Leicester
City Council

Minutes of the Meeting of the
HEALTH SCRUTINY COMMITTEE

Held: TUESDAY, 29 MARCH 2011 at 6.00 pm

P R E S E N T :

Councillor Bayford- Chair
Councillor Manjula Sood – Vice Chair

Councillor Newcombe

IN ATTENDANCE

Darren Hines	–	Leicester Local Involvement Network
Carole Ribbens	–	Director of Nursing, University Hospitals of Leicester NHS Trust
Caroline Trevithick	–	Deputy Director of Quality, University Hospitals of Leicester NHS Trust
Deb Watson	–	Director of Public Health and Health Improvement
Jo Yeaman	–	Programme Director – Service Redesign, NHS Leicester City

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66. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Clayton.

Apologies for absence also were received from Councillor Naylor as, although not a member of the Committee, he attended regularly in his capacity as Lead Member for Health and Community Safety.

67. DECLARATIONS OF INTEREST

Councillor Bayford declared a personal interest in the general business of the meeting, in that his wife was a salaried GP, although she was not a partner in the practice.

Councillor Manjula Sood declared personal interests in relation to the general business of the meeting, in that she was a patron of CLASP, the Chair of the Leicester Council of Faiths and an ambassador for the East Midlands for Sporting England.

68. MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on 9 February 2011 were approved as a correct record.

69. PETITIONS

The Director of Corporate Governance reported that no petitions had been received.

70. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Director of Corporate Governance reported that no questions, representations, or statements of case had been received.

71. PLANS TO INCREASE INTERMEDIATE CARE BED CAPACITY WITHIN LEICESTER CITY

Jo Yeaman, (Project Director working for Primary Care Trusts in Leicester, Leicestershire and Rutland), presented a report on NHS Leicester City's tendering process to increase community based beds in the City. The Committee noted that this report had been approved at the NHS Leicester City and NHS Leicestershire County and Rutland Board Meeting on 10 March 2011.

Jo Yeaman explained that, typically, patients needing intermediate care beds were over 65, but this was not a requirement. There were three types of intermediate care beds, so patients went in to them with a very clear care plan:-

- To avoid admission to hospital: These tended to be used by elderly, frail patients who were experiencing some kind of crisis, but which was not acute enough to lead to them being admitted to hospital, (for example, when help was needed in managing a condition);

- For patients who had been in hospital: These were used by patients who were medically fit, but needed more care before they went home; and

- Rehabilitation: These were the most used type of intermediate care beds. Patients were able to learn new skills that enabled them to look after themselves at home.

It was acknowledged that there could be better outcomes for patients if there was better access to intermediate care, so a target of having 57 intermediate care beds had been set. There currently were 27 in the City, which were spot-purchased, (ie, as needed), from Brookside (for hospital avoidance) or

Clarendon Mews (for rehabilitation). The 18 beds in the County were located across various hospitals.

It was proposed to increase the number in the City by 12. It had been suggested that Leicester General Hospital would be the most appropriate place to have these beds, but the accommodation there was not right to enable patients to be rehabilitated effectively. This option had not been rejected, but had been put on hold. Different types of staff were needed for the different types of intermediate care beds, so if all of the beds were in one unit the staff could be deployed where they were needed.

An advertisement would be released on 30 March 2011, inviting expressions of interest. It was hoped that the new arrangements could be in place in time to deal with the increased pressures experienced over winter periods, to ensure there was no service disruption. Some suppliers could need a longer time to prepare beds, (for example, if they were a new supplier), but until options had been identified, it would not be possible to do a risk assessment. Jo Yeaman offered to bring this assessment to the Committee when it was complete.

The following points were made in response to questions from Members:-

- People typically stayed in an intermediate care bed for a maximum of between four and six weeks. However, in the City a lot of beds were for rehabilitation purposes, from which people moved on in approximately two weeks;

- The provision of additional beds would reduce delays currently experienced by people needing an intermediate care bed. Achieving this reduction was a performance indicator and a key reason for increasing provision;

- Different suppliers made different charges for their beds, which accounted for the differences in costs between the City and the County. There also were differences in accommodation and staffing costs, due to the different needs of the users of the different types of bed. It was hoped that the new contract would make the provision of beds more cost-effective;

- The modelling used to assess the need for beds had taken in to account expected long-term population growth; and

- NHS Leicester City was working with Leicestershire County Council to develop a joint strategy for intermediate care, as it was very important that the work being done was more co-ordinated. It was expected that the strategy would be available in May 2011 and Jo Yeaman offered to report it to this Committee when it was available.

72. CARE OF ELDERLY PATIENTS BY THE NHS

The Chair welcomed the members of the public who had attended the meeting for this item. He indicated that he was willing to let a few of these people speak

to the meeting, but would not let the item be debated for too long. He also stressed that the Committee was not able to discuss individual cases.

Carole Ribbins, (Director of Nursing, University Hospitals of Leicester NHS Trust), gave a presentation on Older People's Care, a copy of which is attached at the end of these minutes for information.

The meeting was reminded that there had been a campaign in the Leicester Mercury over recent weeks regarding patient care, and particularly that of the elderly. 97% of patients reported that they had had a good experience with the NHS, but this meant that 3% had not. These situations were taken very seriously and the issues identified addressed. To help in this, key targeted interventions had been examined a few years ago, in order to change staff behaviour, so that it became second nature to provide the best care possible.

