1 2014-15	-	-	not avail			not avail												

				Data collected
Regulation & External Assurance	CQC Conditions/Warnings		September 2014 - awaiting follow up on Outcome 14 - Supporting Workers.	As and when
	Trust Development Agency (TDA) Governance Risk Assessment	2	Level 2 - emerging concerns. August 2013-January 14	Aug 13 - Jan 14
Patient Safety	NPSA NRLS	14.3%	% of incidents reported to NRLS resulting in severe harm or death.	6 monthly - Oct 13 - March 14. Next update due for release end of March 2015.
Clinical Effectiveness	CQUINs	57%	57% achieved Q1 2014-15	Quarterly

Back to Menu

Quality and Safety Dashboard
BMI Huddersfield

Quality & Safety Committee
Quality Dashboard Report March 2015
13.03.2015

Quality Domain	Indicator	Reporting Frequency	BMI Huddersfield: Period Target	BMI Huddersfield: Month/ Period	BMI Huddersfield: YTD	BMI Huddersfield: Month/ Period/Year data from	Trend information: Direction of Travel: Previous Month/Period	Trend information: Direction of Travel: Corresponding month 2013/14	2013-14: D	2013-14: J	2013-14: F	2013-14: M	2014-15: A	2014-15: M	2014-15: J	2014-15: J	2014-15: A	2014-15: S	2014-15: O	2014-15: N	2014-15: D	2014-15: J	2014-15: F
Patient Experience	F&FT Return Rate	Monthly	n/a	48.20%	29.4%	Dec-15	↑	↑	33.00%	6.86%	29.80%	21.76%	31.18%	20.00%	13.33%	24.14%	26.90%	12.90%	41.60%	45.90%	48.20%	18.40%	
	F&FT Total Eligible	Monthly	n/a	NA	56	Oct-14			103	175	174	170	170	40	30	29	32	38	NA	NA	NA	NA	
	F&FT Net promoter score	Monthly	n/a	NA	82	Oct-14			91	92	87	84	79	75	100	86	57.00%	100	NA	NA	NA	NA	
	EMSA	Monthly	0	0	0	Dec-14	↔	↔	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Patient Safety	C Diff	Monthly	0	0	0	Dec-14	↔	↔	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	MRSA	Monthly	0	0	0	Dec-14	↔	↔	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	MSSA	Monthly	n/a	0	0	Dec-14	↔	↔	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	VTE Risk Assessment	Monthly	95%	100.0%	99.0%	Dec-14	↑	↓	97%	98%	96%	97%	98%	98%	96%	100%	100%	100%	100%	99%	100%	100%	
	Never Events	Monthly	0	0	0	Dec-14	↔	↔	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Serious Incidents	Monthly	n/a	0	0	Dec-14	↔	↔	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	NPSA Safety Alerts	Monthly	n/a	0	0	Dec-14	↔	↔	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

		Rating	Data collected
Patient Experience	CQC Conditions/Warnings		Jan-14
	BMI Inpatient Survey - involved satisfactorily in decisions about care & treatment (question 1)	97.87% positive response	Monthly Dec 2014
	BMI Inpatient Survey - privacy when discussing conditon / treatment (question 3)	97.25% positive responses	Monthly Dec 2014
Clinical Effectiveness	CQUINs	100%	Quarterly - 100% achieved Q3, 2014-15

Quality & Safety Committee
Quality Dashboard Report February 2015
18.02.15

Quality and Safety Dashboard
Spire Healthcare - Elland

Quality Domain	Indicator	Reporting Frequency	Spire Elland: Period Target	Spire Elland: Month/ Period	Spire Elland: YTD	Spire Elland: Month/ Period/Y	Direction of Travel: Previous Month/Period	Direction of Travel: Corresponding month 2012/13	Trend information: 13/14 O	13/14 N	13/14 D	13/14 J	13/14 F	13/14 M	14/15 A	14/15 M	14/15 J	14/15 J	14/15 A	14/15 S	14/15 O	14/15 N	14/15 D	14/15 J
Patient Experience	F&FT Return Rate	Monthly	20% by Q4	15.14%		Dec-14	n/a	n/a	17.56%	76.90%	52.79%	31.27%	40.70%	47.45%	43.51%	47.19%	34.74%	28.75%	54.55%	69.88%	48.19%	34.12%	15.14%	-
									Q3 - 49.1%			Q4- 39.8%			Q1 - 41.81%			Q2 - 51.06%			Q3 - 32.5%			-
	F&FT Total Eligible	Monthly	n/a	340			n/a	n/a	279	277	197	259	216	255	239	267	285	240	233	249	351	340	284	-
	F&FT Percentage recommend	Monthly	n/a	97%			n/a	n/a	90	80	83	80	90	79	79	82	83	84	84	99%*	98%	97%	95%	-
	EMSA	Monthly	0	0	0	Jan-15	↔	↔	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Patient Safety	C Diff	Monthly	0	0	0	Jan-15	↔	↔	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	E Coli	Monthly	n/a	0	0	Jan-15		↔	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	MRSA	Monthly	0	0	0	Jan-15	↔	↔	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	MSSA	Monthly	n/a	0	0	Jan-15	↔	↔	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	VTE Risk Assessment	Quarterly	95%	99.2%	98.1%	Q2 2014-15	↔	↔	95.34%	100.00%	95.00%	95.00%	95.00%	100.00%	97.00%	97.00%	97.00%	100.00%	100.00%	98.00%	97.00%	100.00%	-	-
									Q3 - 97%			Q4- 96.6%			Q1 - 97%			Q2 - 99.17%			Q3 - Not Avail			-
	Never Events	Monthly	0	0	0	Jan-15	↔	↔	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Serious Incidents	Monthly	n/a	0	0	Jan-15	↔	↔	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	NPSA Safety Alerts	Monthly	n/a	0	0	Jan-15	↔	↔	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Back to Menu

