Leicester
City Council

MEETING OF THE HEALTH AND WELLBEING SCRUTINY COMMISSION

DATE: TUESDAY, 15 OCTOBER 2013
TIME: 5:30 pm
PLACE: THE OAK ROOM - GROUND FLOOR, TOWN HALL, TOWN HALL SQUARE, LEICESTER

Members of the Commission

Councillor Cooke (Chair)
Councillor Sangster (Vice-Chair)

Councillors Chaplin, Cleaver, Desai, Grant, Singh and Westley

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

G. J. Carey

For Monitoring Officer

Officer contacts:
Graham Carey (Democratic Support Officer):
Tel: 0116 2298813, e-mail: Graham.Carey@leicester.gov.uk
Anita Patel (Members Support Officer):
Tel: 0116 2298825, e-mail: Anita.Patel@leicester.gov.uk)
Leicester City Council, Town Hall, Town Hall Square, Leicester LE1 9BG

INFORMATION FOR MEMBERS OF THE PUBLIC

ACCESS TO INFORMATION AND MEETINGS

You have the right to attend Cabinet to hear decisions being made. You can also attend Committees, as well as meetings of the full Council. Tweeting in formal Council meetings is fine as long as it does not disrupt the meeting. There are procedures for you to ask questions and make representations to Scrutiny Commissions, Community Meetings and Council. Please contact Democratic Support, as detailed below for further guidance on this.

You also have the right to see copies of agendas and minutes. Agendas and minutes are available on the Council's website at www.cabinet.leicester.gov.uk or by contacting us as detailed below.

Dates of meetings are available at the Customer Service Centre, King Street, Town Hall Reception and on the Website.

There are certain occasions when the Council's meetings may need to discuss issues in private session. The reasons for dealing with matters in private session are set down in law.

WHEELCHAIR ACCESS

Meetings are held at the Town Hall. The Meeting rooms are all accessible to wheelchair users. Wheelchair access to the Town Hall is from Horsefair Street (Take the lift to the ground floor and go straight ahead to main reception).

BRAILLE/AUDIO TAPE/TRANSLATION

If there are any particular reports that you would like translating or providing on audio tape, the Democratic Services Officer can organise this for you (production times will depend upon equipment/facility availability).

INDUCTION LOOPS

There are induction loop facilities in meeting rooms. Please speak to the Democratic Services Officer at the meeting if you wish to use this facility or contact them as detailed below.

General Enquiries - if you have any queries about any of the above or the business to be discussed, please contact Graham Carey, Democratic Support on 0116 229 8813 or email graham.carey@leicester.gov.uk or call in at the Town Hall.

Press Enquiries - please phone the Communications Unit on 0116 252 6081

PUBLIC SESSION

AGENDA

1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

Members are asked to declare any interests they may have in the business to be discussed.

3. MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on 3 September 2013 have been circulated and the Commission will be asked to confirm them as a correct record.

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

http://www.cabinet.leicester.gov.uk:8071/ieListDocuments.aspx?CId=737&MId=5925&Ver=4

4. PETITIONS

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

5. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

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

6. WORK PROGRAMME **Appendix A Page 1**

The Members Services Officer submits a document that outlines the Health and Community Involvement Scrutiny Commission's Work Programme. Commission is asked to consider the Programme and make comments and/or amendments as it considers necessary.

7. CORPORATE PLAN OF KEY DECISIONS **Appendix B Page 11**

The Commission is recommended to note the items that are relevant to its work in the Corporate of Key Decisions that will be taken after 1 October 2013.

8. BRADGATE ADULT MENTAL HEALTH UNIT **Appendix C Page 23**

Professor David Chiddick, Chair of the Leicestershire Partnership Trust (LPT), Dr Satheesh Kumar, Medical Director, LPT, and Cheryl Davenport, Director of Business Change, LPT will attend the meeting to provide an update on the measures taken in response to the Care Quality Commission's Notices issued in relation to the Bradgate Unit.

Following consideration of the LPT's report at the last meeting position statements have been requested from other relevant bodies as listed below:-

Care Quality Commission	**Appendix D (Page 41)**
NHS England	**Appendix E (Page 43)**
Leicester City Clinical Commissioning Group	**Appendix F (Page 45)**

A recent article in the Leicester Mercury on 24 September is also attached at **Appendix G** (**Page 47**) for information.

9. NHS 111 **Appendix H Page 49**

To receive an update report on the NHS 111 service. The update will be provided by a representative of the Leicester City Clinical Commissioning Group.

10. ACCESS FOR ALL **Appendix I Page 53**

Paul Leonard Williams, Disabled Access Officer will present the report and give a short presentation on the overall strategy and policy for Access for All and will give specific examples relating to health and wellbeing.

11. PUBLIC HEALTH COMMISSIONING AND CONTRACTING **Appendix J Page 87**

Rod Moore, Divisional Director, Public Health, and Nicola Hobbs, Head of Contracts and Assurance, Care Services and Commissioning to present a report on commissioning, contract management procurement arrangements for the public health responsibilities that were transferred to the City Council in April 2013.

12. CONGENITAL HEART DISEASE REVIEW UPDATE **Appendices K – Q Pages 97 – 113**

To receive an update on the progress of the Congenital Heart Disease Review. The following documents are attached to provide Members with background information:-

Letter from NHS England to Cllr Cooke	**Appendix K (Page 97)**
Response by Cllr Cooke to NHS England Letter	**Appendix L (Page 99)**
NHS England 6th Update	**Appendix M (Page 101)**
NHS England 7th Update	**Appendix N (Page 105)**

NHS England 8th Update **Appendix O (Page 109)**
Notes of a Meeting between NHS England and the Local Government Association and the Centre for Public Scrutiny **Appendix P (Page 111)**

NHS England held a New Congenital Heart Disease Review: Board Task and Finish Group meeting on 30 September 2013. The meeting considered a 'Proposed Scope and Interdependencies' document which is attached at **Appendix Q (Page 113).** The document outlines what NHS England already known about the review, as well as illustrating those areas where more work is needed before a judgement can be made. In 1 October 2013, NHS England notified the Council that it planned to take questions about the scope of the review to the first meeting of the Clinical Advisory Panel on 15 October 2013 and asked for comments on the paper by 7 October 2013 so that these could be fed into the Panel's meeting. A copy of the paper was sent to Health Scrutiny Officers for Rutland County Council and Leicestershire County Council asking them to share it with their members and make any comments direct to the Congenital Heart Review Team by 7 October.

The Chair will provide an update on any further progress or developments which arise before the meeting.

13. ALCOHOL AWARENESS UPDATE **Appendix R Page 115**

Julie O'Boyle, Consultant Public Health, to present an update report on the Alcohol Awareness Campaign that was originally presented to the Commission at its meeting on 17 July 2103.

14. EXTERNAL REVIEW OF HEALTH SCRUTINY UPDATE **Appendix S Page 119**

To receive an update report on the External Review 'Fit for Purpose' Health Scrutiny by Expert Advisor (Brenda Cook) Centre for Public Scrutiny. The update also includes the notes of the first development session held on 18 September 2013.

15. REVIEW OF RESPONSES TO SCRUTINY REVIEWS

To review the responses received in relation to the Commissions' Scrutiny Reviews of the 'Mental Health Review for Working Age Adults in Leicester' and the 'Review of Voluntary and Community Sector Groups who raised concerns about Funding, Commissioning and Tendering issues'.

These reviews were completed in June 2013 and forwarded to the Executive and interested partners. The Chair will provide an update on progress.

16. PROPOSED JOINT SCRUTINY REVIEW OF WINTER CARE ARRANGEMENTS

Appendix T
Page 127

The Chair to report on a proposed joint Scrutiny Review by the Commission and the Adult Social Care Scrutiny Commission on 'Winter Planning For Health and Social Care Provision for Elderly and Vulnerable People in Leicester.' A Draft Scoping Report is attached and will be considered at the Adult Social Care Scrutiny Commission at its meeting on 10 October 2013. Any amendments to the draft made by Adult Social Care Scrutiny Commission will be reported at the meeting.

17. UPDATE ON PROGRESS WITH MATTERS CONSIDERED AT A PREVIOUS MEETING

Verbal updates, as appropriate will be given on progress with any matters discussed at a previous meeting which are not being considered as a specific item on the agenda.

18. ITEMS FOR INFORMATION / NOTING ONLY

Appendices U – V
Pages 133 -143

a) Health and Wellbeing Board

The minutes of the Health and Wellbeing Board meeting held on 11 July 2013 are attached at **Appendix U (Page 133)** . The attachments in the minutes are not included. These can be found at the following link:-

http://www.cabinet.leicester.gov.uk:8071/documents/g5648/Public%20minutes%20Thursday%2011-Jul-2013%2010.00%20Health%20and%20Wellbeing%20Board.pdf?T=11

Alternatively copies can be obtained from Democratic Services at the contact details shown in the 'Information For Members of the Public' section at the beginning of the Agenda.

b) Being the Best

To receive a letter issued by the East Midland Ambulance Service NHS Trust on the progress with the Being The Best Review (**Appendix V – Page 143)**

19. ANY OTHER URGENT BUSINESS

Leicester
City Council

SECOND DESPATCH

HEALTH & WELLBEING SCRUTINY COMMISSION
15 OCTOBER 2013

ADDITIONAL INFORMATION

Further to the agenda for the above meeting which has already been circulated, please find attached the following:-

8. BRADGATE ADULT MENTAL HEALTH UNIT

Attached is a further response in relation to the Bradgate Unit:-

LAMP (**Appendix F (1)**)

12. CONGENITAL HEART DISEASE REVIEW

Cllr Cooke to inform members of the response that has been sent to the 'Proposed Scope and Interdependencies' document issued by NHS England (Appendix Q on the agenda) A copy of the response is attached for Members information**.**
(Appendix Q (1))

16. WINTER CARE ARRANGEMENTS

A revised draft scoping document is attached which now includes further comments. The draft was considered at the Adult Social Services Scrutiny Commission on the 10 October 2013 and was approved without amendment. **(APPENDIX T)**

Please bring the papers above with you to the meeting.

18. ITEMS FOR INFORMATION/NOTING

To formally note the following reports submitted to the Health and Wellbeing Board on 8 October 2013. (These reports were sent to you by e-mail for information)

Urgent Care
Healthwatch Update
Fulfilling Lives – A Better Start

Graham Carey
Democratic Support
Tel: 0116 229 8813
Internal: 39 8813
E-mail: graham.carey@leicester.gov.uk

Health & Wellbeing Scrutiny Commission
PROPOSED DRAFT WORK PROGRAMME 2013/14

CURRENT / ONGOING / FUTURE ISSUES – Updated SEPTEMBER 2013

DATE OF COMMISSION MEETING	PROPOSED TOPICS / ITEMS AND LEADS	ACTIONS / OUTCOMES
Standing Items - Accountability of Deputy City Mayor – lead for Health issues, Councillor Rory Palmer	1) The broad issues around the implementation of NHS & Public Health White Paper (Deb Watson/Rod Moore) 2) Public Health Work by the City Council & Health & Wellbeing Board (Deb Watson/Rod Moore) 3) Implementation of the Health and Social Care Act (Deb Watson / Tracie Rees) 4) Public Health Budget (Deb Watson / Tracie Rees/Rod Moore) 5) Commissioning Process for Patient Representative Body - HealthWatch (Tracie Rees) 6) Leicester City Council City Mayors Forward Plan (Cllr Palmer/Deb Watson / Tracie Rees) 7) Leicester City Clinical Commissioning Group (Simon Freeman/Richard Morris)	
9 April 2013, (agenda 26/03/13)	1) **Draft Work Plan 2013/14** (Cllr Cooke/Anita) – work in progress	**Action** - To be discussed in private planning session 18th September to enable effective scrutiny.
	2) **The Francis Report** – Implications for Health Scrutiny Commission and lessons to be learnt a) An overview of the Francis Report and the implications for the local authority (Rod Moore) b) Responses from LCCCG on the Francis Report (Richard Morris) c) Responses from UHL on the Francis Report (Stephen Ward)	**Actions:** a) Agreed, an external review of the council's scrutiny arrangements for scrutinising the provision of health services in the city. Agreed 'Fit For Purpose' Review to be led by CfPS expert advisor. b) To explore health commission members to receive mandatory training Liaise with John/legal re: constitution.

Appendix A

Health & Wellbeing Scrutiny Commission
PROPOSED DRAFT WORK PROGRAMME 2013/14

DATE OF COMMISSION MEETING	PROPOSED TOPICS / ITEMS AND LEADS	ACTIONS / OUTCOMES
		Actions (conti).. c) Arrange private sessions to discuss francis report and health scrutiny forward planning. (planned for September) d) Review engagement arrangements with partners involved in health scrutiny e.g. LLR Joint Committee and OSC (part of Fit for Purpose Review) e) To review the development and delivery plans of partner organisations/bodies in light of the Francis Report recommendations (ongoing)
	3**) LINKS** (Local Involvement Network for Patients) – The Emergency Pathways (Michael Smith/Sue Mason) 4) Regulations on new Health & Wellbeing Board – Implications for Health Scrutiny (Pretty Patel)	**Actions:** a) Private Policy meeting to be added to the work plan b) Healthwatch to reassure the commission that the Emergency Pathways work will continue. c) Contact LPT re: views on LINKs treatment during Bradgate Unit visit (pending)

Health & Wellbeing Scrutiny Commission
PROPOSED DRAFT WORK PROGRAMME 2013/14

DATE OF COMMISSION MEETING	PROPOSED TOPICS / ITEMS AND LEADS	ACTIONS / OUTCOMES
	5) **Healthwatch** and Scrutiny – Framework (Tracie /Jo Clinton)	**Action** – for 28th May meeting - Healthwatch to bring a paper on draft protocol, setting out how it will actively engage with the scrutiny commission.
	7**) Councils Forward Plan**	Noted.
28th May 2013 (agenda 14/05/13)	**1) University Hospitals of Leicester (UHL)** 1a) UHL - Strategic Direction Presentation (Stephen Ward/John Adler) 1b) UHL Annual Quality Accounts (Sharon Hotson, UHL) 1c) UHL Unannounced Hospital Visits – feedback report (Richard Morris) 1d) Urgent Care Centre (A&E) at Leicester Royal Infirmary, to monitor progress on the pilot programme to refer non urgent cases to GP (Richard Morris)	**Actions:** 1a) The Strategic Direction report was noted. 1b) The Quality Accounts 2013/14 report noted and comments to be sent to UHL (done) 1b) HSC members invited to visit the hospital to see how services are provided (to be arranged). 1c) Report noted. HSC to receive further updates on future visits. 1d) Report noted. Further update to HSC in 6 months.
	2) NHS 111 Non-Emergency Helpline – Information/update report on plans for this emergency helpline to go live in Leicestershire on 25th June 2013 (Richard Morris)	**Action:** The report was noted and comments made by HSC to be taken into account by the West Leicestershire CCG when implementing the NHS 111 System (Richard to action).

Health & Wellbeing Scrutiny Commission
PROPOSED DRAFT WORK PROGRAMME 2013/14

DATE OF COMMISSION MEETING	PROPOSED TOPICS / ITEMS AND LEADS	ACTIONS / OUTCOMES
	3) Public Health Structure – to include organisation chart, posts and functions, plus current areas of work, budgets and schedule of commissioning areas and timescales (Rod Moore)	**Action:** Private session to be arranged to discuss functions and commissioned services. Report noted.
	4) Healthwatch – Protocols of how HW will actively engage with and support the commission in its scrutiny of health issues (Vandna Gohill, VAL/ Jo Clinton)	Report noted.
	5) Drugs and Alcohol Scrutiny Review – draft report of findings for members of the commission to discuss/approve (cllr Sangster/Anita)	**Actions:** - Draft report and recommendations endorsed. Final report to go to OSC, then to the City Mayor. - Chair to discuss procedures and mechanisms for council to commission drug and alcohol services.
	6) Work Plan 6a) Draft Work Programme 2013/14 – update/suggestions from commission members (cllr Cooke/Anita) 6b) Summary of Work Completed 2012/13 – for information, commission contribution to Scrutiny Annual Report (cllr Cooke/Anita)	6a ongoing & 6b noted.
	7) City Mayor's Delivery Plan – Leicester City Council 2013/14, referred from Overview Select Committee for comments (Rod Moore)	**Actions:** - Chair to arrange private session for further discussion on the Plan. - HSC reserved the right to submit comments

Health & Wellbeing Scrutiny Commission
PROPOSED DRAFT WORK PROGRAMME 2013/14

DATE OF COMMISSION MEETING	PROPOSED TOPICS / ITEMS AND LEADS	ACTIONS / OUTCOMES
		at a later date. - HSC request progress report in 6 months - Joint scrutiny reviews with Adult Social Care SC is supported.
	8) Items for noting: a) Health & Wellbeing Board – minutes of last meeting b) Council's Forward Plan c) Glenfield Hospital Heart Unit Review – verbal update (cllr Cooke)	All noted.
17th July 2013 (agenda 25/06/13)	1) East Midlands Ambulance Service "Being the Best" Report (Karlie Thompson) 2) Update on Glenfield Hospital Heart Unit Review (Cllr Cooke) 3) 'Alcohol Awareness Social Marketing' consultation proposals (Julie/Rod) 4) Development Training Session for HSC members to cover the following: a) 'Better Understanding of the New Structures of the NHS' (Rod) c) Feedback from Derbyshire CfPS Workshop 8th July on 'Developing Relationships with Public Health England and NHS England, including lessons from the Francis Report' (Anita/Rod) 5) External Review of Health Scrutiny Arrangements (Cllr Cooke/Anita)	1) **Action:** Six monthly updates n order to monitor progress Re: detailed management performance criteria and data (Anita add to w/p) 2) **Action:** Update to September meeting. 3**) Action**: Feedback to September meeting 4c) **Action:** Proposal for Leicester to be offered as a venue for a future regional event (Anita to liaise with CfPS) **5) Action:** Engaged expert advisor from CfPS.

Health & Wellbeing Scrutiny Commission
PROPOSED DRAFT WORK PROGRAMME 2013/14

DATE OF COMMISSION MEETING	PROPOSED TOPICS / ITEMS AND LEADS	ACTIONS / OUTCOMES
6th August 13	1) Glenfield Heart Unit – NHS ENGLAND new review process to discuss. **SPECIAL MEETING ARRANGED FOR THIS ITEM ONLY**	**Actions:** HSC to monitor progress
3rd September 2013 (agenda 14/08/13)	1) Council's Procurement Plan – Health & Wellbeing Topics (Neil Bayliss) 2) Access for All Document – referred by Overview Select Committee to all scrutiny commissions for comments (Paul Lenard-Williams) 3) Alcohol Awareness – Project feedback (Julie) 4) LCCCG Response to Francis Report – Update (Simon Freeman) 5) UHL Emergency Floor Scheme Report – (Stephen/Mark) RE: to brief the Commission on UHL Emergency Floor scheme and the associated enabling scheme under which it is proposed to move temporarily some outpatient services from Leicester Royal Infirmary to Leicester General Hospital. 6) Leicestershire Partnership NHS Trust 7) Items for noting: a) Glenfield Heart Unit NHS England Review – Update b) External Review of Health Scrutiny Arrangement – Update	**Item 1** – Further breakdown of Commissioning Contracts re: Public Health budgets to future meeting – Nicola Hobbs/Rod Moore **Item 2** – Deferred to future meeting **Item 3** – Project not started, deferred to future meeting. **Item 4** – An update to further responses by the CCG still to be reported to future meeting. **Item 5** – Noted and agreed in principle. **Item 6** – Viv Addey submitted a letter of representation on concerns about the number of recent suicides of people in Bradgate Unit calling for an independent inquiry into the failing. **Outcome:** HSC members voiced their concerns /disappointment for the failings at Bradgate Unit and at LPT.

Health & Wellbeing Scrutiny Commission
PROPOSED DRAFT WORK PROGRAMME 2013/14

DATE OF COMMISSION MEETING	PROPOSED TOPICS / ITEMS AND LEADS	ACTIONS / OUTCOMES
18th September 2013 **PRIVATE SESSION FOR HSC MEMBERS**	*Private session planned to discuss the work programme to enable effective scrutiny and give members the opportunity to shape and direct the commission's activities.* To be led by the Chair, assisted by Brenda Cook, expert health scrutiny advisor, and Anita Patel/Graham Carey	
15th October 2013 (agenda 01/10/13)	1) **Procurement & Commissioning Public Health Budget** – Further breakdown of Commissioning Contracts to better understand Public Health budgets and who provides services (Nicola Hobbs/Rod Moore) **2) Access for All** – Deferred from last meeting (Paul Leonard-Williams) 3) **Work Programme** – Update from 18th September private members session (Chair/Anita) 4) **Glenfield Heart Unit Review** Update - NHS England letter and Response from Cllr Cooke RE NHS England Review Team request to visit Joint Health Scrutiny (Chair/Anita) 5**) Leicestershire Partnership NHS Trust** – Update on Progress to improve services and feedback from minutes of last meeting RE Bradgate MHU. (tbc) 6) **'Fit for Purpose' Health Scrutiny Review –** Progress update (Chair/Anita) 7) **Alcohol Awareness Project** – feedback on progress (Julie/Rod) 8**) NHS 111 Service** – Update on progress (Dr Johri/Richard Morris)	

Health & Wellbeing Scrutiny Commission
PROPOSED DRAFT WORK PROGRAMME 2013/14

DATE OF COMMISSION MEETING	PROPOSED TOPICS / ITEMS AND LEADS	ACTIONS / OUTCOMES
26th November 2013 (agenda 12/11/13)	1) Francis Report Recommendations - Progress Reports from UHL, LCCCG, LCC Public Health 2) Mayors Delivery Plan – Progress Report 3) Hospital Unannounced Visits – Reports from LCCCGs 4) UHL Emergency Department Assessment Service – Progress Report	
14th January 2014	1) East Midlands Ambulance Service "Being the Best" Progress Report (Karlie Thompson) – see 17th July minutes.	
25th February 2014		
8th April 2014		
20th May 2014		

Suggested Items for above Work Plan:

- Public Health Team – Structures, responsibilities, budgets and outputs
- Leicestershire Partnership NHS Trust – The Agnes Unit and Bradgate Unit (follow up)
- Better Care Together

Health & Wellbeing Scrutiny Commission
PROPOSED DRAFT WORK PROGRAMME 2013/14

DATE OF COMMISSION MEETING	PROPOSED TOPICS / ITEMS AND LEADS	ACTIONS / OUTCOMES
	- Health Variations – Public Health Team - NHS Reconfiguration – G.P practices fit for purpose - NHS Commissioning - LPT/UHL – to review and monitor their performance data / complaints data - Lead Commissioners of Health Services across the city – work plans - Annual Reports – LOROs, UHL, ICAS, LPT NHS TRUST and HEALTHWATCH - ICAS and HEALTHWATCH – Regular Reports - Hospital Discharges - Homelessness Strategy – Implementation - Capital Programme – monitoring role - Forward Plan – monitoring role - Corporate Strategies – monitoring role - Stickle Cell Anemia Services - BME groups – targeting of specific health services - HIV/AIDs Services - Mental Health Services for BME e.g. Aqwaabaa - EMAS	

Health & Wellbeing Scrutiny Commission
PROPOSED DRAFT WORK PROGRAMME 2013/14

DATE OF COMMISSION MEETING	PROPOSED TOPICS / ITEMS AND LEADS	ACTIONS / OUTCOMES
…….List in progress/ commission members to suggest items		

Leicester City Council

CORPORATE PLAN OF KEY DECISIONS

On or after 1 October 2013

What is the plan of key decisions?

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

What is a key decision?

A key decision is an executive decision which is likely:

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

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

What information is included in the plan?

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

The plan is published on the Council's website.

