Leicester
City Council

# MEETING OF THE HEALTH AND WELLBEING SCRUTINY COMMISSION

**DATE:** **TUESDAY, 26 NOVEMBER 2013**
**TIME:** **5:30 pm**
**PLACE:** **THE TEA ROOM - FIRST 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):***
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## 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 on the agenda.

**3. MINUTES OF PREVIOUS MEETING**

The minutes of the meeting held on 15 October 2013 have been circulated and the Commission is 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=5792&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 Scrutiny Support Officer submits a document that outlines the Health and Community Involvement Scrutiny Commission's Work Programme. The 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 Plan of Key Decisions that will be taken after 1 December 2013.

## 8. CQC INSPECTION OF UHL NHS TRUST — Appendices C-D

To receive the following reports relating to the announcement of the CQC to inspect 8 aspects of the Trust's work as part of the CQC's second phase of inspections. 19 acute trusts will be inspected and will be the first to be given ratings by the CQC. Representatives of the Trust will be at the meeting to discuss the reports.

The following reports are attached for Members' information.

| | |
|---|---|
| A report to the UHL Board meeting. | **Appendix C (Page 19)** |
| CQC Intelligent Monitoring Report – 21 October 2013 | **Appendix C1 (Page 29)** |
| Letter to Chief Executive UHL | **Appendix C2 (Page 41)** |
| Statement Issued by the CQC on the proposed visits. | **Appendix D (Page 43)** |

## 9. BRADGATE ADULT MENTAL HEALTH UNIT — Appendix E (Page 47)

To receive an update report from the Leicestershire Partnership Trust (LPT) on the progress made with outcomes in QIP since the last meeting. The Commission will also receive an update on the Second Report of the Care Quality Commission (CQC) as a result of the return inspection of the Bradgate Unit. This report is expected to be published late November/early December.

Representatives of the Trust will attend the meeting to discuss the reports.

## 10. ORAL HEALTH IN THE CITY — Appendices F-H

Dr Jasmine Murphy, Consultant in Public Health will submit a report on improving oral health in the City. The report outlines the oral health needs of children in the City, NHS reforms and dentistry and the development of the Oral health Promotion Strategy for pre-school children. **Appendix F (Page 111)**

The following documents are also attached for information:-

| | |
|---|---|
| Draft Oral Health Strategy | **Appendix G (Page 115)** |
| Draft Action Plan | **Appendix H (Page 125)** |

Copy of the presentation to be given on the report **Appendix I (Page 129)**

The report makes reference to the Dental health Survey Results of 5 year olds 2011/12 and the Draft Terms of Reference for the Oral Health Promotion Partnership Board. It was considered that these documents did not need to be circulated in with the agenda. If Members wish to see a copy these documents they can be requested from Democratic Services.

## 11. CLOSING THE GAP — Appendix J (Page 143)

To receive the first bi-annual monitoring report on progress in delivering he Joint Health and Wellbeing Strategy 'Closing the Gap'. The report was submitted to the Health and Wellbeing Board at its meeting on 8 October 2013. The report seeks to provide assurances that actions identified in the strategy are being delivered and flag up any potential risks to delivery and reports on performance indicators set out on the strategy.

The Commission is asked to comment upon the progress being made.

## 12. HEALTH VISITORS — Appendix K (Page 163)

To receive a joint briefing report from Leicester City Council and NHS England on the commissioning of health-visiting services and Family Nurse Partnership in Leicester.

David Giffard, Public Health Commissioning Manager NHS England will attend the meeting to discuss the report.

## 13. UPDATE ON MATTERS CONSIDERED AT A PREVIOUS MEETING — Appendices L-S

To receive updates on the following matters that were considered at previous meetings of the Commission:-

1. **Winter Care Plan**

   Councillor Chaplin to provide an update on the Joint Scrutiny Review meetings held on 24 October, 14 November and 19 November in relation to the Winter Care Plan. It is understood that the draft report of the review may be considered at the meeting of the Adult Social Care Scrutiny Commission at its meeting on 5 December.

2. **Francis Report**

   To receive the following update reports on progress made in relation to the recommendations in the Francis Report

Leicestershire Partnership Trust **Appendix L (Page 167)**

Clinical Commissioning Group (CCG) **Appendix M (Page 175)**

3. **Unannounced Visits to UHL**

   To receive a verbal update report from the CCG

4. **Public Health Budgets**

   The Chair to provide an update on discussions in relation to Public Health Budgets.

5. **Response to the Commissions Scrutiny Review Reports.**

   The Chair to report on his presentation of the two scrutiny review reports below to the Council's Executive on 5 November 2013.

   a) Revisiting the Review of Mental Health Working Age Adults in Leicester
   b) Review of Voluntary and Community Sector Groups who have raised concerns about Funding, Commissioning and Tendering issues.

   A joint response from Adult Social Care Services and the CCG to the Voluntary and Community Sector Review is attached. **Appendix N (Page 183)**

   To receive the any further responses to the two scrutiny reviews which are received before the meeting.

6. **Impact Assessment for NHS 111**

   The CCG to provide an update on the submission of the Impact Assessment on the NHS 111 service requested at the last meeting of the Commission.

7. **Congenital Heart Disease Review**

   To receive the following update reports and information in relation to the Congenital Heart Disease Review:-

   **a)** The Scoping Document for the Review **Appendix O (Page 189)**

   **b)** 9th NHS England Bulletin **Appendix P (Page 193)**

**c)** 10th NHS England Bulletin **Appendix Q (Page 197)**

**d)** Note of Meeting with John Holden, Lead for NHS England Review Team **Appendix R (Page 199)**

8. **East Midland Regional Health Scrutiny Network**

To receive a briefing note. **Appendix S (Page 203)**

9. **External Scrutiny Review by CfPE**

The Chair to provide an update on the progress with the review.