Quality and Safety Dashboard
NHS 111 / West Yorkshire Urgent Care

Quality & Safety Committee
Quality Dashboard Report March 2015
13.03.15

Quality Domain	Indicator	Reporting Frequency	NHS 111 Period Target	NHS 111 Month/ Period	NHS 111 YTD	NHS 111 Month / Period / Year data from	Direction of Travel Previous Month / Period	Trend information 2013-14 D	2013-14 J	2013-14 F	2013-14 M	2014-15 A	2014-15 M	2014-15 J	2014-15 J	2014-15 A	2014-15 S	2014-15 O	2014-15 N	2014-15 D	2014-15 J	2014-15 F	2014-15 M	2014-15 A
Patient Safety	Serious Incidents	Monthly	n/a	2	5	Jan-15	↔	0	0	1	0	0	1	1	0	0	0	0	0	0	2			
	The contractor must have a robust system for identifying all immediate life threatening conditions; these calls must be passed to the ambulance service within 3 minutes.	Monthly	Yes	Yes	Yes	Jan-15	↔	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes			
Clinical Effectiveness	Warm transfer from NHS 111 call handler to NHS 111 clinician where input from NHS 111 clinician is deemed necessary (*please see local indicator below)	Monthly	95%	32.80%	33.10%	Jan-15	↑	46.40%	55.60%	32.40%	38.00%	36.50%	24.60%	51.00%	25.30%	38.30%	35.10%	30.70%	29.70%	27.10%	32.80%			
Patient Experience	Percentage of patients surveyed	Quarterly	1%	1%	1%	Q2 2014-15	↔		1%			n/a			1%	n/a	n/a	n/a	n/a	1%	NA			
	Callbacks within 10 mins	Monthly	> 98%	28.00%	28.90%	Jan-15	↑	44.10%	46.40%	36.20%	38.70%	37.20%	31.80%	31.70%	29.30%	30.10%	32.70%	24.60%	24.00%	19.70%	28.00%			
	Complaints received	Monthly	n/a	26	12	Jan-15	↑	8	14	3	13	11	7	5	9	16	11	5	13	16	26			
	Abandoned calls (no more than 5% calls abandoned) after 30 seconds	Monthly	less than 5%	0.80%	1.62%	Jan-15	↑	0.70%	0.40%	0.70%	0.70%	1.00%	1.30%	0.80%	1.00%	0.60%	1.00%	1.30%	2.90%	5.50%	0.80%			
	% of calls answered within 60 seconds	Monthly	95%	96.20%	92.60%	Jan-15	↑	96.60%	98.30%	96.50%	96.50%	95.10%	94%	96.50%	94.30%	97.60%	95.50%	93.30%	86.10%	77.90%	96.20%			
*New Local KPIs (introduced June 2014)	*Warm Transfer and 10 minute call back	Monthly	≥ 65%	37.30%	49%	Jan-15	↑							51%	47%	57.4%	52.9%	47.8%	46.60%	37.30%	52.20%			
	Callbacks within 2 hours	Monthly	≥ 95%	83.90%	91%	Jan-15	↑							94%	92%	93%	92%	90%	87.80%	83.90%	91.80%			
Local Care Direct (West Yorkshire out of hours urgent care provider)																								
Patient Safety	Face to face consultation for emergencies within 1 hour	Monthly	95%	50.10%	52.60%	Jan-15	↑	47.10%	55.10%	49.40%	50.90%	51.10%	50.10%	55.70%	60.40%	52.10%	56.40%	55.40%	49.10%	45.70%	50.10%			
	Face to face consultations for urgent cases within 2 hours	Monthly	95%	66.90%	67.30%	Jan-15	↑	64.00%	76.40%	68.80%	67.40%	64.20%	65.40%	70.60%	74.10%	67.30%	71.40%	68.70%	65.00%	58.20%	66.90%			
	Face to face consultations, less urgent, within 6 hours	Monthly	95%	93.00%	94.65%	Jan-15	↑	96.60%	98.00%	96.40%	94.70%	94.50%	95.50%	95.60%	96.50%	95.50%	96.40%	95.50%	94.20%	89.80%	93%			
Clinical Effectiveness	Start definitive clincial assessment for patients with urgent needs within 20 minutes of arriving at PCC; start definitive clinical assessment of all other patients within 60 minutes of arriving at the PCC	Monthly	95%	99.10%	98.90%	Jan-15	↑	98.30%	97.80%	99%	98%	97%	99.40%	99.00%	99.60%	99.70%	99.60%	99.60%	98.40%	98%	99.10%			

		Rating	Data collected
Patient Experience	% of patients likely or extremely likely to recommend the service (Friends and Family Test)	59%	Q3
	% of patients agreed or strongly agreed that they were happy with how long it took for the telephone to be answered	93%	Q3
	% of patients agreed / strongly agreed that the were happy that the call taker listened carefully	93%	Q3
	% of patients agreed / strongly agreed that the call handler was reassuring	88%	Q3
	% of patients who agreed / strongly agreed that they were treated with dignity and respect	94%	Q3
	% of patients agreed / strongly agreed that they understood what the call taker said to them	95%	Q3
	% of patients agreed / strongly agreed that they understood the information and advice given	85%	Q3
	% of patients outlined that they followed the advice given	94%	Q3
Patient Safety	% of staff that have attended Basic Adult Safeguarding training to include updates on local policies and procedures	100%	Annual
	% of eligible staff who have had a CRB check within the last 3 years	100%	Annual
	% of new staff recorded as having received training on the awareness of the Mental Capacity Act (2005) and Mental Advocate Act (2007) at induction	100%	Annual

Back to Menu

Calderdale Clinical Commissioning Group
CQC Inspections

Provider		
Date of Review		
Type of review		
Link to report		
Ratings		
Overall rating		
Safe		
Effective		
Caring		
Responsive		
Well-led		

Back to Menu

Exception Report March 2015

CCCG Quality Dashboard			
Amber/Red	**Comments**	**Action**	**Outcome**
MRSA	No further cases of MRSA, the CCG has 1 unavoidable case YTD	No further action required	
C Diff	CCCG reported 2 C Diff cases in January giving a year to date figure of 31 against a target of 47, the CCG remains under trajectory for the year. CCG C Diff target for 2015/16 is set at 39.	Continue to monitor through Quality Committee.	