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

Corporate Plan of Key Decisions

On or after 1 October 2013

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1. A place to do business

What is the Decision to be taken?	LEICESTER FOOD PARK DEVELOPMENT To approve the scheme funding package.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2013
Who will be consulted and how?	Consultation underway with stakeholders. Consultation to be undertaken as part of the planning process.
Who can I contact for further information or to make representations	AndrewL.Smith@leicester.gov.uk

What is the Decision to be taken?	LEICESTER TO WORK PHASE 2 To approve the project and funding.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2013
Who will be consulted and how?	Consultation as part of the Economic Action Plan with key stakeholders.
Who can I contact for further information or to make representations	AndrewL.Smith@leicester.gov.uk

What is the Decision to be taken?	FRIARS MILL WORKSPACE To approve the project and funding.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2013
Who will be consulted and how?	Consultation as part of the planning application and with key stakeholders.
Who can I contact for further information or to make representations	AndrewL.Smith@leicester.gov.uk

What is the Decision to be taken?	ENTERPRISING LEICESTER Approval for funding agreement for delivery of business grant scheme and inward investment activities funded by European Regional Development Fund.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2013
Who will be consulted and how?	Grant scheme developed with business community stakeholders.
Who can I contact for further information or to make representations	AndrewL.Smith@leicester.gov.uk

What is the Decision to be taken?	REGIONAL GROWTH FUND ROUND 4 Approval for City Council to act as accountable body for LLEP's regional growth fund 4 programme.
Who will decide?	City Mayor (Individual Decision)
When will they decide?	Not before 10 Oct 2013
Who will be consulted and how?	LLEP Board including Business Stakeholders.
Who can I contact for further information or to make representations	Frank.Jordan@leicester.gov.uk

2. Getting about in Leicester

What is the Decision to be taken?	HAYMARKET BUS STATION IMPROVEMENT SCHEME To approve the project design and funding package, and the making of any necessary compulsory purchase orders.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2013
Who will be consulted and how?	With stakeholders and wider community on the proposed designs.
Who can I contact for further information or to make representations	AndrewL.Smith@leicester.gov.uk

What is the Decision to be taken?	BUS LANE ENFORCEMENT - AYLESTONE QUALITY BUS CORRIDOR Decision to implement Bus Lane Enforcement on the Aylestone Road corridor bus lanes.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2013
Who will be consulted and how?	Done as part of Aylestone Bus Corridor Scheme.
Who can I contact for further information or to make representations	AndrewL.Smith@leicester.gov.uk

What is the Decision to be taken?	LEGIBLE LEICESTER To approve funding for the project.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2013
Who will be consulted and how?	Consultation will be undertaken as part of development of specific scheme.
Who can I contact for further information or to make	Sarah.Harrison@leicester.gov.uk

representations	

What is the Decision to be taken?	REAL TIME BUS INFORMATION Approve details of project and funding package.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2013
Who will be consulted and how?	ABCP consultation during October. Bus User Panel – 18/9/2012, 18/2/2013, 25/3/2013.
Who can I contact for further information or to make representations	AndrewL.Smith@leicester.gov.uk

What is the Decision to be taken?	CONNECTING LEICESTER STREET IMPROVEMENT SCHEME/S
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2013
Who will be consulted and how?	Consultation through Connecting Leicester initiative and TRO process.
Who can I contact for further information or to make representations	AndrewL.Smith@leicester.gov.uk

3. A low carbon city

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

4. The built and natural environment

What is the Decision to be taken?	VICTORIA PARK CAR PARK AND WAR MEMORIAL Approval of project design and funding package.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2013
Who will be consulted and how?	Consultation with stakeholders including park user group and public through online consultations and public exhibitions.
Who can I contact for further information or to make representations	Adrian.Russell@leicester.gov.uk

What is the Decision to be taken?	CATHEDRAL GARDENS Proposal to approve the Council's contribution and related scheme funding package.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2013

Who will be consulted and how?	Consultation undertaken as part of planning application.
Who can I contact for further information or to make representations	AndrewL.Smith@leicester.gov.uk

What is the Decision to be taken?	TOWNSCAPE HERITAGE INITIATIVE Scheme and funding approval.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Mar 2014
Who will be consulted and how?	Requirement for external consultation. Community engagement included in the project.
Who can I contact for further information or to make representations	AndrewL.Smith@leicester.gov.uk

What is the Decision to be taken?	RELEASE OF THE PROPERTY MAINTENANCE PROVISIONS 2013/14
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2013
Who will be consulted and how?	Not applicable.
Who can I contact for further information or to make representations	john.stevens@leicester.gov.uk

5. A healthy and active city

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

6. Providing care and support

What is the Decision to be taken?	ELDERLY PERSONS HOMES To consider options for the future of the Council's Elderly Persons Home (EPH) following consultation.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2013
Who will be consulted and how?	Consultation with original service users complete. Consultation with new residents also complete and collective consultation with the Unions has ended.
Who can I contact for further information or to make representations	Tracie.Rees@leicester.gov.uk

What is the Decision to be taken?	DEVELOPMENT OF AN INTERMEDIATE CARE FACILITY To consider the options for the development of intermediate care facilities In Leicester.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2013
Who will be consulted and how?	N/A
Who can I contact for further information or to make representations	Ruth.Lake@leicester.gov.uk

What is the Decision to be taken?	CONSULTATION ON THE FUTURE OF THE MOBILE MEALS SERVICE To consider the outcome of a consultation exercise regarding the future of the Mobile Meals Services.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2013
Who will be consulted and how?	Formal consultation started with the existing service users on 9th July 2013.
Who can I contact for further information or to make representations	Tracie.Rees@leicester.gov.uk

What is the Decision to be taken?	REVIEW OF INTERNAL DAY CARE SERVICES FOR PEOPLE WITH A LEARNING DISABILITY AND OR PHYSICAL DISABILITY Formal consultation will be required with existing service users and other stakeholders.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2013
Who will be consulted and how?	Formal consultation will be required with existing service users and other stakeholders.
Who can I contact for further information or to make representations	Tracie.Rees@leicester.gov.uk

What is the Decision to be taken?	CONSULTATION ON THE REDESIGN OF ADULT SOCIAL CARE PREVENTATIVE SERVICES The re-design will inform future procurement activities.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2013
Who will be consulted and how?	Formal consultation will be required with existing Service Providers.
Who can I contact for further information or to make	Tracie.Rees@leicester.gov.uk

representations	

What is the Decision to be taken?	RESIDENTIAL CARE FEES REVIEW To consult with the providers of residential care on the level of fees to be paid for 2012/13, 2013/14 and 2014/15.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2013
Who will be consulted and how?	Consultation in progress with external providers.
Who can I contact for further information or to make representations	Tracie.Rees@leicester.gov.uk

What is the Decision to be taken?	REVIEW OF DISTRICT HEATING CHARGES FOR COUNCIL TENANTS
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2013
Who will be consulted and how?	Tenants Forum
Who can I contact for further information or to make representations	Ann.Branson@leicester.gov.uk

What is the Decision to be taken?	HRA BUDGET, CAPITAL PROGRAMME AND RENT SETTING
Who will decide?	Assistant City Mayor - Housing
When will they decide?	Not before 1 Oct 2013
Who will be consulted and how?	Tenants Forum
Who can I contact for further information or to make representations	Ann.Branson@leicester.gov.uk

What is the Decision to be taken?	TO CLOSE TWO COUNCIL HOMELESSNESS HOSTELS
Who will decide?	Assistant City Mayor - Housing
When will they decide?	Not before 1 Oct 2013
Who will be consulted and how?	Full public consultation complete. Consultation with Trade Unions and staff in progress.
Who can I contact for further information or to make representations	Ann.Branson@leicester.gov.uk

7. Our children and young people

What is the Decision to be taken?	STRATEGIC COMMISSIONING REVIEW OF SERVICES FOR CHILDREN AND YOUNG PEOPLE 0-19

	A summary report on the implementation programme to date, associated commissioning issues and future decisions will be brought before the Executive and Scrutiny.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2013
Who will be consulted and how?	No widespread consultation is envisaged. Progression of the next stage of the 0-19 Strategic Commissioning Review will provide an opportunity however for a limited number of organisations to comment upon the impact upon them of the proposed course of action.
Who can I contact for further information or to make representations	Trevor.Pringle@leicester.gov.uk

What is the Decision to be taken?	LSCB ANNUAL REPORT Statutory report where there is a requirement to present the report to the Executive and Council.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2013
Who will be consulted and how?	None.
Who can I contact for further information or to make representations	Andy.Smith@leicester.gov.uk

What is the Decision to be taken?	ANNUAL PRIVATE FOSTERING REPORT Annual report on private fostering, including case audit.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2013
Who will be consulted and how?	Not applicable.
Who can I contact for further information or to make representations	Andy.Smith@leicester.gov.uk

What is the Decision to be taken?	ADOPTION ACTION PLAN Action plan in relation to achieving performance against score card targets.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2013
Who will be consulted and how?	Not applicable.
Who can I contact for further information or to make representations	Andy.Smith@leicester.gov.uk

What is the Decision to be taken?	CORPORATE PARENTING ANNUAL REPORT Annual report on LCC's corporate parenting role with proposals for embedding the role across LCC amongst elected members and senior officers.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2013
Who will be consulted and how?	Not applicable.
Who can I contact for further information or to make representations	Andy.Smith@leicester.gov.uk

What is the Decision to be taken?	FOSTERING STATEMENT OF PURPOSE To provide an update of the new fostering statement of purpose and function.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2013
Who will be consulted and how?	Not applicable.
Who can I contact for further information or to make representations	Andy.Smith@leicester.gov.uk

What is the Decision to be taken?	INDEPENDENT REVIEWING OFFICER (IRO) ANNUAL REPORT Update on the work of the IRO Service.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2013
Who will be consulted and how?	Not applicable.
Who can I contact for further information or to make representations	Andy.Smith@leicester.gov.uk

What is the Decision to be taken?	APPROVAL FOR CONSULTATION ON SEN PRESCRIBED ALTERATIONS IN BSF SCHOOLS The Council has consulted on changes to three special schools (Ellesmere College, Keyham Lodge and Millgate) and to the establishment of Designated Special Provision at Babington Community College and Hamilton Community College. This report seeks approval to proceed to the statutory notice stage of the process.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2013
Who will be consulted and how?	Any interested party will be able to respond to the publication of a statutory notice followed by a six week period for statutory representations, at the end of which a further decision will need

	to be taken by the Council to determine whether to implement the proposals or not.
Who can I contact for further information or to make representations	Trevor.Pringle@leicester.gov.uk

What is the Decision to be taken?	CHILDREN IN CARE COUNCIL AND PLEDGE To provide an update on the Children in Care Council and Pledge.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2013
Who will be consulted and how?	None.
Who can I contact for further information or to make representations	Andy.Smith@leicester.gov.uk

8. Our neighbourhoods and communities

What is the Decision to be taken?	AFFORDABLE HOUSING PROGRAMME: LA NEW BUILDS ON LABURNUM ROAD
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2013
Who will be consulted and how?	
Who can I contact for further information or to make representations	Ann.Branson@leicester.gov.uk

What is the Decision to be taken?	SOUTHFIELDS DRIVE COMMUNITY FACILITIES PROJECT Proposals are being considered and consulted on in relation to the Library, Sports Hall and Community Centre and these will require a decision.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2013
Who will be consulted and how?	Service users already engaged and wider community consultation in the area is underway.
Who can I contact for further information or to make representations	Liz.Blyth@leicester.gov.uk

9. A strong and democratic council

What is the Decision to be taken?	POLICY FOR TRANSFERRING LOCAL GOVERNMENT PENSION SCHEME ASSETS AND LIABILITIES FOR A SCHOOL CONVERTING TO AN ACADEMY Determination of the principles and methodology for transferring local government pension liabilities and assets for a school converting to academy status.
Who will decide?	City Mayor/Executive
When will they decide?	Not before 1 Oct 2013
Who will be consulted and how?	No public or stakeholder consultation but scrutiny by Pension Fund Management Board of the Leicester Local Government Pension Scheme.
Who can I contact for further information or to make representations	Trevor.Pringle@leicester.gov.uk

Leicestershire Partnership NHS
NHS Trust

REPORT TO THE LEICESTER CITY COUNCIL HEALTH SCRUTINY COMMISSION - 15 October 2013	
Title	Progress Report on the Trust's Response to the CQC Report and the Development of the Quality Improvement Programme

Executive summary

This paper updates the commission on the Trust's progress in responding to the CQC report of August 2013 and the development of our Quality Improvement Programme.

Following the Risk Summit led by the Trust Development Authority one of the main actions was for the Trust to develop a quality improvement programme. The quality improvement programme contains a number of themed actions beyond the immediate 30 day period described in our last report.

The programme is designed to consolidate and drive all the necessary improvements in the culture of care, professional practice and quality assurance within the Trust in the medium term. This work is essential so that high quality adult mental health services can be sustained and assured for local patients, the public, and the wide range of stakeholders and agencies engaged in the Trust's work. Although the improvement plan initially addresses changes within the adult mental health service, the Trust will be using this plan as a foundation from which further improvements in other clinical divisions and corporate services will be delivered.

The TDA has convened an Assurance Oversight group to work with the Trust on the development and delivery of the programme. Whilst it is the Trust Board's responsibility to approve and implement the programme, the Assurance Oversight group which was formed following the Risk Summit, will scrutinise and hold the Trust to account for delivery.

Since the initial CQC visit in July, and subsequent report in August, the CQC has returned to the Trust in September to assess the progress made with respect to the areas of concern raised in the two warning notices. At the time of writing this report the CQC are on site at the Trust completing their follow up assessment and we will update the commission and other stakeholders as soon as possible on the outcome.

1. Clinical Change at the Bradgate Unit

- The Trust's Medical Director and Chief Nurse are jointly accountable for delivering clinical change and provide the day to day leadership to professional practice, clinical governance and quality assurance feeding directly into the Board.

- The two posts for additional Senior Matrons on a six month fixed term contract have been advertised and recruited to. These post-holders are champions for sustainable change in nursing clinical practice at the Bradgate Unit. The Deputy Medical Director has also been assigned to offer additional leadership to the improvement programme in Adult Mental Health and there are two lead consultants in place for the Bradgate Unit. This leadership team is working closely with the ward matrons, ward staff and all members of multidisciplinary teams at the unit.

- The initial process for review and correction of all records is now an ongoing programme of work, comprising robust weekly audits of a sample of care records per week per ward, to provide assurance that improvements are being sustained. This has included publishing progress / performance by ward with the Chief Nurse and lead matrons having data on individual performance, with feedback and support given via clinical supervision so that staff are fully aware of the changes needed and the accountability they have for providing and documenting high quality care.

- On-going senior manager presence on the unit and three times weekly task force meetings take place to communicate key messages for all Ward Matrons at the unit. Implementation of the actions in the CQC action plan

- Work continues with all staff on the Bradgate Mental Health Unit to support them, identify any skill deficits and provide the required development.

- Further drill down is being undertaken in relation to the weekly audits to identify any rationale for non-compliance with expected standards. These results are shared by ward with Trust Board members and the service.

- Some refurbishment of the Bradgate reception area has been undertaken to provide a more welcoming environment for patients and visitors

Representatives from the Trust Board have attended all three local authority scrutiny committees in September. There have also been engagement sessions with patient representatives, a meeting between the Trust's Chairman and Local Healthwatch representatives and a meeting with voluntary and community sector groups representing mental health service users, their carers, families, advocates and communities.

The Trust's AGM and Legacy Towers event on 7 September provided a further opportunity to address questions and concerns from local people.

In all these activities the Trust has continued to be open and transparent and engage in honest dialogue with all stakeholders, sharing information and responding to detailed questions, following up actions as required.

Our programme of internal communications with staff continues via team briefings / meetings, Listening into Action, our clinical leadership routes, and routine communications such as e-news.

2. Risk Summit Outcome and Assurance Oversight Group

At the Trust Board meeting on 29 August, we reported that on that same day the Trust would be attending a risk summit where local agencies and regulators from the health and care sector met with the Trust to share their concerns about care quality and agree next steps.

A statement summarising the outcome of the Risk Summit is given at Appendix A of this paper.

Following the completion of the immediate 30 day action plan in response to the CQC warning notices by the end of August, it is recognised that the Trust has now moved into a second phase of development to improve and sustain the quality of care in the medium to longer term including cultural change.

The forward plan for the Trust comprises 4 key areas which incorporate the outcome of the risk summit:

- Participating in the Assurance Oversight Group.

- Developing and implementing a comprehensive quality improvement plan to which the Trust Board will be held accountable by the Assurance Oversight Group (see separate report on this agenda on this process).

- Setting in place an operational situation report (SITREP) for ward and Trust management and commissioners which provides daily/weekly assurance on staffing/bed occupancy and other operational metrics to assure the safety and quality of care at the Bradgate Unit.

- Further collaborative work on the pathway for mental health service users between the acute and community settings of care including assessing alternatives to admission and re-assessing local bed capacity in light of demand.

The Assurance Oversight Group comprises representatives from local Healthwatch, the Trust Development Authority, local clinical commissioning groups, and a representative from voluntary and community sector organisations representing the interests and views of mental health service users is also being arranged. Attendees are invited from LPT to participate in

the oversight group meetings. Appendix B is the draft terms of reference of the Assurance Oversight Group.

3. The Trust's Quality Improvement Programme

The Trust's Quality Improvement Programme consolidates and draws upon a number of important pieces of work including the relevant recommendations from the following:

a. CQC Action Plan
b. Francis, Keogh and Berwick Reports
c. Professor Louis Appleby Report
d. Personality Disorder pathway progress
e. Single-Sex Accommodation Action Plan
f. Quality Governance Framework action plan
g. Customer Relationship Management Programme
h. Listening into Action (LiA) Programme
i. Board Development Programme
j. Communications Plan
k. Annual Planning Cycle

In addition, the Programme will incorporate oversight of some existing improvement projects already in existence within Divisions and Enabling Services.

The TDA has provided a template that the Trust is adopting which has been used by other Trusts. LPT has populated this initially with those elements concerned with ensuring improvements in the Clinical and Operational Effectiveness of our Adult Mental Health Services. Our medical director has developed this element of the plan with the clinical division and active involvement of the consultant team.

It is essential that the quality improvement plan is shaped by our stakeholders and that there is confidence that the Trust has a credible and comprehensive approach to improving quality and restoring public confidence in the Bradgate Unit and across the entire pathway of care in adult mental health. The Trust therefore welcomes the feedback of stakeholders on the draft quality improvement plan during October with a view to finalising the plan for LPT Board sign off by the end of October.

The LPT Executive Team and Chairman initially met with a cross section of CCG Board members from all 3 CCGs (including CCG lay members) on 24 September to discuss the work in progess to develop the quality improvement plan. At this stage the quality improvement plan was a very early draft.

The meeting with the CCGs on 24 September was very constructive with CCG Board members providing initial feedback on the aims of the programme and how it would be measured, the approach to professional and cultural change in adult mental health services, the governance arrangements for the programme within LPT and the role of the LPT Trust Board in leading this work.

It was agreed that CCGs would continue to work closely with the Trust on finalising the quality improvement plan ahead of LPT's October Trust Board meeting, where the product is due to be signed off. During October there will be a meeting of LPT Non-Executive Directors and CCG lay representatives and a clinically focused discussion between the LPT Medical Director and CCG lead GPs for mental health to assist with this. The Trust will also continue to engage with patient groups, local Healthwatch, voluntary sector agencies, local councils (Scrutiny Committees and Health and Wellbeing Boards) and other stakeholders as the QIP is developed and delivered.

The Trust Board discussed the draft outline plan at its September Trust Board meeting in public, and the Trust also expects to meet with the Assurance Oversight group on 7 October to review progress. Over the next two to three weeks, we will be able to provide more information about how delivery of the plan will be governed within LPT, the capacity and resources needed to deliver the changes, how we will define our current baseline, trajectory for improvement and the metrics for measuring our progress against the plan. All of these matters will be discussed with the Assurance Oversight group during October as we finalise the plan.

Appendix C to this report shows how the improvement plan is constructed in terms of the themed areas of work that will apply to all areas of improvement, and a populated template showing the initial details of the plan with respect to the Adult Mental Health Division.

Appendix D to this report provides a response to the Enter and View report queries as requested.

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Appendix A

Summary of NHS England Risk Summit for Leicestershire Partnership NHS Trust

Background

Risk summits are a tried and tested approach to understanding and mitigating risks within an NHS organisation.

They aim to address potential or actual service quality problems which may mean providers, such as hospitals, failing to meet the essential standards of quality and patient safety. Such problems may relate to a specific service or be indicative of more serious and systemic problems within a provider organisation.

A risk summit may be triggered in a number of ways. It could be the result of regular performance and quality reviews between the provider and commissioners, an external regulator (such as the Care Quality Commission or Monitor) or from concerns raised by staff, patients or other parties.

When NHS England calls a risk summit it brings together representatives from the provider organisation, commissioners, key clinical leaders and other regulatory and stakeholders to explore and understand the issue. Together they agree what interventions, if any, may be necessary to ensure patient safety and quality can be guaranteed in the short, medium and longer term and whether further risk summits are required.

Action

On Thursday 29 August 2013, NHS England hosted a risk summit for Leicestershire Partnership NHS Trust relating to concerns about patient care and safety at the Bradgate Unit, including the findings outlined in the recently published CQC report. All key partner agencies were represented at this summit.

Outcomes

Following in depth discussion of the issues raised the following outcomes were agreed:

1) An urgent meeting on Friday 30 August 2013 between the Trust, Clinical Commissioning Groups and the Local Authorities to agree what immediate actions are required to ensure safe patient care at the Bradgate Unit in the short term.

2) NHS Trust Development Authority, in partnership with local Clinical Commissioning Groups, to develop a plan to provide additional support to the Trust Board of Leicestershire Partnerships NHS Trust in order that the Trust can provide assurance and move forward their plans to improve patient safety on a longer term basis.

3) No follow up risk summit would be required at this stage.

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NHS
Trust Development Authority

Appendix B

ASSURANCE OVERSIGHT GROUP FOR
LEICESTERSHIRE PARTNERSHIP NHS TRUST
TERMS OF REFERENCE

1. PURPOSE

To collectively share intelligence and support the Trust to ensure they become a sustainable quality organisation.

The Oversight Group is an advisory body and will achieve assurance directly from the Trust Board. The Trust remains accountable to the TDA. The roles of each organisation are set out in the table below:

NHS Trust Development Authority	• To act in accordance with the Accountability Framework and relevant policy and legislation. • To oversee the assessment of the Trust in its totality • To oversee safety and delivery. • To oversee board and leadership arrangements. • To Chair the Group. • To engage relevant stakeholders. • To work with all parties to ensure effective oversight.
Healthwatch	• To update the Oversight Group in respect to the views of service users • To work with all parties to ensure effective oversight.
CCG's	• To ensure that services commissioned by the CCG's from the Trust meet the quality and other standards laid out in the contract. • To update and inform the oversight Group in respect to the delivery of the Trust. • To inform the Oversight Group in respect to risks and mitigations and ensure pace takes account of service quality and delivery. • To lead commissioner engagement in respect to Trust issues and outcomes. • To work with all parties to ensure effective oversight.
Local Authority	• To update the Oversight Group in respect to quality and safety concerns • To work with all parties to ensure effective oversight.
Leicestershire Partnership NHS Trust	• To ensure quality and safety of services are improved and maintained • review and improve the Mental Health Services Pathway • To review ward to board governance • To embed its staff engagement programme across the Trust. • To flag risks and mitigations. • To work with all parties to ensure effective oversight.
NHS England (Leicestershire & Lincolnshire)	• Responsible for holding the CCGs to account. • To lead commissioner engagement in respect to NHS England and relevant Area Teams.

	• To engage as a direct commissioner of services and to inform the oversight group on procurement and other relevant issues. • To inform the Oversight Group in respect to risks and mitigations. • To work with all parties to ensure effective oversight.

In addition it will be the responsibility of each member representative to ensure that information and reporting on progress and outcomes is disseminated to appropriate individuals within their own organisation and back into the Oversight Group. All parties will ensure relevant wider stakeholder engagement is in place.

2. Key Objectives

The key objectives of the Oversight Group shall be collectively:-

- Fully understand the Trust's risks
- To manage the accountability of the Trust to its agreed action plan
- To coordinate and organise additional support to the trust in terms of capacity and delivery of the agreed action plan
- To be responsible for signing off changes to the action plan
- To monitor agreed Quality KPI's for the Adult Mental Health Services.

For the TDA to fulfil it's role as set out in the accountability framework
http://www.ntda.nhs.uk/wp-content/uploads/2012/04/framework_050413_web.pdf

3. Risk and Issue Management to ensure:

- The identification assessment and prioritization of risks and mitigating actions.
- The identification and management of the actions recorded in the action log to ensure all agreed actions are undertaken in a timely manner.
- The process is managed in line with the Accountability Framework.

4. Membership

Membership for the Oversight Group is as follows:

Healthwatch	Responsible for representing the views of service users Representative:
CCG's	Commissioner of majority of services. Representatives:
Local Authority	Responsible for representing the views of the local authority Representatives:
The Trust	Legal body accountable for all current Trust services & staff. Representatives:
NHS Trust Development Authority (NTDA)	Responsible for holding the Trust to as set out in the Accountability Framework. Representatives:
NHS England (Leicestershire & Lincolnshire)	Responsible for holding the CCG's to account and as direct commissioner of a range of Trust services (e.g.). Representative:

5. Authority and Decision Making

Authority and decision making in relation to the organisational impact and form will be the responsibility of the TDA. Assurance in relation to organisational performance will be in line with the responsibilities and processes of each accountable organisation.

6. Chairmanship

The Oversight Group will be chaired by Jeffery Worrall (Portfolio Director, TDA Programme SRO).

7. Governance and Reporting Arrangements

Jeffrey Worrall shall act as Senior Responsible Owner for this programme and is responsible for the delivery of the programme objectives.

8. Communication Arrangements

The TDA will lead communication at key points. The Oversight Group will inform and support this process. The Trust will remain responsible for internal communications and engagement with the stakeholder group on the contents prior to publication.

9. Quorum

Responsibility shall be with each organisation to ensure appropriate representation at each meeting and appropriate alternate to attend in place of a member who is unavailable at each meeting. A quorum is not required.

9. Meeting Frequency

The Oversight Group shall meet every **TBC** months for **TBC** hours.

Schedule of meetings

Date	Time	Location
11th September 2013	17.30hrs	Meeting Room 3 1st Floor West Fosse House Leicester (car parking arranged for all attendees)
30th September 2013	10.00hrs	TBC

10. Administration

Administration will be managed by the TDA with the intention that:

- The risk register and action log will be reviewed at each Oversight meeting.
- Notes and actions from meetings shall be circulated to members one week after the meeting has taken place via email.
- Meeting papers shall be circulated to members one week prior to each scheduled meeting via email.