**14. ANY OTHER URGENT BUSINESS**

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

## CURRENT / ONGOING / FUTURE ISSUES – Updated November 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)<br>2) Public Health Work by the City Council & Health & Wellbeing Board (Deb Watson/Rod Moore)<br>3) Implementation of the Health and Social Care Act (Deb Watson / Tracie Rees)<br>4) Public Health Budget (Deb Watson / Tracie Rees/Rod Moore)<br>5) Commissioning Process for Patient Representative Body - HealthWatch (Tracie Rees)<br>6) Leicester City Council City Mayors Forward Plan (Cllr Palmer/Deb Watson / Tracie Rees)<br>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** - 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<br>a) An overview of the Francis Report and the implications for the local authority (Rod Moore)<br>b) Responses from LCCCG on the Francis Report (Richard Morris)<br>c) Responses from UHL on the Francis Report (Stephen Ward) | **Actions:**<br>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.<br>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)..**<br>c) Discussed francis report and health scrutiny forward planning.<br>d) Review engagement arrangements with partners involved in health scrutiny e.g. LLR Joint Committee and OSC (part of Fit for Purpose Review)<br>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)<br>4) Regulations on new Health & Wellbeing Board – Implications for Health Scrutiny (Pretty Patel) | **Actions:**<br>a) Private Policy meeting taken place<br>b) Healthwatch to reassure the commission that the Emergency Pathways work will continue.<br>c) Contact LPT re: views on LINKs treatment during Bradgate Unit visit (pending) |
| | 5) **Healthwatch** and Scrutiny – Framework (Tracie /Jo Clinton) | **Action** – Healthwatch to bring a paper on draft protocol, setting out how it will actively |

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

| DATE OF COMMISSION MEETING | PROPOSED TOPICS / ITEMS AND LEADS | ACTIONS / OUTCOMES |
|---|---|---|
| | | engage with the scrutiny commission. |
| | 7**) Councils Forward Plan** | Noted. |
| **28th May 2013**<br>(agenda 14/05/13) | **1) University Hospitals of Leicester (UHL)**<br>1a) UHL - Strategic Direction Presentation (Stephen Ward/John Adler)<br>1b) UHL Annual Quality Accounts (Sharon Hotson, UHL)<br>1c) UHL Unannounced Hospital Visits – feedback report (Richard Morris)<br>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:**<br>1a) The Strategic Direction report was noted.<br>1b) The Quality Accounts 2013/14 report noted and comments to be sent to UHL (done)<br>1b) HSC members invited to visit the hospital to see how services are provided (to be arranged).<br>1c) Report noted. HSC to receive further updates on future visits.<br>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). |
| | **3) Public Health Structure** – to include organisation chart, posts and functions, plus current areas of work, budgets and schedule of commissioning | **Action:** Private session to be arranged to discuss functions and commissioned services. |

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

| DATE OF COMMISSION MEETING | PROPOSED TOPICS / ITEMS AND LEADS | ACTIONS / OUTCOMES |
|---|---|---|
| | areas and timescales (Rod Moore) | 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:**<br>- Draft report and recommendations endorsed. Final report to go to OSC, then to the City Mayor.<br>- Chair to discuss procedures and mechanisms for council to commission drug and alcohol services. |
| | **6) Work Plan**<br>6a) Draft Work Programme 2013/14 – update/suggestions from commission members (cllr Cooke/Anita)<br>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:**<br>- Chair to arrange private session for further discussion on the Plan.<br>- HSC reserved the right to submit comments |

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

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|---|---|---|
| | | at a later date.<br>- HSC request progress report in 6 months<br>- Joint scrutiny reviews with Adult Social Care SC is supported. |
| | **8) Items for noting**:<br>a) Health & Wellbeing Board – minutes of last meeting<br>b) Council's Forward Plan<br>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)<br>2) Update on Glenfield Hospital Heart Unit Review (Cllr Cooke)<br>3) 'Alcohol Awareness Social Marketing' consultation proposals (Julie/Rod)<br>4) Development Training Session for HSC members to cover the following:<br>a) 'Better Understanding of the New Structures of the NHS' (Rod)<br>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)<br>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)<br>2) **Action:** Update to September meeting.<br>3**) Action**: Feedback to September meeting<br>4c) **Action:** Proposal for Leicester to be offered as a venue for a future regional event (Anita to liaise with CfPS)<br>**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.<br>**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)<br>2) Access for All Document – referred by Overview Select Committee to all scrutiny commissions for comments (Paul Lenard-Williams)<br>3) Alcohol Awareness – Project feedback (Julie)<br>4) LCCCG Response to Francis Report – Update (Simon Freeman)<br>5) UHL Emergency Floor Scheme Report – (Stephen/Mark)<br>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.<br>6) Leicestershire Partnership NHS Trust<br>7) Items for noting:<br>a) Glenfield Heart Unit NHS England Review – Update<br>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<br>**Item 2** – Deferred to future meeting<br>**Item 3** – Project not started, deferred to future meeting.<br>**Item 4** – An update to further responses by the CCG still to be reported to future meeting.<br>**Item 5** – Noted and agreed in principle.<br>**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.<br>**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**<br><br>**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.*<br><br>To be led by the Chair, assisted by Brenda Cook, expert health scrutiny advisor, and Anita Patel/Graham Carey | Notes taken and submitted to HSC meeting. Work plan to be updated / progressed as part of the Fit for purpose review outcomes. |
| **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)<br><br>**2) Access for All** – Deferred from last meeting (Paul Leonard-Williams)<br><br>3) **Work Programme** – Update from 18th September private members session (Chair/Anita)<br><br>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)<br><br>5**) Leicestershire Partnership NHS Trust** – Update on Progress to improve services and feedback from minutes of last meeting RE Bradgate MHU. (tbc)<br><br>6) **'Fit for Purpose' Health Scrutiny Review –** Progress update (Chair/Anita)<br><br>7) **Alcohol Awareness Project** – feedback on progress (Julie/Rod)<br><br>8**) NHS 111 Service** – Update on progress (Dr Johri/Richard Morris) | 1) Further reports on commissioning items to future meetings.<br><br>2) report noted<br><br>3) Updating work programme - in progress<br><br>4) Meeting with John Holden, NHS England Review team lead on 25th Oct<br><br>5) to be invited to October meeting to report progress.<br>6) In progress<br>7) report noted<br><br>8) NHS 111 Equality Impact Assessment report for local service – to Oct mtg. |

**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 13/11/13) | 1) Francis Report Recommendations - Progress Reports from UHL, LCCCG, LPT, LCC Public Health<br>2) Closing the Gap – Review of progress (Adam Archer/Rod)<br>3) Hospital Unannounced Visits – Reports from CCG (Richard Morris)<br>4) UHL Emergency Department Assessment Service and CQC planned inspection – Progress Reports (Mark / Richard)<br>5) Winter Care Plan Review – Update (Cllr Chaplin)<br>6) Bradgate Adult Mental Health Unit – LPT update report and CQC latest inspection report (Cheryl Davenport)<br>7) Oral Health in the City, Dental Health Policy and Strategy (Jasmine Murphy)<br>8) City Mayors Delivery Plan – update (Miranda)<br>9) Health Visitors report (Rod/Jo)<br>10) Responses to Scrutiny Review Reports (MHR and VCS) from UHL, CCG, LPT and City Counciil<br>11) Congenital Heart Disease Review – Update (Chair)<br>12) East Midlands Regional Health Scrutiny Network – update (Chair)<br>13) External Scrutiny Review 'Fit for Purpose' by CfPS – update (Chair) | |