Carole Ribbins drew particular attention to the following points:-

- An interactive training module had been developed, which encompassed the fundamental things that needed to be at the heart of patient care. All nursing staff went through this and a 100% pass rate was expected;

- Extra hourly ward rounds by a designated nurse for every patient had been introduced in the United States of America in recent years, as a supplement to care. The experience of patients and their relatives had improved as a result of this and staff stress levels had reduced. Following its introduction in Leicester, other hospitals in the East Midlands also were considering introducing it;

- "Nurse in Charge" badges had been used in the Accident and Emergency Department for some time. This had been extended to wards for elderly patients in the last few weeks and had received very positive feedback;

- It was planned to introduce large red badges for Matrons;

- Data was collected from many different sources, but this could result in conflicting reports and sometimes did not give the whole picture of a situation. It therefore was proposed to include information such as complaints and compliments, and feedback from staff and patients in data analysis;

- It was important to celebrate and recognise good role models amongst staff, but it was equally important to recognise when staff were not working to expected standards of care;

- The roll-out of the proposed interventions would be done in conjunction with other work, such as that being done in dementia care; and

- The University Hospitals of Leicester NHS Trust was committed to making the changes needed to make poor patient experience a thing of the past.

Caroline Trevithick, (Deputy Director of Quality, NHS Leicester City), then briefed the Committee on the Care of Older People. A copy of her presentation is attached at the end of these minutes for information.

Caroline Trevithick drew particular attention to the following points:-

- Work was ongoing to ensure that all issues raised by the public were directed to one place;

- A link had been put on the University Hospitals Leicester website to advertise the Patient Advice and Liaison Service for people wishing to raise concerns and complaints;

- The contractual process could be used to reduce themes and trends in complaints. However, NHS Leicester City did not necessarily want to reduce the number of complaints, as they provided very useful feedback;

- In this context, quality was measured through three elements: patient safety, patient experience and clinical effectiveness;

- The process being used helped the organisation to understand the problems it was facing and see why some things were not progressing as they should be;

- The care of stroke patients was a very important area and showed how indicators could be set nationally to improve standards; and

- Care was taken to ensure that standards were improving across the whole area, not just in a few locations.

The Committee welcomed these presentations and the recognition that, while a lot of good work was being done, improvements needed to be made in some areas. The stories recently featured in the Leicester Mercury highlighted the need for the improvements being discussed, to have mechanisms that ensured that care of the expected quality was being given and to highlight any shortfalls in this as soon as possible.

However, it was equally important to ensure that staff morale was good and that the correct staffing levels were being used. Carole Ribbins assured the Committee that staffing levels were reviewed ward by ward on a daily basis, and formally once a month. As well as this, a formal review of elderly people's wards was being undertaken and should be completed by the end of April 2011. Caroline Trevithick explained that formal quality visits were made as part of the monitoring process and were joined by non-executive directors. These had been invaluable in ensuring that action was taken where needed.

In addition, staff surveys were carried out, from which it had been found that morale on wards for elderly patients was not lower than on other wards. Although morale was recognised as a potential factor in maintaining care standards, other factors could be equally important, including effective

leadership and high standards of nursing care.

The following responses were made to points raised by Daren Hines, of Leicester Local Involvement Network:-

- *One ward should not be better than another. Although elderly people could have very complex needs, there could be people who had no-one to speak up for them*.

  Carole Ribbins stressed that all wards should give the same standards of care, even though they could have very different types of patient needs.

- *Did hourly visits to wards by matrons mean that something else was not being done?*

  Carole Ribbins confirmed that it had been found that these visits released time, as issues could be identified and resolved before they became major issues.

- *Could wards be staffed properly, when new staff were not being recruited and the NHS was having to make significant reductions in costs?*

  Safety came before financial considerations. Where there were shortages of permanent staff, in-house agency staff could be deployed. This was working well.

- *There did not appear to be a process that could be followed to determine which agency staff had been working on a ward when a particular problem occurred.*

  Carole Ribbins confirmed that this could be tracked, as the agency staff had to be booked through a central office and an audit trail was required.

  Carole Ribbins also advised that the work being done by volunteers was being reviewed. These people could offer their time for as little as one hour a month, or substantially more frequently, and provided very useful services, such as hand massages, hair dressing, or writing cards or letters. This was particularly important for anyone who did not have visitors while in hospital.

- *Cleaning and catering staff often seemed to know the patients better than the nursing staff did. Could a system be established where they could be used as a conduit through which patients could raise issues or concerns?*

  If anyone had a fear of complaining to staff on the ward, there already were other ways in which their issues could be raised.