CHFT Quality Dashboard			
Amber/Red	**Comments**	**Action**	**Outcome**
C Diff	4 cases of C-Diff reported in FEbruary 2015, giving a YTD total of 26 against a target of no more than 18. The 2015/16 Targets have been published for 2015/16 CHFT is set at 21.	Actions to date include: - Review of the Bristol Stool chart and a Norovirus awareness campaign covering the new stool chart focusing on when to take stool samples and when to isolate was held during September. - Use of UV technology (pens) has been introduced to ward areas to provide assurance of cleaning standards	Further work identified: - increase the timeliness of isolating patients with suspected infective diarrhoea - Promote the timeliness of obtaining stool specimens - Increase training on hand hygiene focusing of the 5 moments for hand hygiene - Review of the laxative policy - Improve the process for shared learning and
MRSA	No post 48 hour MRSA cases for February.	No Action required by Quality Committees at this time	No outcome to report from the appeal.
Serious Incidents	18 incidents were reported in February 2015	A verbal update will be given at the Q&S meeting	
SHMI	Latest published information shows figures for RY Q4 13/14 data rank CHFT 13th with a SHMI of 111.1. Percentage variance compared to RY Q2 1314 (6 months earlier) is 4.7%. The percentage of deaths within 30 days of elective admissions increased 0.03% between Q2 1112 and Q4 1314 at England, while the national value decreased 0.06% over the same period. Hospital mortality rate for under 16's is 0.06% higher than the national value. Cardiology, Gastro intestinal and Mental Health diagnosis bundle groups were significantly above the national average for crude in-hospital mortality, while Cancer and Other Medical diagnosis bundle groups were significantly below the national average.	Work continues on the Acutely Ill patient programme with key themes to help to reduce SHMI and HSMR, These include reliable implementation of care bundles, focus on frail patients, coding and condition specific work where mortality rates appear to be outlying.	Continue to report through Clinical Quality Board
Overall HSMR	The most recent 12 months data indicates a non-rebased 106.2 against the national average of 95.67. At present our rates are falling in line with the average.	As above	No Further update
Weekend HSMR (non elective)	Weekend mortality has again fallen slightly from 108.9 to 104.1	Work on-going as part of the mortality reduction work.	
Intelligent Monitoring Report	Draft Intelligent Monitoring Report published for December 2014 and overall banding remains at 5, which is positive. Two risks removed - - Maternity Survey C12 - did staff treating & examining you introduce themselves? - Composite of Central Alerting System (CAS) Safety Alerts indicators One "elevated risk" remains from previous reporting period - - The proportion of cases assessed as achieving compliance with all nine standards of care measured within the National Hip Fracture Database One new "elevated risk" added - Consistency of NRLS reporting	National Hip Fracture data base summary report has been produced by CSU, report has been shared with CHFT and we have requested an update at the Jan Clinical Quality Board. Consistency of NRLS reporting is legacy from 2013, the Trust informed us of this at the time, process has been strengthened as a result. Continue to monitor through Intelligent Monitoring.	A report was received on the ongoing work around Hip Fracture was recived at the March Clinical Quality Board, a lot of work has been undertaken and it is hoped that the next published inormation will reflect a much improved position.
NPSA NRLS - Incidents reported per 100 admissions	Information unchanged from June 2014 report. CHFT have dropped into the lowest 25% of reporters. The median has remained the same, however other trusts have increased there reporting of incidents per number of bed days. The following reasons have been identified and actions implemented: 1) There has been an error in uploading onto the national system from the local system onto NRLS meaning that fewer incidents were being uploaded to the national system. 2) Since the introduction of the electronic reporting system, reported incidents have decreased. The expectation in the roll out phase numbers may reduce however once the system was fully implemented numbers would increase and	1) **Action:** Implementation of a new system however, the results will not show until the report after next (March/April 2015) 2) **Action:** For monitoring through Clinical Quality Board	
Staffing levels	Levels of qualified nurses are about the same as last month with an 81.2% fill rate on days and 91.4% on nights. Carers have also stayed about the same, 91.5% on days and 116.7% on nights, although the numbers are about the same CHFT continue to work on improving recruitment of qualified nurses.	Continue to monitor through Clinical Quality Board	
Safety Thermometer	Overall harms reported have reduced during February.	The Trust shared a comprehensive Quality Report at Clinical Quality Board. Information from this report will be incorporated into the dashboard over the coming months	
Monitor Governance	Risk rating has changed from green to red following the Monitor investigation of financial risks and sustainability concerns at the trust, triggered by a deterioration in the trust's financial position.	No Action required by Quality Committees at this time	

SWYPFT Quality Dashboard			
Amber/Red	**Comments**	**Action**	**Outcome**
Serious Incidents	10 reported overall for February 2015. One of these related to Barnsley and were pressure ulcers	Continue to monitor through Serious Incident Management Process.	Serious Incident is reported quarterly with any themes/trends and learning identified.
CQUIN Service User Survey - inpatient survey	Quarter 3 results show a slight deterioration in inpatient percentage achievement. The breakdown is as follows: Calderdale - (12 out of 14) remains static but have failed on the question of overall rating of care, Kirklees - (11 out of 14) deterioration of particular note is the failure to achieve against the question relating to who to contact in case of queries or concerns, Wakefield (13 out of 14) an improvement of one.	Wakefield have only failed to achieve on one question for 2 out of 3 quarters on the Inpatient and Community Surveys and the suggestion has been made that there may be learning for the other BDUs around the approach used in Wakefield to involve of service users in their care and care plan.	A CQUIN relating to standard of care plans, including service user involvement is currently being discussed for 2015/16. At Quality Board SWYPFT confirmed that service user involvement in care plans was going to be an area of focus for Patient Experience group in 2015/16.
CQUIN Service User Survey - community survey	Quarter 3 results show an improvement in results from 85% to 92.8% . The breakdown is as follows: Calderdale - 12/14, Kirklees - 13/14, Wakefield 14/14. The results show 100% achievement for Wakefield BDU with Calderdale and Kirklees both failing to achieve whether a copy of the care plan had been offered or given to the service user and Calderdale failing to achieve whether their care plan was helping the service user.	Wakefield have only failed to achieve on one question for 2 out of 3 quarters on the Inpatient and Community Surveys and the suggestion has been made that there may be learning for the other BDUs around the approach used in Wakefield to involve of service users in their care and care plan.	Raised at Quality Board. Development of sharing good practice is underway across BDUs with the practice development coaches.
Safety Thermometer	February 2015 has seen a slight increase by one of overall harm. There has been a gradual increase since December 2014 however it is slightly less than the numbers reported for the corresponding month last year.	All of these relate to Barnsley Community Services and are managed through NHS Barnsley CCG	
Delayed Transfer of Care	Although still green the percentage of delayed transfers of care has risen for four consecutive quarters and is 57% higher than the corresponding quarter in 2013/14	To continue to monitor through quality and safety committee and alert commissioning manager.	
Staffing Levels	Staffing levels for day time in both registered nurses and health care staff have increased across the organisation. Fill rate for registered nurses at night has reduced by over 1% and is particularly low on the Priestley Unit (59%). Average fill rate for health care staff has risen by 4%. Priestley Unit showed 177% fill rate for health care staff at night.	Continue to monitor monthly through quality and safety committee. Regular updates received at SWYPFT Quality Board regarding pressure areas and the development of the acuity tools to understand required levels for each area.	
CQC	No update from previous month. Remains amber however SWYPFT have given assurance in SWYPFT Quality Board 1/9/14 that actions are complete.	Awaiting CQC re-inspection however actions are complete.	
National Staff Survey	Results have been published for the Staff Survey results relating to 2014. There has been a slight deterioration in percentage of staff recommending the trust as a place to work. There has been a slight improvement in the percentage of staff who feel satisfied with the quality of work they are able to deliver.	Staff recommending the trust as a place to work continues to be monitored quarterly through the friends and family test and is discussed at the quality board. Results of the survey and SWYPFT action plans will be discussed at the April Quality Board.	