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

| DATE OF COMMISSION MEETING | PROPOSED TOPICS / ITEMS AND LEADS | ACTIONS / OUTCOMES |
|---|---|---|
| **14th January 2014** | 1) East Midlands Ambulance Service "Being the Best" Progress Report – Anita to contact lead officer - see 17th July minutes.<br>2) NHS Complaints Procedures – process of CCG, UHL, LPT, City Council<br>3) Maternity Services<br>4) BME Mental Health Review?<br>5) Intelligence Monitoring?<br>6) Public Health Budgets and Commissioning<br>7) External 'Fit for Purpose' Health Scrutiny Review – update | |
| **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<br>- NHS Reconfiguration – G.P practices fit for purpose<br>- NHS Commissioning<br>- LPT/UHL – to review and monitor their performance data / complaints data<br>- Lead Commissioners of Health Services across the city – work plans<br>- Annual Reports – LOROs, UHL, ICAS, LPT NHS TRUST and HEALTHWATCH<br>- ICAS and HEALTHWATCH – Regular Reports<br>- Hospital Discharges<br>- Homelessness Strategy – Implementation<br>- Capital Programme – monitoring role<br>- Forward Plan – monitoring role<br>- Corporate Strategies – monitoring role<br>- Stickle Cell Anemia Services<br>- BME groups – targeting of specific health services<br>- HIV/AIDs Services<br>- Mental Health Services for BME e.g. Aqwaabaa | |

# Leicester City Council

# CORPORATE PLAN OF KEY DECISIONS

# On or after 1 December 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 known about, that are intended to be taken by the Council's Executive (City Mayor, Deputy City Mayor and Assistant City Mayors) over the next few months. Each plan runs from the first of each month.

## What is a key decision?

A key decision is an executive decision which is likely:

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

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

## What information is included in the plan?

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

The plan is published on the Council's website.

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

# Corporate Plan of Key Decisions

# On or after 1 December 2013

# Contents

## 1. A place to do business

| | |
|---|---|
| What is the Decision to be taken? | LEICESTER FOOD PARK DEVELOPMENT<br>To approve the scheme funding package. |
| Who will decide? | City Mayor/Executive |
| When will they decide? | Not before 1 Dec 2013 |
| Who will be consulted and how? | Consultation 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<br>To approve the project and funding. |
| Who will decide? | City Mayor/Executive |
| When will they decide? | Not before 1 Dec 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<br>To approve the project and funding. |
| Who will decide? | City Mayor/Executive |
| When will they decide? | Not before 1 Dec 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? | LEICESTER MARKET PHASE 2<br>Final approval and inclusion of the scheme in the capital programme. |
| Who will decide? | City Mayor/Executive |
| When will they decide? | Not before 1 Dec 2013 |
| Who will be consulted and how? | Consultation undertaken as part of the planning process and with key stakeholders. |
| Who can I contact for further information or to make representations | AndrewL.Smith@leicester.gov.uk |

## 2. Getting about in Leicester

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|---|---|
| What is the Decision to be taken? | BUS LANE ENFORCEMENT - AYLESTONE QUALITY BUS CORRIDOR<br>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 Dec 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? | CONNECTING LEICESTER STREET IMPROVEMENT SCHEME/S<br>Approval of funding for second phase of Connecting Leicester street improvement projects. |
| Who will decide? | City Mayor/Executive |
| When will they decide? | Not before 1 Dec 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<br>Approval of project design and funding package. |
| Who will decide? | City Mayor/Executive |
| When will they decide? | Not before 1 Dec 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/Brian.Stafford@leicester.gov.uk |

| | |
|---|---|
| What is the Decision to be taken? | TOWNSCAPE HERITAGE INITIATIVE<br>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.<br>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<br>Release of block fund from Capital Programme. |
| Who will decide? | City Mayor/Executive |
| When will they decide? | Not before 1 Dec 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? | DEVELOPMENT OF AN INTERMEDIATE CARE FACILITY<br>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 Dec 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 |

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|---|---|
| What is the Decision to be taken? | REVIEW THE POTENTIAL OPTIONS FOR PROVIDING THE MOBILE MEALS SERVICE IN FUTURE<br>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 Dec 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 |

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|---|---|
| What is the Decision to be taken? | THE REDESIGN OF ADULT SOCIAL CARE PREVENTATIVE SERVICES<br>The re-design will inform future procurement activities. |
| Who will decide? | City Mayor/Executive |
| When will they decide? | Not before 1 Dec 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 representations | Tracie.Rees@leicester.gov.uk |

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|---|---|
| What is the Decision to be taken? | RESIDENTIAL CARE FEES REVIEW<br>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 Dec 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 |

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|---|---|
| What is the Decision to be taken? | THE FUTURE OF DOUGLAS BADER DAY CARE CENTRE<br>To consider the outcome of a consultation exercise regarding the future of the service. |
| Who will decide? | City Mayor/Executive |
| When will they decide? | Not before 1 Dec 2013 |
| Who will be consulted and how? | Formal consultation started with the existing service users on 17th September 2013. |
| Who can I contact for further information or to make representations | Tracie.Rees@leicester.gov.uk |

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|---|---|
| What is the Decision to be taken? | LOCAL ACCOUNT<br>To consult with a range of stakeholders to provide an overview of the quality of their services provided by ASC. |
| Who will decide? | City Mayor/Executive |
| When will they decide? | Not before 1 Dec 2013 |
| Who will be consulted and how? | Consultation in progress with a range of stakeholders. |
| Who can I contact for further information or to make representations | Tracie.Rees@leicester.gov.uk |

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|---|---|
| What is the Decision to be taken? | APPROVAL OF INTERMEDIATE CARE AND SHORT TERM RESIDENTIAL BEDS STRATEGY |
| Who will decide? | City Mayor/Executive |
| When will they decide? | Not before 1 Dec 2013 |
| Who will be consulted and how? | Not required. |
| Who can I contact for further information or to make representations | Tracie.Rees@leicester.gov.uk |