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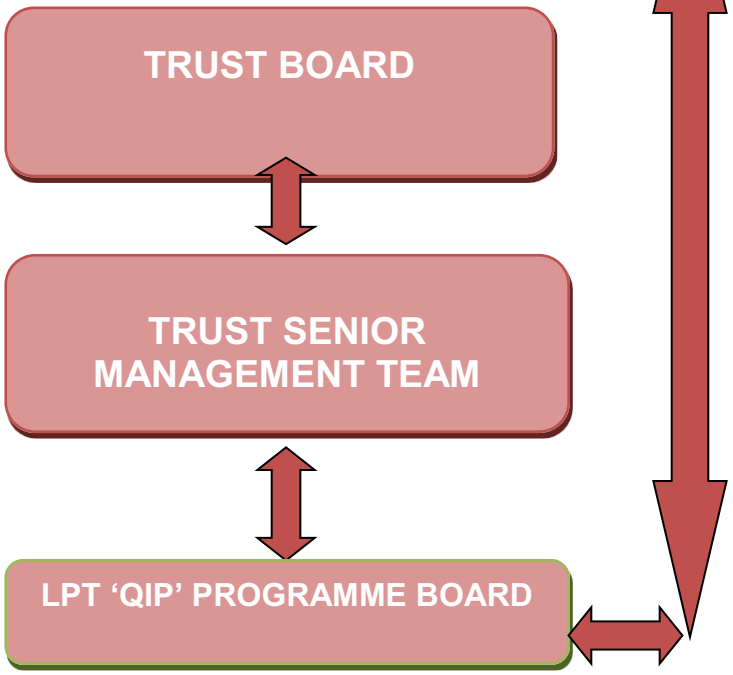
Appendix C

Governance Structure



Board Committee for Assurance

The Quality Improvement Programme does not replace existing management responsibilities or alter the assurance role of existing Board Committees

Themed Work Streams

GOVERNANCE
Governance Systems

WORKFORCE & LEADERSHIP
Organisational Development & Leadership

QUALITY STRATEGY

QUALITY ASSURANCE + CLINICAL AND OPERATIONAL EFFECTIVENESS
Safety, Effectiveness, Experience
Clinical Risk assessment
Operational performance ward to board
Early warning systems
Policies / procedures
Records / documentation
Thresholds for escalation
Environment of care
Patient experience

CULTURAL CHANGE AND TRANSPARENCY
Patient centred values
Cultural 'Ward to Board'
Francis Report

STAKEHOLDER ENGAGEMENT & COMMUNICATIONS

EXTERNAL REGULATION + REVIEWS
CQC REMEDIAL PLAN
Improved internal CQC regulatory processes/internal assurance
SI investigation improvements/themes
Louis Appleby Report

Appendix C (C)

Themes of Action Plan - Acute Mental Health

This is a draft of the themes in the Acute Mental Health focused action plan which integrates the aims articulated in section 3. Acute Mental Health includes Crisis Support in the Community and the Bradgate Mental Health Inpatient Unit.

Quality Assurance + Clinical and Operational Effectiveness	
Improving the acute care pathway	
Theme / Key issue	
Crisis Support (CRT)	To improve the response, efficiency and quality of assessment and support provided to patients with acute mental health problems.
Pre-admission	To improve the quality of care and patient safely throughout the process of the admission
Admission	To improve the quality and effectiveness of clinical care in the first 72 hours of In-Patient stay
On-going care in In-Patient	
Discharge	
	Additional Specific Actions
Physical Health care	
People with Personality Disorder	Improving the skills of staff in managing people with Personality Disorder.
Care plans	Improving the ease of developing and using care plan as well as embedding care plans within the care process
Risk Assessment	Enhancing the skills of staff in the assessment and effective management of risk
Checking and searching procedure	Checking and searching procedure to be clear and consistent. Guided with intelligence on risk posed by the patient.
Hand over	Improving the quality of nursing hand over
Continuous learning	Embedding the culture of continuous learning
Staff support	
Environmental improvement	Improving the patient experience, healing nature and safety of environment

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The Leicester City LINk contacted the Trust before Christmas 2012 to inform us that following concerns, it was their intention to carry out an Enter and View visit of both the Agnes Unit and the Bradgate Unit. This was not something the Trust had participated in before and ensured that the visit was facilitated by the Head of the Division, Teresa Smith, on 7 January 2013.

Subsequently, it has arisen that there were difficulties during the visit, particularly in relation to the scope and opportunities offered to explore the whole Bradgate Unit and to speak to patients. These are opportunities that we usually offer to visiting organisations, bodies and colleagues and this oversight was not an intentional approach to the visit. The Trust apologises that it did not make LINk members feel welcome on this occasion.

It was intended that the requirements of the visit would be directed by the visiting LINk members and the Head of Access and Patient Experience and Partnerships Manager accompanied the visiting team to two wards; an older-type ward and new ward to enable the observation of the differences.

The LINk members raised a number of areas within their report but their main concerns were in relation to;

- Translation and interpretation
- Chaplaincy
- Links with advocacy
- Staff being able to raise concerns

All of these points are being addressed in the overall improvement plans for the Trust. As part of the Trust's merger with the two community arms of the PCTs in 2011, the Trust now has two translation / interpretation services. A review is being carried out to look at the need for translation and to create an understanding of requirements for the future. The current contract for translation services ends on 31 March 2014 and it is anticipated a revised service will be commissioned.

A review of the chaplaincy service (spiritual and pastoral care) has also been undertaken with a new Chaplaincy Manager in post. The service carried out a survey with patients in January 2013 in order to assess levels of satisfaction and overall, the results were extremely positive. The members of the chaplaincy team are very well advertised in the wards and the service offers a 24 hour on call service.

The Trust has recently engaged with Mental Health advocacy organisations such as LAMP, Peoples Forum, Leicester LGBT Centre, Healthwatch and Genesis in order to enter into discussions as to how they can support the Trust in its aim to improve services. The Trust met with representatives of these groups in September and they have all shown considerable support to the Trust in its aims. There is also a meeting scheduled with these groups to discuss the implementation of externally run ward forums at the Bradgate Unit as it was felt that these would be very helpful to both patients and staff in looking at the experience of patients whilst they are on the wards.

The issue of staff feeling able to and knowing how to raise concerns is something the Trust has taken extremely seriously. Work towards improving this has already begun with the launch of the Listening into Action programme, and a confidential telephone number is already in place. The Trust also carries out regular 'pulse surveys' which are used to measure staff experience with an aim of picking up any warning indicators that there may be

an area of concern. Finally, as part of the Trust's 'Changing Your Experience for the Better' programme, staff were offered the opportunity to provide feedback on their own experience and raise any concerns they have through confidential and anonymous 'graffiti boards' and focus group sessions called 'In Our Shoes'. The findings of these are being looked at alongside other staff feedback and the delivery of an action framework is being overseen by a core group with staff, patient and carer representation.

In terms of learning from the Enter and View, the Trust and the new Healthwatch representatives have met to create a joint working protocol which makes clear the expectations in working collaboratively, including the organisation and implementation of Enter and View visits. The Trust's Chairman has also met with the two acting Chairs of Healthwatch to discuss their concerns, provide more detail on the work being undertaken across the Trust and to agree next steps. This meeting proved to be very beneficial in terms of involving Healthwatch more in the business of the Trust and also in agreeing ways in which Healthwatch can further support the Trust.

Appendix D

Care Quality Commission

Briefing Note for the Chair of the Health and Wellbeing Scrutiny Commission

Leicester City Council

13 September 2013

Subject

Leicestershire Partnership NHS Trust, Bradgate Unit.

Purpose

The purpose of this note is to outline the current position of the CQC with regard to the Leicestershire Partnership NHS Trust.

This briefing should be read in conjunction with the "Guide for overview and scrutiny committees for health and social care" which is attached.

Background

The Bradgate Mental Health Unit was registered as a location under the provider Leicestershire Partnership NHS trust in April 2010. We inspected the unit in the spring of 2011 and found that it was failing to be compliant with a number of the regulations contained in the Health and Social Care Act (2008). This was mirrored at the Evington Centre, another location under this registration. We issued compliance actions.

We inspected both units again in the autumn of 2011 and found that they were now compliant with those regulations.

We inspected the Bradgate Unit again in October 2012. We found that the trust was not compliant with three regulations. These related to how the trust was supporting staff, clinical governance and record keeping. We again set compliance actions.

We returned to check whether these actions had been met in February 2012. We found that they had made sufficient progress to comply with these regulations. We found that while the trust had not embedded actions taken following the inspection in October they had taken action and staff and patients reported positive impacts of these actions taken. We also found that the governance system had been strengthened by recent developments. However we remained concerned about the sustainability of the actions taken by the trust.

Our continuing monitoring of the trust after February indicated that safeguarding, supporting workers and governance processes may have been potential new areas of non-compliance.

Current Position

We inspected the unit in July. The team reviewed care plans and discharge arrangements which had been a concern previously at the trust. Inspectors found significant concerns in respect of staff understanding and managing risks.

The report of this and other inspections is available on our website.

Overall we found that the trust was failing to be complaint with five regulations. We issued compliance actions in respect of three of these regulations. These related to aspects of safeguarding, supporting workers and quality assurance / governance.

We also issued warning notices in respect of two further regulations. These related to care and welfare and cooperating with other providers. The trust was required to be compliant with these latter regulations by the end of August.

We are currently inspecting the unit again to check whether they are now compliant with the two regulations that were the subject of the warning notices.

In general terms if we find that the trust has not met the requirements of the warning notices then there are a number of other courses CQC can take to enforce compliance. We can issue a simple caution or fixed penalty notice and fine the trust, we can impose a condition on their registration or we can cancel their registration. We also have an opportunity to seek approval from the secretary of state to undertake a special investigation.

Wider Regulatory Context

We are in continuing dialogue with partners about the LPT. These partners include the CCGs, NHS England, the Trust Development Agency and Healthwatch organisations across Leicester Leicestershire and Rutland.

We have also recently briefed the Leicestershire County Council Overview and Scrutiny Committee.

We met with other key stakeholders at the Quality Surveillance Group in August 2013. This group includes all the partners mentioned above as well as Directors of Adult Social Services. We discussed the concerns of the CQC and others. We discussed the impact of having a new management team, including Chief Executive Officer, Director of Nursing, Medical Director and Operating Officer.

At this meeting it was agreed that key stakeholders would work together to continue to monitor and ensure that safety of people using the unit.

We continue to work closely with these partners to ensure that we share as common an understanding as possible of the challenges and that the combined actions we take are as coherent as possible. We welcome the attention that the trust is now receiving from the Leicester Health and Wellbeing Scrutiny Commission

Tim Birtwisle

Compliance Manager

Care Quality Commission

September 2013

Summary of NHS England Risk Summit for Leicestershire Partnership NHS Trust

Background

Risk summits are a tried and tested approach to understanding and mitigating risks within an NHS organisation.

They aim to address potential or actual service quality problems which may mean providers, such as hospitals, failing to meet the essential standards of quality and patient safety. Such problems may relate to a specific service or be indicative of more serious and systemic problems within a provider organisation.

A risk summit may be triggered in a number of ways. It could be the result of regular performance and quality reviews between the provider and commissioners, an external regulator (such as the Care Quality Commission or Monitor) or from concerns raised by staff, patients or other parties.

When NHS England calls a risk summit it brings together representatives from the provider organisation, commissioners, key clinical leaders and other regulatory and stakeholders to explore and understand the issue. Together they agree what interventions, if any, may be necessary to ensure patient safety and quality can be guaranteed in the short, medium and longer term and whether further risk summits are required.

Action

On Thursday 29 August 2013, NHS England hosted a risk summit for Leicestershire Partnership NHS Trust relating to concerns about patient care and safety at the Bradgate Unit, including the findings outlined in the recently published CQC report. All key partner agencies were represented at this summit.

Outcomes

Following in depth discussion of the issues raised the following outcomes were agreed:

1) An urgent meeting on Friday 30 August 2013 between the Trust, Clinical Commissioning Groups and the Local Authorities to agree what immediate actions are required to ensure safe patient care at the Bradgate Unit in the short term.
2) NHS Trust Development Authority, in partnership with local Clinical Commissioning Groups, to develop a plan to provide additional support to the Trust Board of Leicestershire Partnerships NHS Trust in order that the Trust can provide assurance and move forward their plans to improve patient safety on a longer term basis.
3) No follow up risk summit would be required at this stage.

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Bradgate Unit Position Statement

The Clinical Commissioning Groups for Leicester Leicestershire and Rutland (LLR) have in place a collaborative model to commission services for LLR. This means that a commissioning team is hosted by one CCG on behalf of all three CCGs and with senior input from each. West Leicestershire CCG (WLCCG) is the lead CCG for the contract with Leicestershire Partnership NHS Trust (LPT). The accountable officer is Toby Sanders. This responsibility is due to pass to Dave Briggs from East Leicestershire and Rutland CCG.

Since taking over the contract (in shadow form in April 2012 and fully authorised from April 2013) the CCGs have had in place a mechanism to monitor the quality and performance standards required within the contract, identify risks to delivery and agree actions to be taken collectively. .

An independent expert review (Professor Louis Appleby) was commissioned by LPT as a result of commissioner concerns, high profile coroner inquests and CCGs visits in October 2012. This independent review was commissioned by LPT at the request of the CCGs, who supported the approach and scope.

The recommendations and findings have been implemented during 2013 and LPT have been reporting positive progress against their plan to the LPT Trust Board and to the CCGs. LPT also received a positive visit to the Bradgate Unit in February 2013 by the CQC, which found the unit to be compliant with essential outcomes.

More recently (April 2013 onwards), the CCGs have had increasing concerns in the following areas:

- *Progress and delivery against deadlines with the Appleby action plan, specifically in relation to the personality disorder pathway development.*

- *LPT's management of bed capacity at the Bradgate Unit, related clinical engagement, delivery of best practice linked to discharge practice and numbers of out of area placements.*

- *The serious incident reports, including those related to further suicides of patients in the care of inpatient services (December 2012 and January 2013) and outpatient suicides (in the care of LPT services), have been of concern due to the quality of investigations, reports and evidence of lessons learnt in practice.*

Our own review of performance and quality data and site visits (June and July) along with the findings from the CQC in July have supported the concerns and led to the following recent actions:

1. Appraisal of the evidence by the governing bodies of the three CCGs followed by an executive level meeting between the CCGs and LPT to explore

their understanding, commitment and capability to take appropriate and timely actions.

2. Escalation to the quality surveillance group to discuss the mental health service risks with all partners and identify further actions required. The quality surveillance group is a collaborative meeting where commissioners, NHS England, Monitor and Healthwatch share intelligence and look at emerging themes.

3. Following another in-patient death in August a Risk Summit was convened (see summary of this summit and key actions agreed). This was convened and chaired by the Medical Director of the NHS England regional team.

4. LPT has taken immediate action to address concerns at the Bradgate Unit including an Executive-led 30 day immediate response to the CQC findings and actions identified at the Risk Summit related to staffing numbers and skill mix.

5. Local commissioners, Trust Development Agency (TDA) , NHS England, Healthwatch and the local authority are working together to ensure LPT develops a robust quality improvement plan that will deliver sustainable change. This will be co- ordinated by an oversight group and will meet every two weeks with LPT and will be chaired by the TDA. This group has local authority representation (city and county) and will have also access to external expertise. It does not include the regulator. The last meeting of this group took place on 23rd September when the trust shared the draft quality improvement plan before submission to LPT Trust Board at the end of September. Further iterations to this draft plan are expected at the next meeting of oversight group on 7th October.

6. Further assessment of the delivery and sustainability of required improvements by LPT will be made via this oversight group with the intention that any risk to delivery will be identified quickly and escalated promptly.

7. LPT has also been requested to consider their internal capacity and capability to make the required sustained change to mental health provision. Any support / intervention required will be presented and considered by the oversight group.

8. The CQC have recently conducted a further visit to the Bradgate Unit, this is not yet concluded.

9. LPT has recently seen significant change to the executive team: CEO, Chief Nurse and Medical Director. Commissioners are mindful that the new team will need to respond with a credible plan that demonstrates required outcomes.

LAMP Response to Health Watch's concerns to the CQC's Inspection Report on the Bradgate Mental Health Unit August 2013

Information Included:

1. Report from Robert Houghton – IMHA Service Manager – LAMP
2. Comments/observations from Mental Health (IMHA) Advocates – LAMP
3. Comments/observations from Carer's Mental Health Advocates – LAMP

LAMP asks the following to be taken into consideration:

1. LAMP advocates want noted that they see a lot of good practice and staff trying their best, working hard at the 'grass roots' level of patient care in mental health. Some of this is highlighted in these reports.
2. LAMP believes that Practice, Policy, Partners, People, Patient involvement, Prevention & Intervention and Promotion of Recovery all contribute to the problems identified, thus should be constituent to the solutions.
3. LAMP believes this is not just about the hospital wards but wider issues which impact on a patients journey – developing effective care pathways for this vulnerable client group.
4. LAMP wants to know how it can help and wants to lend its expertise to improve and implement change. Since the transition to clinical commissioning groups, multi agency meetings have reduced significantly. We would have welcomed the opportunity, by LPT, to have been involved, at a much earlier stage with the difficulties experienced on the Bradgate Mental Health Unit.

Denise Chaney
Executive Director
09th September 2013

<u>Care and welfare of people who use services – People should get safe and appropriate care that meets their needs and supports their rights.</u>

I have been approached by both staff and patients about the lack of staff on the wards. This has an impact on patients in terms of their care, treatment and safety. In particular, patients commonly raise the issue that, although they have been allowed escorted leave off the ward, there are often no members of staff available to take them, which effectively means that they have no leave or that their leave is heavily restricted. This seems to be less of a problem on Watermead, as Assertive Outreach Workers can provide some escorted leave.

One member of staff on a ward told me that there is a severe shortage of both qualified and unqualified staff and that patients' care and safety has been affected. They told me that understaffed Health and Social Care Workers have been left to care for patients, as the low numbers of qualified nurses are unavailable as they are needed to perform other tasks on the ward, leading to poor care for patients; Health and Social Care Workers then being been blamed when things have gone wrong.

Another frequent problem is the arrangement of ward rounds for patients. On most wards, patients continue not to be given times for their ward round and, therefore, finding it difficult to arrange for an advocate to attend. When patients are given a time, it is within a broad range e.g. 9am – 12noon. Our advocates have frequently arranged specific times with wards in the ward diaries, to arrive and find that the ward round has been cancelled, without informing us, or that it has already been done earlier than arranged.

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

LAMP continues to have serious concerns that some informal patients have not been made fully aware of their rights - as is required by the Code of Practice - to be able to go on leave from the ward or discharge themselves, leading to some patients mistakenly believing that they are not allowed freedom of movement. This could result in an unlawful deprivation of their liberty under Article 5 of the Human Rights Act and false imprisonment.

We have experienced a number of instances where, although patients are informal, they have been told that they are not allowed to leave the ward. Sometimes they are given no further information, other times they are told that they will have to talk to the doctor about it next time they see them, but no time for this has been given.

The locked doors on the wards should not be in place to prevent informal patients from leaving and, such patients should have the right to request them to be opened and, unless they fulfil the criteria of a holding power, to be allowed to leave. There appears to be discordance between what nurses see to be the best interests of informal patients and the latter's rights of free movement and what seems like a marked reluctance to use appropriate holding powers in circumstances where informal patients are demanding to leave the ward.

A number of LAMP advocates have witnessed instances where informal patients have been misled, ill-informed or simply told they cannot leave the ward by staff. On other occasions, we have witnessed staff refusing to open the doors, telling patients that they cannot go out until they see the doctor or merely ignoring patients' demands to leave. On some occasions when patients are told that they cannot leave the ward until they see a doctor, the staff member is unable to say when the doctor might be able to see them, or promises are made that they will be able to see the doctor in a given time-frame, but no doctor subsequently arrives. LAMP is currently assisting a client through the complaints process at Health Service Ombudsman level for a client who claims that she was unlawfully detained for a week on a ward, when staff either refused to open the door, ignored her requests for the door to be opened or placed conditions on her going e.g. seeing a doctor, which were never fulfilled.

LAMP has met with senior management at the Bradgate Unit about the issue of informal patients' rights and it was agreed that LPT would produce a leaflet for

informal patients, explaining their rights, obligations and entitlement, but no leaflet has yet been circulated.

Robert Houghton – IMHA Service Manager
September 2013

RESPONSES FROM IMHA ADVOCATES

Care and welfare of people who use services – People should get safe and appropriate care that meets their needs and supports their rights.

- One client was an in-patient on the Bradgate Unit & was disabled with mobility problems and in a wheelchair. She was moved to a different ward in the night due to pressure on beds & had to sleep on the settee in the main sitting area. This was resolved the next day but she feels she did not receive appropriate care for her needs at the time. **(Respecting & involving people who use services)** the client did not feel she was treated with respect & there was no prior consultation with her about the course of action which was taken.

- An incident where IMHA was informed by a patient that bank staff had fallen asleep whilst conducting level 1a observations.

- **Good Practice** - Qualified staff listened to IMHA suggestions about providing patient in seclusion with some distraction and were supportive of this, and promised to consider in the handover period.

- Client who was suffering with depression had been advised by her Cons Psy in the ward round that she would remain an in patient whilst the effect of her meds was monitored. Due to pressure on beds she was discharged home very suddenly. The Cons Psy was not available at the time & junior Dr made the decision & arranged follow up by CPN. Client informed nursing & medical staff that she did not feel well enough but discharge went ahead. Client relapsed following discharge. I assisted her to make a formal complaint & arranged a resolution meeting but unfortunately client did not feel well enough to attend. Client **did not feel she was listened to or treated with respect**, & believes her proposed plan of care by Cons Psy was breached. She also feels her **welfare was not protected.**

- Patient on Thornton Ward with learning difficulties in addition to mental health condition appears to have unmet needs. Often presents in unclean clothing and appearance is generally dishevelled. During my frequent visits to the ward patient has appeared very distressed, sometimes crying uncontrollably and other times showing more aggressive behaviour due to frustration. Generally staff seem to be desensitised to this patient's apparent distress. Staff have admitted that this is an inappropriate care setting for patient.

People should get safe and coordinated care when they move between different services:

- IMHA had arranged for an interpreter for a client, asking qualified staff to arrange, and she entered this in the diary, however the interpreter did not arrive for the appointment. Had to use a nurse who spoke that language (client agreed to this), however nurse was not trained in interpreting, IMHA unable to fully exercise role.

- **Good Practice** One client on Ashby Ward had a very well managed transition to Exaireo, a specialist supported housing setting for people with mental health needs and drug/alcohol dependency issues.

- Some patients have commented that they believe that they are being discharged too early. They perceive that the decision to discharge has been based on a lack of beds and someone else having a greater need, rather than this being in the best interests of the patient.

- Some patients feel that they do not have enough involvement in their care plans and there have been occasions when clients have reported being discharged without a copy of their care plan.

- Some clients discharged without adequate support in place, resulting in a readmission to hospital.

- Long waiting lists for therapy services.
- Access to services in community very difficult.

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

- Generally there is a misconception with informal patients on acute mental health wards that they are 'not allowed' to leave the ward.

- I am unsure how much time is spent communicating and reassuring patient (mental health & learning difficulties) but from observations, it would appear that his needs are being unmet currently. I also feel that his dignity is not being protected.

- **Good Practice** Recently, I had a positive experience with new Ward Matron on Thornton. I had a conversation with her regarding an informal patient who was clearly indicating that they wanted to leave the ward. In discussion with the patient, the Ward Matron was very clear about what she felt was in the patient's best interests. She did not prevent the patient from leaving the ward and asked that the patient return to the ward in the evening. This situation was managed well and the patient was happy with the result.

- **Good Practice** Ward Matron on Ashby Ward supports and promotes patients rights to advocacy. There have been occasions when she has rescheduled ward rounds to enable an advocate to attend a ward round with a patient.

Supporting Workers: Staff should be properly trained and supervised and have the chance to develop and improve their skills:

- One staff nurse on Ashby ward did not know the difference between an IMHA/IMCA.

RESPONSE FROM CARER'S ADVOCATES

- **Carers' Resource Packs** – all wards should be giving these out to carers but this is not consistently the case as several carers who have used our services say that they have not received a copy of it when the person they care for is admitted to Bradgate Unit.

- **Good Practice:** Belvoir Unit is the exception to this.

- Carer concerned when advised the best course of action was for her son to be placed on Section 2. She expressed concern about the staff at Bradgate Unit being experienced in coping with her son who has a diagnosis of autism and OCD. My client was assured there would be no problem. This turned out **not** to be the case and her son was injected with a tranquilliser and left on a mattress on the floor all night. This resulted in her soon being paralysed with fear.

- Inadequate communication about risk caused by a patient; A patient successfully absconded from Ashby ward by rushing through an entrance door as someone else was exiting, the carer felt the patient should not have been left wandering near the exit. The patient unfortunately went on to commit suicide.

- An unwell patient was admitted voluntarily on the ward for over a month and ended up being discharged without a proper diagnosis. The carer said that the psychiatrist did not tell her or her son what was wrong

- A carer was worried that her husband who was on Beaumont ward, was told to wait until after discharge for some of his physical health issues to be attended to. Her husband had been on the ward for three months and had no definite discharge date.

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Bradgate Unit: Calls for inquiry into quality of care

By Leicester Mercury

Tuesday, September 24, 2013

By Cathy Buss

A health watchdog is considering asking the Health Secretary to hold a public inquiry into the quality of care at a city mental health unit.

It follows a call from a city councillor for a public inquiry after a damning report from the Care Quality Commission (CQC) about the Bradgate Unit, on the Glenfield Hospital site.

1. 

   The Bradgate Unit, at Glenfield Hospital, may soon be subject to a public inquiry

The Leicestershire Partnership NHS Trust, which runs the unit, has been served with two warning notices by the CQC over poor standards.

It has also been under fire over the suicides of nine patients since the start of 2010.

Leicester councillor Baljit Singh, from the Evington ward, believes "serious consideration" should be given to getting a public inquiry.

He said: "In view of the critical nature of the CQC investigation into operational failures, which may have contributed to suicides, I do think there should be serious consideration to request the Secretary State of Health to institute a public inquiry. To me, an inquiry like this would carry out a detailed investigation.

"Where there has been loss of lives, how do you reconcile that with just an apology?

"We need to know what kind of systems are in operation, where changes have been made, who has overseen them and the resolution, to ensure systems are more robust.

"Suicides seem to happen time and time again. There is no greater tragedy than the loss of life, especially when it is unnatural."

Coun Rory Palmer, deputy city mayor and chairman of the council's health and wellbeing board, said: "Leicestershire Partnership NHS Trust has apologised and set out an action plan.