Friends and Family Test			
CHFT	**Comments**	**Action**	**Outcome**
A&E & Inpatient Response Rates	Response Rate for A&E improved in January to 12.9%, however this still leaves CHFT below the Q4 target of 20%. This is attributed to the change in process (removal of tokens) on both sites.	Focused work continues, including staff awareness and engagement, this will include a briefing document for staff, reminding them of what FFT is about and informing them of their roles and responsibilities.	This was discussed at Clinical Quality Board, areas where the process is working well will be identified and shared with CHFT.
SWYPFT	**Comments**	**Action**	**Outcome**
FFT Staff response	Staff response rates both for recommending SWYPFT as a place to receive care and as a place to work have dropped significantly in Q2. Transformation continues within SWYPFT and therefore it will be important for the trust to monitor staff's feedback and well-being measures at this time	Updates on these measures are received through SWYPFT Quality Board in the Quarterly Compliance Report. To discuss at December 2014 SWYPFT Quality Board Meeting	Discussed at SWYPFT Quality Board meeting on 15 December 2014 and advised that “hot spots” are being looked at and specific pieces of work identified as a result of reviewing the results. If any specific areas are identified as a result of this, eg, nursing, then a survey will be developed to focus on that particular area. All information will be reviewed by the Trust's Patient Experience Group.

YAS Quality Dashboard			
Amber/Red	**Comments**	**Action**	**Outcome**
Staff sickness rate (Trust)	Sickness absence rates continue above the target of 5% at 6.85%. It is understood that the ongoing national discussions relating to terms and conditions are adversely affecting this target. This is the subject of management focus by YAS.	YAS continues to seek a reduction in absence rates. Absence rates are expected to reduce further once national talks on unsocial hours payments are concluded; however these talks may continue beyond March 2015.	No improvement demonstrated as yet from the management focus
PDRs for all of workforce within the last 12 months (all staff)	PDR rates remain below target at 71.78% for Quarter 2, with a target of 75%. This was identified at the last CQC inspection relating to outcome 14 - supporting workers. YAS reports that there is a specific focus on PDR rates, which have dropped in the last month, due to a larger number of staff PDRs becoming due during the month that have not been completed.	Actions around PDR are still outstanding. Update requested to the lead commissioner.	
CQC inspection	Outcome 14 - Supporting Workers - still outstanding. CQC now intend to carry out a new style inspection sometime in January 2015 and will pick up Outcome 14 as part of the inspection.	Awaiting the visit to follow up outcome 14 (Supporting workers).	CQC visit took place 13-15 January 2015, awaiting feedback.

Trust Development Agency (TDA) Governance Risk Assessment	The latest grading from the Trust Development Agency rates YAS as 2 indicating that the organisation has significant delivery issues. Currently YAS are experiencing significant delivery issues and a recovery plan has been agreed with commissioners and implemented. Performance remains challenged in the response times. A trajectory has been agreed envisaging that combined Red 1 and 2 8 minute performance for the region as a whole will reach at least 75% in each month from January to March 2015. The impact of performance on quality and safety is being closely monitored with additional clinical reviews being undertaken where serious incidents have been reported relating to response times to establish any causal factor of delay on outcome.	Performance continues to be monitored against the recovery trajectory through the contract management mechanisms. Further detail was available in the September dashboard. The effects of performance on quality and safety is being closely monitored through the contract management mechanisms and lead commissioners and YAS are strengthening the quality reporting mechanisms.	
NPSA NRLS	14.3% of incidents reported by YAS resulted in severe harm or death. Nationally just under 1% are reported as severe harm or death. The data published does not present an accurate reflection of the organisations incident reporting data. The data published states that YAS reported 70 patient safety incidents with 8 graded as severe harm (11.4%) and 2 as death (2.9%). The published national averages are severe harm 1.4% and death 0.8%. YAS inclusive of NHS 111 has conducted a retrospective analysis of incidents reported during the NRLS data reporting period 1.10.13 - 31.3.14. This analysis has identified that there were 1019 patient safety concerns reported on Datix. Of these, 18 were graded as severe/catastrophic, giving an overall level of harm 1.8%. The combined national average of severe/death incidents based on the published NRLS data set for this period is 2.25%, indicating that YAS fall below the national average.	The process for reporting from YAS to NRLS has now been corrected and NRLS reports with data from April 2014 will contain benchmarkable information.	Next update due March 2015
CQUINs	The Quarter 2 submission has been received and is the process of validation.	Awaiting outcome of validation process.	

BMI Huddersfield Quality Dashboard			
Amber/Red	**Comments**	**Action**	**Outcome**
Friends and Family Test return rate	FFT Response rate dropped again in January to 18.4%, a significant drop from December but remains above target	No action required, will continue to monitor at quality contract meetings.	

Spire Elland			
Amber/Red	**Comments**	**Action**	**Outcome**
Friends and Family Test	Both Spire Elland and Spire Methley have a significant decrease in their response rate for December 2014 from 34.12% to 15.14% (Elland) and 36.24% to 13.19% (Methley).	This decrease in performance has been raised with both hospitals and assurance will be sought via the Quality Board mechanisms. It is expected that this dip in performance is temporary and a recovery will be seen in January's data.	

NHS 111 / Local Care Direct Quality Dashboard			
Amber/Red	**Comments**	**Action Taken/Completion of action**	**Outcome**
Warm Transfer from NHS 111 call handler to NHS 111 clinician where input from an NHS 111 clinician is deemed	Performance is back on track for January at 32.8%, YTD now stands at 33.1% . Remaining far below the target of 95% but a significant improvement in month.	This is reflective of the challenge in meeting this KPI which has been reported through previous Contract Reports. Will continue to monitor through contracting board.	Continue to monitor through Contract Board
Call backs within 10 minutes	Performance in January improved in month to 28% - Bringing the YTD figure to 28.9%.	Continue to be monitored through the Contract Board	
Face to face consultation for emergencies within 1 hour	Performance in January was 50.1% an improvement on the previous months, however remains well below the target of >95%.	Continue to monitor the indicator through the Sub Regional Contracting Group.	
Face to face consultations for urgent cases within 2 hours	Performance in January is 66.9% against a target of >95%.	Continue to monitor the indicator through the Sub Regional Contracting Group.	
New local indicator - Warm transfer and 10 minute call back	The local target for this indicator is ≥ 65%. YAS achieved 52.2% a significant improvement on previous months and YTD remains well below target at 49%.	Continue to monitor through the sub-regional contracting group	A number of actions have been taken at Contract Board including increasing the numbers of Call Handlers and Clinical Advisors in order to cope with the increased demand. Monitoring continues at Contract Board.
New local indicator - Call backs within 2 hours	The local target is ≥ 95%. YAS achieved 91.8% in January, and increase on December but YTD remains below target at 91%.	As this is baseline data we will continue to monitor through the sub-regional contracting group	As above