## 7. Our children and young people

| | |
|---|---|
| What is the Decision to be taken? | CHILDREN IN CARE COUNCIL AND PLEDGE<br>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 Dec 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? | PROPOSALS FOR FUTURE USE OF LOWER HASTINGS STREET AND LOUGHBOROUGH ROAD HOSTEL BUILDINGS |
| Who will decide? | City Mayor/Executive |
| When will they decide? | Not before 1 Dec 2013 |
| Who will be consulted and how? | None required. |
| Who can I contact for further | julia.keeling@leicester.gov.uk |

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|---|---|
| information or to make representations | |

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|---|---|
| What is the Decision to be taken? | SOUTHFIELDS DRIVE COMMUNITY FACILITIES PROJECT<br>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 Dec 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

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

# Appendix C

**UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST**

**REPORT TO:** **Health Scrutiny Commission Leicester City Council**

**DATE:** **26th November 2013**

**REPORT FROM:** **Chief Nurse**

**SUBJECT:** **Care Quality Commission Inspection at University Hospitals of Leicester 13th January 2014**

---

## 1.0 Introduction

**1.1** The attached paper was presented at University Hospitals of Leicester's public Trust Board meeting on 31st October providing information in respect of:-

- the new CQC Intelligent Monitoring Tool and University Hospitals of Leicester's results.
- information in respect of those indicators where UHL is an outlier.
- details of the Care Quality Commission's wave 2 inspections, in which UHL is included.

**1.2** University Hospitals of Leicester's Chief Executive has since received a follow up letter confirming the date of the visit - commencing on 13th January 2014.

**1.3** Representatives of University Hospitals of Leicester NHS Trust will be in attendance to present this report take questions on the forthcoming inspection at the meeting on the 26th November.

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**UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST**

**REPORT TO:** **Trust Board**

**DATE:** **31st October 2013**

**REPORT FROM:** **Chief Nurse**

**REPORT BY:** **Director of Clinical Quality**

**SUBJECT:** **Care Quality Commission Intelligent Monitoring Report and Impending Inspection**

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## 1.0 Introduction

**1.1** The Care Quality Commission (CQC) has developed a new model for monitoring a range of key indicators about NHS acute and specialist hospitals. These indicators relate to the five key questions they will ask of all services – are they safe, effective, caring, responsive and well-led?

**1.2** On Thursday 24th October the CQC published for the first time the results of new surveillance model, also known as the Intelligent Monitoring tool, which sets out a range of information which the CQC hold on each of the 161 acute and specialist Trusts. This information helps the CQC prioritise their inspections.

**1.3** At the same time it was announced that the University Hospital's of Leicester (UHL) will be inspected using the new Care Quality Commission model some time between January to March 2014.

**1.4** This paper provides details of the CQC's intelligent monitoring report in addition to the impending visit.

## 2.0 CQC's Intelligent Monitoring Report

**2.1** The new reports give the CQC's overall view of every Trust and how they arrive at that view. This helps the CQC to decide when, where, and what to inspect under their new model. The reports draw together a range of information to give the CQC inspectors a clear picture of the areas of care that may need to be followed up.

**2.2** The intelligent monitoring system is based on 150 indicators that look at a range of information including patient experience, staff experience and statistical measures of performance. The indicators relate to the five key questions CQC will ask of all services. The indicators are used to raise questions not to make judgements about the quality of care. CQC's judgements will always follow their inspections, which take into account the results of the intelligent monitoring and reports from other organisations.

**2.3** The CQC has analysed each of the 150 indicators and identified one of the following levels:

- 'no evidence of risk'
- 'risk'
- 'elevated risk'

**2.4** UHL has been identified as having 5 indicators at risk and 5 at an elevated risk.

**2.5** An overall summary band for each Trust is then created by reviewing the proportion of indicators that have been identified as 'risk' or 'elevated risk' for each Trust out of all applicable indicators in the model.

**2.6** Guidance has been produced by the CQC to explain how they have created a summary view for each NHS Trust as well as indicators definitions for each indicator they explain:-

- how the numerator and denominator have been constructed (for quantitative
- indicators)
- how we have determined 'risk' and 'elevated risk'
- time period of the data source
- data source and links to the original source (where this is available)

The CQC has also produced an additional methodology document, describing the statistical methods they have used.

**2.7** The following fields have been calculated for each NHS trust by the CQC and are provided on each Trust level profile:

- **Number of risks**: total number of indicators identified as 'risk' (thresholds and rules for identifying risk are provided in the individual indicator details below).
- **Number of elevated risks:** total number of indicators identified as 'elevated risk' (thresholds and rules for identifying elevated risk are provided in the individual indicator details below).
- **Number of applicable indicators:** a count of the number of indicators that apply to the individual trust
- **Overall risk score:** a weighted sum of (number of risks) + (number of elevated risks x 2).
- **Maximum possible risk score:** the score a trust would receive if they had flagged as elevated risk for every single applied indicator in the model.
- **Proportional Score:** calculated from (overall risk score)/ (maximum possible risk score)
- **Band:** CQC has categorised trusts into one of six summary bands, with band 1 representing highest risk and band 6 with the lowest. These bands have been assigned based on the proportion of indicators that have been identified as 'risk' or 'elevated risk' or if there are known serious concerns (e.g. trusts in special measures) trusts are categorised as band 1. For the trusts assigned a category based on the proportion of indicators, we have used the following thresholds:

  Band 1 ≥ 7.5%
  Band 2 ≥ 5.5%
  Band 3 ≥ 4.5%
  Band 4 ≥ 3.5 %
  Band 5 ≥ 2.5 %
  Band 6 < 2.5 %

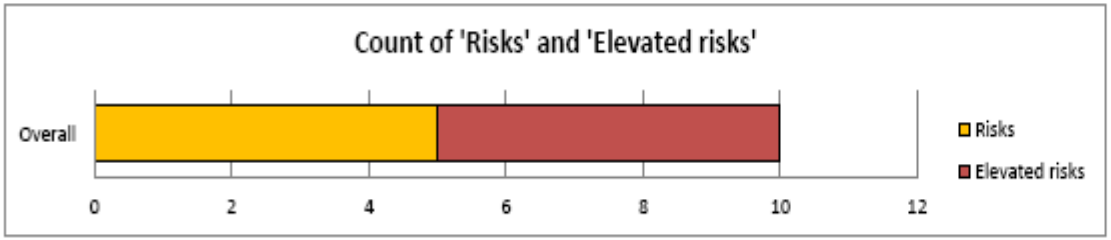
### 3.0 Results- October 2013

**3.1** The CQC intelligent monitoring report- October 2013 is attached at Appendix 1. This can be accessed online at http://www.cqc.org.uk/.