"Ultimately, it needs to be judged on its actions.

"The trust needs to get to a point to provide assurance it is heading in the right direction."

However, Coun Palmer added that "formal avenues" through the scrutiny commission and the health and wellbeing board remained open "if we feel the need to secure more impetus or pace".

Coun Michael Cooke, chairman of the council's health and community involvement scrutiny commission, said he is seeking advice on whether a referral for a public inquiry can be made to the Health Secretary.

A spokesman for the NHS Trust said: "The trust met with the city's health overview and scrutiny committee in early September to hear the concerns of the council, and we will be returning to its next meeting, where the progress on addressing quality concerns at the Bradgate Unit will be further discussed. We are working hard to resolve the issues highlighted."

Dr Peter Miller, a child psychiatrist and medical director of the Nottinghamshire Healthcare NHS Trust, takes over the reins as chief executive of the Leicestershire Partnership NHS Trust on October 1.

LEICESTER CITY HEALTH AND WELLBEING SCRUTINY COMMISSION
15th OCTOBER 2013

Subject:	Leicester, Leicestershire & Rutland NHS 111 Service
Author:	Tony Menzies

EXECUTIVE SUMMARY:

The NHS 111 service commenced roll out across Leicester, Leicestershire & Rutland on 9th September 2013, with NHS Direct and the GP out of hours service in West Leicestershire CCG transferring call handling to the LLR NHS 111 service as part of a phased roll out. To date the performance of the service has been encouraging, with the provider achieving the required standard for the key performance indicators.
Further stages of the roll out are dependent upon the continued good performance and the clinical quality of the service being maintained.

RECOMMENDATIONS:

The Health and Wellbeing Scrutiny Commission is requested to:
Note the contents of this paper.

Planned roll out of the Service

The LLR service was initially planned to launch in June, however in April it became apparent that the service provider, Derbyshire health United (DHU) were experiencing performance problems following the launch of the Northampton NHS 111 service. Following a clinical review of the potential risks of launching the service in June, it was agreed that in the interest of patient safety the launch of the service would be delayed until there had been at least four weeks of stable service in Derbyshire, Nottinghamshire and Northamptonshire. This decision was taken in consultation with the Local Medical Council, commissioners for the service in the other Counties and NHS England.

Due to the experiences both nationally and locally the project board insisted that the service was rolled out in a phased way, keeping the existing GP out of hours service in place throughout the roll out period. The project board felt that this would offer the greatest chance of success and present the least risk to patient safety. When the service launch plans were being developed it was believed by the project team that the NHS Direct service was being withdrawn at the end of September 2013 and therefore it was decided that this would be the first phase of the mobilisation. Following the successful transfer of NHS Direct services to NHS 111, West Leicestershire CCG GP practices would change the message of their practices, asking patents to ring “111” rather than contact the GP OOH service directly. Three weeks following that East Leicestershire & Rutland CCG GP practices will follow suit and two weeks after that Leicester City GPs will change their practice out of hours messages. The existing GP out of hours service will remain in place until the last tranche of the NHS 111 service has been rolled out. The existing GP OOH provider will then TUPE its call handling staff to DHU who will be trained as NHS 111 Call advisors.

DHU call centres are in Derby and Chesterfield and these call centres have sufficient call capacity to manage calls from all four Counties, including the increase due to winter pressure. It has always been the intention for the NHS 111 service to have a call centre in Leicestershire and the current OOH service call centre at Fosse House in Enderby, will be mobilised as a call centre once the NHS 111 service has been successfully rolled out and the existing OOH call handling capacity decommissioned. The Fosse House call centre is not on the critical path for the roll out of the service and it will be mobilised as part of the service following successful technical and operational testing, which is expected to be completed by mid-November 2013.

Performance to date

The NHS 111 service went live across Leicester, Leicestershire & Rutland at 11 a.m. on Monday the 9th September. Anyone dialling “111” within Leicester, Leicestershire & Rutland will be connected directly to the service.

On Tuesday 10th September the NHS Direct service was made unavailable in Leicester, Leicestershire & Rutland, with any calls reaching a voice message advising callers to replace the handset and re-dial 111.

West Leicestershire CCG GP practices began the process of directing patients that contact the practice during out of hour towards the NHS 111 service on Tuesday 24th September.

The performance of the service to date has been encouraging, with the service levels being above the targets within the service specification. See below:-

Performance between 9th and 22nd September

Total Number of calls	2,481
Percentage of calls answered within 60 seconds	98.46%
Percentage of calls abandoned after 60 seconds	0.44%

The service is being monitored very closely by the commissioners, both to ensure the performance standards are met and that the quality of the service delivered is of the required clinical standards. There are a number of ways that this monitoring is being carried out:-

There is a daily meeting which reviews the performance over the previous twenty four hours, operationally and clinically. The meeting is a tele-conference which is led by the commissioners and involves all three CCGs, the clinical lead, the GP out of hours service, the service provider and clinicians from other LLR urgent care services.

The clinical lead and deputy clinical lead also hold a weekly call review meeting with clinicians from across the LLR urgent care services. The purpose of these meeting is to audit a sample of the calls received by the NHS 111 service provider to ensure that an effective, efficient and safe service is being provided to the public.

The impact upon other local urgent care services is also clearly important and this is being monitored by the team to ensure that there isn't any significant effect on those services.

The performance and quality information is reviewed fortnightly by the Clinical Governance Group, which is made up of primary and secondary care clinicians from across the Leicester, Leicestershire & Rutland health community.

Further roll out

The planned phasing of the roll out is that East Leicestershire CCG GP practice will transfer their out of hours call handling to NHS 111 and then Leicester City CCG will follow them before the end of October 2013. This plan is subject to the successful roll out of the West Leicestershire out of hours call handling transfer, as measured by the daily performance review and the clinical auditing of the service.by the clinical lead.

Only when the commissioners are happy that the service is delivering the required quality of service will the NHS England gateway process will be followed to gain

approval from the local and regional NHS England teams for the next phase of the roll out.

Patient safety is the most important factor during the mobilisation of this service, and any further steps will only be taken if the mobilisation team are assured that it is safe to do so.

DOCUMENT END

Leicester City Council

WARDS AFFECTED
All

FORWARD TIMETABLE OF CONSULTATION AND MEETINGS:
Overview Select Committee **18th April 2013**

Access for All: Inclusive Design Action Programme Progress Report 2010-13

Report of the Director, Planning Transportation & Economic Development

1. Purpose of Report

To present the Progress report (Appendix A) on behalf of the council's Inclusive Design Advisory Panel (IDAP), which has been requested by the Chair of the Overview Select Committee. Its purpose is to enable OSC to judge the success of the Inclusive Design Action Programme, and progress made towards meeting the agreed aims.

2. Summary

The Progress Report sets out:

- progress made across various council services and projects in achieving the council's agreed inclusive design aims;
- progress made against specific Action Programme priorities (and possible recommendations/ options for taking these forward);
- aspects/ services where improvements can be made;
- the continuing and growing strategic importance of inclusive design to the city's future.

IDAP's view is that whilst there is still some way to go before the council consistently achieves inclusive design outcomes, over-all progress since 2010 has been in a positive direction.

3. Recommendations

In the Progress Report (section 6.0) IDAP asks OSC to consider the report as a broad basis for:

- further consideration of inclusive design and progress made since 2010, and
- making recommendations to the City Mayor and Executive on taking this work forward.

The Report (in section 5.0) includes options/ recommendations (relating to specific Programme priorities) for OSC to consider further.

5. FINANCIAL, LEGAL AND OTHER IMPLICATIONS

5.1. Financial Implications

There are no direct financial implications arising from this report.

Paresh Radia – Principal Accountant.

5.2 Legal Implications

The Inclusive Design Action Programme supports the council in meeting its duties under the Equality Act 2010.

Jamie Guazzaroni - Legal Services

6. Other Implications

OTHER IMPLICATIONS	YES/NO	Paragraph References Within Supporting information
Equal Opportunities	Yes	All
Policy	Yes	Section 5.0, recommendation / option 1.1
Sustainable and Environmental	Yes	Appendix 3
Crime and Disorder	No	
Human Rights Act	No	
Elderly/People on Low Income	Yes	Appendices 1& 3

8. Background Papers – Local Government Act 1972

- Leicester City Council Cabinet, 25th January 2010 (reports and minutes)

9. Consultations

The progress report has prepared in consultation with:

- Councillor Paul Newcombe, Chair of the Inclusive Design Advisory Panel (IDAP),
- Other IDAP members: Eric Day, Barry Pritchard and Mike Richardson
- Leicestershire Centre for Integrated Living
- Leicester Disabled People's Access Group

10. Report Author: Paul Leonard-Williams, Disabled People's Access Officer x (29)7290 paul.leonard-williams@leicester.gov.uk

Appendix I (A)

Access for All: Inclusive Design Action Programme progress report 2010-13

Inclusive Design Advisory Panel

Leicester City Council

March 2013

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2.0 Purpose of this report page 4.

3.0 Progress summary page 4.

4.0 Inclusive design and council projects / services page 6.

5.0 Progress against Action Programme priorities page 9.

6.0 Conclusions and recommendations page 14.

Appendices

pages 15-29.

Appendix 1: Inclusive Design and the Action Programme

Appendix 2: Inclusive Design Advisory Panel (IDAP) – an introduction

Appendix 3: Context & trends - the growing need for inclusive design

Appendix 4: Progress & capacity issues

Appendix 5. The Equality Act and UN Convention

Appendix 6. Disabled People's Access Officer/ IDAP work load

Appendix 7. Inclusive Design and the council's statutory powers

This report has been prepared by Paul Leonard-Williams, Leicester City Council's Disabled People's Access Officer, on behalf of (and in discussion with) the council's Inclusive Design Advisory Panel (IDAP), chaired by Councillor Paul Newcombe.

For more information about IDAP and Action Programme please contact Paul Leonard-Williams

Tel (0116) 252 7290 paul.leonard-williams@leicester.gov.uk

Access for All: Inclusive Design Action Programme

Progress Report 2010-13

Inclusive Design Advisory Panel (IDAP) report to Leicester City Council's Overview Select Committee, April 2013

1.0 Background

- In 2010 the council's first Inclusive Design Action Programme was agreed by the Leicester City Council's Cabinet. This was to help implement a set of strategic inclusive design aims, which Cabinet also agreed. The programme responded to the recommendations of a scrutiny Task Group review of how access and inclusion issues are addressed by city council projects and services.

- The agreed aims (which also provide a useful definition of inclusive design) are:
    - to make places (and specify products) which everyone can use safely, easily and with dignity
    - to remove (and not create) barriers that cause undue effort or separation
    - to enable everyone to participate equally, confidently and independently in everyday activities
    - to achieve these aims through a clear commitment to achieving best practice, rather than minimum standards.

- Since 2010, the **Inclusive Design Advisory Panel (IDAP)** has met monthly under Councillor Newcombe's chairmanship to advise on a range of projects and programmes. Although IDAP's work focuses on day to day case work, this is in the context of the Action Programme's priorities.

- **Appendix 1** of this report provides more information on Inclusive Design and the Action Programme. **Appendix 2** summarises IDAP's role.

2.0 Purpose of this Report

- This report has been commissioned by the Chair of the Overview Select Committee (OSC) to allow scrutiny to judge the success of the Inclusive Design Action Programme, and progress made towards meeting the agreed aims. He has also asked IDAP to consider whether inclusive design has been embedded in the council's key projects (including Connecting Leicester). The report also considers how well key functions within the council help achieve inclusive design through service delivery (including statutory powers such as planning).

- When considering this report OSC intends to take evidence from key disability organisations - including the Leicester Disabled People's Access Group (LDPAG) which was involved in formulating the Action Programme.

3.0 Progress summary

- In our view the commitment and programme agreed in 2010 has been successful in helping to establish and sustain:
    - a good policy commitment to Inclusive Design - including in the Core Strategy of the Local Development Framework;
    - an increasing awareness and understanding of inclusive design - primarily through the Access Awareness event programme;
    - the role of IDAP as a means of influencing and supporting projects from the earliest stages;
    - involvement of disability organisations – particularly the Leicester Disabled People's Access Group (LDPAG), Leicestershire Centre for Integrated (LCIL), and Vista (Society for the Blind);
    - a modest budget to support IDAP, Access Awareness Events and this wider involvement;
    - a clearer mandate for IDAP and the Disabled People's Access Officer's roles in influencing projects;
    - some good examples of implementation (practical inclusive design outcomes) – including some projects specifically

focussed on improving/ promoting access (e.g. Changing Places programme and “Accessible Leicester” access guide.

- LDPAG welcomes the progress made, but is concerned that the weighting given to inclusive design in implementation is still patchy. IDAP shares this concern (although in our view implementation is less patchy than it was), and believes there’s a need to shift the focus of the programme towards achieving these day to day outcomes.

- There have been two major challenges in delivering the Action Programme, the first of these being the rapidly changing context within which the council and its partners work. This includes changes in government and their strategic priorities (at both national and local level), the economic recession, extreme financial and organisational pressures on the council (as a whole - and on individual officers), and ever increasing pressures on disabled people and disability organisations. Although achieving inclusive design has become more difficult in this context (despite the legal requirements of the Equality Act), the social, environmental and economic need for it has also grown, as illustrated in **Appendix 3.**

- The second key challenge is limited capacity. The Action Programme was agreed on the basis it would be delivered within existing resources. This primarily relies on the time availability of the Disabled People’s Access Officer – a 0.8 full time equivalent post. It was acknowledged from the outset that delivering the programme on this basis (alongside dealing with day to day case work) would be an ambitious undertaking. In 2011 these pressures increased further when Property Services’ DDA (Disability Discrimination Act) Officer retired and the Access Officer became the only dedicated officer advising the council on this area of work. **Appendix 4** further explains the links between capacity and progress.

- A further change during this period was the replacement of the Disability Equality Act (and eight other pieces of legislation) by the Equality Act 2010. This aims to strengthen the rights of disabled people, and people sharing other “protected characteristics”.

Appendix 5 briefly summarises duties under the Act relating to physical access for disabled people.

4.0 Inclusive design in council projects and services

a) City Council Projects/ programmes/ services generally

- **Appendix 6** lists the range of projects and issues IDAP and the Access Officer are involved in. The range and quantity of these has increased steadily since 2010, which reflects progress made in raising the profile of inclusive design. Day to day interest has certainly increased – particularly amongst officers who have attended the Access Awareness Events, and resulted in an expanding network of officers the Access Officer and IDAP are regularly in touch with and consulted by.
- This greater awareness provides a better starting point for our input. The only down-side is that increased involvement and consultation adds significantly to the time and capacity pressures mentioned above.
- The degree to which inclusive design is given priority in the council's work varies across services and projects, depending (in varying degrees) on:
    - the services, projects and individuals involved (level of awareness and commitment, complexity, number of people involved)
    - the strategic "drivers" of each project/ programme (and whether inclusive design is amongst them);
    - the degree of control/influence the council has over outcomes;
    - the consistency with which inclusive design is considered during the life of a project from the earliest stages (at a strategic and detailed level by all involved in the project);
    - the degree of co-ordination between different services;
    - the amount (and influence) of Access Officer and IDAP input;
    - the project management and communications processes adopted and how well they are used (including consultation & involvement)
    - how conflicting priorities are considered and resolved, and how much weighting is given to inclusive design in this process.
    - the resources available – budget, time and staff capacity.

- These factors go some way to explain the "patchiness" of inclusive design outcomes across the authority.

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b) **Inclusive Design and key council functions**

Appendix 7 summarises how certain key services promote inclusive design, and some of the issues relating to this. The key challenges are as follows.

- Ensuring that our local planning policies for high inclusive design standards (and the standards required by building regulations) are reflected in the quality of the schemes approved. The national trend and local pressures towards deregulation are likely to make this increasingly difficult.

- Embedding and supporting inclusive design within Property functions (since the retirement of the service's DDA officer, and given the Access Officer's limited capacity).

- Addressing (through highways & transportation functions) a number of access and inclusion impacts relating to other strategic objectives. This includes addressing the impacts of:
    - anti-social and "unaware" cycling (particularly on pavements and in "shared use" areas) on disabled and older pedestrians;
    - pavement cafes, A boards and other obstructions to pavement access;
    - inaccessible bus transport
    - "Shared Space" design – an approach to street design being heavily promoted nationally, but which can significantly disadvantage many disabled people;
    - Other strategic city centre/ "Connecting Leicester" challenges listed under d) below.

c) Access Specific Projects

City council projects which focus specifically on improving/ promoting inclusive access include:

- "Changing Places" campaign/ programme: to increase the number of these essential facilities (combined WC/ changing/ shower rooms) for people with complex and multiple disabilities – see

http://www.changing-places.org/ . The Access Officer and IDAP are working with Adult Social Care and disability organisations to help increase the number of these key facilities.

- "Accessible Leicester – city centre guide and information for disabled people": led by the Access Officer, this well-received publication is now on its 2nd edition.
- DisabledGo! http://www.disabledgo.com/en/org/leicester-city-council detailed on-line access information, funded (and input led) by Adult Social Care.

d) Connecting Leicester

- The Access Officer is involved on a day to day basis, primarily in the public realm aspects of programme (including Jubilee Square). IDAP and LDPAG are kept in touch with the projects and seek to influence them as they evolve.

- Much of this work is about promoting good practice, often based on practical "lessons learnt" from previous schemes and from our Access Awareness programme, e.g. in street furniture and paving design. The over-all standard of design and implementation has improved on this basis.

- Connecting Leicester is a complex, large scale, fast moving programme with many people involved (including external consultants) where close attention is required to ensure high quality practical outcomes from the programme.

- As well as getting the detailed designs right, there are several strategic "Connecting Leicester" challenges which need consideration as part of the process of project development, namely:
  - the potential impacts on many disabled and older people of further expansion of the pedestrian preference zone due to walking distances increasing further;
  - the increasing pressure on (and competition for) kerb space, for taxi, private hire, loading and blue badge parking, and for bus stops;
  - the expanding area of "shared use" pedestrian zone in the city centre (including potential for pedestrian/ cycle conflicts.

- the need to manage physical disruption to access caused by a number of projects being undertaken over a limited timescale.
- These are matters which are being/or will be addressed as the programme proceeds.

- Looking ahead, the significant increase in tourism expected (arising from the Richard III find and a successful UK City of Culture bid) will add to the need for good inclusive design. The Access Officer and IDAP are getting involved in the Richard III visitor attraction project, and will help influence other "Connecting to Leicester's Past" initiatives.

5.0 Progress against Action Programme priorities

The programme's actions relate to the following five interrelated priorities/ work areas, progress on which is summarised below:

- **Establish a clear commitment** to Inclusive Design, supported by strong leadership
- **Ensure a sound understanding** of Inclusive Design issues and solutions by those delivering relevant projects and services
- **Ensure effective involvement** of disabled people and access advisors in schemes and services
- **Establish robust systems and procedures** to help achieve our aims and deliver inclusive outcomes
- **Ensure good progress** towards achieving our aims.

Priority 1. Establish a clear commitment to Inclusive Design, supported by strong leadership

Achievements	Gaps/ not yet achieved
• Communicating the council's commitment to inclusive design on the council web site and in information provided to project teams. See www.leicester.gov.uk/inclusivedesign .	• A "core brief" - to further clarify the standards required, and "sign post" to more detailed information and

• Local Development Framework Core Strategy (and supporting supplementary planning documents): adopted with strong policy commitment to inclusive design. • City Mayor and Executive strong commitment to equalities, and support in principle for inclusive design.	guidance. • A consistent level of Member engagement and awareness rising (see priority 2).
Options/ recommendations 1.1 Recommend the City Mayor and Executive re-affirm the council's commitment to inclusive design as a core principle (in response to this OSC review). 1.2 Produce a brief "Access For All" policy document ("core brief") explaining this commitment, and promoting practical outcomes. This would "sign post" people to detailed information to help them achieve high standards of inclusive design.	

Priority 2. Ensure a sound understanding of Inclusive Design issues and solutions by those delivering relevant projects and services

Achievements	**Gaps/ not yet achieved**
• **Access Awareness event programme** – established and sustained (including funding for Vista's involvement), 25 events, over 120 officers participated (+ some key external partners). Programme features in RNIB/OPB national report as example of good practice • **Regional inclusive design training** event led by Commission for Architecture and the Built Environment (CABE) and Town & Country Planning Association (TCPA). • **Training events** (with Housing) on Lifetime Home Standards and Accessible Housing and on the "Access Chain" approach to inclusive planning and design. • **Inclusive Design web pages** established with key information - particularly for planning applicants	• Corporate programme to expand the range of inclusive design training available (significant amount of initial specialist input needed). • A good level of Member engagement / awareness raising (focus has been on raising awareness of key officers) • Developing a

www.leicester/inclusivedesign • **Disability awareness training** introduced by Corporate Workforce Development (CWD) in 2012 (and set to continue in 2013-14).	formal "Inclusive Design "Champions" network (capacity issues + extensive organisational / staff changes).
Recommendations/ options 2.1 Continue and develop the Access Awareness Events Programme (and secure resources for this); 2.2 Consider further specialist training (once "Access for All" core document produced) – to focus on improving outcomes. 2.3 Increase Member awareness through a) involvement in (and promotion of) IDAP, and b) targeted training. 2.4 Develop Disability Equality Training as an on-going programme for all key council staff and Members - which in IDAP's should be mandatory. This would under-pin the Access Awareness Event programme by giving attendees a greater level of understanding. 2.5 Develop the range of information sheets, and web site information/ links, to complement the "Access for All" core document.	

Priority 3: Ensure effective involvement of disabled people and access advisors in schemes and services

Achievements	**Gaps/ not yet achieved**
• **Inclusive Design Advisory Panel (IDAP)** was re-established in 2010 with new format and supported by modest revenue funding. External advisor from Leicestershire Centre for Integrated Living (LCIL), supplemented recently by specialist input from Vista and Guide Dogs Association (GDBA). • IDAP also features in RNIB/OPB national report as example of good practice http://www.rnib.org.uk/getinvolved/campaign/localcuts/localservices/Pages/quickwins_report.aspx • **Regional/ national networks:** Access Officer and IDAP's external advisor in touch with a number of networks, including the Access Association –	All actions completed. Key areas of on-going concern are included in the options/ recommendati-ons below.

essential sources of information, advice, and learning. Currently considering involvement in a national "shared space" design network.
• **Leicester Disabled People's Access Group** (LDPAG):
  ○ capacity and focus developed to champion inclusive design and access, and as "critical friend" to the city council.
  ○ input into many key projects
  ○ support by Access Officer, enables efficient input to key city council projects and services.
• **Identifying a wider network of disabled people and disability organisations:** an extensive network can now be accessed via LCIL. Access Officer and LDPAG also have a network of contacts, many of which are listed in the "Accessible Leicester" Access Guide.
• **Consultation guidance and practice** (has been a major source of concern): Access Officer supporting corporate Research and Intelligence Team to develop consultation guidance and practice.	

Recommendations/ options

3.1 Establish and develop IDAP's role and status as a key working group informing the decisions of the City Mayor and Executive.

3.2 Increase involvement of Members and of access specialists in IDAP, but without losing its responsiveness and focus.

3.3 Ensure early and on-going involvement of Access Officer and IDAP in all key projects.

3.4 Leicester Disabled People's Access Group: continue to support and involve as a key means of involving disabled people in achieving inclusive design outcomes.

3.5 Continue work with corporate Research and Intelligence Team to ensure accessible and meaningful consultation.

3.6 Address capacity and resource issues to support this area of work.

Priority 4: Establish robust systems and procedures to help achieve our aims and deliver inclusive outcomes.

Achievements	Gaps/ not yet achieved
• **Highway and Transportation: Project Delivery Manual (PDM):** Inclusive Design requirements (including need for "Access Statements") included in current draft (currently being reviewed for final version). • **"Lessons learnt" process:** is included in the corporate project management procedures. Much of the Access Officer's, IDAP's and LDPAG's input (and the focus of Access Awareness Events) is based on lessons learnt from past projects. • **Lifetime Homes** policy compliance: system established and being implemented. • **Guidance notes** developed to support various aspects of design and summarise legal requirements of the Equality Act. • **Equality Impact Assessments:** City Mayor and Executive commitment to this process has increased their use. •	Highway & Transportation's Project Delivery Manual still in draft form (final version currently being finalised). Lessons learnt processes: better "capturing"of lessons learnt to influence subsequent projects and decisions. Equality Impact Assessment (EIA) process - needs better embedding in the project management process.

Recommendations/ options

4.1 Refine (and/ or supplement) the Equality Impact Assessment process and guidelines to ensure it's a useful project management tool for achieving inclusive outcomes.

4.2 Complete re-drafting of PDM procedures and encourage their use.

4.3 Complete the re-drafting of PDM procedures and start to implement.

4.4 Promote and develop this approach for other projects with inclusive design implications across the council.

4.5 (Corporately) Review and improve effectiveness of "Lessons Learnt" processes to inform subsequent projects/ programmes.

Priority 5. Ensure good progress towards achieving our aims

Achievements	Gaps / not yet achieved

The main areas of progress are summarised under the other priorities.	Staff capacity continues to be a major challenge in embedding inclusive design and delivering this programme. The Access Officer has to balance the need to improve processes and procedures, against an expanding volume of day to day case work**.** Although the programme's aims and priorities have guided this work, the process has been less structured than envisaged in 2010.
Recommendations/ options 5.1 The "Access for All" core document should communicate and take forward the "joined up" approach of the first action programme, but a) in a more accessible and higher profile format, and b) more clearly supporting day to day case work and outcomes. 5.2 Capacity and resources issues need to be addressed if inclusive design outcomes are to be achieved consistently across the council's services.	