Back to Menu

Datasource

CHFT			
Quality Domain	Indicator	Reporting Period	Datasource
Patient Experience	**F&FT Response Rate**	Quarterly	http://www.england.nhs.uk/statistics/statistical-work-
	F&FT Total Eligible	Quarterly	
	EMSA	Monthly	http://www.england.nhs.uk/statistics/statistical-work-areas/
	C Diff	Monthly	HCAI Team
Patient Safety	**E Coli**	Monthly	HCAI Team
	MRSA	Monthly	HCAI Team
	MSSA	Monthly	HCAI Team
	Overall HSMR	Quarterly	Figures - Quality Surveillance Report (from Penny) Exception Report - CHFT Board report - http://www.cht.nhs.uk/publications/board-papers/
	SHMI		
	Mortality by weekend data		
	Never Events	Monthly	CSU
	Serious Incidents	Monthly	CSU
	Safety Thermometer - % of harm free care	Monthly	http://www.hscic.gov.uk/thermometer
	Staffing levels	Monthly	http://www.cht.nhs.uk/about-us/open-and-honest-care/

CHFT			
Quality Domain	Indicator	Reporting Period	Datasource
Patient Experience	**CQC Conditions/Warnings**	As & when	www.cqc.org.uk
	CQC Intelligent Monitoring Report	Monthly	www.cqc.org.uk
	CQC Inpatient Survey - involved satisfactorily in decisions about care & treatment	Annually	http://www.nhssurveys.org/surveys/703
	CQC Inpatient Survey - overall level of respect & dignity	Annually	http://www.nhssurveys.org/surveys/703
	Staff Survey - satisfied with quality of work & patient care able to deliver	Annually	http://www.nhsstaffsurveys.com/Page/1010/Home/Staff-Survey-2013/
	Staff Survey - staff rec of trust as a place to work or recieve treatment	Annually	http://www.nhsstaffsurveys.com/Page/1010/Home/Staff-Survey-2013/
Patient Safety	**NPSA NRLS**	6 monthly	http://www.nrls.npsa.nhs.uk/patient-safety-data/organisation-patient-safety-incident-reports/directory/
	NPSA Safety Alerts - CAS	Monthly	Login access required (via Sam/Sahdia) https://www.cas.dh.gov.uk/Home.aspx
	Patient-Led Assessment of the Care Environment (PLACE)	Annually	http://www.hscic.gov.uk
Clinical Effectiveness	**Monitor Governance**	Quarterly	http://www.monitor-nhsft.gov.uk/about-your-local-nhs-foundation-trust/nhs-foundation-trust-directory-and-register-licence-holders/calderdale-and-huddersfield-nh
	CQUINs	Quarterly	CQUINs submission

PROMs	Quarterly	http://www.hscic.gov.uk/proms
Safety Thermometer (CHFT & SWYPFT)	Monthly	http://www.hscic.gov.uk/thermometer

SWYPFT			
Quality Domain	**Indicator**	**Reporting Period**	**Datasource**
Patient Experience	**EMSA**	Monthly	http://www.england.nhs.uk/statistics/statistical-work-areas/
	CQUIN Service User Survey	Monthly	CQUIN submission
	% Complaints incl staff attitude as an issue	Quarterly	SWYPFT Integrated Performance Report - available via SWYPFT website - http://www.southwestyorkshire.nhs.uk/about-us/performance/reports/
Patient Safety	**Never Events**	Monthly	CSU
	Serious Incidents	Monthly	CSU
	Safety Thermometer - % of harm free care	Monthly	http://www.hscic.gov.uk/thermometer
	Staffing Levels	Monthly	http://www.southwestyorkshire.nhs.uk/about-us/performance/staffing-levels/
Clinical Effectiveness	**% Service users on CPA followed up within 7 days from inpatient care**	Quarterly	SWYPFT Integrated Performance Report - available via SWYPFT website: http://www.southwestyorkshire.nhs.uk/about-us/performance/reports/
	% Service users on CPA having formal review within 12 months	Quarterly	SWYPFT Integrated Performance Report - available via SWYPFT website: http://www.southwestyorkshire.nhs.uk/about-us/performance/reports/
	Delayed Transfer of Care	Quarterly	SWYPFT Integrated Performance Report - available via SWYPFT website: http://www.southwestyorkshire.nhs.uk/about-us/performance/reports/

SWYPFT			
Quality Domain	**Indicator**	**Reporting Period**	**Datasource**
Patient Experience	**CQC Conditions/Warnings**	As & when	www.cqc.org.uk
	CQC Inpatient Survey - involved satisfactorily in decisions about care & treatment	Annually	http://www.nhssurveys.org/surveys/703
	CQC Inpatient Survey - overall level of respect & dignity	Annually	http://www.nhssurveys.org/surveys/703
	Staff Survey - satisfied with quality of work & patient care able to deliver	Annually	http://www.nhsstaffsurveys.com/Page/1010/Home/Staff-Survey-2013/
	Staff Survey - staff rec of trust as a place to work or recieve treatment	Annually	http://www.nhsstaffsurveys.com/Page/1010/Home/Staff-Survey-2013/
Patient Safety	**NPSA NRLS**	6 monthly	http://www.nrls.npsa.nhs.uk/patient-safety-data/organisation-patient-safety-incident-reports/directory/
	NPSA Safety Alerts - CAS	Monthly	Login access required (via Sam/Sahdia) https://www.cas.dh.gov.uk/Home.aspx
Clinical Effectiveness	**CQUINs**	Quarterly	CQUINs submission
	Monitor Governance	Quarterly	http://www.monitor.gov.uk/about-your-local-nhs-foundation-trust/nhs-foundation-trust-performance/actual-performance/risk-ratin