**3.2** The Trust summary for October 2013 is as follows:

**University Hospitals of Leicester NHS Trust**

Trust Summary




| | |
|---|---|
| Band | 1 |
| Number of 'Risks' | 5 |
| Number of 'Elevated risks' | 5 |
| Overall Risk Score | 15 |
| Number of Applicable Indicators | 83 |
| Proportional Score | 0.09 |
| Maximum Possible Risk Score | 166 |

| | |
|---|---|
| Elevated risk | Dr. Foster: Deaths in low risk diagnosis groups |
| Elevated risk | Maternity outlier alert: Puerperal sepsis and other puerperal infections |
| Elevated risk | A&E waiting times more than 4 hours |
| Elevated risk | Whistleblowing alerts |
| Elevated risk | Serious Education Concerns |
| Risk | Composite indicator: In-hospital mortality - Paediatric and congenital disorders and perinatal mortality |
| Risk | PROMs EQ-5D score: Groin Hernia Surgery |
| Risk | TDA - Escalation score |
| Risk | Composite risk rating of ESR items relating to staff turnover |
| Risk | Composite risk rating of ESR items relating to staff stability |

## 4.0 Trust Response

**4.1** A number (although not all) of the indicators are already monitored and reported in the Quality and Performance Report. These include mortality, A&E waiting times, TDA escalation score and workforce indicators. A number of the indicators have also been subject to detailed reports, and/or presentations at the Trust Board or Quality Assurance Committee.

**4.2** A response to each of the indicators identified as elevated risk/risk is detailed below:

- **Dr. Foster: Deaths in low risk diagnosis groups (Elevated Risk)**

  There were 81 patients who died in 2012/13 that were coded as having a 'low risk diagnosis'. The types of diagnosis included in this group are: abdominal pain, transient cerebral ischemia, chest pain, abdominal hernia, normal pregnancy, crushing injury/internal injury. Preliminary review of the data suggests that some patients were subsequently confirmed as having a 'higher risk diagnosis' (stroke, myocardial infarction). Others appeared to have other co-morbidities that significantly affected their outcome (e.g. patient admitted with 'internal injury' also had alcoholic cirrhosis of the liver and oesophageal varices).

  The details of each of the patients in this group are now being cross referenced with the relevant Morbidity and Mortality reviews to ensure that any areas for learning have been acted upon. At the same time, the clinical coding will be checked as one patient was coded with a 'primary diagnosis of abdominal pain' but was admitted to the coronary care unit.

- **Maternity outlier alert: Puerperal sepsis and other puerperal infections (Elevated risk)**

  In August 2013 the CQC wrote to notify UHL of the fact that analysis of maternity indicators undertaken by the Care Quality Commission had indicated that rates of puerperal sepsis and other puerperal infections within 42 days of delivery at our Trust have remained significantly high since the previous alert for this indicator was closed in April 2012.

  A case-note review, the review of audit data regarding serious septic illness and the review of audit data regarding post-caesarean section wound infection all confirmed good clinical outcomes and failed to identify any concerns regarding quality of care. However there were a number of issues identified that need to be addressed.

  These include:

  - A need to improve coding of septic illness diagnoses to more accurately reflect the clinical diagnoses
  - A need to validate and benchmark the data being collected with regard to severe septic illness on our E3 database
  - A need to identify and implement at least one Quality Outcome Indicator to be included as a regular item on our maternity dashboard
  - A review of pathways of care for women after discharge from hospital in conjunction with primary care colleagues

An action plan is being implemented to address these points.

- **A&E waiting times more than 4 hours (Elevated risk)**
  Performance against the 4 hour wait is subject to regular detailed reporting at the Trust Board. It is well recognised that the current Emergency Department is too small, having been designed for around 115,000 patients a year rather than 160,000 that come through the department. A scheme for investment in the Emergency Department has been developed.

  Working with partners a "single front door" process was introduced in July 2013 guiding patients to the most appropriate care.

  Executives across the healthcare community have been meeting on a weekly basis to work on sustainable solutions that will improve performance, patient experience and staff satisfaction.

- **Whistleblowing alerts (Elevated risk)**
  From the reporting period UHL have received three whistle blowing concerns; one in relation to overcrowding in the Emergency Department and two in relation to the cleanliness at the LRI and LGH.

  UHL provided the CQC with a response for each concern raised. The Director of Clinical Quality liaised with the Medical Director, Chief Nurse, Interim Director of Operations and Senior Management team of the Acute Division and Emergency Department to be able to provide a comprehensive response to address the issues raised with regards to standards of care.

  The Lead Nurse Infection Prevention and the Deputy Director of Facilities compiled a response with regards to the standards of cleanliness across the hospital sites.

- **Serious Education Concerns (Elevated risk)**

  We are aware of and are addressing the ongoing issues with medical education. The Medical Director presented a report to the Executive Team on a recent Local Education Training Boards Education Review for Trainee Doctors which focused on areas such as Paediatrics, Obstetrics and Gynaecology, Anaesthetics, Trauma and Orthopaedics, and all Foundation Trainees. This year there are 48 areas of improvement, of which 13 areas are RAG rated red to indicate urgent action being required. Some of the areas of improvement can be categorised into the following areas:

  - Education Resources
  - Identification of Different Levels of Medical Staff
  - Trainee Rotas:
    - Foundation Year 1 doctors working core level doctor rotas is a concern.
    - Doctors advised that they were often required to work longer than the duty rota
    - Excessive hours being worked over consecutive days
  - IT Systems
  - Phlebotomy

- Service Level Induction

A number of these issues have already been resolved by the Trust, for example there are plans for a new library at the LRI site, and there will be an Educational Lead for each Clinical Management Group and implementation of the colour coded ID badge holders and lanyards for Medical Staff.

- **Composite indicator: In-hospital mortality- Paediatric and congenital disorders and perinatal mortality (Risk)**
  Better understanding of the methodology is required in order to properly investigate as this is a composite indicator of two groups of patients (paediatric/congenital disorders and perinatal mortality) and different methods are used for creating the outcomes for each of the groups

  The 'risk' is associated with the first part of the indicator and not the perinatal mortality. The indicator assessed as at 'risk' is a combined indicator and includes paediatric and congenital disorders plus perinatal mortality.