6.0 Conclusions and recommendations

This report aims to give OSC a broad basis for a) further consideration of inclusive design, including progress made since 2010, and b) making recommendations to the City Mayor and Executive on taking this work forward. To help in this process, OSC is invited to:

- seek evidence from disability organisations - particularly the Leicester Disabled People's Access Group (LDPAG) and;
- consider (in discussion with IDAP and the LDPAG) a few specific projects/ programmes in more depth - to find out what specific issues arose, and what lessons could be learnt.

Appendices

Appendix 1: Inclusive Design and the Action Programme

Appendix 2: Inclusive Design Advisory Panel (IDAP) – an introduction

Appendix 3: Context & trends - the growing need for inclusive design

Appendix 4: Over-all progress (practical outcomes through day-to-day case work)

Appendix 5. The Equality Act and UN Convention

Appendix 6. Disabled People's Access Officer/ IDAP work load

Appendix 7. Inclusive Design and key council services/ functions

Appendix 1: Inclusive Design and the Action Programme

Inclusive Design (as defined in section 1.0 of this report):

- is a process of designing, constructing, and managing buildings, streets, spaces, transport systems, and products (including information), which everyone can use;
- encompasses where people live or work; the buildings, streets, spaces and products they use, as well as their means of getting around;
- addresses the rights and needs of people with ill health, injury or disability (including mobility, dexterity, sensory, learning, communication, continence and mental health impairments), ensuring they are supported by thoughtfully crafted and managed environments;
- recognises and accommodates differences in the way people use and respond to their environment;
- provides solutions that enable all of us to participate in mainstream activities equally, with choice and with dignity, and as independently as possible.

Aims, priorities and actions

The Inclusive Design Action Programme sets out agreed strategic inclusive design aims and key priority/ work areas which were adopted to help take the Action Programme forward (*see sections 1.0 and 5.0 of this report*).

The actions listed are to help:

- communicate the Council's commitment to inclusive design, with an emphasis on supporting those who are developing new policies , projects and programmes, as well as those implementing existing policies;
- provide links to more detailed information to support the Inclusive Design process;
- ensure that development projects meet the highest standards of accessibility and inclusion, as well as contributing positively to an

area's character and appearance; the Council's view is that good designers should be able to achieve both (as required by draft LDF Core Strategy policy CS 3).

- develop a clear framework for decision making, which will have Inclusive Design as a key consideration from the earliest stages of projects;
- ensure that potential conflicts with other priorities (whether at a strategic or more detailed / operational level) are fully considered and resolved early in the planning & design process;
- provide clear and simple planning and design guidance which wherever possible will be 'mainstreamed' in relevant supplementary planning documents and advice notes (rather than create a new policy framework.

Appendix 2: Inclusive Design Advisory Panel (IDAP) – an introduction

1. What is IDAP?

- The Panel, which meets monthly, was founded by the City Council and Leicestershire Centre for Integrated living in 2006 primarily in response to the rapid regeneration of the city centre.

- IDAP aims to provide the Council with clear and timely advice on inclusive design matters. This includes developing best practice in the context of the council's Inclusive Design Action Programme, and the city's Core Strategy (our key land use planning document), both of which call for the highest standards of access and inclusion.

- In 2010 the council's Cabinet decided that the IDAP should continue in order to support this positive approach to inclusive design.

- Current membership is as follows:
    - Chair: Councillor Newcombe
    - External Access Advisor: Eric Day, Leicestershire Centre for Integrated Living (LCIL)
    - Additional external specialists: Fiona Hind (Vista, Society for the blind), and Terry Smith (Guide Dogs Association)
    - City Council officers: Barry Pritchard (Highways & Transportation), Mike Richardson (Planning), and Paul Leonard-Williams (Disabled People's Access Officer)

- IDAP's role complements (and should not be confused with) that of the Leicester Disabled People's Access Group (LDPAG). Although LDPAG works closely with the council on access matters, it is an independent organisation representing disabled people, rather than a specialist advisory panel.

2. IDAP's recent work

- IDAP plays a valuable role in positively influencing a range of projects and programmes (listed in **Appendix 6** of this report).

- The Panel is also an important source of information on new legislation, standards, guidance and research.

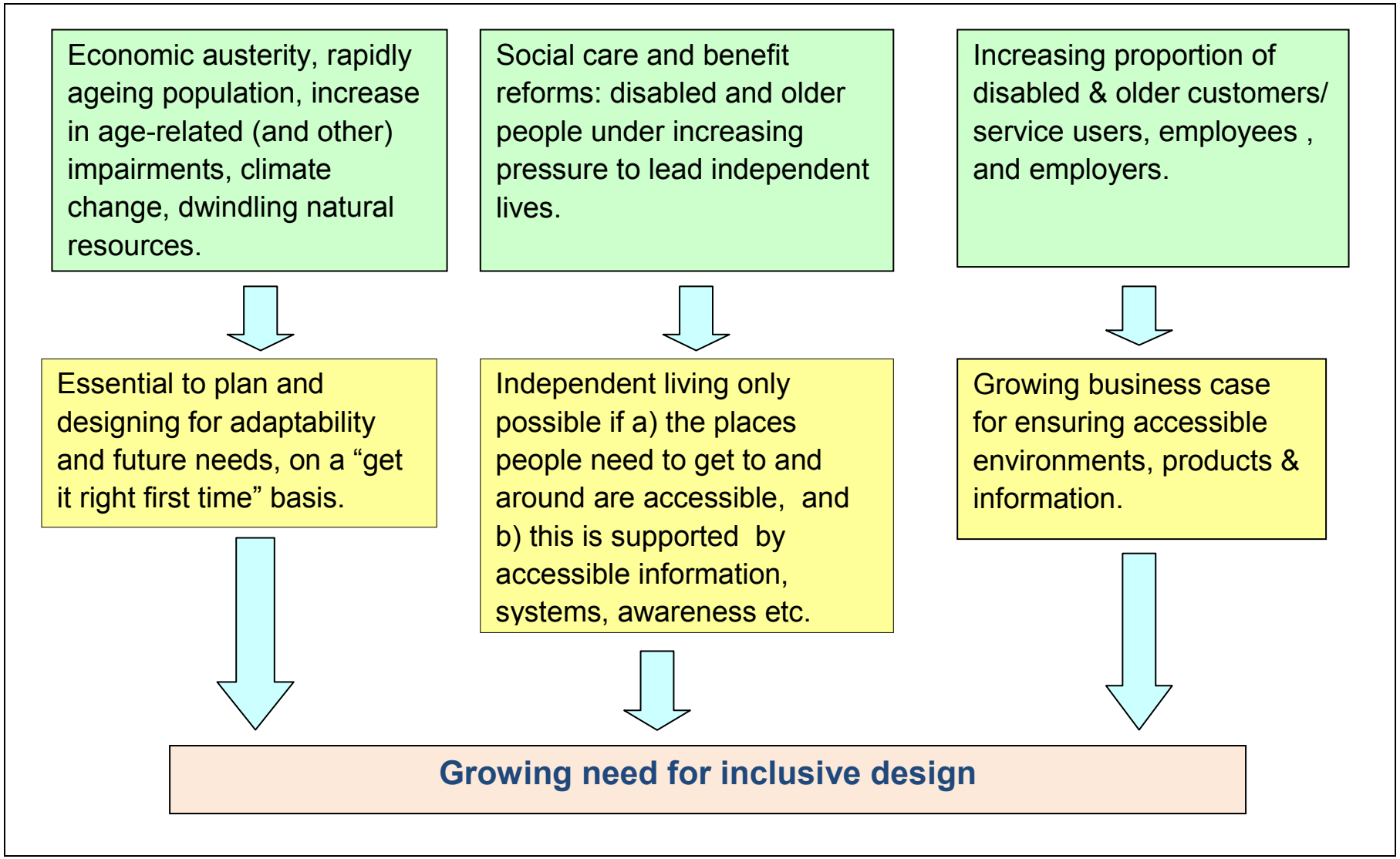
- IDAP has been identified as an example of good practice at a national level in *"Quick wins… and missed opportunities: how local authorities can work with blind and partially sighted people to build a better future"* (RNIB/ OPN report) http://www.rnib.org.uk/getinvolved/campaign/localcuts/localservices/Pages/quickwins_report.aspx , and in work currently being undertaken by the Equality and Diversity Forum relating to the Equality Duty.

3. Taking IDAP forward

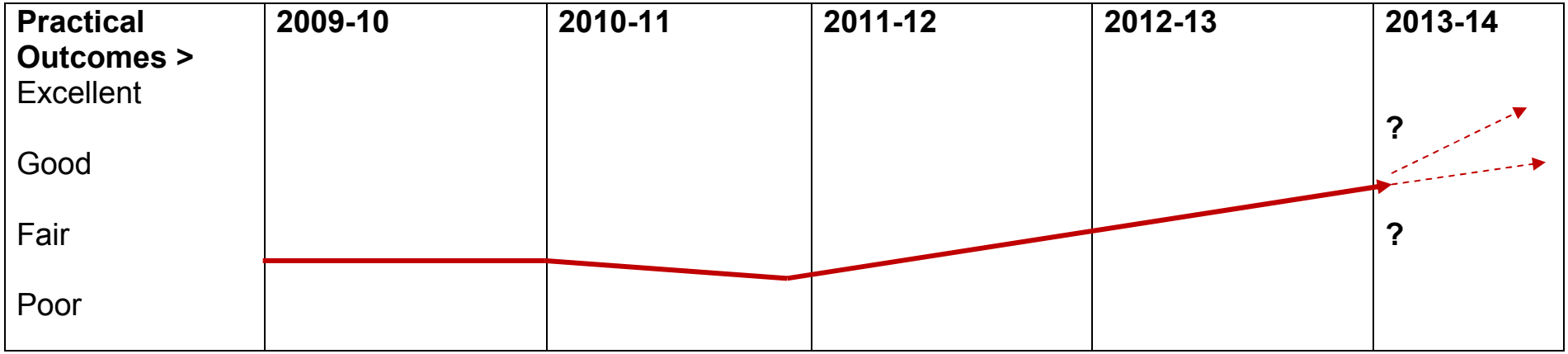
- IDAP is well placed to support delivery of the City Mayor and Executive's commitments and priorities – including the "Connecting Leicester" Programme. Its role helps to put into action the administration's strong commitment to equalities.

- The future of the panel is considered in section 5.0 of this progress report, which identifies the need for establishing a higher profile for its role within the council.

Appendix 3 : Context & trends – and the need for inclusive design



Appendix 4. Over-all progress (practical outcomes through day-to-day case work)



	2009-10	2010-11	2011-12	2012-13
Access Officer/ IDAP Case Work >	Intermittent input, and poor/patchy outcomes	Awareness increases > time to respond decreases (because of this strategic work)	Awareness increases> influence widens> time input more productive. Volume increase continues.	Volume further increases (e.g. Connecting Leicester, property, planning cons. (esp. housing).
Policy, processes, awareness raising etc.>	Processes reflect general low level of awareness and commitment. Scrutiny Task Group review to address.	Major time input to improve e.g. Core Strategy, IDAP etc.	Effects of strategic work start to kick in, but context more challenging, procedural work increases e.g. lifetime homes.	IDAP review of Action Prog. starts (remaining capacity needed for case work).

Appendix 5: the Equality Act and UN Convention

1. Equality Act 2010 and disability equality – a very brief summary

The Equality Act 2010: replaces/ brings together 9 pieces of legislation "to strengthen and streamline discrimination law". It protects people from discrimination relating to 9 "protected characteristics":

Race; Religion/belief;
Age; Disability;
Marriage & civil partnership;
Pregnancy & maternity;
Sexual orientation; Gender; Gender reassignment

"Reasonable adjustments" = where a disabled person is placed at a 'substantial disadvantage' (defined as "more than minor or trivial") in comparison to non disabled people, this must be rectified by:

- changing the built environment, and / or
- changing the way things are done,
- providing auxiliary aids and services (including providing information in accessible formats).

It also protects disabled people from a) discrimination that happens because of:

- something connected to a person's disability ("discrimination arising from disability")
- a person's association with a disabled person, or
- a person wrongly being perceived to be disabled

b) disability-related harassment or victimisation.

c) less favourable treatment because of the disability or age of the person for whom they care.

Public Sector Equality Duty: In addition Public Authorities must "have due regard for advancing equality" by:

- **Eliminating conduct prohibited** under the Act (including unlawful discrimination, harassment & victimization);

- **Advancing equality of opportunity** (between people who share a protected characteristic, and those who don't)
- **Fostering good relations** (between people who share a protected characteristic and those who don't).

This involves:

- **Removing/ minimizing disadvantages** suffered by people due to their protected characteristics
- **Taking steps to meet the needs of people** from protected groups, where these are different from the needs of other people;
- **Encouraging people from protected groups to participate** in public life or in other activities where their participation is disproportionately low.

2. The United Nations Convention on the Rights of People with Disabilities (ratified by UK Government in 2009)

The Convention is an international agreement to protect and promote the human rights of disabled people throughout the world. Key points:

- It's not just a paper 'declaration' without any teeth.
- It requires governments to take action to remove barriers and give disabled people real freedom, dignity and equality.
- Disabled people are encouraged to use it, to make sure their rights are respected and to get a better deal.

Appendix 6.

Disabled People's Access Officer / IDAP Work Load

Key:
A= Active project/ programme (1= current, 2 = looming)
B = Displaced (move to C or A)
C = "Parked"/ pending – pursue at later date.
D = Off (or on edge of) radar (1 = to pursue/ respond, 2 = don't pursue)

1. **Information, Involvement, Awareness Raising**

- "Accessible Leicester" Access Guide (A1),
- DisabledGo! (C),
- Web site information (C)
- Access Awareness event programme (B>A1),
- Other Inclusive Design/ Disability Equality Awareness Training (C)
- Inclusive Design Advisory Panel (IDAP) (A1),
- Leicester Disabled People's Access Group (A1),
- Other Groups/ organisations – including, Vista, LCIL, DEG, Access Association (A1)

2. **Policy/ strategy/ process**

- Inclusive Design Action Programme review (B>A1)
- Inclusive Design/ Access for All Guidance ("Core Brief" + additional guidance/ links) (B>A1)
- EIA/ Access statement process (B>A1), Project Delivery Manual (H&T) (B>A1)
- Connecting Leicester – strategic issues/ access statement, EIA etc., site management processes etc (B > A1)
- Cycling Strategy/ PFC Discussions (D1>A1?)
- Street Café review and guidance (design/ procedures) (B>C),
- Local Plan/ Core Strategy/ SPDs (A2)
- Highway 6Cs design guide (D)
- LCC Equality Strategy/ Improvement Group (LCC Eq strategy) (D2?)

3. <u>Projects / case work (design/ implementation)</u>

- Connecting Leicester street work schemes (A1),
- Jubilee Square (A1),
- Market development (A1),
- Haymarket bus station (A1),
- Belgrave Road (C>A2),
- Richard III visitor attraction (A2)

- DMU/ Mill Lane Public Realm (A1)
- Great Central Railway (A2)
- Ashton Green (D1?)
- BSF (D2)

- LCC accommodation review/ access arrangements – CS centre, Attenborough House etc (A1)
- LCC property emergency egress discussions (A1)

- Other Case Work: Planning/ H&T/ Property/ Health & Safety etc.– advice on major and minor schemes and programmes - including Lifetime Homes standards, access/ frontage arrangements, street improvements and H&S cases (A1, B & D)

- Advice to other services/ individuals – including enquiries from Members, City Mayor & Executive and customer services, and directly from customers (A1)

Appendix 7: Inclusive Design and key council services/ functions (this is not a comprehensive list, e.g. does not include Adult Social Care, Children's Services, Licensing, Parks & Open Spaces etc).

Planning	
Issues Implementing the policies is the main challenge (as with all qualitative aspects of planning). Factors include: • national moves towards deregulation ("presumption in favour of sustainable development") • learning curve for case officers of introducing new policies • more detailed guidance and systems needed to support the broad policy requirements (i.e. what we mean by "high standards" of inclusive design) • importance of determining applications within statutory timescales • major time implications (for Access Officer) of increased case work - particularly implementing Lifetime Homes policy.	**Current situation** • Inclusive design embedded in the council's Core Strategy (specifically in CS policies 3 and 6) and the planning guidance which supports it (major step forward) • Planning service re-organisation: Access Officer better placed to work with case officers and influence outcomes; • Case officers' awareness improved through discussion and training (focus so far on the Lifetime Homes Standards requirements); • Lifetime Home Standards: procedures and guidance produced and being implemented (also see Housing below). • Various planning applications challenged by LDPAG (based on these policies), and improvements to schemes sought (and where possible secured). • Options for addressing LTH standards capacity issues currently being considered.
Housing (Housing Development Team)	
Issues Generally as for Planning above.	**Current situation** • Wheelchair Housing Standards: Housing Development Team pro-active in promoting and securing standards (at least10%

	of units in all affordable housing schemes).
Building Control	
Issues • Although building regulations set minimum inclusive design standards, the many in the development industry tend to use them as a starting point from which to negotiate compromises. • Local Authority building control services compete in a commercial market with "approved inspectors" who are more likely to agree compromises to design standards. • The scope of Building Regulations is limited (e.g. they cover access to and within buildings – but not applicable to wider area, do not apply to "fit out" aspects such as signs and other fixtures/ fittings, and do not include all Lifetime Home Standards. • National moves towards deregulation could seriously compromise the accessibility of buildings.	**Current situation** • Officers' knowledge of detailed inclusive design requirements generally sound. • Access Officer works closely with officers on particular projects and issues and helps to ensure that planning and building regulation requirements are mutually supportive. • The scope for involving the service in delivering Lifetime Home Standards is currently being discussed.
Property	
Issues • Risk that inclusive access/ design becomes a lower priority following the loss of property's dedicated officer (DDA officer post). • Accommodation strategy and other property related projects	**Current situation** • Officers have started consulting the Access Officer's on specific projects and issues. • Joint working started with Fire Safety Officer, and Corporate Health and Safety committee to address emergency egress

are creating greater need/ demand for this input. • There's a significant amount of work (identified in DDA officer's audits), to bring operational premises up to minimum access standards. • Addressing emergency evacuation issues (without compromising duties to provide inclusive access), has recently arisen as a key priority. • Access Officer has insufficient capacity to respond fully to this additional area of work.	issues (including moving towards specifying evacuation lifts in major building/ refurbishment projects). • Need to address staff capacity issues is highlighted in the main body of this report (sections 4.0 and 5.0)
Highways & Transportation	
Issues • See main report re. key issues which need addressing (Cycle/ pedestrian conflicts, street obstructions, Bus transport, "Shared Space" + other strategic city centre/ Connecting Leicester issues). • Use of consultants (particularly engaged on public realm projects): need to recognise (and plan for) external consultants generally having a low level of inclusive design knowledge and experience.	**Current situation** • Access Officer works closely with officers across the service, both at a strategic and operational level (and including the "Connecting Leicester" work described above. • Officers generally aware and supportive of inclusive design objectives, and have been particularly responsive to the Access Awareness events. • Work underway/ planned to address the key issues: e.g. LDPAG / Leicester Cycle Campaign dialogue re. cycle pedestrian conflicts/ common ground, IDAP review of street cafe procedures (started but on hold), City Mayor seeking more powers to influence bus transport, and engagement with Guide Dogs Association and Vista regarding "shared space"

Cultural & Neighbourhood Services	
Issues • Anticipated increase in visitor numbers to the city highlights the need for high inclusive design standards e.g. in visitor journey/ experience planning, interpretation, and physical infrastructure. • Accessibility to and between key destinations needs improving. • Emergency egress issues (identified above) need addressing.	**Current situation** • Some examples of good practice e.g. Access/ inclusion standard achieved at DeMontfort Hall. • Generally low level of IDAP/Access Officer input into projects. • Need to consolidate and take forward existing good practice, particularly through "flag ship" projects such as Richard III visitor attraction and "Connecting Leicester's Past" projects.
Other Environmental Services: Health & Safety, Parks & Open Spaces	
Issues (public safety) • Hazards incorporated into buildings with public access (particularly small/ medium sized shops and other businesses) – often due to misguided attempts to improve access. • Need for more simple and accessible information for businesses on improving access. **Issues (parks & open spaces)** • Managing/ designing out anti-social use e.g. by motor cyclists, without excluding disabled people is a regular issue which arises.	**Current situation** • Access Officer regularly works with the Health & Safety Team to address access/ safety issues (e.g. well- meaning but misguided attempts to provide ramped access to businesses) • Access Officer input to management plans and development proposals + policy/ procedural advice (e.g. on anti-social use & detailing access).

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Appendix J

Report to Scrutiny

Scrutiny Commission: Health and Wellbeing

Date of scrutiny committee: 15th October 2013

Public Health Commissioning and Contracting

Lead director: Rod Moore, Divisional Director of Public Health

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Useful information

- Ward(s) affected: All wards
- Report author: Nicola Hobbs / Rod Moore
- Author contact details: 37 2317 / 37 2034
- Report version number: 5.0

1. Summary

1.1 This report provides details of the commissioning, contract management and procurement arrangements for the Public Health responsibilities that were transferred to the Local Authority in April 2013.

2. Main report:

2.1 Transfer of Public Health Duties

2.1.1 The Health and Social Care Act (2012) lays out specific responsibilities of the Local Authority with regard to public health and the Director of Public Health (DPH). Some responsibilities are mandatory either as a mandate of the Secretary of State for Health or as part of a universal system.

2.1.2 Other responsibilities are to be applied in relation to local need following assessment. Prevention of ill health is important for the population and quality of life and will also drive future reductions in adult social care as well as NHS care. Public health is a vital part of the work of the Health and Wellbeing Board and the implementation of the Health and Wellbeing Strategy.

2.1.3 A number of new responsibilities of the local authority are mandatory;

- Commissioning of open access sexual health services
- Health protection (duty on DPH to ensure plans in place to protect health of population) including community infection prevention and control and the local authority role in dealing with health protection incidents, outbreaks and emergencies.
- Public Health advice, analysis and support to NHS commissioners
- Implementing the National Child Measurement Programme
- Commissioning NHS health checks for 40-74 year olds
- Joint Strategic Needs Assessment
- Pharmaceutical Needs Assessment
- Clinical governance arrangements
- Community acquired infection, prevention and control

2.1.4 Other commissioning responsibilities are as follows;

- tobacco control and smoking cessation services
- alcohol and drug misuse services
- public health services for children and young people aged 5-19

(including Healthy Child Programme 5-19) and from 2015/16 all public health services for children and young people 0-19 years.

- interventions to tackle obesity, such as community lifestyle and weight management services
- locally-led nutrition initiatives
- increasing levels of physical activity in the local population
- public mental health services
- dental public health services
- accidental injury prevention
- population level interventions to reduce and prevent birth defects
- behavioural and lifestyle campaigns to prevent cancer and long-term conditions (e.g. diabetes, chronic obstructive pulmonary disease)
- local initiatives on workplace health
- local initiatives to reduce excess deaths as a result of seasonal mortality
- public health aspects of promotion of community safety, violence prevention and response
- public health aspects of local initiatives to tackle social exclusion
- local initiatives that reduce public health impacts of environmental risks.

2.2 Commissioning for Public Health

2.2.1. Some £16.3m commissioned spend was transferred to the City Council on 1st April and commissioning activity is now entirely within the processes and procedures of the City Council. The transferred commissioned activity is now subject to a programme of review and re-procurement which will reflect mandatory requirements (as indicated above), City Council priorities and partnership priorities as set out in the Leicester Health and Wellbeing Strategy, *Closing the Gap*. Decisions on policy and direction of commissioning are taken by the Executive with advice and options being developed by the Director of Public Health. Currently the Lead Member for Health and the Executive are in the process of considering a range of issues in relation to the future use of the ring-fenced budget and thus future commissioning priorities.

2.3 Contracting for Public Health

2.3.1 As indicated above the transfer of Public Health Services in April 2013 resulted in the Local Authority assuming responsibility for approximately £16.3m worth of Public Health contracted spend. Services are delivered by a wide range of organisations within different sectors of the Health and Social Care market.

2.3.4 Resources have been committed (initially for 2013/14 & 2014/15) within the Public Health budget for Contract Management and Procurement support in the Contracting and Assurance Service. The officers will act as the lead and/or main liaison point Public Health Services with specialist input as agreed from relevant Public Health team members.

2.3.5 In recognition of the higher spend/higher risk activity formal agreements for 12/13 have been established with the City Clinical Commissioning Group (CCG) and West Leicestershire CCG to manage the University Hospitals Leicester and Leicestershire Partnership Trust contracts respectively on behalf of the

Authority.

2.3.6 The monitoring of these agreements will be led by the Head of Contract and Assurance reporting to the Divisional Director of Public Health.

2.3.7 All services have been issued with a formal contract or for internal services a Service Level Agreement to extend the current arrangements until March 2014. Within the agreement, service objectives and targets have been set by the relevant Public Health lead.

2.3.8 Quantitative reporting systems are being established to be able to report performance against targets to inform the contract management framework being developed. This will ensure that there is a comprehensive approach to evidencing the quality and performance of services. This framework will provide the foundation for a consistent approach to contract compliance and thus further improve the quality of services procured.

2.3.9 Appendix A provides a summary of Public Health Services detailing current procurement activity and those where future commissioning considerations are under review. This will form a Public Health Procurement Plan that will be incorporated into the Corporate Procurement Plan.

3. Details of Scrutiny

3.1 This report is for the Scrutiny Commission: Health and Wellbeing.

4. Financial, legal and other implications

4.1 Financial implications

4.1.1 There are no direct financial implications, as this report provides details of the contract management and procurement arrangements for the Public Health Contracts.

Yogesh Patel, Accountant (37 x 4011)

4.2 Legal implications

4.2.1 Since the focus of this report is on public health contract management, assurance and monitoring, there is no legal implication. All public health contracts will be managed and monitored in accordance with existing contractual terms and conditions.