The following points were then made in response to questions and comments from the Committee:-

- The number of nurses on each ward depended on the size of the ward. Approximately 30 – 40 nurses were employed for each ward, including care assistants. They worked on a shift system, so approximately 8 nurses would be on the ward at one time, although this number could vary depending on the speciality of the ward. There usually was a ratio of 60% qualified staff to 40% unqualified staff;

- The majority of nurses were employed to work on a specific ward. Temporary (bank) nurses were the exception to this;

- Lack of cleanliness in hospitals was a major concern to many people;

- It would be very useful if some indication could be provided of the level of complaints now and in the future, so that it could be seen if the new measures introduced were working;

- A booklet had been produced that translated information about raising concerns and making complaints and translators were available, as the NHS wanted to ensure that the needs of the whole population of the City were being met. However, it appeared that this had not been happening;

- If people were aware of the complaints procedure, more complaints would be made, which would be of benefit to the organisations concerned;

- There was a lack of understanding about what the various organisations were and their respective roles, (for example, the primary care trust, University Hospitals Leicester, Patient Advice and Liaison Service, Patient Information and Liaison Service); and

- Websites needed to be clear and easy to access and consideration needed to be given to which websites the general public were likely to access to find the information they needed. The driver for this needed to be ensuring that the public knew who to approach and how to use the various processes available to them.

At the invitation of the Chair, various members of the public in attendance at the meeting were then invited to address the Committee. The following points were made and responded to as indicated:-

- *If a lot of people were afraid of complaining, many complaints would not be made, even if the procedure for doing so was very clear*.

  Carole Ribbins advised that this was a pivotal issue which the University Hospitals of Leicester NHS Trust was committed to addressing, although it was recognised that it was hard to resolve, as the public generally did not like complaining.

- *Why were nurses allowed to work 12 or 14 hours a day on wards with vulnerable patients? After shifts of this length they had no energy and no*

interest in what was happening on a ward. When a complaint about this was made at the Evington Centre this a few years ago, assurances had been given that procedures to avoid this were being brought in, but staff were still working these hours.

Caroline Trevithick undertook to check the patient safety reports from the Evington Centre, as this was somewhere from which services were commissioned. If anyone wished to make a formal complaint about care received there, they could approach the Leicester Partnership Trust. Alternatively, the Primary Care Trust could investigate a matter on someone's behalf.

Carole Ribbins confirmed that, over a number of years, various shift patterns had been established nationally, which had been supported by the nursing and midwifery councils. The main driver was patient care, but on some wards it was feasible to do a 12 hour shift, with appropriate breaks, with two shifts being worked over a five day period.

If it was found that nurses were not functioning to the standards required for any reason, (not just the hours being worked), they would become subject to the hospital's disciplinary process. The final sanction under this was dismissal and this was used where necessary.

- *There could be many frustrations involved in getting the care needed. For example, it could be difficult to get appointments with doctors, there was a known case where a doctor had refused to treat someone because the patient was on a research programme, appointments were often cancelled and some doctors were unaware of how some conditions should be treated. This meant that, if someone was not able to speak up for themselves, they could have difficulty in getting the care they needed, which was of particular concern for the vulnerable.*

  These points were recognised and assurances given that the importance of focussing on areas where the NHS was not performing properly was recognised.

- *What was being done to increase the currently low staff morale?*

  It was noted that it was easy to state that morale was low, but it was important to ensure that there was evidence to support such a claim. Staff were surveyed anonymously and the results of these surveys were taken very seriously, it being a large part of managers' remit to analyse them in great detail.

- *Consideration needed to be given to the hours being worked by nurses, as 12 hour shifts were designed to meet the needs of the nurses, not the patients*. *It also needed to be clear which matrons were allocated to each ward.*

  Carole Ribbins explained that long shift systems were used widely

throughout the country and abroad. Not all nurses were allowed to work these longer hours, as the shift system adopted for each ward had to meet the needs of that ward. However, staff also needed to have shifts that enabled an appropriate work-life balance to be maintained. Consequently, staffing was monitored very carefully and, if issues were identified, staffing rotas were amended as needed.

The importance of clearly identifying matrons was recognised. Although they were a tier of management, they were very clinically focused and so had an important role to play.

RESOLVED:

that consideration of the complaints procedure be included in the future work programme for this Committee.

73. PRIMARY CARE TRUSTS STRATEGIC OPERATING PLAN

Sue Bishop, (Director of Finance with NHS Leicester City, Leicestershire County and Rutland), tabled an updated version of the presentation on the 2011/12 Strategic Operating Plan (SOP) and Financial Plan that had been circulated with the agenda. A copy of this is attached at the end of these minutes for information.

Sue Bishop drew particular attention to the following points:-

- The 2011/12 operating framework was issued in December 2010. The main themes of this were transition and reform, transparency and local accountability, and service quality;

- Part of the dis-establishment of primary care trusts involved moving some services to local authorities and some to national provision, (for example, specialist services would be focussed in a small number of units around the country). The proposed GP consortia would be nearer to the patients, so would have a greater understanding of their needs;

- The City, county and Rutland areas all had very different health needs. This was recognised in the Plans and underpinned what it was expected would be delivered during 2011/12;

- The areas for improvement had been identified nationally. The underlying theme of these was the protection of vulnerable groups in the population;

- Locally, an additional £44 million of funding had been agreed to protect services. This equated to approximately 3% of the budget. Just under £564 million was available to spend across Leicester City;

- Incentives for health and social care services to work together would be provided through the Plans. In this way, it was hoped to increase social support and reduce hospital admissions and readmissions. To assist with

reducing readmissions, approximately £10 million had been made available for re-ablement services;

- Just over £28 million had been set aside for service transformation. Advances in technology and treatments meant that it now was possible to treat patients to a more complex level, so the way in which services were provided needed to change. Under the current Plans, it was expected that a surplus of just under £10 million would be generated, which could be used to fund services in future years;

- The SOP was supported by the newly emerging GP consortia and had been submitted to the Department of Health for approval. It was expected that this would be received in the next few weeks. Consultation would be undertaken if needed before it was implemented;

- QIPP was a programme created nationally, but delivered locally, to improve Quality, Innovate, gain Productivity and achieve the Prevention of disease; and

- Challenges and risks had been identified, to ensure that things that would make the biggest difference to the public remained the main focus of the Plans and that clinical engagement was maintained.