  The Risk only relates to the Paediatric and Congenital Disorders
  Within the indicator are 5 main diagnostic groups:
  - Cardiac and circulatory congenital anomalies
  - Other congenital anomalies
  - Genitourinary congenital anomalies
  - Digestive congenital anomalies
  - Nervous system congenital anomalies

  We believe that the group that is alerting is 'other congenital anomalies' and within that group there is a subgroup which is alerting – congenital diaphragmatic hernia (there were 5 deaths in 34 patients).

  The Children's Mortality and Morbidity lead for both the LRI and GH has reviewed all paediatric cardiac deaths in 2012 by himself and the PICANET lead. Within this review were 3 of the congenital diaphragmatic hernia patients (2 of the patients died subsequent to being transferred back to their original hospitals). All 3 babies had been accepted for ECMO and known complications of ECMO and subsequently died.

  The majority of Trusts where babies are managed with these conditions will only have those babies that require relatively minor operations and specifically in respect of the Congenial Diaphragmatic Hernia babies (closing of the diaphragm area where the hernia is) - so their mortality numbers will be next to 0 whilst because we have ECMO (and subsequently receive the complex babies), our numbers will be substantially higher.

  Our congenital anomalies mortality is unlikely to compare favourably with the majority of hospitals in England because we will get babies with the worst type of congenital abnormality, both because we are a cardiac centre but more so because of ECMO (there are only 4 centres in the UK). Our deaths have been reviewed and any learning acted upon and our outcomes are monitored both by PICANET and NICOR (previously CCAD).

- **PROMs EQ-5D score: Groin Hernia Surgery (Risk)**
  UHL's patients reported a similar health gain to the England average for 11/12 (UHL 0.85 England 0.88). For 12/13 the provisional data published on the HSCIC website, shows UHL's performance dropping to 0.39 (England average remains at 0.88). This drop appears to be disproportionate and UHL has requested validation of the data by Quality Health.

- **TDA- Escalation Score (Risk)**
  The Accountability Framework sets out five different categories by which Trust's are defined depending on key quality, delivery and finance standards

  The five categories are (figures in brackets are number of non FT Trusts in each category as at July 2013):

  **Category 1:** No identified concerns (18 Trusts)
  **Category 2:** Emerging concerns (27 Trusts)
  **Category 3:** Concerns requiring investigation (21 Trusts)
  **Category 4:** Material issue (29 Trusts)
  **Category 5:** Formal action required (5 Trusts)

  Confirmation was received from the NHS Trust Development Authority during October that the University Hospitals of Leicester NHS Trust was escalated to Category 4 – Material issue. This decision was reached on the basis of the significant variance to financial plan for quarter one and continued failure to achieve the A&E 4hr operational standard.

- **Composite risk rating of ESR items relating to staff turnover (Risk)**

  Using the Electronic Staff Record as its data source, the CQC calculate turnover as the number of leavers in the last 12 months divided by the average headcount in the last 12 months. During 2012/13 specifically, this figure has been distorted by the transfer of 406 facilities and switchboard staff to the employment of Interserve. This quantity equates to approximately three month's turnover. In addition our figures are distorted by the significant numbers of medical trainees who transfer between East Midlands organisations. Each transfer will be recorded as a leaver.

  Turnover rates are regularly monitored and reported to the Board on a monthly basis via the Quality and Performance Report. No specific issues have recently been highlighted. In addition the National Workforce Assurance Tool does not indicate that turnover is a specific issue at the Trust when compared to our peers.

- **Composite risk rating of ESR items relating to staff stability (Risk)**
  The same data set is used by the CQC for staff turnover however the stability index measures the number of employees with greater than 12 months service divided by the number of employees 12 months ago. This is equally distorted by the turnover attributed to the TUPE transfer of facilities staff (98.77% of those transferring had more than 12 months service).

## 5.0 Wave 2 Inspection Programme

**5.1** The CQC has announced that they will be inspecting 19 acute Trusts between January and March 2014. UHL is one of these 19 Trusts. A copy of the letter from Professor Sir Mike Richards (Chief Inspector of Hospitals) to John Adler is attached at Appendix 2).

**5.2** The team of over 20 will be headed by a senior NHS Clinician or Executive, working alongside senior CQC Inspectors and they will spend at least 2 days inspecting our sites that deliver acute services and the following eight key service areas: A&E; acute medical pathways including the frail elderly; acute surgical pathways; critical care; maternity; paediatrics; end of life care and outpatients.

**5.3** The inspection will result in a rating of one of the following; good, requires improvement or inadequate.

## 6.0 Conclusion

**6.1** The results of the CQC's intelligent monitoring report (October 2013) identifies that UHL has 5 indicators in the category of 'risk' and 5 at an 'elevated risk' and this places UHL in the risk category of 1 overall.

**6.2** UHL will be within the next wave of inspections commencing in January 2014. Further reports will be provided to the Trust Board and the Quality Assurance Committee regarding the detail of this inspection.

**6.3** The Trust is already in the process of reviewing our assurance escalation and response systems to ensure those indicators that the CQC are monitoring are captured and reported.

## 7.0 Recommendation

**7.1** The Trust Board are asked to receive the report and note the findings of the CQC surveillance published in the Intelligent Monitoring report on the 24th October and inclusion in wave 2 of the acute hospital inspection programme.

# Intelligent Monitoring Report

Report on

**University Hospitals of Leicester NHS Trust**

21 October 2013



Appendix C1

CQC has developed a new model for monitoring a range of key indicators about NHS acute and specialist hospitals. These indicators relate to the five key questions we will ask of all services – are they safe, effective, caring, responsive and well-led? The indicators will be used to raise questions about the quality of care. They will not be used on their own to make judgements. Our judgements will always be based on the result of an inspection, which will take into account our Intelligent Monitoring analysis alongside local information from the public, the trust and other organisations.

**What does this report contain?**

This report presents CQC's analysis of the key indicators (which we call 'tier one indicators') for University Hospitals of Leicester NHS Trust. We have analysed each indicator to identify two possible levels of risk.

We have used a number of statistical tests to determine where the thresholds of "risk" and "elevated risk" sit for each indicator, based on our judgement of which statistical tests are most appropriate. These tests include CUSUM and z scoring techniques. For some data sources we have applied a set of rules to the data as the basis for these thresholds - for example concerns raised by staff to CQC (and validated by CQC) are always flagged in the model.