BMI Huddersfield			
Quality Domain	**Indicator**	**Reporting Period**	**Datasource**
Patient Experience	F&FT Return Rate	Quarterly	http://www.england.nhs.uk/statistics/statistical-work-areas/friends-and-family-test/friends-and-family-test-data/
	F&FT Total Eligible	Quarterly	
	F&FT Net promoter score	Quarterly	
	EMSA	Monthly	http://www.england.nhs.uk/statistics/statistical-work-areas/mixed-sex-accommodation/
Patient Safety	C Diff	Monthly	Monthly contract performance report from BMI Huddersfield
	E Coli	Monthly	
	MRSA	Monthly	
	MSSA	Monthly	
	VTE Risk Assessment	Monthly	http://www.england.nhs.uk/statistics/statistical-work-areas/vte/
	Never Events	Monthly	Monthly contract performance report form BMI Huddersfield
	Serious Incidents	Monthly	
	NPSA Safety Alerts	Monthly	
Patient Experience	CQC Conditions/Warnings	As and when	www.cqc.org.uk
	BMI Inpatient Survey - involved satisfactorily in decisions about care & treatment (question 1)	Monthly	Monthly contract performance report form BMI Huddersfield
	BMI Inpatient Survey - privacy when discussing conditon / treatment (question 3)	Monthly	

NHS 111			
Quality Domain	**Indicator**	**Reporting Period**	**Datasource**
Patient safety	**Serious Incidents**	Quarterly	Monthly performance report from West and South Yorkshire and Bassetlaw Commisisoning Support Unit
	Complaints received	Quarterly	
	Compliments received	Quarterly	
	The contractor must have a robust system for identifying all immediate life threatening conditions; these calls must be passed to the ambulance service within 3 minutes.	Quarterly	
Patient Experience	**Number of patients surveyed for patient satisfaction survey**	Quarterly	
	Contractual KPI - % of patients surveyed (indicator QA10PE1)	Quarterly	
	Callbacks within 10 mins (indicator P1AR3)	Quarterly	
	Warm transfer from NHS 111 call handler to NHS 111 clinician where input from NHS 111 clinician is deemed necessary (indicator P1AR4)	Quarterly	
	Warm transfer to an out of hours service (indicator P1AR5)	Quarterly	

NHS 111			
Quality Domain	**Indicator**	**Reporting Period**	**Datasource**
Patient Experience	**% of patients likely or extremely likely to recommend the service**	Quarterly	Monthly performance report from West and South Yorkshire and Bassetlaw Commisisoning Support Unit
	% of patients agreed or strongly agreed that they were happy with how long it took for the telephone to be answered	Quarterly	
	% of patients agreed / strongly agreed that the were happy that the call taker listened carefully	Quarterly	
	% of patients agreed / strongly agreed that the call handler was reassuring	Quarterly	
	% of patients who agreed / strongly agreed that they were treated with dignity and respect	Quarterly	
	% of patients agreed / strongly agreed that they understood what the call taker said to them	Quarterly	
	% of patients agreed / strongly agreed that they understood the information and advice given	Quarterly	
	% of patients outlined that they followed the advice given	Quarterly	
Patient Safety	**% of staff that have attended Basic Adult Safeguarding training to include updates on local policies and procedures**	Annual	
	% of eligible staff who have had a CRB check within the last 3 years	Annual	
	% of new staff recorded as having received training on the awareness of the Mental Capacity Act (2005) and Mental Advocate act (2007) at induction	Annual	

Back to Menu

Definitions of indicators/targets

F&FT– Friends and Family Test (CHFT and BMI Huddersfield only)	RAG rating
The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. It is initially for providers of NHS funded acute services for inpatients (including independent sector organisations that provide acute NHS services) and patients discharged from A&E (type 1 & 2) from April 2013. Return Rate (2013/14) – 15% at Quarter 1, Quarter 2,3 & 4 must be at least 20%. Total Eligible – Total of number of patients within the reporting period eligible to reply Net Promoter Score The scores are calculated as follows: "Proportion of respondents who would be extremely likely to recommend. Response Category: Extremely Likely" - "Proportion of respondents who would be unlikely to recommend. Response category: neither likely or unlikely, unlikely and extremely unlikely"	There is no amber within this category. Red = > Return rate quarterly target Green = < Return rate quarterly target

EMSA – Elimination of Mixed Sex Accommodation (CHFT, SWYPFT and BMI Huddersfield only)	RAG rating
The NHS Operating Framework for 2012-2013 confirmed that all providers of NHS funded care are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient. From 1 December 2010, the collection of monthly Mixed-Sex Accommodation (MSA) breaches was introduced. NHS organisations submit data on the number of occurrences of unjustified mixing in relation to sleeping accommodation. The collection will enable the analysis and publication of consistently defined data to allow patients and members of the public to understand the extent to which MSA is occurring at individual organisation (NHS England)	There is no amber for this category. Red = > 0 for the number of mixed sex breaches Green = 0 for the number of mixed sex breaches

CQUIN Service User Survey - inpatient survey and community survey (SWYPFT only)	RAG rating
The measure complrises 9 questions with target of greater than 75% positive response per question.	RAG rating is part of the overall CQUIN scheme performance measured quarterly

% Complaints including staff attitude as an issue (SWYPFT only)	RAG rating
Target reported as priority in the Quality Account under the objective: Listen to service users and act on feedback. This links to Francis recommendations. Target is less than 25% of complaints include staff attitude as an issue.	

Complaints received (NHS 111 only)	RAG rating
Number of complaints received across the whole NHS 111 service for Yorkshire and the Humber	There is no RAG rating for this.

Compliments received (NHS 111 only)	RAG rating
Number of compliments received across the whole NHS 111 service for Yorkshire and the Humber	There is no RAG rating for this.

% of new staff recorded as having received training on the awareness of the Mental Capacity Act (2005) and Mental Advocate act	RAG rating

% of patients likely or extremely likely to recommend the service (NHS 111 only)	RAG rating
An internal patient experience measure for the NHS 111 service. An external company surveys a minimum of 1% of patients who have accessed the service. Links to domain 4 of the NHS Outcomes Framework.	There is no RAG rating for this.

% of patients agreed or strongly agreed that they were happy with how long it took for the telephone to be answered (NHS 111	RAG rating
An internal patient experience measure for the NHS 111 service. An external company surveys a minimum of 1% of patients who have accessed the service. Links to domain 4 of the NHS Outcomes Framework.	There is no RAG rating for this.

% of patients agreed / strongly agreed that the were happy that the call taker listened carefully (NHS 111 only)	RAG rating
An internal patient experience measure for the NHS 111 service. An external company surveys a minimum of 1% of patients who have accessed the service. Links to domain 4 of the NHS Outcomes Framework.	There is no RAG rating for this.