The following points were made discussion on this item:-

- There was a need to ensure that quality services were delivered. Sue Bishop confirmed that more was being required from fewer resources. This was helped by the quality of data available, as this helped in making more accurate comparisons and benchmarking against other areas;

- In many parts of the country, respiratory disease was dealt with in the community, as this could reduce, or avoid, hospital admissions, and improved outcomes for patients. Financial savings also could be made, as hospitals and GPs could pay different rates for drugs, due to the different ways in which they bought them;

- Most respiratory disease was driven by smoking. Helping smokers to stop, and stopping the recruitment of replacement smokers, therefore as key areas of work between the City Council and the NHS. The importance of air quality, including traffic pollution, also was important, so work on this included the promotion of activities such as walking or cycling; and

- Under the current White Paper on reforming health services, responsibility for health improvement would move from the NHS to local authorities, which would help health improvement become embedded in local services.

74. IMPROVING HEALTH IN LEICESTER - THE ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH AND IMPROVEMENT 2010

The Director of Public Health and Health Improvement 2010 presented the

Annual Report of the Director of Public Health and Health Improvement 2010, "Improving Health in Leicester".

The Committee welcomed this report, recognising the importance of the matters reported on, and

RESOLVED:

that the Annual Report of the Director of Public Health and Health Improvement 2010 be noted.

75. HEALTH SCRUTINY COMMITTEE WORK PROGRAMME 201/11

RESOLVED:

that the Health Scrutiny Committee Work Programme for the 2010/11 municipal year be noted.

76. ANY OTHER URGENT BUSINESS

FUTURE OF EAST MIDLANDS CONGENITAL HEART CENTRE (EMCHC)

The Chair agreed to accept this item as urgent business, as there was a fixed period of consultation on proposals for the future of the EMCHC, but due to the forthcoming elections it was not known when this Committee's next meeting would be held.

The Committee was reminded verbally that the NHS recently had launched a major consultation on the way in which children's congenital heart services should be provided in the future. The outcome of this would determine the future of the EMCHC, which was based at Glenfield Hospital. Members therefore were asked to support the retention of the Centre, which featured as Option A of the consultation.

The Committee expressed its support for the statement made at the Council meeting on 24 March 2011 by the Lead Member for Health and Community Safety in favour of keeping the Centre at Glenfield Hospital.

77. CLOSE OF MEETING

The meeting closed at 8.52 pm

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University Hospitals of Leicester NHS
NHS Trust
Caring at its best

Carole Ribbins
Director of Nursing
University Hospitals of Leicester NHS Trust

Older People's Care

One team shared values

Caring at its Best Training

University Hospitals of Leicester NHS
NHS Trust
Caring at its best

- An interactive training module has been developed for nursing staff which deals with the basics of clinical patient care (Falls / Tissue Viability / Pain / Nutrition / Continence / etc)
- The purpose of the training is to remind ward staff what the gold standard of care should be. Our wards have begun to focus on these issues through the nursing metrics; the interactive training will remind people that we not only measure these important components of care but why they are important in the first place.

One team shared values

Hourly Ward Rounds

University Hospitals of Leicester NHS
NHS Trust
Caring at its best

- We are supplementing current nursing practice with an extra hourly ward round by a designated nurse for every patient. During this round each patient will be asked…
  - How are you feeling / are you in any pain?
  - Would you like a drink?
  - Do you need to go to the toilet?
  - Are you comfortable in bed?
  - Make sure the call bell is within reach
  - Ask if there is anything you need before leaving
  - Explain a nurse will be back again in 1 hour

One team shared values

Nurse in Charge

University Hospitals of Leicester NHS
NHS Trust
Caring at its best

- We assume that patients and relatives understand the 'code / status' which our uniforms indicate. The reality is that they do not. And as such patients and relatives are often unsure of who to talk to about care issues. So whilst we look into the wider issue of wholesale change to uniforms we will ensure that on every ward at every time of the day or night the person in charge wears a large, red, 'Nurse in Charge' badge.

One team shared values

Matron Rounds

University Hospitals of Leicester NHS
NHS Trust
Caring at its best

- Daily ward visits by matron during visiting times already take place. Matrons are usually responsible for 3-4 wards and though they will already visit these wards on a daily basis we will introduce dedicated time on each ward, every day for patients and or their relatives to sit down and talk to the matron about any aspects of their / their relatives care.

One team shared values

Measurement

University Hospitals of Leicester NHS
NHS Trust
Caring at its best

- We collect lots of data, at lots of different points, for all of our wards. However this data is not currently triangulated as best as it could be. As such the data often confirms when a ward has problems after the problems have become apparent but does not act as a predictor.