Adeola Sonola, Legal Services (37 1417)

4.3 Climate Change and Carbon Reduction implications

4.3.1 There are significant synergies between the Public Health responsibilities outlined in the report and the City Mayor's priority for addressing climate change. These include the areas of: air quality, healthy diet and the expected health impacts of a changing climate – particularly in relation to the increasing risks of heatwaves. Effective joint working between health and environmental officers is already underway in the field of healthy diet via the Food Plan Board and there is potential for similar joint working in other areas. Council commissioning and contract compliance monitoring systems can help to ensure climate change implications are properly addressed in each commissioned service.

Duncan Bell, Senior Environmental Consultant, Environment Team. Ext. 37 2249.

4.4 Equality Impact Assessment

4.4.1 Our public sector equality duty focuses on how we understand and meet the needs of service users and whether service changes have any impact, particularly negative, on those needs continuing to be met. Therefore, equality impact assessments of proposed service changes and their likely effect on service users will be undertaken, where required.

Irene Kszyk, Corporate Equalities Lead

4.5 Other Implications (You will need to have considered other implications in preparing
this report. Please indicate which ones apply?)

4.5.1 No other implications

5. Background information and other papers:

5.1 None

6. Summary of appendices:

6.1 Appendix A**.** Summary of Public Health Commissioning and procurement time table and activity.

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26/09/13 Summary of Public Health Commissioning and procurement time table and activity.

Appendix A

	Procurement Completed
	Process underway
	Not yet started
	Contracts Ceased

Contract Code	Provider Name	Contract Area	Estimated Annual Value £	End date	PH Lead Commisioner	Consultant Lead	Relates to mandatory responsibility	PH Lead Commissioning Review Coment/Expected Review Date
Leicestershire Partershop NHS Trust								
LPT1	**Leicestershire Partnership NHS Trust**	Public health dietetic support	213,550	31 March 2014	Stephanie Dunkley/Joanne Atkinson (SD/JA)	Joanne Atkinson (JA)		Procurement process commence 2014/15 for new service 2015/16
LPT2	**Leicestershire Partnership NHS Trust**	Food and activity buddies (FAB)	206,000	31 March 2014	Stephanie Dunkley/Joanne Atkinson (SD/JA)	Joanne Atkinson (JA)		Procurement process commence 2014/15 for new service 2015/16
LPT3	**Leicestershire Partnership NHS Trust**	National Child Measurement Programme Admin Support	22,550	31 March 2014	Joanne Atkinson (JA)	Joanne Atkinson (JA)	Yes	to be reprocured with School Nursing and Health Visiting
LPT7	**Leicestershire Partnership NHS Trust**	STOP! Smoking Service, including Nicotine Replacement Therapy	1,197,000	31 March 2014	Rod Moore (RM)	Rod Moore (RM)		Procurement process commence 2014/15 for new service 2015/16
LPT10	**Leicestershire Partnership NHS Trust**	Community Health Development Co-ordinators inc healthy Living Centres	454,000	31 March 2014	Joanne Atkinson (JA)	Joanne Atkinson (JA)		Procurement process commence 2014/15 for new service 2015/16
LPT13	**Leicestershire Partnership NHS Trust**	Drug & Alcohol Detoxification beds	259,000	31 March 2014	Julie O'Boyle (JOB)	Julie O'Boyle (JOB)		Sub regional arrangement with LCC contract extension required to March 2015 with a view to new services by April 2015.
LPT14	**Leicestershire Partnership NHS Trust**	Healthy Child programme 5-19: School Nursing	1,909,000	31 March 2014	Jasmine Murphy/ Rod Moore (JM / RM)	Jasmine Murphy (JM)		Review in 2014/15. Procurement process commence 2015/16 for new Healthy Child Programm 0-19 service 2016/17
New responsibility from 2015/16	**Leicestershire Partnership NHS Trust**	Healthy Child programme 0-5: Health visiting	Not yet established	Will become LA responsibility in 2015/16. Currently with NHS England.	jasmine Murphy/ Rod Moore (JM / RM)	Joanne Atkinson (JA)		Review in 2014/15. Procurement process commence 2015/16 for new Healthy Child Programm 0-19 service 2016/17
LPT17	**Leicestershire Partnership NHS Trust**	Specialist Domestic Violence Nurse	50,000	31 March 2014	Julie O'Boyle (JOB)	Julie O'Boyle (JOB)		Currently under review for reprocurement in 2014/15
	Leicestershire Partnership NHS Trust	CQUIN - quality incentive payment	129,575	31 March 2014	Rod Moore (RM)	Rod Moore (RM)		Will not be renewed
University Hospital of Leicester								
UHL3	**University Hospital of Leicester NHS Trust**	Alcohol Liaison Workers for City (UHL)	88,000	31 March 2014	Priti Raichura/Julie O'Boyle(PR/JOB)	Julie O'Boyle (JOB)		Sub regional arrangement with LCC contract extension required to March 2015 with a view to respecified services by April 2015.
Primary Care								
PC1	**Primary Care (GP)**	Sexual Health Services (GP LES - Chlamydia)	87,000	31 March 2014	Liz Rodrigo (LR)	Jasmine Murphy (JM)		Review 2012/13 for new service 2014/15
PC2	**Primary Care (GP)**	Sexual Health Services (GP LES - Coils and devices)	76,160	31 March 2014	Liz Rodrigo (LR)	Jasmine Murphy (JM)		Review 2012/13 for new service 2014/15
PC3	**Primary Care (GP)**	Sexual Health Services (GP LES - Implanon and devices)	145,664	31 March 2014	Liz Rodrigo (LR)	Jasmine Murphy (JM)		Review 2012/13 for new service 2014/15
PC4	**Primary Care (Pharmacies)**	Sexual Health Services (Pharmacy LES - EHC and Chlamydia testing for under 25s)	58,000	31 March 2014	Liz Rodrigo (LR)	Jasmine Murphy (JM)	Yes	Review 2012/13 for new service 2014/15
PC6	**Primary Care (GP)**	Alcohol LES	39,000	31 March 2014	Priti Raichura/ Julie O'Boyle (PR/JOB)	Julie O'Boyle (JOB)		Review 2012/13 for new service 2014/15
PC7	**Primary Care (GP)**	NHS Health Checks	591,000	31 March 2014	Ivan Browne (IB)	Ivan Browne (IB)	Yes	Review 2012/13 for new service 2014/15
Voluntary Sector								
VCS1	**Leicestershire & Rutland Rural Community Council**	Suicide Awareness Programme (Rural Communities Council)	40,000	31/03/14	Mark Wheatley (MW)	Julie O'Boyle		Review 2012/13 for new service 2014/15
VCS2	**Trade Sexual Health**	HIV Prevention (support for Gay men's sauna)	80,266	31/03/14	Liz Rodrigo (LR)	Jasmine Murphy (JM)		Review 2014/15 for new service by April 2016.
VCS3	**LASS**	HIV Prevention (LASS main contract)	197,000	31/03/14	Liz Rodrigo (LR)	Jasmine Murphy (JM)		Review 2014/15 for new service by April 2016.
VCS5	**Faith in People with HIV**	HIV Prevention - reducing stigma	62,000	31/03/14	Liz Rodrigo (LR)	Jasmine Murphy (JM)		Review 2014/15 for new service by April 2016.
VCS6	**New Futures**	STI/HIV prevention (New Futures main contract)	62,000	31/03/14	Liz Rodrigo (LR)	Jasmine Murphy (JM)		Review 2014/15 for new service by April 2016.

Appendix J (A)

Contract Code	Provider Name	Contract Area	Estimated Annual Value £	End date	PH Lead Commisioner	Consultant Lead	Relates to mandatory responsibility	PH Lead Commissioning Review Coment/Expected Review Date
Leicester City Council								
LCC1	**Leicester City Council**	Active lifestyle scheme (LCC Sports Services - GP Exercise Referral)	90,000	31 March 2014	Stephanie Dunkley (SD)	Joanna Atkinson (JA)		No current plans to re-procure - service provided by LCC
LCC2	**Leicester City Council**	Cycling and walking	30,000	31 March 2014	Stephanie Dunkley (SD)	Joanna Atkinson (JA)		No current plans to re-procure - service provided by LCC
LCC5	**Leicester City Council**	Alcohol Treatment	1,092,000	31 March 2014	Priti Raichura/Julie O'boyle (PR/JOB)	Julie O'Boyle		Integrated Drug and Alcohol services reprocured by City Council from July 2013 for 3 years +1+1. Young people's service under review to be reprocured April 2015.
LCC6	**Leicester City Council**	Drug Treatment	3,962,000	31 March 2014	Priti Raichura/Julie O'boyle (PR/JOB)	Julie O'Boyle		Integrated Drug and Alcohol services reprocured by City Council from July 2013 for 3 years +1+1. Young people's service under review to be reprocured April 2015.
LCC7	**Leicester City Council**	Drugs Public Health funding	590,000	31 March 2014	Priti Raichura/Julie O'boyle (PR/JOB)	Julie O'Boyle		Integrated Drug and Alcohol services reprocured by City Council from July 2013 for 3 years +1+1. Young people's service under review to be reprocured April 2015.
Procurement Underway								
OTHER5	**Leicestershire & Rutland Probation Trust**	Probation Health Trainer Service	75,000	31 March 2014	Joanne Atkinson (JA)	Joanne Atkinson (JA)		Currently being procured, new contract to commence 1/04/14 to 31/03/17 poss +1+1 year ext)
CSSE1	**Parkwood Healthcare Ltd,**	Health Trainers (Parkwood)	181,000	31 August 2014	Joanne Atkinson (JA)	Joanne Atkinson (JA)		Out to tender November 2013
CSSE4	**Mytime Active (Formally Mend Ltd)**	Children's Weight Management Service	55,000	31-Mar-14	Joanne Atkinson (JA)	Joanne Atkinson (JA)		Currently being procured. New contract to commence 01/04/14 to 31/03/16 poss 1+1year ext)
Contracts Transferred but Procurement Completed								
LPT4	**Leicestershire Partnership NHS Trust**	Chlamydia Screening + Sexual Health Promotion	679,000	31 December 2013	Liz Rodrido (LR)	Jasmine Murphy (JM)	Yes	new contract for Integrated Sexual Health Services to commence 01/01/14 to 31/12/17 with poss of ext 2 yrs + 1+1)
LPT6	**Leicestershire Partnership NHS Trust**	Choices (LPT Health Visiting, School Nursing and Choices)	186,000	31 December 2013	Liz Rodrigo (LR)	Jasmine Murphy (JM)	Yes	new contract for Integrated Sexual Health Services to commence 01/01/14 to 31/12/17 with poss of ext 2 yrs + 1+1)
LPT9	**Leicestershire Partnership NHS Trust**	LPT GUM Loughborough	26,650	31 December 2013	Liz Rodrigo	Jasmine Murphy (JM)	Yes	new contract for Integrated Sexual Health Services to commence 01/01/14 to 31/12/17 with poss of ext 2 yrs + 1+1)
UHL1	**University Hospital of Leicester NHS Trust**	Sexual Health Services (UHL GUM) + Sexual Health Services (UHL Contraceptive Services)- formally UHL2.	2,818,263	31 December 2013	Liz Rodrigo(LR)	Jasmine Murphy (JM)	Yes	new contract for Integrated Sexual Health Services to commence 01/01/14 to 31/12/17 with poss of ext 2 yrs + 1+1)
LCC3	**Leicester City Council**	Safer Sex Project (LCC Condoms, Pregnancy Testing and Training collaboration)	58,000	31 December 2013	Liz Rodrigo (LR)	Jasmine Murphy (JM)	Yes	new contract for Integrated Sexual Health Services to commence 01/01/14 to 31/12/17 with poss of ext 2 yrs + 1+1)
PC5	**Primary Care (GP)**	Sexual Health Services (GP APMS - SHACC)	208,470	31 March 2014	Liz Rodrigo (LR)	Jasmine Murphy (JM)	Yes	new contract for Integrated Sexual Health Services to commence 01/01/14 to 31/12/17 with poss of ext 2 yrs + 1+1)
Contracts transferred but funding and responsibility clarified as lying elsewhere								
OTHER1	**University of Leicester**	Trent Neonatal Survey	12,000	31 March 2014	Rod Moore (RM)	Rod Moore (RM)		Funded now by Public Health England
OTHER	**University of Leicester**	Congenital anomalies register	12,000	31 March 2014	Rod Moore (RM)	Rod Moore (RM)		Funded now by Public Health England

Contract Code	Provider Name	Contract Area	Estimated Annual Value £	End date	PH Lead Commisioner	Consultant Lead	Relates to mandatory responsibility	PH Lead Commissioning Review Coment/Expected Review Date
OTHER	**University of Leicester**	Data input and analysis to support confidential enquiries around perinatal mortality	6,210.00	01 April 2014	Rod Moore (RM)	Rod Moore (RM)		No longer funded from local public health budgets.
OTHER4	**University of Leicester**	Support to Public Health training scheme	110,000	31 March 2014	Rod Moore (RM)	Rod Moore (RM)		Wrongly disaggregated funding and responsibility to transfer to LETB
CSSE5	**Inclusion Healthcare Social Enterprise CIC**	Homeless Alcohol Worker	45,000	not known	Priti Raichura/ Julie O'Boyle (PR/JOB)	Julie O'Boyle		Funded as health care block contract.
LCC4	**Leicester City Council**	Alcohol Contract Management (LCC DAAT)	25,000	31 March 2014	Priti Raichura/Julie O'boyle (PR/JOB)	Julie O'Boyle		Included in Integrated Drug and Alcohol Services

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NHS England

New Congenital Heart Disease Review
Southside
105 Victoria Street
London SW1E 6QT

Cllr Michael Cooke
Chairman
Leicester, Leicestershire and Rutland
Joint Health Overview and Scrutiny
Committee
By email only:
Anita.Patel@leicester.gov.uk

4 September 2013

Dear Cllr Cooke

Re: New congenital heart disease review

I am writing to you in your capacity as a Chair of the Leicester, Leicestershire and Rutland Joint Health Overview and Scrutiny Committee.

Following the suspension of the Safe and Sustainable review of children's congenital heart services by the Secretary of State in June, NHS England established a new review to consider the whole lifetime pathway of care for people with congenital heart disease.

This is described in more detail in a paper received by the NHS England board on 18 July 2013 (available at http://www.england.nhs.uk/wp-content/uploads/2013/07/180713-item13.pdf). We are seeking to keep all stakeholders informed about our work through our website (http://www.england.nhs.uk/ourwork/qual-clin-lead/chd/), and in particular, via regular blogs by John Holden, Director of System Policy at NHS England (http://www.england.nhs.uk/publications/blogs/john-holden/). These may be of interest to committee members so I would be grateful if you could bring them to their attention.

We are also seeking to engage with stakeholders, including local government,

and as part of that would welcome the opportunity to talk to your committee as one that took a particular interest in the earlier work. This would be an opportunity to brief the committee on the new review, our commitment to a national service against national standards, and to discuss ways of working with local government. It would also provide us with a valuable opportunity to hear the committee's views.

If you agree, my colleague Zuzana Bates will liaise with your scrutiny officers to agree a suitable date for us to attend the committee.

Kind regards

Michael Wilson
Programme Director
New Congenital Heart Disease Review
NHS England

Appendix L

From: Cllr Michael Cooke
Sent: 23 September 2013 15:05
To: 'zuzana.bates@nhs.net'
Cc: Anita Patel
Subject: New Congenital Heart Disease Review

Zuzana

Sorry for the slight delay in responding since our telephone conversation on the 13th September. You will recall that I welcomed the opportunity for a briefing on the new review, but raised a number of points for;

1. The Joint Scrutiny Commission for Leicester, Leicestershire and Rutland is no longer operational; it came together for one meeting to considerer representations on the outcome of the Safer and Sustainable Review, which as you know resulted in the referral to the S o S.
2. The Scrutiny Commission is an organ of the City Council and has no Executive power; and is probably not the right part of the Council to consult on new proposals. That would be down to the Mayor, the Chair of the Health and Wellbeing Board with support from Officers. The Executive is keen to be involved in consultation and would be able to foster and manage community involvement on your behalf on such consultation.
3. I acknowledged the difficulty in arranging a meeting with such different players but undertook to broker an acceptable meeting to address the needs or the different Councils, Executives of those Councils and Scrutiny Commissions.

We have had positive soundings with the other Councils and I believe the joint Scrutiny group will reform but it may still be necessary to arrange 2 meetings, one for scrutiny and the other for "Local Government", both on the same day.

My colleague Anita Patel will be making the arrangements and will be in touch with you shortly

Sincerely

Councillor Michael Cooke
Chair Leicester City Health and Wellbeing Commission

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NHS ENGLAND WEBSITE

News

The new Congenital Heart Disease review: 6th update – John Holden

9 September 2013 - 18:58

Your feedback

Thank you for your continued feedback. There are two issues which have been raised with us that I wanted to mention this week – both housekeeping, but important nonetheless:

- How to contact the new CHD review team
- Where to find information relating to the new CHD review

How to contact the new CHD review team: You have told us that you want a more reliable way of getting in touch than commenting on the blog. So, we are setting up a dedicated email address – england.congenitalheart@nhs.net – which we expect to go live during w/c 9 September. As stated previously, we cannot commit to respond to every individual correspondent, but we promise to take account of all comments and queries. We have also been asked about the possibility of a dedicated phone line, in particular to meet the needs of those who may not have internet access. Our main contact number is **0207 932 9128**. We do not have the capacity to guarantee to staff this number at all times, but we will respond promptly to any voicemail messages. Our postal address is New congenital heart disease review, NHS England, Southside, 105 Victoria Street, London SW1E 6QT.

Information relating to the new CHD review: As the review progresses we will have an increasing amount of material – agendas, reports, meeting notes and so on – that we want to make available, in line with our commitment to openness. Some of you have already asked about documents that we intend to make available. To date we have enclosed documents and used web-links in the blog, which is a useful way of drawing attention, but it is not a systematic way of storing and retrieving previous and current information. So, we have set up a web page here which will over time become the definitive archive for all relevant material. We have started to populate this web page, and we are adding material all the time, but it is a work in progress and you may not yet find everything you would expect.

Patients, families and their representatives

On 27 August Michael Wilson (Programme Director for the new CHD review) and I met Geoff Alltimes (Associate, Local Government Association) and Tim Gilling (Deputy Executive Director, Centre for Public Scrutiny). You can read a note of the meeting here: notes from the meeting with LGA and CfPS. We discussed the best way for the review to work with local government. Their advice was that we should get on with it! As a result we are in the process of setting dates to attend a meeting of the health oversight and scrutiny committees (OSCs) that referred the *Safe and Sustainable* process to the Secretary of State. I will attend the Yorkshire & Humber health OSC on Friday 13 September. We know that other OSCs may be interested in the review and that the areas and issues they cover might change over time. We are also preparing a briefing to be sent to all councils in England, explaining our work and offering to meet. We also plan to invite council leaders from those areas that include a specialist congenital heart unit to meet us, to talk about the new review, to hear how they would like us to work with them, and to share lessons from the *Safe and Sustainable* process – what worked and what didn't.

****

At the invitation of group chair Sally Brearley, on 5 September Michael Wilson attended a meeting of the Specialised Services Patient and Public Engagement Steering Group. This was a good opportunity to provide a briefing on the work of the review and our emerging approach to working with patients, families and the public. There was a lot of interest from the group, but not enough time for a full discussion, so we agreed to meet again in the near future so that the review can benefit from the experience and insight of group members. The group challenged us to consider how the patient viewpoint would be represented in every group where decisions might be made. You can see the membership of the group here: Specialised Services PPE steering group.

Clinicians and their organisations

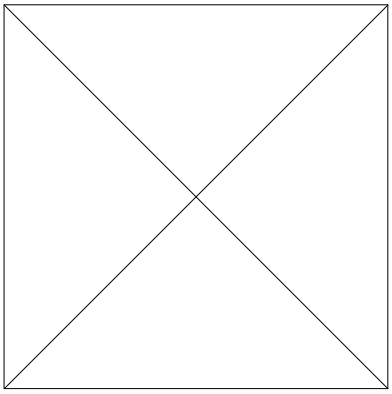
I have previously referred to the importance of quality standards. Last week, Professor Sir Bruce Keogh wrote to the chair of the group working on standards for children's services, Dr Tony Salmon, and to the chair of the group that has developed standards for adult services, Professor John Deanfield. Sir Bruce emphasised the importance of a comprehensive and consistent set of standards covering the whole pathway and asked that the two groups to work together to achieve this. He also highlighted NHS England's intention to achieve the highest possible quality, within the available resources, now and for future generations. He asked the chairs to ensure that the standards set out what is needed to achieve this, recognising that it is likely that there will be some standards that are very challenging for existing providers. He also asked that each group makes sure that the nature and limitations of the available evidence underlying the standards was made clear. You can read the letters here: letter from Sire Bruce Keogh to Tony Salmon, letter from Sir Bruce Keogh to John Deanfield.

NHS England and other partners

I have used previous blog entries to describe our efforts to run an inclusive process where everyone feels well informed, they have the opportunity to be heard and for their views to be fairly reflected. This is not always easy – the road to hell is paved with good intentions – and I was relieved to see I am not the only one struggling to get it right… you may find this blog an interesting read: NHS Networks blog – the Gary Test.

****

MPs and peers (members of the House of Lords) ask questions of health ministers, and the answer (or the transcript when there is a debate) is published in Hansard. See here to see questions relating to the new CHD review (and other topics relating to heart disease) which have been answered recently.



Categories: Home • John Holden • News

Tags: blog

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News

The new Congenital Heart Disease review: 7th update – John Holden

23 September 2013

Your feedback

Thank you for your continued feedback. There are two issues I wanted to highlight this week:

- Membership of Clinical Reference Groups (CRGs)
- The work of the CRGs and how this links to the work of the review

Membership of CRGs: Concerns have been raised about public/patient representation on the Clinical Reference Group (CRG) responsible for congenital heart disease, and in particular the process by which members were appointed. Each CRG has four patient experience representatives. Members were recruited through an open process (described in full here – CRG information pack). And – as with every other CRG – public and patient involvement can be achieved in other ways. All patients and their representatives may also register as stakeholders of the CRG(s). In my 5th blog (23 August) I highlighted the opportunity to become a stakeholder and to tailor your involvement according to your level of interest.

The work of this review, and the work of the CRGs (responsible for developing commissioning products such as service specifications) are separate. The review has no role in making appointments to CRGs. So – we have drawn the concerns raised with us to the attention of the chair of the CHD group and James Palmer, NHS England's Clinical Director for Specialised Services (who has responsibility for all the CRGs). They will consider and decide any further action that may now be required. This issue will be dealt with in the same way as for any other CRG, and the resolution of any issues will be decided in accordance with the same rules which would apply to any other CRG.

The work of the CRGs and how this links to the work of the review: CRGs provide NHS England with clinical leadership and user engagement in support of specialised commissioning. CRGs develop commissioning "products", including scope of services, policies, service specifications, and quality measures and "dashboards". Service specifications set out what is

expected from service providers, and define access to a service. The work of the new CHD review is related to a number of CRGs, but most closely to CRG E05: Congenital Heart Services.

In my last blog I included Sir Bruce Keogh's letters in which he wrote to the clinicians who are leading two strands of work on the development of standards. In parallel I have also written to ask Professor Deirdre Kelly to oversee the completion of the review's work on additional standards for children's congenital heart services, and – working with the other standards groups – to make a joint recommendation on a single combined set of standards. The correspondence is here **-** letter to Professor Deirdre Kelly, letter to John Holden. Once the work of developing proposed standards for congenital heart disease services has been concluded, these standards will be passed to the congenital heart CRG to be included in a proposed updated specification. This specification will then be subject to a full 12 week public consultation. **This will allow everyone, not just members of the CRG, to have their say on the specification and its standards**. Following this the CRG will make recommendations to NHS England on the final specification for children's and adult congenital heart services. More information on clinical reference groups can be found here.

The review will manage its links with the CRGs through the National Clinical Directors for i) Specialist Services, ii) Children, Young People & Transition to Adulthood, and iii) Cardiac Care.

Patients, families and their representatives

On 13 September I attended a meeting of the Yorkshire & Humber Joint Health Overview and Scrutiny Committee, in Leeds. On 18 September I attended the monthly meeting of the Health Scrutiny Committee for Lincolnshire, in Lincoln. Notes of these meetings will be prepared by the relevant bodies, and when they are available I will share them here. I found both events to be really helpful and constructive; an opportunity for me to explain how we are approaching the new review, and for Councillors to raise concerns and emphasise the importance they attach to early and continuing engagement.

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On 9 October NHS England will attend a meeting of the All-Party Parliamentary Group on Heart Disease – to discuss the provision of congenital heart disease services and the new CHD review. The group is chaired by Chris Ruane MP and is an opportunity for MPs and peers (members of the House of Lords) to hear the latest developments and to express their views. The meeting has been arranged by the British Heart Foundation who act as secretariat to the All-Party Group. For more information about viewing the meeting please contact Rachel Almeida almeidar@bhf.org.uk.

Clinicians and their organisations

The first meeting of our Clinical Advisory Panel will be on 15 October. We will provide more information nearer the time.

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We would like the new review to have some external, international perspective. Professor Pedro del Nido, Chief of Paediatric Cardiac Surgery at Boston Children's Hospital, USA, has kindly agreed to provide advice and support to Professor Sir Mike Rawlins (chair of the Clinical Advisory Panel).