% of patients agreed / strongly agreed that the call handler was reassuring (NHS 111 only)	RAG rating
An internal patient experience measure for the NHS 111 service. An external company surveys a minimum of 1% of patients who have accessed the service. Links to domain 4 of the NHS Outcomes Framework.	There is no RAG rating for this.

% of patients agreed / strongly agreed that they understood what the call taker said to them (NHS 111 only)	RAG rating
An internal patient experience measure for the NHS 111 service. An external company surveys a minimum of 1% of patients who have accessed the service. Links to domain 4 of the NHS Outcomes Framework.	There is no RAG rating for this.

% of patients outlined that they followed the advice given (NHS 111 only)	RAG rating
An internal patient experience measure for the NHS 111 service. An external company surveys a minimum of 1% of patients who have accessed the service. Links to domain 4 of the NHS Outcomes Framework.	There is no RAG rating for this.

BMI Inpatient Survey - involved satisfactorily in decisions about care & treatment (question 1)	RAG rating
Internal patient experience measure included by BMI Huddersfield in their inpatient survey. Links to domain 4 of the NHS Outcomes framework.	(Set by BMI Huddersfield.) Green = 95% or above satisfied. Red = below 95% satisfied

BMI Inpatient Survey - privacy when discussing conditon / treatment (question 3)	RAG rating
Internal patient experience measure included by BMI Huddersfield in their inpatient survey. Links to domain 4 of the NHS Outcomes framework.	(Set by BMI Huddersfield.) Green = 95% or above satisfied. Red = below 95% satisfied

Never Events (CHFT and BMI Huddersfield only)	RAG rating
Number of never events which have occurred. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.	Green = 0 Red = above zero

MSSA (CHFT and BMI Huddersfield only)	RAG rating
Number of MSSA cases. No national targets set but CCGs are required to monitor levels.	No RAG rating

C-Diff – Clostridium Difficile (CHFT and BMI Huddersfield only)	RAG rating
Targets are set nationally and are based on the previous year's figures with a reduction. The calculation of the targets are applied nationally. Acute trust calculation is based on bed days, and CCGs on population rates.	Green - below trajectory and below annual target Amber - above trajectory but below annual target Red - above annual target

MRSA (CHFT and BMI Huddersfield only)	RAG rating
Objectives for MRSA for 2013/14 have been set at zero tolerance. NHS England has published guidance on the reporting arrangements for MRSA – "Guidance on the reporting and monitoring arrangements and post infection review process for MRSA bloodstream infections from 1st April 2013". A Post Infection Review (PIR) for all MRSA bloodstream infection cases will now take place, which replaces the current requirement to undertake a root cause analysis. For CCGs this guidance provides an opportunity to collaborate closely with the organisations involved in providing patient care. CCGs will be responsible for leading the PIR, and the Quality and Safety Committee agreed that this work should continue to be carried out by the Infection Control Team on behalf of the CCG.	Red = > 0 avoidable cases Green = 0 avoidable or unavoidable cases

VTE (Venous Thromboembolism) Risk Assessment (CHFT and BMI Huddersfield only)	RAG rating
VTE risk assessment measures were introduced as part of CQUIN schemes in 2010/11. The performance for CHFT against the measure of the % of all adult in patients who have had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool is included in the table below. The national performance target is 95%.	This particular rag rating is based on a banding number using the 99.8% control limit derived from an exact Poisson distribution (decided nationally) with: 1 - Higher than expected (red), 2 - As expected (blue), 3 - Lower than expected (green).

Overall Hospital Standard Mortality Rate (HSMR) (CHFT only)	RAG rating
HSMR - The HSMR compares the expected rate of death in a hospital with the actual rate of death. The deaths are within 56 conditions that account for 80% of the deaths. 100 is the national average - it is inevitable that half of hospitals will fall below this rate. If the number is more than 100 then this shows that the Trust is above the national average. However the RAG is based on national outliers.	This particular rag rating was changed in October 2014 with the development of the new regional dashboard. Green = Rate observed as expected Amber = statistically worse than other trusts in England Red = Cause for concern

Summary Hospital Level Mortality Indicator (SHMI) (CHFT only)	RAG rating
SHMI – The SHMI compares the observed number of all hospital deaths together with those 30 days after discharge to the expected number of hospital deaths together with those 30 days after discharge. The SHMI indicator gives an indication of whether the mortality ratio of a provider is as expected, higher than expected or lower than expected when compared to the national baseline (England).	This particular rag rating was changed in October 2014 with the development of the new regional dashboard. Green = Rate observed as expected Amber = statistically worse than other trusts in England Red = Cause for concern

Mortality by weekend data HSMR (CHFT only)	RAG rating
Non elective HSMR with a Saturday or Sunday admission. This is a relative measure comparing the organisation to an England average of 100 - it is inevitable that half of hospitals will fall below this rate. If the number is more than 100 then this shows that the Trust is above the national average. However the RAG is based on national outliers.	This particular rag rating was changed in October 2014 with the development of the new regional dashboard. Green = Rate observed as expected Amber = statistically worse than other trusts in England Red = Cause for concern

Never Events	RAG rating
Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. There is zero tolerance for “never events.” The full ‘never events’ list for reference is:	Red = > 0 never events occured Green = 0 never events occurred
1. wrong site surgery 2. wrong implant/prosthesis 3. retained foreign object post-operation 4. wrongly prepared high-risk injectable medication 5. maladministration of potassium-containing solutions 6. wrong route administration of chemotherapy 7. wrong route administration of oral/enteral treatment 8. intravenous administration of epidural medication 9. maladministration of insulin 10. overdose of midazolam during conscious sedation 11. opioid overdose of an opioid-native patient 12. inappropriate administration of daily oral methotrexate 13. suicice using non-collapsible rails 14. escape of a transferred prisoner 15. falls from unrestricted windows 16. entrapment in bedrails 17. transfusion of AB-incompatible blood components 18. transplantation of ABO-incompatible organs as a result of error 19. misplaced naso - or oro-gastric tubes 20. wrong gas administered 21. failure to monitor and respond to oxygen saturation 22. air embolism 23. misidentification of patients 24. severe scalding of patients 25. maternal death due to post partum haemorrhage after elective Caesarean section	