One team shared values

Sanctions When Staff Break With Our Values

University Hospitals of Leicester NHS
NHS Trust
Caring at its best

- As well as celebrating the many staff who do such wonderful jobs and who often go above and beyond for their patients we need to be clear about what the response is to staff who break with our values and behave in ways which are at odds with our desire to give patients the kind of care we would expect for ourselves.

Targeted Action

University Hospitals of Leicester NHS
NHS Trust
Caring at its best

- Every intervention described is intended for Trust wide roll out. However we want to get moving quickly; as such we have already introduced each of these measures on the elderly care wards at the Leicester General Hospital.

One team shared values

Conclusion

University Hospitals of Leicester NHS
NHS Trust
Caring at its best

- Whilst the vast majority of patients tell us they receive a positive patient experience, we are committed to making changes to ensure distressing accounts of poor patient experience are a thing of the past and that all our patients receive Caring at its Best within UHL.

One team shared values

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Briefing for Leicester City Overview and Scrutiny Committee
29th March 2011
Care of Older People

Caroline Trevithick
Deputy Director of Quality

1. Customer Care policies

Since late 2009 NHS Leicester City has handled customer care including complaints and PALS via its Customer Services team, who remained responsible for speaking directly with patients. This also includes ensuring patients are kept informed and involved with their complaint. By handling PALS concerns too, this allowed them to have a broad overview of the complaints and concerns landscape across the city. Learning's from complaints was disseminated to the appropriate teams for follow up to ensure any actions were taken. This includes (but is not limited to) Fitness to Practice, patient safety, infection control and Primary care contracting teams.

Work is ongoing to bring together LCR and LC complaints systems. This new process will be robust, fair and encourage learning across our organisations. The investigatory work will now be lead by staff employed within the directorates. It gives directorate's access to greater intelligence on what is happening in the localities and within the commissioned services themselves. This in turn, can allow staff to pick up on and target any causes for concern earlier and also contribute to making more informed commissioning choices.

The Customer Services team will now also work more closely with the Patient Safety Manager and Patient Experience Manager to ensure patients are receiving a first class service.

All reported concerns and complaints (regardless of how serious or how small) will be held on one database, which will allow us to report accurately on any trends and allow us to pin point any area that needs improvement.

UHL Complaints

As a PCT commissioning services, we are also able to support patients in making complaints about UHL services. If a patient does not feel comfortable approaching UHL, under the NHS Complaints regulations 2009, we can investigate their complaint. UHL are informed of this and an investigation is led by the PCT, with UHL cooperating with this process. Clinical advice can be taken from our clinical advisor, or sought independently.

Any learning from this process is fed back into UHL via the contracts manager who uses the information to inform discussions regarding quality of service with UHL.

Any significant failings found as a result of a complaint would be escalated to the appropriate Director/AD within the PCT and directed to UHL at this level.

Publicising our policy

Our complaints policy is found online and available from the organisation at any time. We also carry literature in other languages, and are able to provide Braille versions and audio tapes if necessary.

2. Complaints monitoring

All patients/carers are advised to talk to a member of staff where they received treatment in order to make a complaint. Often talking things through straight away, problems can be resolved there and then. If the decision is made to make a formal complaint, this is done in writing either to the complaints department of the organisation where the care was provided, or to the commissioning Primary Care Trust. As a PCT commissioning services, we are also able to support patients in making complaints about provider services. If a patient does not feel comfortable approaching the organisation directly, under the NHS Complaints regulations 2009, we can investigate their complaint. The provider organisation is informed of this and an investigation is led by the PCT, with them cooperating with this process. Clinical advice can be taken from our clinical advisor, or sought independently.

Any learning from this process is fed back via the contracts manager who uses the information to inform discussions regarding quality of service with UHL. Any significant failings found as a result of a complaint would be escalated to the appropriate Director/AD within the PCT and directed to UHL at this level.