NHS England and other partners

I have previously referred to some of the work we have underway, eg, to describe our proposals for advisory & decision-making processes, to resolve questions about the scope of the review, and so on. This remains a work in progress and we will provide an opportunity for everyone to see it and to give us their views. But experience tells us that if we don't set everything in context and instead just reveal part of the picture then – not unreasonably – it sets lots of hares running and generates lots of questions. So our preferred approach is to pull together the different strands, which we will be doing at the next meeting of our Board's task and finish group (I've previously referred to this as a "sub group", or "committee"). The task and finish group is due to meet on 30 September and will be asked to consider and provide an initial steer on:

1. draft governance, advisory, participation and involvement arrangements (including proposed terms of reference),
2. draft publication scheme (what correspondence and documents we will routinely publish)
3. proposals for the scope of the new CHD review (which services are included in the review and which are not)
4. proposals for how we will develop a "proposition" (about the options for future CHD service delivery, on which we can engage with stakeholders from Autumn onwards).

Papers will be published on our web pages and we will invite comments from all interested parties.

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We have asked NHS England's analysts to develop a proposal for refreshing the data which underpins our understanding of the services currently being provided, and which may be required in future. The draft specification they have drawn up for the first stage of this work is attached here – CHD analysis scope note. We welcome views on the approach described. We are asking clinicians which procedures and diagnoses are relevant to this analysis. To start the discussion our analysts have identified the attached list of diagnoses and procedures – CHD diagnoses and procedures as possibly relevant to the data refresh. This work will provide us with a basic data set, including the most recently available data on volume of activity by procedure (for both adults and children, at all providers), and will help shape assumptions about future demand in the light of demographic change, clinical developments and other factors. We do not think that this is the only analysis we will need; we will need further analytical work to examine specific issues as part of this review. We welcome views from all stakeholders on the proposed analytical work and the procedures and diagnoses in question. If you have any comments please submit them to our email address – england.congenitalheart@nhs.net

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News – NHS England Website

The new Congenital Heart Disease review: 8th update – John Holden

27 September 2013 - 16:07

Not your usual blog….

A different sort of blog this week, breaking the usual fortnightly cycle. I'm blogging today to draw your attention to a number of papers we have published on our new CHD review web-pages. These papers will be considered by our Board's Task and Finish Group at its meeting on Monday 30 September 2013.

We are taking the slightly unusual step of asking the Group for a steer in parallel with asking for your comments. We wanted our Group to be able to give their steers on these issues now, but we also wanted your views to be taken into account. Realistically, there won't be enough time for you to consider and comment before the Group meets. That's OK – let us have your comments and we will ensure that any final decisions (e.g. about the proposed governance model, terms of reference etc.) take full account of your views.

I would like to specifically draw your attention to Item 5: Proposed scope and interdependencies As you will see the paper outlines what we already know about the scope of the review, as well as illustrating those areas where more work is needed before a judgement can be made. We plan to take questions about the scope of the review to the first meeting of the Clinical Advisory Panel on 15 October 2013, and we really do want to feed your views in to that process.

Please let us have any comments on this, or any of the other papers, by Monday 7 October 2013.

Categories: John Holden • News

Tags: blog • CHD • John Holden

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RE: NEW CONGENITAL HEART DISEASE REVIEW

Notes from the meeting with Geoff Alltimes (Local Government Association) and Tim Gilling (Centre for Public Scrutiny), 27 August 2013.

The following points were raised in the discussion:

1) Early engagement with OSCs is appropriate because their role is both overview and scrutiny. It would be for each OSC to manage any potential conflict raised by involvement.

2) Concerns were raised that John Holden's blog seemed to suggest that the engagement with local authorities is an 'afterthought' when it prioritised engagement with clinicians and patients. This was not appropriate: local authorities represent patients or potential patients.

3) OSCs, although important, are only one part of local government. Engaging with councils therefore needs to be wider than just OSCs and should also include leaders, cabinet, lead members, health and wellbeing boards, executives.

4) It is helpful to agree the principles in any proposed health service change before moving on to the detail.

5) The NHS has not been good at selling the benefits even when these have been demonstrably achieved – changes to stroke and major trauma services were cited as examples. The benefits of any proposed changes would need to be carefully articulated, ideally by specialist clinicians.

6) NHS England considers it important to develop solutions within a year because services are vulnerable having been in 'limbo' for a long time. Any decisions will be developed working closely with the stakeholders.

7) NHS England will need to ensure that the stakeholders have trust in the process used to reach the decision and that the decision is strongly supported by those that will be affected by it.

8) NHS England agreed that it should seek to engage with local government early in the process. NHS England will want them to have a strong role in designing services as well as in scrutinising them.

9) The potential for establishing a single joint scrutiny committee was discussed (as envisaged in the relevant directions on overview and scrutiny). This seemed to offer advantages to the NHS in giving a single point of engagement and the opportunity for a more in depth approach. It was considered by CfPS that it was unlikely that a single national committee would be formed because of the practical challenges involved in doing so.

10) NHS England set out the considerable challenge of engaging effectively with every council across England and sought to explore possible approaches.

11) It was agreed that not all local councils, OSCs and Health and Wellbeing Boards would be interested in the review to the same extent. NHS England should make sure that some types of information will be sent to all councils but there will be some who will interested in additional in-depth briefings.

12) NHS England will also organise a meeting with all concerned local authorities and Health and Wellbeing Boards to explain the issues and ensure there is a national perspective. NHS England will also brief all OSCs, Council leaders and HWBBs in writing about the Review.

13) NHS England will continue to ask CfPS for advice regarding engagement with the OSCs. CfSP suggested that NHS England organise a meeting with the OSCs to explore how they want to be engaged with. The OSCs will be approached through their regional networks.

NHS ENGLAND REVIEW TEAM.

Scope and Interdependencies

Introduction

1. The new Congenital Heart Disease review has been established to consider the whole lifetime pathway of care for people with congenital heart disease. In order to conduct the review and to ensure that there is a manageable programme of work it is necessary to define its scope in more detail.

2. This paper outlines what is already known about the scope of the review as well as illustrating those areas where more work is needed before a judgement can be made. It also sets out the process by which scope will be defined.

Defining scope

3. Stakeholders have already expressed views on a number of issues and made suggestions about their relationship to the review. Further views will be sought from the Clinical Reference Group and more widely through John Holden's blog and in response to publication of this task and finish group paper. The review's clinical advisory panel will then be asked to advise on the clinical issues at its first meeting on 15 October 2013.

4. It will also be necessary to consider the relationship of the review to the devolved administrations and the potential impact on services for congenital heart disease offered in those countries and used by their populations. This may be different for each country. The NHS in each of the devolved administrations will therefore be asked to agree their relationship to the review and appropriate channels of communication.

5. The final definition of scope will be taken by a subsequent meeting of the task and finish group taking account of the recommendations of the clinical advisory panel and the agreements with the devolved administrations.

In scope

6. As a review of the whole lifetime pathway of care for people with congenital heart disease it is considered that the following will be in scope:

   a) Improving the quality of care of people with suspected or diagnosed congenital heart disease along the whole patient pathway:

      - Fetal diagnosis of congenital heart disease.
      - Pre-natal care (including care of women whose unborn child has suspected or confirmed congenital heart disease).
      - Care for children and young people.

- Transition from children's services to adult services.
- Care for adults.
- End of life care

b) Care and support for families suffering bereavement and / or poor outcomes from surgery or other intervention for congenital heart disease.

c) The review covers all care for congenital heart disease commissioned by the NHS for people living in England.

Out of scope

7. The following services related to or used by congenital heart disease services are considered to be out of scope, but links with these services will need to be managed by the review (the way in which these relationships will be managed will be set out in the programme initiation document):

- Neonatal, paediatric and adult intensive care unit (ICU) services and transport and retrieval services.
- Other interdependent clinical services (for example other tertiary paediatric services).
- Local maternity services.

To be determined

8. There are a number of other related clinical services where a judgement will need to be made about whether they should be in scope for the review.

- Children, young people and adults with congenital heart arrhythmias.
- Children and young people with acquired heart disease.
- Children and young people with inherited heart disease.
- Adults with inherited heart disease.
- Cardiac extra corporeal membrane oxygenation (ECMO) for children and young people.
- Respiratory ECMO for children and young people.
- Cardiac extracorporeal life support (ECLS) for adults.
- Respiratory ECMO for adults.
- Complex tracheal surgery.
- Heart transplant and bridge to transplant services for child and young person.
- Heart transplant for adults.

7th October 2013

FAO – CONGENITAL HEART DISEASE SERVICES REVIEW TEAM, NHS ENGLAND

SUBJECT - Comments from Leicester City Council, RE: Proposed Scope and Interdependencies Paper

We welcome the opportunity to feed in our comments on the document outlining the scope of the review.

These are our brief comments:

1. The approach overall seems sensible and we recognise that there is a need for expert clinical advice on the issues raised in the document.

2. Following a life course approach to define the services that are in scope is a necessary requirement of the review's purpose – to consider the whole lifetime pathway of care for people with congenital heart disease.

3. The excluded services, those not intrinsically linked to the treatment of congenital heart disease itself, as in the out of scope list, but which are used by patients with congenital heart disease or related to services for them, require robust pathways for access. Thus detail of the managed linkages to be made in the course of the review with these services is to be welcomed.

4. Expert advice on the inclusion or exclusion of the items on the "to be decided" list is essential. Bearing in mind the issues of the previous "Safe and Sustainable" review it would also be essential to provide an explicit rationale for the final position taken regarding these items. In particular, we would support the inclusion of ECMO from the outset, as from the evidence we took during our scrutiny process it is apparent that ECMO is an essential part of the treatment of congenital heart disease in children.

Many thanks,

Councillor Michael Cooke
Chair of Health & Wellbeing SCRUTINY Commission
LEICESTER CITY COUNCIL
7th October 2013.

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Safer Leicester Partnership Alcohol Harm Reduction Delivery Group

Alcohol harm reduction social marketing campaign

1.0 Introduction

The Alcohol Harm Reduction Delivery Group of the Safer Leicester Partnership commissioned ICE Creates Ltd to undertake a social marketing campaign in 7 wards across Leicester City. The purpose of this paper is to update the Health Scrutiny Commission of progress to date.

2.0 Background

The Leicester Alcohol Harm reduction strategy (2009-12) set out a number of priority areas to address the high levels of alcohol harm within our city. One of these priorities was to develop a targeted campaign aimed at increasing and higher risk drinkers in some of our most deprived wards where levels of alcohol harm are particularly high. It was decided to develop a campaign based on social marketing principles and techniques.

3.0 The campaign

The aim of the campaign is to reduce alcohol related harm and encourage safe and responsible drinking habits. It is specifically targeted at;

- Increasing and higher risk drinkers aged 25-44
- Residents of Beaumont Leys, New Parks, Braunstone Park & Rowley Fields, Eyres Monsell, Castle, Freeman, or Charnwood Wards
- People for whom alcohol use is an everyday reality
- People for whom alcohol is a natural part of socialising
- People who regularly drink above recommended guidelines
- People who wouldn't call themselves dependant drinkers

The insight gained from previous work tells us that this group;

- feel patronised by traditional alcohol campaigns
- hate feeling "talked down to" and being told what to do
- Are distrustful of (but often reliant on) local authorities and Government
- Want to be treated with respect, and as adults
- Aren't interested in the long term
- Are interested in short-term results, gains and benefits
- are NOW PEOPLE

With this in mind the campaign has been developed to ensure that it is not perceived as:

- nagging
- preaching
- patronising
- concentrating on long term effects

4.0 Progress and Timescales

The campaign is currently being rolled out in the target ward areas. Local community venues and shopping centres are hosting the events. Specialist workers, experienced in delivering alcohol brief interventions and motivational interviewing, are asking local residents "What are you doing tonight?" to spark a conversation about alcohol. Using motivational interviewing techniques, workers then begin a face-to-face conversation and dialogue with residents around their drinking habits.

Residents are invited to take the World Health Organisation (WHO) Alcohol Use 10-point Audit (i.e. 'alcohol quiz') to screen and identify 'increasing' and 'higher-risk' drinkers, i.e. the target audience.

People identified as 'low risk' are given free advice, 'top tips', to help maintain safe and responsible drinking habits, and are entered into a free draw for a cinema package (£50 value).

People identified as 'possible dependence' are referred and signposted to appropriate local alcohol service providers.

People identified as 'increasing' or 'higher-risk' (i.e. target audience) are encouraged to sign-up to the 'pledge' to have 3 alcohol-free days a week and are given a pledge pack. The pledge pack includes, information on the social, health and financial short-term benefits; recommended drinking guidelines; exercise/calorie equivalents; potential money savings; 'top tips' and everyday coping strategies; sociable alternatives to drinking; key contacts and signposting to local alcohol support services; and discounts for local alcohol-free activities. Those who sign up to the pledge are also asked to become part of a cohort who will be followed up as part of the post-intervention evaluation.

Initially the external company were to set up the digital media aspects of the campaign; however LCC internal digital media team were not comfortable with this and opted to take over this aspect of the campaign. There is a webpage dedicated to the campaign on the council's website but this is difficult to find and the project team are currently working with our internal teams to make this more prominent.

To date three events have taken place at Beaumont Leys Shopping Centre, The BRITE Centre, and Braunstone Leisure Centre.

We have some initial data from the first three events.

"Opportunities to see" the campaign - approx. 800

Number of 'We're On Tour!' flyers handed-out - 235

Number of alcohol quizzes (Audit-C) completed - 75

Number of 'Well Done You!' (people drinking within safe limits) flyers handed-out - 55

Number of referral cards handed-out - 0

Number of people taking part in the alcohol-free days pledge - 20

These results indicate that the project is on target to deliver the target cohort of 50 adults signed up to the pledge.

Julie O'Boyle Consultant Public Health

Priti Raichura Public Health Principal

Dates of Events

Beaumont Leys Shopping Centre - Saturday 21 September, 9.00am - 5.00pm

The BRITE Centre - Wednesday 25 September, 9.00am - 2.00pm

Braunstone Leisure Centre - Wednesday 25 September, 5.00pm - 8.30pm

Aylestone Leisure Centre - Saturday 28 September, 9.00am - 3.00pm

Southfields Drive Sports Centre - Thursday 3 October, 3.30pm - 8.00pm

Haymarket Shopping Centre - Saturday 5 October, 9.00am - 5.00pm

New Parks Centre Library - Wednesday 9 October, 10.00am - 2.00pm

New Parks Leisure Centre - Wednesday 9 October, 5.00pm - 8.00pm

Tesco Leicester Hamilton Extra - Saturday 12 October, 9.00am - 5.00pm

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Leicester City Council

Appendix S

Briefing Report for members of the Health & Wellbeing Scrutiny Commission – 15th October 2013

Agenda Item: External Review 'Fit for Purpose' Health Scrutiny by Expert Advisor (Brenda Cook) Centre for Public Scrutiny.

Purpose

This briefing report updates members of the commission on the progress made in relation to this review.

The Health & Wellbeing Scrutiny Commission have engaged the Centre for Public Scrutiny, Expert Advisor (Brenda Cook) to carry out a 'Fit for Purpose' Review of the Health Scrutiny Arrangement at Leicester City Council.

The draft Action Plan for the review includes:

1) To facilitate private session on work programme planning on 18th September 2013 (***Briefing Notes from this session are attached at Appendix 1***)
2) 360 degrees feedback from stakeholders
3) Review on how the commission works
4) Training and development needs assessment
5) Review report and recommendations

The proposed Timeline for the review

The review to start in September 2013. Review to aim for a final report at the end of December 2013.

The Objectives/Outcomes of the project includes:

1) To provide direction and guidance for developing Health Scrutiny in Leicester.

2) To review the steps being taken to implement the lessons of the Francis report by those NHS organisations serving Leicester residents.
3) To recommend relevant changes to the Health Scrutiny Commission practices in light of the Francis Inquiry.
4) To carry out a 'fit for purpose' exercise for the Health & Wellbeing Scrutiny Commission.
5) To provide expert advice and guidance for Health Scrutiny Commission members to carry out their functions e.g. through workshops and tailored training sessions.
6) To identify the training, skills and development needs of Health Scrutiny Commission members.

Future Work Programme Planning

The briefing notes from the private session on 18th September, as ATT, will enable members to effectively plan the future work of the commission.

The commission will continue to receive updates on the progress of this review at future meetings.

Councillor Cooke

Chair of Health & Wellbeing Scrutiny Commission

Anita Patel

Health Scrutiny Support Officer

Anita.Patel@leicester.gov.uk

SCRUTINY DEVELOPMENT SESSION

HEALTH AND WELLBEING SCRUTINY COMMISSION

WEDNESDAY 18 SEPTEMBER 2013 at 5.30pm

PRESENT

Councillors

Councillor Cooke
Councillor Chaplin (from 6.57pm onwards)
Councillor Desai
Councillor Sangster
Councillor Singh

Observers

Mr S Sharma

Officers
Rod Moore
Graham Carey

Facilitator
Brenda Cook

Apologies for Absence
Councillor Chaplin (attending Planning Committee)
Councillor Cleaver
Councillor Grant (attending Children and Young Peoples Scrutiny Commission)
Councillor Westley
Anita Patel

Introductions and Welcome

Councillor Cooke welcomed everyone to the meeting and introduced Brenda Cook who had been engaged through the Centre for Public Scrutiny (CfPS) as an Expert Health Scrutiny Advisor to carry out a 'Fit for Purpose' review. Brenda's role would be to advise and assist members in their discussions to plan the work programme.

The work programme was a flexible document which would be continually reviewed throughout the scrutiny year. This session had been arranged to discuss the Commission's workload and determine how best it could carry out its responsibilities.

Principles of Scrutiny

Members agreed with the four principles suggested by the CfPS, namely:-

- To provide a critical friend challenge to the executive policy makers and decision makers;
- To enable the voice and concerns of the public and communities to be heard;
- To carry out scrutiny by 'independent minded governors' who lead and own the scrutiny process;
- To drives improvements in services and finds efficiencies.

Members added two further local principles:-

- To prevent duplication of effort and resources;
- To seek assurances of quality from stakeholders and providers of services.

During discussion on potential barriers to scrutiny and to the issues that should be considered as part of a successful scrutiny process, the following points were raised:-

- New service areas to local government, e.g. Public Health, could be wary of questions being asked of services, priorities and processes.
- If scrutiny is carried out in a positive atmosphere, it can be beneficial to both the service area and the Council.
- Scrutiny should be focused at a strategic rather than local/parochial level.
- The Francis report emphasised the need for Scrutiny Commissions to listen to issues/concerns of patients, carers and communities however these were expressed. Scrutiny should also pick up on media reports etc and move them forward. Scrutiny Commissions should pull together and strengthen the public's 'voice' by asking questions of providers and services.
- The NHS was traditionally regarded as being an insular institution and cultural changes were needed to open the relationship with Scrutiny Commissions to engage in positive scrutiny of their services locally.
- Scrutiny should not be 'political' in nature but objective and factually based to provide evidence based influencing to improve services.
- Scrutiny should avoid merely asking questions and seeking knowledge of a subject area rather than trying to look for lessons from past and existing service provision etc with a view to focusing on making improvements.

- Members raised an issued where they had previously been consulted at the end of the process and had too little time in which to make a realistic contribution and public consultation had been based upon 2% sample. In future, Scrutiny could raise the concerns over the process with an overarching body such as NHS England, indicate to the health body that that a greater period of consultation should be allowed for the Scrutiny Commission to respond and that the Commission would expect to see more than a 2% consultation coverage with the public. The Commission could also devise a protocol for consultation and ask the health body for their comments upon it.
- A clear protocol needed to be developed to differentiate between the work and role of the Health and Wellbeing Board and that of the Commission, to both avoid duplication and have a clear understanding of both bodies' functions and roles.
- Some Council's include their key principles of scrutiny at the front of an agenda to identify and reinforce their role to the public.
- Although health scrutiny by local authorities has been in existence for over ten years, the health economy had undergone dramatic changes since April 2013 and both the health economy and scrutiny needs to evolve together to accommodate the requirement of scrutiny, particularly in relation to the post 'Francis Report' era.
- Scrutiny needed to recognise and reflect upon the different perceptions that each party involved in scrutiny can have of each other and this should be managed and accommodated as part of the scrutiny process.

Discussion took place on where scrutiny should place itself to maximise its effectiveness within the resources available and to provide the maximum benefit to the provision of health care services to local residents. The following methods and thoughts for future consideration were noted:-

- It was vital to identify what issues were important locally and to identify gaps in service based on information provided by the stakeholders.
- The CfPS had various tried and tested 'modelling tools' to define and determine how scrutiny could quantify its impact. These included tools to carry out impact assessments and to measure the return on investment of scrutiny.
- A starting point could be to identify and address the major causes of death and illnesses in the City such as:-
    - Cancer
    - COPD/Smoking
    - Heart disease
    - Diabetes
    - Infant Mortality

- Infectious diseases such as TB, HIV, and health protection measures
- Integrated care

Rod Moore undertook to carry out the initial work on this process.

- It was also important to monitor how the population was changing and the impacts this could have upon service provision and to look at what changes were needed in the provision of existing services to address any changing needs. E.g. some local communities had high levels of diabetes in 20-30 year old age range but the NHS model is geared to the diagnosis of diabetes in the 40 plus years old age range. Is that model suitable for Leicester's needs? Should more be done to look at the management of people diagnosed with diabetes in the primary care sector?
- Private providers of health care services were now within the remit of local authority scrutiny if the services were funded through NHS funds.
- Part of scrutiny's strength was that it could ask for assurances from NHS funded health providers at all levels in the sector and, if the scrutiny is not satisfied with the assurances given or the performance of a service, it has a valid role in stating that view publically in order to raise the profile of the issue.

Areas of work that the Commission could consider

- Public Health Budgets and structures –some priorities may be driven by national policy and may not be a local priority. The Commission should have assurance that the focus of the local Public Health resources was on local public health priorities

- Quality Accounts and Performance – likely to be available for scrutiny in March/April each year. Some local authorities, e.g. Warwickshire, were now approaching Trusts to indicate that they wished to be involved in discussions at an early stage and were involved in dialogue all through the year as a 'critical friend' to target the approach to what is important locally.

- Key Decisions Impacting Upon Health – City Mayor's Forward Plan.

- Responding to consultations and engaging in formal and informal NHS consultation processes. Commissioners and providers have a duty to consult the local authority scrutiny function on substantial variations and changes to service provision, although 'substantial' is not defined in law. Scrutiny could be proactive by initiating dialogue with commissioners and providers to indicate the scope of issues and the circumstances in which it would expect to be consulted. This template for consultation could also incorporate advice for

when consultation should take place and to avoid consultation during religious festivals etc.

- From April 2013 the Council has to be consulted by the commissions and providers though the mechanism which the Council has adopted for its scrutiny of health matters. The Health and Wellbeing Board should be consulted separately. There is no automatic right for the Council to be consulted on how the NHS intends to undertake its consultation of the public, only its consultation of the Council.
- If the NHS determines that the issue is not considered to be 'substantial', then this should be supported by evidence of involvement of working with different communities/county groups etc to come to this view . The Council, however, would have a valid role in scrutinising how the NHS engaged with those communities and groups.

- Holding to Account Health Care Providers and Commissioners. How this is done is entirely at the Commission's discretion. It can also incorporate the other statutory monitoring processes such as the role of the CQC and the newly appointed Chief Inspector of Hospitals.

- Receiving Reports/Updates on changes in Health Service Provision and Strategies.

- Ensure Reduced Health Inequalities. This could involve considering issues such as, access to services, quality health services and patient care and protection.

Possible Topics of interest to future scrutiny work programme could include:-

- On-going post Francis Issues
- Winter Planning of Health Service Provision
- EMAS – Being the Best
- Transition of NHS Trusts to become Foundation Trusts
- Developments in local Healthwatch and Health and Wellbeing Board
- NHS commissioning landscape
- Better Care Together
- NHS Trusts – review/monitor performance data and complaints data
- Annual Reports - LOROS, UHL, ICAS. LPT and Healthwatch
- NHS 111 Service
- Hospital Discharges
- A+E – Elderly and Frail Unit
- Homelessness Strategy - Implementation
- Corporate Strategies – monitoring role e.g 'Closing the Gap'
- Sickle Cell Anemia Services

- BME Groups – targeting specific health services
- HIV/Aids Services
- Mental Health Services, including BME provision
- Public Health Team Structures
- Fit for Purpose Review – addressing actions and outcomes
- Drugs an d Alcohol – specific campaigns
- Dementia Care Strategy

Joint Working

a) the Chair of the Commission had already agreed in principle with the Chair of the Adult Social Care Scrutiny Commission to undertake joint scrutiny on cross cutting issues. The following issue were considered as suitable for joint scrutiny:-
   - Winter Planning.
   - A&E – Emergency Floor Scheme.
   - Elderly and Frail services.
   - Hospital Discharges processes.
   - Mental Health Services.

   It was agreed that the issue of Winter Planning should be considered at the next Commission meeting.

b) there were also merits and economies in undertaking joint scrutiny with the Leicestershire, Leicester and Rutland Joint Health Scrutiny Committee to avoid duplication on major topics of interest where health trusts wished to consult all three Councils. By having one discussion at a Joint Scrutiny Committee instead of a trust visiting all three local authorities could be beneficial to all concerned.

c) regional methods of scrutiny should also be explored further.

d) the Commission could contact health care providers to indicate that it would welcome and value the opportunity to visit service providers. Members undertaking such visits could formally report back to the Commission on their visits.

The Chair thanked everyone for their participation in the discussions and felt that it had raised some very useful reference points for the future. A number of these issues would be taken further in future development sessions.

The meeting ended at 7.35pm.

Leicester City Council

Leicester City Council Scrutiny Review

''Winter Care Plan for Leicester and Particularly Winter Planning of Health and Social Care Provision for Elderly and Vulnerable People'

A Joint Review by the Health & Wellbeing Scrutiny Commission and the Adult Social Care Scrutiny Commission

October 2013

Background to scrutiny reviews

Getting the right topics for scrutiny reviews is the first step in making sure scrutiny provides benefits to the Council and the community.