Serious Incidents (CHFT, SWYPFT, BMI Huddersfield and NHS 111)	RAG rating
In summary, this definition describes a serious incident as an incident that occurred during NHS-funded services and care (including in the community), which resulted in one or more of the following; • Unexpected or avoidable death or severe harm of one or more patients, staff or members of the public; • A never event - all never events are defined as serious incidents although not all never events necessarily result in severe harm or death (Never Event Framework, 2010; updated list 2012 2013); • A scenario that prevents, or threatens to prevent, an organisation’s ability to continue to deliver healthcare services, including data loss, property damage or incidents in population programmes like screening and immunisation where harm may extend to a large population; • Allegations, or incidents, of physical abuse and sexual assault or abuse; and/or • Loss of confidence in the service, adverse media coverage or public concern about healthcare or an organisation (Serious Incident Framework, NHSCB, 2013)	There is no RAG rating for this measure

National Patient Safety Agency (NPSA) Safety Alerts CAS (CHFT, SWYPFT and BMI Huddersfield)	RAG rating
Alerts cover a wide range of topics, from vaccines to patient identification. Types of alerts include Rapid Response Reports, Patient Safety Alerts, and Safer Practice Notices. Providers are required to respond to the alerts regarding the action they have taken as outlined in the alert.	• Green – percentage completed within deadline date is greater than or equal to 90% in 6 month rolling period • Red – percentage completed within deadline date is less than 90% over a 6 month rolling period

% Service users on Care Programme Approach (CPA) followed up within 7 days from inpatient care (SWYPFT only)	RAG rating
These targets are set by Monitor. Forensic settings are excluded from this target nationally	Green = achieving target Amber = within 10% of target Red = More then 10% away from target

% Service users on Care Programme Approach (CPA) having formal review within 12 months (SWYPFT only)	RAG rating
These targets are set by Monitor. Older adult services are excluded from this target nationally.	Green = achieving target Amber = within 10% of target Red = More then 10% away from target

Delayed Transfer of Care (SWYPFT only)	RAG rating
This target is set by Monitor. This is to ensure that service users are treated in the most appropriate setting	Green = achieving target Amber = within 10% of target Red = More then 10% away from target

CQC Inpatient Survey (CHFT)	RAG rating
This is an annual inpatient survey undertaken by Acute Trusts.	Score is on a scale of 0-10. RAG rating – Green = better than national average Amber = about the same as the national average Red = worse than other similar trusts that participated within the survey

Staff Survey (CHFT & SWYPFT)	RAG rating
	Score is on a scale 0-5 RAG rating – Green = best performing trusts Amber = about the same Red = worst performing trusts

Monitor Governance (CHFT & SWYPFT)	RAG rating
Foundation trusts' risk ratings are updated each quarter. Monitor also update risk ratings in 'real time' to reflect, for example, a decision to find a trust in significant breach of its terms of authorisation or the Care Quality Commission's regulatory activities.	• Red - Likely or actual significant breach of terms of authorisation • Amber-red - Material concerns surrounding terms of authorisation • Amber-green - Limited concerns surrounding terms of authorisation • Green - No material concerns

CQUINs (CHFT, SWYPFT, YAS, Locala, BMI, Spire)	RAG rating
CQUIN (Commissioning for Quality and Innovation) - The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.	Above 90% - Green 89-71% - Amber Below 70% - Red

PROMs (CHFT only)	RAG rating
4 conditions. Previously reporting has been on response rates only. Now it is on actual outcomes and response rates. 3 types of outcome are collected for all but The first 2 are patient questionnaires based on how patients perceive their function – self reported. The condition specific for hip and knee is carried out with a Interesting to see that the ones where they actually assess the function show a better improvement than patient perception. If dark blue is shorter than triangle then CHFT are doing better than average. If light blue is longer than triangle then CHFT doing better than national average. 2012/13 changes to methodology: using differences between pre and post scores rather than the ratio of post to pre scores; allocating health gains to the provider who carried out the procedure, rather than the one who conducted the pre-op survey (where these differ). Neither change makes a difference to the national scores. The first has a small impact on the adjusted scores for individual organisations; the second, only for those organisations with significant numbers of patients having their operation at a provider which was not the one who administered the questionnaire.	Key – blue bar is CHFT. Triangles are national average. Dark blue = patients reporting worse outcome following treatment. Light blue = patients reporting better outcome than treatment.

Safety Thermometer (CHFT & SWYPFT)	RAG rating
The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. The Safety Thermometer gives providers of NHS care the ability to measure and monitor local improvement over time. Each organisation collects and inputs real time data relating to inpatients on one specific day per month. A timetable is provided for submission and published nationally each month. Once submitted, data is collated with data provided from other organisations and then made available for analysis at local, regional and national level by the Health and Social Care Information Centre. At present information for SWYPFT is collated on measures that have been set for acute trusts. A system for mental health is being piloted and is now in its second phase.	A RAG rating has not been developed for this measure, however robust reporting and a reduction in the prevalence of pressure ulcers is part of the CQUIN scheme.

PLACE (CHFT & SWYPFT)	RAG rating
The introduction of PLACE was announced in February 2013 for all providers of NHS funded care. The first annual assessments took place between April and June 2013 with results published during September 2013. The aim is to provide a snapshot of performance against 4 non-clinical activities impacting on patient care: Cleanliness Privacy, dignity and wellbeing Condition, appearance and maintenance Food and Hydration	Red = <80% and below national average Amber = >80% but below national average Green = >80% and above national average

CQC Intelligence Monitoring	RAG rating
As from October 2013, CQC no longer use the Quality Risk Profiles (QRPs) in the monitoring of NHS acute and specialist hospitals. These have now been replaced with Intelligent Monitoring Reports. The surveillance model is built on a suite of indicators that relate to the five key questions that CQC will ask of all services – are they safe, effective, caring, responsive and well led. These indicators will be used to raise questions about the quality of care but will not be used on their own to make final judgements. These judgements will be based on a combination of what CQC find at inspection, national surveillance data and local information from the trust and other organisations.	Each indicator is analysed to identify one of the following levels for each trust: • "No evidence of risk" • "Risk" • "Elevated risk" CQC then create an overall summary band for each trust, by reviewing the proportion of indicators that have been identified as "risk" or "elevated risk" for each trust out of all the applicable indicators in the model. Trusts are categorised into one of six summary bands, with Band 1 representing highest risk and Band 6 with the lowest

Warm transfers (NHS 111)	RAG rating
The contractoer will deliver warm transfer from 111 call handler to the 111 clinician for 95% of calls within the 111 service, where input from 111 clinician is deemed necessary.	Green = 95% or above Amber = 90% to 95% Red = below 90%

The contractor must have a robust system for identifying all immediate life threatening conditions; these calls must be passed to the ambulance service within 3 minutes. (NHS 111)	RAG rating
The NHS pathways system is used. This is a national tool which been developed and approved by clinicians and is used by all NHS 111 providers nationally.	Green = yes Red = no

Staffing Levels (CHFT & SWYPFT)	RAG rating