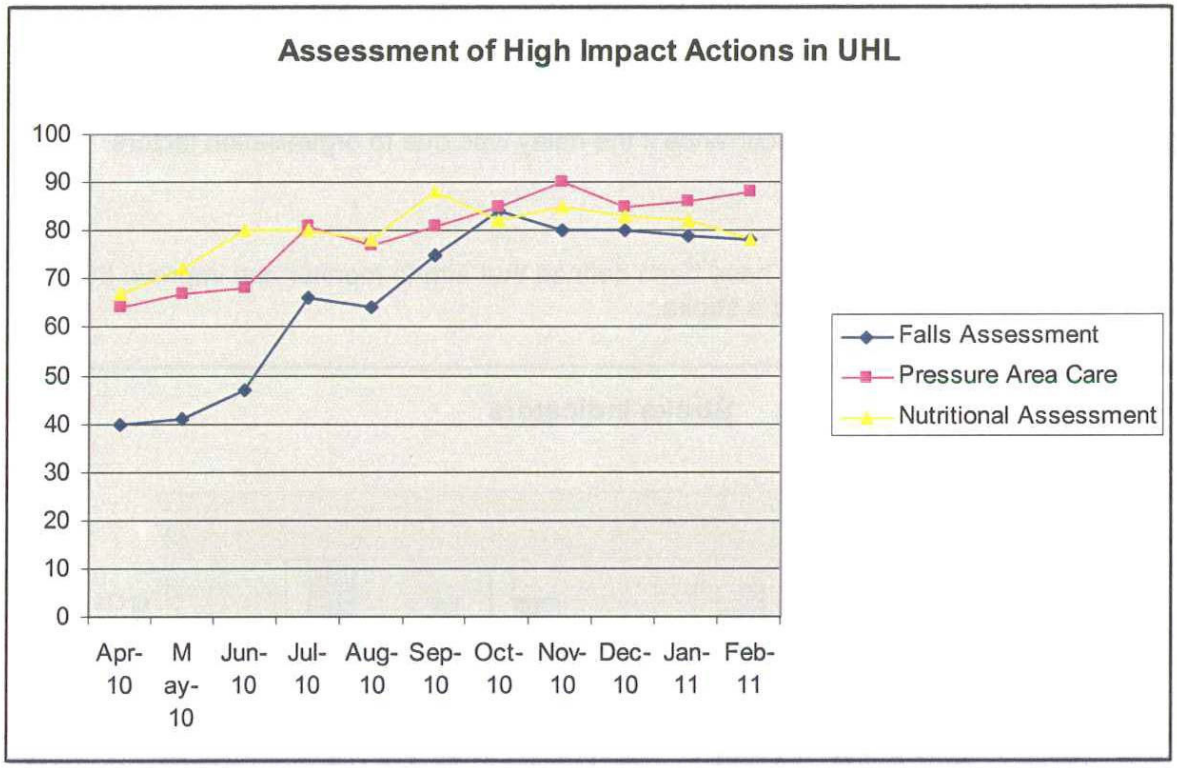
In order to monitor the standard of care provided to patients by the organisations the PCT commissions from, themes and trends are monitored to see if there is a pattern emerging. If this is the case the organisation will be asked to undertake a review and report findings and actions to the PCT. In addition to this the PCT monitors complaint themes, numbers and response time through the contractual process. This allows the PCT to gain assurance that both individual complaints and trends are acted upon in a timely manner.

3. Statistics and performance

There are a number of areas included in contracts set by the PCT that look to improve the provision of care for older people. These include indicators for UHL, LPT and Community health services. The following are examples of the areas monitored by the PCT. Where performance is less than would be expected, the PCT ensures that actions implemented by the organisations are sufficient to make a difference. Such indicators include falls, pressure ulcer, nutrition assessments, continence assessments, stroke care, fractured hip performance, complaints, serious incidents, dementia care, and safe discharge. Examples of performance are as follows:

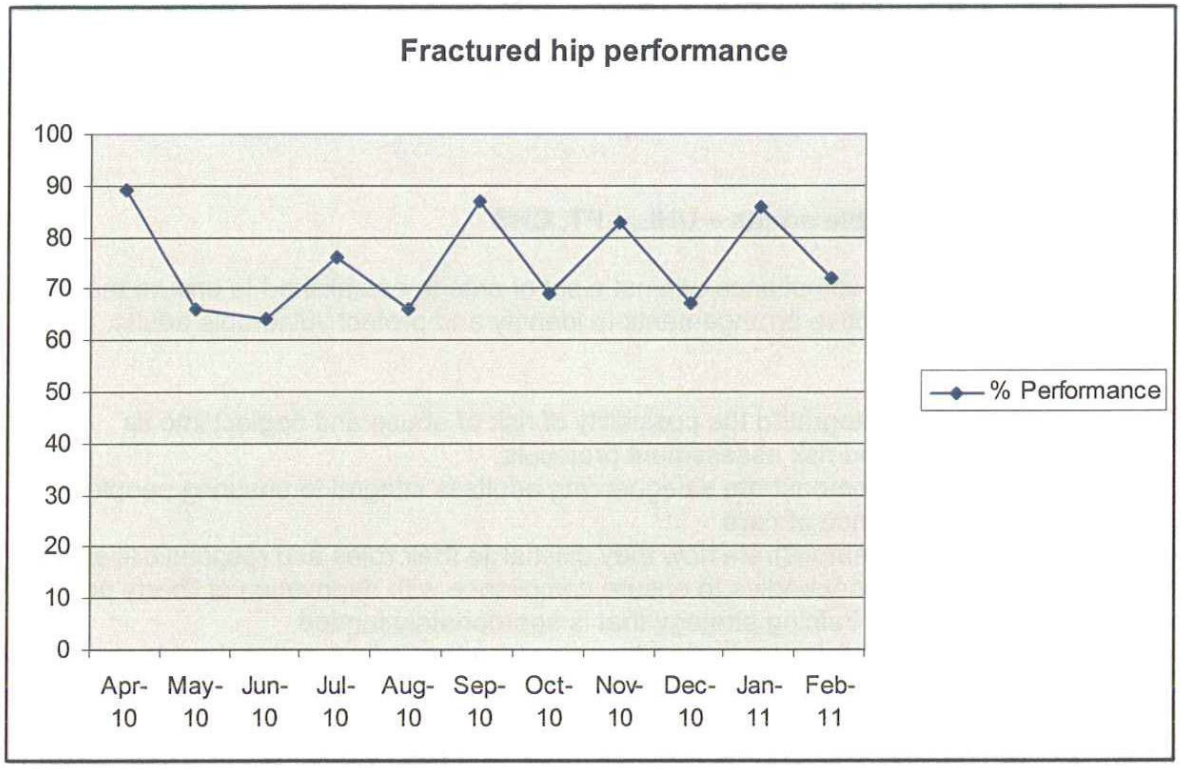
3.1 High Impact Actions – UHL

The High Impact Actions for Nursing and Midwifery were developed following a 'call for action' which asked frontline staff to submit examples of high quality and cost effective care that, if adopted widely across the NHS, would make a transformational difference. Compliance with these actions is monitored within UHL:



3.2 Performance following fractured hip – UHL

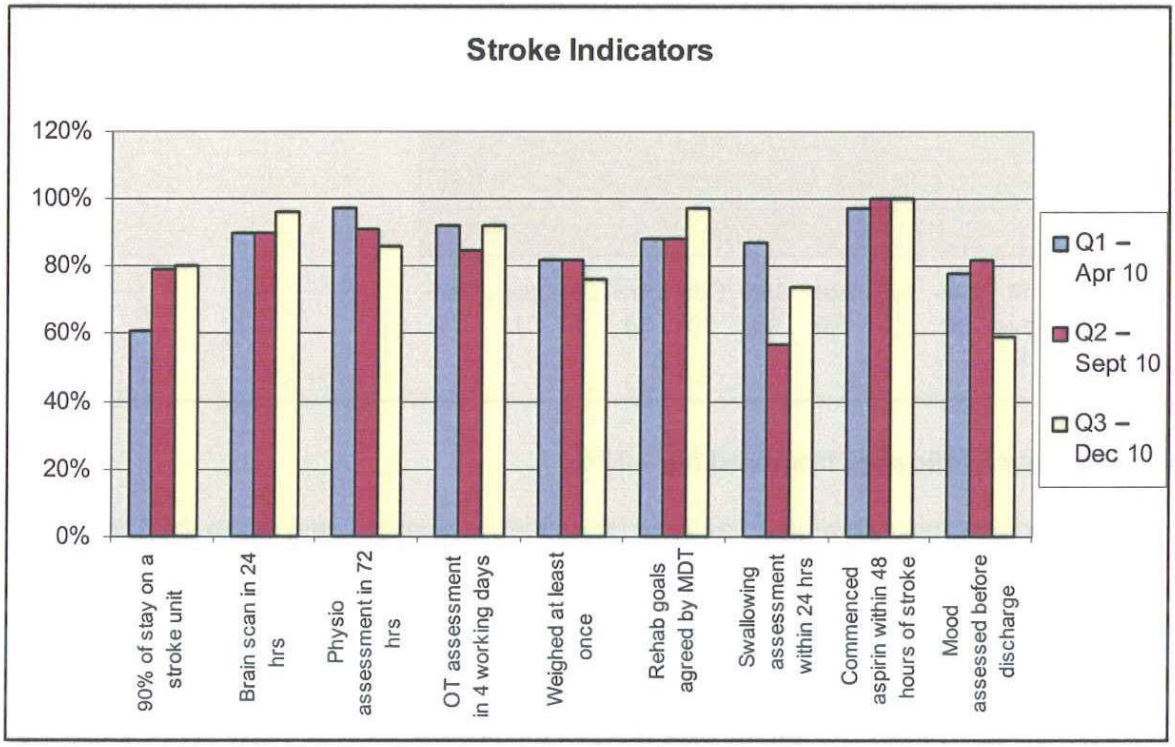
It is acknowledged that, following a fractured hip, patients recover better when they are operated on earlier. Therefore UHL are monitored to ensure that the majority of patients are taken to theatre within 36 hours. In some cases this cannot be done, especially if the patient needs to be made medically fit prior to the operation.



On a daily basis, each time a patient has to wait longer than 36 hours for their operation, an investigation is undertaken to identify the reasons for the delay and ensure there are action in place to reduce the risk of reoccurrence if the delay was due to organisation factors.

3.3 Stroke indicators – UHL

There are national indicators that have been defined that aim to monitor and improve the management of patients following a stroke.



The trust has recently made changes to the stroke unit to assist in improving the care received.

3.4 Safeguarding vulnerable adults – UHL, LPT, CHS

All organisations report full compliance against a set of criteria established to ensure that services have in place effective arrangements to identify and protect vulnerable adults. Such indicators include:

- The organisation has integrated the possibility of risk of abuse and neglect into its assessment practice and risk assessment protocols.
- The organisation can demonstrate safeguarding adults is integral to ensuring people have a positive experience of care
- The organisation can demonstrate how they discharge their roles and responsibilities as managing and supervisory bodies to ensure compliance with deprivation of liberty policy.
- The organisation has a training strategy that is appropriately funded
- The organisation has policies and procedures in place that reflect national guidance and LSAB procedures.