This scoping template has been designed to assist in thinking through the purpose of a review and the means of carrying out the review. This scoping document needs to be completed by the member proposing the review but advice can be sought from a Scrutiny Officer (contact details below).

In order to be effective, every scrutiny review must be properly project managed. This is to make sure that the review achieves its aims and has measurable outcomes. One of the most important ways to make sure that a review goes well is to ensure that it is well defined at the outset. This way the review is less likely to get side-tracked or be overambitious in what it hopes to tackle. The Commission's objectives should, therefore, be as SMART (Specific, Measurable, Achievable, Realistic & Time-bound) as possible.

This template includes a section for the Department to complete to allow the Scrutiny Commission and OSC to consider any additional factors that may influence the proposed review. It also includes a section on public and media interest in the review which should be completed in conjunction with the Council's Communications Team. This will allow the Commission to be properly prepared for any media interest and to plan the release of any press statements.

Scrutiny reviews will be facilitated by a Scrutiny Officer.

Evaluation

Reviewing changes that have been made as a result of a scrutiny review is the most common way of assessing effectiveness. Any scrutiny review should consider whether an on-going monitoring role for the Commission is appropriate to the topic under review.

For further information please contact the Scrutiny Team on (0116) 229 8898

1. Title of Proposed Scrutiny Review

Winter Care Plan for Leicester and Particularly Winter Planning of Health and Social Care Provision for Elderly and Vulnerable People

Proposed by - Councillor Lucy Chaplin, Member of the Health & Wellbeing Scrutiny Commission and Vice Chair of the Adult Social Care Scrutiny Commission

2. Rationale

Members should outline the background to this review and why it is an area worthy of in-depth investigation.

The reasons why this review is necessary:

1) Over the last few years the Accident & Emergency (A&E) Department at the Leicester Royal Infirmary has faced capacity and overcrowding issues. The review would like to determine if situation is deteriorating and assess the impact on the general population.

2) With winter 2013 approaching, the review will seek to investigate if the A&E Department can cope, particularly caring for elderly and frail patients.

3) During the winter months, elderly people are far more vulnerable to illnesses and require increased care and attention from primary health care providers (including social care services) and secondary health care providers.

4) Local press headlines have highlighted various cases where elderly people have suffered neglect from health and social care services in Leicester. There are also news reports in winter about virus' that close down wards and restrict access to hospitals for the general population.

5) Healthwatch, Leicestershire have written to the Health & Wellbeing Scrutiny Commission raising their concerns in relation to the capacity of the Leicester Royal Infirmary (LRI) A&E Department to cope with the quality of care for patients.

6) With many adult social care services being provided outside of the local authority there is a need to ensure elderly people are still appropriately cared for and safeguarded during the winter.

7) The University Hospitals Leicester (UHL) trust has announced plans to reconfigure the A&E Department in time for next winter.

3. Purpose and Objectives of Review

Members should consider what the objectives of the review are

This reviews objectives are:

1) To scrutinise the winter care plan for Leicester but particularly the elderly to ensure health services and in particular the A&E Department at LRI, is well prepared to provide quality health care for elderly and frail patients.

2) To identify how adult social care services work with health services to offer appropriate care for elderly people once they leave A&E in the winter.

3) To ensure an appropriate system is in place to monitor the progress against the winter care plan for this winter.

4) To identify future improvements for winter planning of health and social care services for elderly patients in the future.

5) To identify what communications are in place across all local NHS and adult social care services to inform people of the services available and how to access them.

4. Methodology/Approach

Members should consider how the objectives of the review will best be achieved and what evidence will need to be gathered from officers and stakeholders, including outside organisations and experts.

Evidence to support this review, will include:

1) Site visit to the A&E at LRI
2) Input from unions
3) Input from UHL
4) Input from patient forums e.g. Healthwatch
5) Input from Clinical Commissioning Group (CCG)
6) Input from elderly forums e.g. Age Concern, Forum for Older People
7) Input from Primary Health Care Providers
8) Input from Secondary Health Care Providers
9) Input from lead officers for health and adult social care services in Leicester
10) Consider best practice from other A&E departments in the region

5. Expected length of the review

Members should anticipate the likely length of the review being proposed.

It is anticipated that this review will be completed by December 2013.

6. Additional resource/staffing requirements

All scrutiny reviews are facilitated by Members Support/Scrutiny Support Officers. Members should anticipate whether any further resource is required, be this for site visits or independent technical advice.

Possible additional resources from:
- Health Sector expertise / professionals
- Adult Social Care expertise /professionals

7. Risks

Members should consider whether there are any additional risks to undertaking this scrutiny review, for example whether there is a similar review being undertaken by the Executive or whether a national or local change in policy or service may supersede the need for this review.

There is a risk of duplication of effort/tasks as the County Council and Rutland will be looking at this issue as well. This could lead consultation fatigue with the agencies concerned.

8. Further Supporting Evidence

Members should consider whether they would like to add further information to support the case for a scrutiny review.

TBC

Before approving this scoping document the Scrutiny Commission should ensure the following boxes should be completed in conjunction with the relevant officers:

9. Likely publicity arising from the review

Members will wish to anticipate whether the topic being reviewed is high profile and whether it will attract media interest. If so, this box should be completed with help from the relevant officer in the Council's PR and Media Team.

This review is likely to attract some media interest because of on-going interest in the A&E department at the Leicester Royal Infirmary.

Debra Reynolds
Media & PR Manager
Leicester City Council

10. Divisional Comments

Scrutiny's role is to influence others to take action. It is, therefore, important for the Scrutiny Commission and OSC to understand the Division's view of the proposed review. The following box should be completed in sufficient time for the Commission to consider as part of its deliberations whether to proceed with the review.

"Within the timescale and timing identified this review can provide assurance over plans for the winter 2013/14 and potentially identify issues where risks can further be minimised and improvements made. If it is intended that the review influence activity in the early months of 2014 then the report will need to be produced in a timely fashion so that it can do so"

Rod Moore
Divisional Director of Public Health and Health Lead Officer for the Health and Well Being Scrutiny Commission

"Winter planning is part of an extensive multi-agency approach to managing the pressures within the health and social care systems, which can be exacerbated during winter months. A review of the plan would provide a further level of scrutiny about organisational preparedness."

Ruth Lake
Director, Adult Social Care and Safeguarding

The Department agrees to assist in the proposed review.

Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: THURSDAY, 11 JULY 2013 at 5.00pm

P R E S E N T :

Present:

Councillor Rory Palmer (Chair)	–	Deputy City Mayor, Leicester City Council
Professor Azhar Farooqi	–	Co-Chair, Leicester City Clinical Commissioning Group
Dr Simon Freeman	–	Managing Director, Leicester City Clinical Commissioning Group
Elaine McHale	-	Interim Strategic Director, Children's Services
Superintendent Mark Newcombe	-	Leicestershire Police – attending for Chief Superintendent Rob Nixon
Councillor Rita Patel	–	Assistant City Mayor, Adult Social Care, Leicester City Council
Philip Parkinson	–	Interim Chair, Healthwatch Leicester
Tracie Rees	–	Director of Care Services and Commissioning, Adult Social Care, Leicester City Council
Councillor Manjula Sood	–	Assistant City Mayor (Community Involvement), Leicester City Council
Deb Watson	–	Strategic Director Adult Social Care and Health Leicester City Council

Invited attendees

Lorraine Austen	-	Head of Service, Leicestershire Partnership NHS Trust
Victoria Gaffney	-	Regional Service Development Manager, British Heart Foundation
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Dr Durairaj Jawahar	-	General Practitioner
Heather Leatham	-	Head of Nursing, University Hospital of Leicester, NHS Trust
Dianne Smith	-	Locality Manager, Alzheimers Society
Hanif Pathan	-	Silver Star Diabetes
Troy Young	-	Age UK

In attendance

Graham Carey	–	Democratic Services, Leicester City Council

Sue Cavill	–	Head of Customer Communications and Engagement - Greater East Midlands Commissioning Support Unit

Observers

Nick Carter	-	Leicester City Clinical Commissioning Group

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14. WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting and asked everyone to introduce themselves to the members of the public who were attending.

15. APOLOGIES

Apologies for absence were received from David Sharp, Leicestershire and Lincolnshire NHS Commissioning Board and Chief Superintendent Rob Nixon, Leicestershire Police.

16. DECLARATIONS OF INTEREST

Members of the Board were asked to declare any interests they might have in the business on the agenda. No such declarations were made.

17. DISCUSSION SESSION - JOINT HEALTH AND WELLBEING STRATEGY PRIORITY 3: SUPPORT INDEPENDENCE

Deb Watson, Strategic Director Adult Social Care and Health and Simon Freeman, Managing Director, Leicester City Clinical Commissioning Group gave a presentation on Priority 3 of the 'Closing The Gap Strategy' on supporting independence. A copy of the presentation is attached. In addition to the points shown in the presentation the following comments were made:-

- Whilst good progress had been made there was still more to be achieved, especially around making the community aware of the issues surrounding dementia and the support that is available.
- There had been a 30% increase in the uptake of Carers personal budgets. Out of approx. 1,800 family carers who are receiving support from adult social care, 978 are now purchasing their support through a personal budget, giving them increased choice over their support and increased control over arrangements.
- 250 carers had received training to support them in their role, including developing coping strategies, recognising the various trigger points when things can go wrong and information on where to get help.
- Although there were 30,000 carers in the City, only a small proportion of carers made formal contacts to seek help. More needs to be done encouraging people to identify themselves as carers and to promote the

use of services available to them.

- Significant contributors to the poorer life expectancy for people in the City were diabetes, cardio-vascular and respiratory diseases.
- Leicester had low rates of recorded diagnosis of respiratory conditions but a high rate of hospital admissions resulting from respiratory conditions.
- Up-skilling of GP's, using risk stratification to focus interventions on people at high risk of deterioration and using a case management approach for people with multiple illnesses/conditions are vital to reduce/prevent people from a 'revolving door' syndrome of discharge and re-admissions to hospitals.
- Half of the hospital admissions for people aged over 65 years accounted for 65% of the time and resources for emergency admissions.
- The Integrated Commissioning Board has submitted an application to become one of 10 'Integration Pioneers' pilot sites for integrated health and social care delivery.

The Healthwatch representative commented that there were a number of initiatives in primary care where people are supported to be independent with the aim of reducing the incidence of hospital admissions. The large number of small initiatives could result in a larger cumulative impact.

The Age UK representative stated that there were a number of good ideas and pilot schemes but often it was difficult to sustain these and integrate them into strategic level and statutory service provision. There was specific funding for 'supporting carers for those approaching end of life' but it was very hard to contact the right people to talk to and it often felt as though they were operating in isolation.

Professor Farooqi commented that, whilst there was widespread support for an integrated approach to service delivery, this often required reducing expenditure in the acute service sector and this presented a huge challenge. As more systems for delivering services in the community were introduced, they usually identified and uncovered unmet needs whilst there was still the same demands being made upon acute service provision.

The Alzheimer Society's representative stated that the increase in dementia sufferers of 800 cases per year would place increasing demands upon services as the current dementia carers advisory service was saturated at present, and more sufferers wished to retain their independence and remain in the community with support. There were also pressures on the follow on and emotional support for carers and dementia sufferers.

Following a member of the public's question raising the following issues:-

- Was the strategy to care for people in community and remain at home driven by a need to reduce costs of hospital services;
- It was difficult to monitor the quality of care provided in a person's home compared to that in a hospital;
- The quality of care could also be affected by multiple

procurements with private providers; and
- Hospital services could be destabilised once services were taken out of hospitals and put into the community.

In response it was recognised that most patients preferred their conditions to be managed at home rather than in hospital. Conditions such as diabetes and respiratory diseases could be managed equally well in the patient's home as in hospital. Often there were benefits in better patient outcomes through an increased awareness and knowledge of their conditions.

It was equally important to monitor the quality of care irrespective of whether it was provided in hospitals or in the community. There were checks and balances in place for both. It was, however, recognised that the care provision was cheaper to provide in someone's home as there were no 'hotel costs' involved. Providing care in the community was not about dismantling hospital services but providing care in a different way. Consultants and expert clinicians delivered services in both hospitals and community facilities and local health practices.

Dr Jawahar referred to the improvements in training in the primary care sector in increasing the diagnosis of COPD and encouraging patients to stop smoking. This could reduce the demands on secondary care services in future years.

Councillor Patel commented that recent evidence clearly demonstrated that there had been a large increase of people since 2007 electing to have personal budgets and purchase their own care packages. An increasing number of people prefer to remain in their own homes. The emphasis was now on personal choice and if the individual was not happy with their care they could change providers. There were good care providers in the community as 80% of individuals with personal care packages purchased services from the private sector. It was becoming harder to provide these services centrally as there were now less central support staff to provide them following the reductions in local government spending in recent years.

It was important to continue to integrate care provision through health workers and carers in the community and to incorporate the goodwill already within the community and existing services. The community and voluntary sector had many examples of good practice and building partnerships was essential to providing quality of care services. The challenge in the current economic climate was to achieve more with less resources. There are also some very good groups such as the Forum for Older People which recently had a presentation on memory cafes for people with dementia. The initiative was well supported and those who came from areas where there was no memory cafe provision were fully supportive of wanting one in their area.

Councillor Palmer commented that part of the solution required a stronger national framework. He also referred to the growing trend whereby 1 in 5 staff employed by care agencies were on Zero Hours contracts and questioned how care staff could be expected to remain motivated and improve quality under these difficult circumstances.

Tracie Rees commented that with the growing trend of personal budgets, there was a greater need to maintain adequate measures to ensure safeguarding. Council contracts amounted to £11m on domiciliary care with providers and the council were hoping for a national framework. The Council have put in place a local Quality Assurance Framework for residential care homes and will develop one for domiciliary care. Joint work was also progressing with the Care Quality Commission looking at themes and trends relating to quality to see the whole picture and to avoid having an isolated approach.

Deb Watson commented that Adult Social Care services were being driven by two main drivers: the changing expectations of individuals and people wishing to have a wider choice of service provision. There was a clear preference for sheltered and home provision with extra care support to maintain a person's independence, and individuals only wanted to go into residential care when it is unavoidable. The Council have made improvements in commissioning these alternative services which makes it possible for people to remain in their homes longer. This type of care can be both cheaper to provide and more beneficial for the individual, although price is not the main driver. Everyone shares concerns for the quality of care provision post Francis and Winterbourne, but whenever there is poor care someone will know and as long as the system is open, approachable and transparent the system will be able to respond quickly to any safeguarding concerns that are raised

The Healthwatch representative commented that if Healthwatch was to be an effective voice for patients then it must be able to asses that care services are what people want them to be, especially for the most vulnerable. Healthwatch will also need to engage with all involved to create a reliable framework in which anyone feels able to raise concerns over the quality of the provision of care services.

The importance of the community getting involved to support clinicians, community carers, local authority and NHS staff was stressed. There was a great deal of potential support in the community but this needed to be identified and incorporated into the strategic response, which would be a significant challenge. Carers and family members need more information about where to go for help.

Councillor Sood felt that an integrated care approach was a better way forward as it could be more easily geared to the needs of the individual. It was also important to engage with new communities that were settling in Leicester to understand their specific health needs. Communications was also important between multiple providers of health services in order to reduce re-admissions.

It was recognised that too many resources were currently directed at providing acute services and there was a need to move away from this 'fire-fighting' response to one of investing resources into earlier intervention and prevention initiatives in the primary and community care sector. Too many people had high health needs and there should be investment into procedures and initiatives that would give rise to changes in generations to come. There were a number

of current initiatives for providing a single point of contact for patients which should contribute to better care for patients, such as Health and Social Care Co-ordinators and 'named clinicians' for patients care.

Lorraine Austen stated that there were now inpatient rehabilitation beds in the city for people coming out of hospital. Services for mental health were being re-designed for patients discharged from hospital to receive additional support in the community in an attempt to reduce the occurrence of future re-admissions.

The Chair thanked everyone for contributing to the discussion.

18. MINUTES OF PREVIOUS MEETING

RESOLVED:

That the minutes of the meeting held on 11 April 2013 be confirmed as a correct record.

19. MID-STAFFORDSHIRE FOUNDATION TRUST PUBLIC INQUIRY

The Board received a report on behalf of the local Clinical Collaborative The Board received a report on behalf of the local Clinical Collaborative Interface Group (CCIG) about the recommendations in the Mid Staffordshire NHS Foundation Trust Public Inquiry Report (Francis Report). At the April meeting of the Health and Wellbeing Board, it had been noted that NHS commissioners and providers in Leicester, Leicestershire and Rutland were working together on an initial response to the Francis Report. It had been agreed that this would be provided to the Health and Wellbeing Board.

The CCIG brought together the clinical leaders from the local CCGs, the NHS provider Trusts and NHS England Local Area Team. Initial proposals for actions to be delivered in partnership included:

a) A coherent system across Leicester, Leicestershire and Rutland (LLR) should be established to collect soft intelligence on patient care.
b) There should be an emphasis on clinical leadership and coherent teamwork.
c) The 'right place, right care' programme should be extended to primary care.
d) An effective single front door to the Emergency Department at UHL NHS Trust be made a high priority.

Six common themes had emerged on what the priorities should be to improve services and to safeguard against the issues highlighted in the Francis Report. These themes were transparency, listening, walking the floors, saving more lives, safe staffing levels and targeting improvement. Details of these were contained in the report.

A number of priorities for the first phase of joint work have been identified and there will be a further update in October. These priorities were listed in the

report, together with a list of each organisation's specific area for priority.

Philip Parkinson commented that it was encouraging that the responses were positive and the commitment to listening to patients, staff and stakeholders views was welcomed. He asked if there were log of reported incidents which could be placed in the public domain. Simon Freemen confirmed that this could be done and that a list of engagements could also be shared.

Professor Farooqi commented that the joint response was 'work in progress' and any feedback on the responses to the individual organisations would be helpful.

RESOLVED:

1) that the assurances on the work underway to progress the recommendation of the Francis Report be received;

2) that the priorities of work identified in the report be supported; and

3) that a further update on the progress achieved be submitted to a future meeting of the Board.

20. HEALTH PROTECTION BOARD

The Strategic Director for Adult Social Care and Health presented a report on the first meeting of the Health Protection Board (HPB) which had taken place on 5 June 2013. The Board had made a number of minor changes to its Terms of Reference which were listed in full in the report. The HPB will meet quarterly and further report will be brought to the health and Wellbeing Board in due course.

RESOLVED:

that the report and the changes to the Terms of Reference be noted.

21. WINTERBOURNE VIEW CONCORDAT

The Board received a letter from Norman Lamb MP (Minister of State for Care and Support) about the Winterbourne View Concordat together with a report summarising progress.

The Strategic Director for Adult Social Care, Health and Housing explained the background to the concordat which had arisen following the 'Panorama' exposé of the treatment of people at the Winterbourne View hospital who had learning difficulties/autism and displayed challenging behaviour or serious mental health issues.

The Minister had asked partners on Health and Wellbeing Boards to provide a stocktake of the local progress following the Winterbourne View Concordat. The stocktake for Leicester had been completed and a timeline had been

identified for moving on/discharge for each person. There was shared understanding of the current care arrangements for the 17 adults and 2 children affected and the register was being updated to ensure the dataset reflected the requirements of the Winterbourne Joint Improvement Programme. The reports also contained other actions that had been carried out in response to the concordat.

RESOLVED:

that letter from the Minister be noted together with the stocktake report that was submitted to the Winterbourne View Joint Improvement Board on 5 July 2013.

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22. ANNOUNCEMENTS

The Chair made the following announcements:-

LGA Peer Challenge

The Chair had accepted an invitation from the Local Government Association to take part in a Peer Challenge Review for Health and Wellbeing Boards next February. He would circulate the details to Board Members.

Integration Pioneer Initiative

The CCG had made an application to become a health and social care integration pioneer. The City Council supported the bid and if it was successful it could result in national and international support to 'pioneers' for 5 years which would help to achieve innovative changes.

Joint Integrated Commissioning Board

The Chair had agreed to the Joint Integrated Commissioning Board having responsibility for taking the Closing The Gap Joint Health and Wellbeing Strategy forward, as it was more appropriate to use an existing organisational structure than create a new one for this purpose.

City of Culture 2017

The City had been successful in becoming one of four Cities on the final shortlist for the City of Culture 2017 together with Dundee, Hull and Swansea Bay. The health community could make a considerable contribution to the bid if it was successful as it could underline and contribute to cultural activities.

23. QUESTIONS FROM MEMBERS OF THE PUBLIC

The Chair invited questions from members of the public and the following questions were received and answered:-

Question - Number of residents not registered with a GP

The number of residents not registered with a GP practice was raised at the last meeting of the Board and what steps had been taken since then to reduce the numbers and how many were still not registered?

Response

The on-going campaign included arrangements for people who attended emergency centres at UHL for treatment to register at the centre if they were not already registered. A campaign would continue to run in part of the City where lower than expected levels of registration were observed. Publicity was undertaken in shopping precincts etc to encourage people to register. The Square Mile Project around the University survey responses suggested that nearly all residents were registered with a GP. The focus of this campaign would now centre on when people last saw their GP and would follow up on those not registered.

It was stated that non- registration had been a longstanding issue but there was no overwhelming evidence to suggest that the level of non-registration was a significant problem or a barrier to the provision of healthcare when it was needed. Registration was important for immunisation and core screening programmes.

NHS England were also known to be undertaking a national clearing exercise of GP lists as the number of people registered with GP's was greater than the total population. It was estimated that this could result in a 2-3% reduction in the number of people registered. The main reason for the discrepancy in numbers appeared to be people who had moved away from an area but were still registered with the GP in that area.

It was also noted that the Secretary of State for Health was considering charging patients from overseas for GP services and if this was introduced it could discourage people from registering.

The Chair stated that he would consider a methodology for asking questions in advance of the meeting so that a detailed written response could be prepared and the questioner may have the opportunity to then ask a supplementary question.

24. DATES OF FUTURE MEETINGS

The Board noted that future meeting would be held on the following dates:-

Tuesday 8 October 2013
Thursday 30 January 2014
Thursday 3 April 2013
Thursday 3 July 2014
Thursday 9 October 2014

Meetings would take place in the Tea Room, 1st Floor Town Hall at 10.00am unless stated otherwise on the agenda for the meetings.

The Chair also invited Board members to submit views and observations on how the Board could conduct its meetings. A number of different approaches had already been tied and feedback would be welcomed.

25. CLOSE OF MEETING

The Chair declared the meeting closed at 11.45am.

East Midlands Ambulance Service NHS
NHS Trust

Trust Headquarters
1 Horizon Place
Mellors Way
Nottingham Business Park
Nottingham
NG8 6PY

Telephone: 0115 884 5000
Fax: 0115 884 5001
Website: www.emas.nhs.uk
Ref: JS/MJW

Tuesday, 17 September 2013

Dear colleague

Being the Best update

I am writing to update you on our Being the Best improvement plans (approved at our Board meeting in March 2013).

Background

You will recall our plans are to implement 108 community ambulance stations (CAS), 18 ambulance stations and nine hubs across the East Midlands. The aim, to provide a better service for patients by improving clinical standards and performance, and providing better facilities, communications, engagement and support for frontline colleagues. The changes to our estate (bricks and mortar) will allow us to achieve this and provide strategically located premises to improve our operational performance.

Twinning of stations

The September EMAS Trust Board meeting will see members discuss the further twinning of stations – an interim measure which involves staff using one station as a base rather than two.

This means when crews are moved from one station and twinned with another, they will start their shift by picking up their emergency ambulance vehicle from the station they are moved to. They will then either respond to a 999 call received at the start of their shift or move to a strategic stand-by point (as they often do now) which, as they are introduced, will include the use of community ambulance stations, and await the next 999 call.

Two station twinnings have already taken place in Nottinghamshire with no derogation of local ambulance service or provision; West Bridgford crews now start and end their shift at Wilford station and Arnold crews now start and end at Carlton station and the crews continue to respond to emergency calls in the local area.

The March 2013 meeting paper referred to this interim twinning solution and confirmed that the full benefits of Being the Best would only be achieved when implementing the preferred option i.e. when the 108 CAS, 18 ambulance stations and nine hubs are in place.

What difference does ‘twinning’ make to local people?

There will be no difference to local people and no derogation of local ambulance service or provision. Twinning is an interim measure which helps us deliver the aims of Being the Best. We continue to respond to local 999 calls as we do now i.e. by getting the nearest available ambulance resource to them as quickly as possible.

What difference does ‘twinning’ make to frontline staff?

Stations not being twinned: The only difference these colleagues will experience is the potential to have more access to a divisional manager. Less stations means we can reduce the time our team leaders and locality

managers spend travelling from site to site. The increase in access to a manager for frontline crews has always been part of our Being the Best plans to improve staff welfare and support.

Stations receiving additional crews: These colleagues will clearly experience an increase in people who are based with them (bearing in mind not all colleagues are on duty at the same time). Work is in progress to ensure these stations are in a fit state to accommodate the additional numbers eg there are enough lockers and toilet facilities. There will be no overcrowding though as most of our stations are empty most of the time i.e. crews spend the vast majority of their shift 'on the road'.

Stations to be vacated: These colleagues will clearly be affected the most; they will continue to respond to emergency 999 calls in fast response cars and double crewed ambulances that operate in their local area, however they will start and end their shift at a different location.

We understand that change is never easy and at EMAS we are experiencing significant developments in all areas of our service. We are supporting our colleagues through this by providing opportunities to attend station engagement meetings and to have a one-to-one meeting with a member of their local management team.

Which stations are being twinned?

The Estate Strategy update will be reviewed by our Trust Board at its meeting on Monday 30 September. The meeting paper will be available on our website – www.emas.nhs.uk - from Tuesday 24 September and will include stations to be twinned.

We will continue to keep you informed as plans progress and hope that you have found this latest update useful.

Yours sincerely

Jon Sargeant
Acting Chief Executive