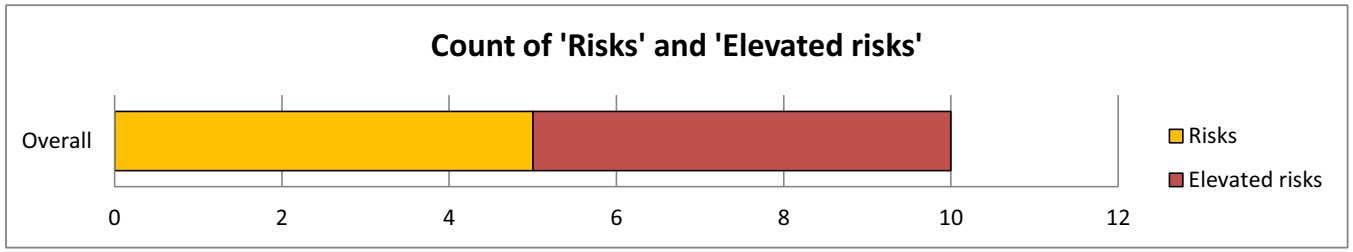
Further details of the analysis applied are explained in the accompanying guidance document.

**What guidance is available?**

We have published a document setting out the definition and full methodology for each indicator. If you have any queries or need more information, please email enquiries@cqc.org.uk or use the contact details at www.cqc.org.uk/contact-us

## University Hospitals of Leicester NHS Trust

### Trust Summary




| | |
|---|---|
| Band | 1 |
| Number of 'Risks' | 5 |
| Number of 'Elevated risks' | 5 |
| Overall Risk Score | 15 |
| Number of Applicable Indicators | 83 |
| Proportional Score | 0.09 |
| Maximum Possible Risk Score | 166 |

| | |
|---|---|
| Elevated risk | Dr. Foster: Deaths in low risk diagnosis groups |
| Elevated risk | Maternity outlier alert: Puerperal sepsis and other puerperal infections |
| Elevated risk | A&E waiting times more than 4 hours |
| Elevated risk | Whistleblowing alerts |
| Elevated risk | Serious Education Concerns |
| Risk | Composite indicator: In-hospital mortality - Paediatric and congenital disorders and perinatal mortality |
| Risk | PROMs EQ-5D score: Groin Hernia Surgery |
| Risk | TDA - Escalation score |
| Risk | Composite risk rating of ESR items relating to staff turnover |
| Risk | Composite risk rating of ESR items relating to staff stability |

University Hospitals of Leicester NHS Trust

Tier One Indicators

| Section | ID | Indicators | Observed | Expected | Risk? |
|---|---|---|---|---|---|
| Never Events | STEISNE | Never Event incidence | - | - | No evidence of risk |
| Avoidable infections | CDIFF | Incidence of Clostridium difficile (C.difficile) | 86 | 87.75 | No evidence of risk |
| | MRSA | Incidence of Meticillin-resistant Staphylococcus aureus (MRSA) | 3 | 6.25 | No evidence of risk |
| Deaths in low risk conditions | MORTLOWR | Dr. Foster: Deaths in low risk diagnosis groups | - | - | Elevated risk |
| Patient safety incidents | NRLSL03 | Proportion of reported patient safety incidents that are harmful | 0.19 | 0.28 | No evidence of risk |
| | NRLSL04 | Potential under-reporting of patient safety incidents resulting in death or severe harm | 2.24 | 1.49 | No evidence of risk |
| | NRLSL05 | Potential under-reporting of patient safety incidents | 366.1 | 235.27 | No evidence of risk |
| Venous Thromboembolism | VTERA03 | Proportion of patients risk assessed for Venous Thromboembolism (VTE) | 0.94 | 0.95 | No evidence of risk |
| Mortality: Trust Level | SHMI01 | Summary Hospital-level Mortality Indicator | Trust's mortality rate is 'As Expected' | - | No evidence of risk |
| | HSMR | Dr. Foster: Hospital Standardised Mortality Ratio | - | - | No evidence of risk |
| | HSMRWKDAY | Dr. Foster: Hospital Standardised Mortality Ratio (Weekday) | - | - | No evidence of risk |
| | HSMRWKEND | Dr. Foster: Hospital Standardised Mortality Ratio (Weekend) | - | - | No evidence of risk |
| Mortality | COM_CARDI | Composite indicator: In-hospital mortality - Cardiological conditions and procedures | - | - | No evidence of risk |
| | COM_CEREB | Composite indicator: In-hospital mortality - Cerebrovascular conditions | - | - | No evidence of risk |
| | COM_DERMA | Composite indicator: In-hospital mortality - Dermatological conditions | - | - | No evidence of risk |
| | COM_ENDOC | Composite indicator: In-hospital mortality - Endocrinological conditions | - | - | No evidence of risk |
| | COM_GASTR | Composite indicator: In-hospital mortality - Gastroenterological and hepatological conditions and procedures | - | - | No evidence of risk |
| | COM_GENIT | Composite indicator: In-hospital mortality - Genito-urinary conditions | - | - | No evidence of risk |
| | COM_HAEMA | Composite indicator: In-hospital mortality - Haematological conditions | - | - | No evidence of risk |
| | COM_INFEC | Composite indicator: In-hospital mortality - Infectious diseases | - | - | No evidence of risk |
| | COM_MENTA | Composite indicator: In-hospital mortality - Conditions associated with Mental health | - | - | No evidence of risk |
| | COM_MUSCU | Composite indicator: In-hospital mortality - Musculoskeletal conditions | - | - | No evidence of risk |
| | COM_NEPHR | Composite indicator: In-hospital mortality - Nephrological conditions | - | - | No evidence of risk |
| | COM_NEURO | Composite indicator: In-hospital mortality - Neurological conditions | - | - | No evidence of risk |
| | COM_PAEDI | Composite indicator: In-hospital mortality - Paediatric and congenital disorders and perinatal mortality | - | - | Risk |
| | COM_RESPI | Composite indicator: In-hospital mortality - Respiratory conditions and procedures | - | - | No evidence of risk |
| | COM_TRAUM | Composite indicator: In-hospital mortality - Trauma and orthopaedic conditions and procedures | - | - | No evidence of risk |
| | COM_VASCU | Composite indicator: In-hospital mortality - Vascular conditions and procedures | - | - | No evidence of risk |