- The organisation must have in place a flagging system to enable staff working with adults at risk of abuse in all services to know when an adult is subject to a safeguarding plan
- The organisation can demonstrate safeguarding adults is integral to treating and caring for people in a safe environment and protecting them from avoidable harm

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NHS
Leicestershire County and Rutland

2011/12 Strategic Operating Plan (SOP) and Financial Plan

Sue Bishop
Director of Finance
NHS Leicester City, Leicestershire County and Rutland

Leading Leicestershire and Rutland to become the healthiest place in the UK

Content

Main themes

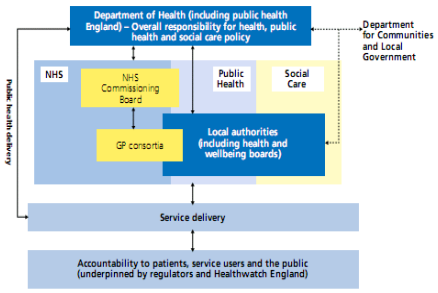
- Transition and reform
- Transparency and local accountability
- Service quality

These themes are supported by:

- Finance and business rules
- Accountability

Transition and Reform

Fig 1: The *Equity and Excellence* system



Transition and Reform

- Formation of PCT clusters by June 2011 with single Executive Team
- Authorised consortia to take on full statutory responsibilities by April 2013
- Development of health and wellbeing boards by April 2012
- Progression of NHS foundation trust status – All to become foundation trusts by the end of 2013/14
- Transforming community services – By 1 April 2011 all PCT directly provided community services must have been separated from PCT commissioning

Transparency and local accountability

- New Outcomes Framework – focus on the health improvement
- Better Patient experience – collection and action
- Better information – new information strategy Quality accounts – will cover CHS.
- Local publication – greater clarity of how expenditure translates into local achievements.
- Extended choice for patients

Key new commitments for 2011/12

- Increase in health visitors
- Family nurse practitioners
- Cancer drugs fund
- Military and veterans health
- Autism
- Dementia strategy
- Support for carers

Maintaining quality improvements

- Referral to treatment times
- A&E services
- Ambulance services
- Healthcare associated infections (HCAI)
- Eliminating mixed sex accommodation
- End of life care
- Cancer reform
- Cancer screening
- Stroke
- Mental health
- Increasing access to psychological therapies (IAPT)
- Safeguarding children
- Dentistry

Areas for improvement

- Healthcare for people with learning disabilities
- Children and young people's physical and mental health
- Diabetes
- Sharing non-confidential information to tackle violence
- Violence against women and girls
- Regional trauma networks
- Respiratory disease

PCT Allocations 2011/12

2011/12	NHSLC TOTAL	NHSLCR TOTAL	TOTAL NHSLLR TOTAL
Allocations			
2011/12 operating framework	570,627	959,647	1,530,274
70% marginal rate lodged with SHA	(1,193)	(2,912)	(4,105)
transfer to Local Authorities	(5,670)	(3,672)	(9,342)
	563,764	953,063	1,516,827

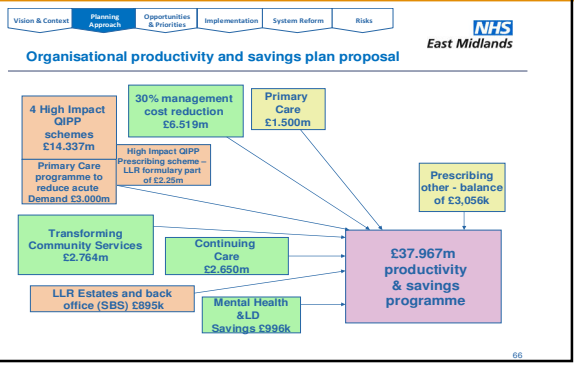
Health and Social Care Funding

- In 2011/12 there is additional non-recurrent funding allocated to PCTs to support joint working between health and social care.
- PCTs will transfer this funding to Local Authorities to supplement investment in social care services to benefit health and improve overall health gain
- PCTs will need to work together with Local Authorities' to jointly agree on appropriate areas for social care investment and the outcomes expected from this investment.

Planning Assumptions

RESOURCES AVAILABLE	100.0%	NHS LC £'000	NHS LCR £'000	Total £'000	
DEDUCT					
Resources to be held by DH - national requirement lodged with SHA	2.0%	10,400	17,780	28,180	This funding is available for service transformation, double running and restructuring costs.
To provide for local transformation	0.7%	3,640	6,223	9,863	Fund set aside to support local delivery of significant efficiencies (paid non-recurrently)
To provide for in year contingency	1.0%	5,200	8,890	14,090	Provide for in year pressures.
Generate surplus	0.7%	3,640	6,223	9,863	Requirement. Provide for future years.
Total Reserves	**4.4%**	**22,880**	**39,116**	**61,996**	
BALANCE AVAILABLE	**95.6%**				

Productivity and Savings



Strategic and Operational Plan process

- Prioritisation process completed to identify:
  - Investments/redesign to meet performance framework, outcomes framework priorities and statutory requirements
  - Opportunities to reduce budgets to minimise savings requirement
  - Development of savings that increase our rate of return on investment – targeted, low clinical evidence base, use of strategy
  - Review of existing Local Operating Plan schemes (2008 - 2011) to ensure schemes are providing value for money
- **17 March** -Final submission to SHA, then to DH
- Savings proposals clinically led, process clinically supported
- Public engagement started and continues with specific work focussing on individual savings schemes
- New performance framework and outcomes framework being developed for Board scrutiny

Challenges/Risks

- Long-term strategic priorities need to align with new operating plan requirements
- Deliver more with reduced funds – growing demand for services is not affordable if patterns of care remain the same
- Clinical engagement needs to be maintained
- Deliver more with less staff – 'work smarter' in a time of transition
- Our plans need to be supported by GP consortia as well as approved by the LLR Cluster Board
- Transformation needs to be championed during a period of substantial change and transition
- Assurance process in place to ensure alignment with strategic plans and those of our providers

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