| Section | ID | Indicators | Observed | Expected | Risk? |
|---|---|---|---|---|---|
| Maternity and women's health | MATELECCS | Maternity outlier alert: Elective Caesarean section | - | - | No evidence of risk |
| | MATEMERCS | Maternity outlier alert: Emergency Caesarean section | - | - | No evidence of risk |
| | MATSEPSIS | Maternity outlier alert: Puerperal sepsis and other puerperal infections | - | - | Elevated risk |
| Re-admissions | MATMATRE | Maternity outlier alert: Maternal readmissions | - | - | No evidence of risk |
| | MATNEORE | Maternity outlier alert: Neonatal readmissions | - | - | No evidence of risk |
| | HESELRE | Emergency readmissions following an elective admission | 1909 | 1724.73 | No evidence of risk |
| | HESEMRE | Emergency readmissions following an emergency admission | 7446 | 7784.56 | No evidence of risk |
| PROMs | PROMS19 | PROMs EQ-5D score: Groin Hernia Surgery | 0.45 | 1 | Risk |
| | PROMS20 | PROMs EQ-5D score: Hip Replacement | 0.97 | 1 | No evidence of risk |
| | PROMS22 | PROMs EQ-5D score: Knee Replacement | 1.09 | 1 | No evidence of risk |
| | PROMS24 | PROMs EQ-5D score: Varicose Vein Surgery | Not included | Not included | Not included |
| Audit | NHFD01 | The number of cases assessed as achieving compliance with all nine standards of care measured within the National Hip Fracture Database. | 0.55 | 0.6 | No evidence of risk |
| | SINAP14 | Key Indicator 1: Number of patients scanned within 1 hour of arrival at hospital | Not included | Not included | Not included |
| | SINAP15 | Key Indicator 8: Number of potentially eligible patients thrombolysed | Not included | Not included | Not included |
| Surgical revisions outlier | SURGHIPREV | Surgical revisions outlier alert: Hip revisions | Not included | Not included | Not included |
| | SURGKNEREV | Surgical revisions outlier alert: Knee revisions | Not included | Not included | Not included |
| Compassionate care | IPSurTalkWor | Inpatient Survey 2012 Q34 "Did you find someone on the hospital staff to talk to about your worries and fears?" | 5.61 | - | No evidence of risk |
| | IPSurSupEmot | Inpatient Survey 2012 Q35 "Do you feel you got enough emotional support from hospital staff during your stay?" | 6.91 | - | No evidence of risk |
| Meeting physical needs | IPSurHelpEat | Inpatient Survey 2012 Q23 "Did you get enough help from staff to eat your meals?" | 7.02 | - | No evidence of risk |
| | IPSurInvDeci | Inpatient Survey 2012 Q32 "Were you involved as much as you wanted to be in decisions about your care and treatment?" | 7.22 | - | No evidence of risk |
| | IPSurCntPain | Inpatient Survey 2012 Q39 "Do you think the hospital staff did everything they could to help control your pain?" | 7.85 | - | No evidence of risk |
| Overall experience | IPSurOverall | Inpatient Survey 2012 Q68 "Overall..." (I had a very poor/good experience) | 7.77 | - | No evidence of risk |
| | FFTNHSEscore | NHS England inpatients score from Friends and Family Test | - | - | No evidence of risk |
| Treatment with dignity and respect | IPSurRspDign | Inpatient Survey 2012 Q67 "Overall, did you feel you were treated with respect and dignity while you were in the hospital?" | 8.68 | - | No evidence of risk |
| Trusting relationships | IPSurConfDoc | Inpatient Survey 2012 Q25 "Did you have confidence and trust in the doctors treating you?" | 8.60 | - | No evidence of risk |
| | IPSurConfNur | Inpatient Survey 2012 Q28 "Did you have confidence and trust in the nurses treating you?" | 8.39 | - | No evidence of risk |

| Section | ID | Indicators | Observed | Expected | Risk? |
|---|---|---|---|---|---|
| Access measures | AD_A&E12 | A&E waiting times more than 4 hours | 0.11 | 0.05 | Elevated risk |
| | RTT_01 | Referral to treatment times under 18 weeks: admitted pathway | 0.89 | 0.9 | No evidence of risk |
| | RTT_02 | Referral to treatment times under 18 weeks: non-admitted pathway | 0.97 | 0.95 | No evidence of risk |
| | DIAG6WK01 | Diagnostics waiting times: patients waiting over 6 weeks for a diagnostic test | 0.01 | 0.01 | No evidence of risk |
| | WT_CAN26 | All cancers: 62 day wait for first treatment from urgent GP referral | 0.82 | 0.85 | No evidence of risk |
| | WT_CAN27 | All cancers: 62 day wait for first treatment from NHS cancer screening referral | 0.96 | 0.9 | No evidence of risk |
| | WT_CAN22 | All cancers: 31 day wait from diagnosis | 0.98 | 0.96 | No evidence of risk |
| | CND_OPS02 | The proportion of patients whose operation was cancelled | 0.01 | 0.01 | No evidence of risk |
| | CND_OPS01 | The number of patients not treated within 28 days of last minute cancellation due to non-clinical reason | 0.1 | 0.07 | No evidence of risk |
| | AMBTURN06 | Proportion of ambulance journeys where the ambulance vehicle remained at hospital for more than 60 minutes | Not included | Not included | Not included |
| Discharge and Integration | DTC40 | Ratio of the total number of days delay in transfer from hospital to the total number of occupied beds | 0.04 | 0.02 | No evidence of risk |
| Reporting culture | NRLS14 | Consistency of reporting to the National Reporting and Learning System (NRLS) | 6 months of reporting | - | No evidence of risk |
| | SUSDQ | Data quality of trust returns to the HSCIC | - | - | No evidence of risk |
| | FFTRESP02 | Inpatients response rate from NHS England Friends and Family Test | 0.23 | 0.26 | No evidence of risk |
| Partners | MONITOR01 | Monitor - Governance risk rating | Not included | Not included | Not included |
| | TDA01 | TDA - Escalation score | 4 Material issue | - | Risk |
| | NTS12 | GMC National Training Survey – Trainee's overall satisfaction | Within Q2/IQR | - | No evidence of risk |
| Staff survey | STASURBG01 | NHS Staff Survey - Percentage of staff who would recommend the trust as a place to work or receive treatment | 0.62 | 0.64 | No evidence of risk |
| | NHSSTAFF04 | NHS Staff Survey - KF7. % staff appraised in last 12 months | 0.94 | 0.82 | No evidence of risk |
| | NHSSTAFF06 | NHS Staff Survey - KF9. Support from immediate managers | 0.65 | 0.65 | No evidence of risk |
| | NHSSTAFF07 | NHS Staff Survey - KF10. % staff receiving health and safety training in last 12 months | 0.73 | 0.74 | No evidence of risk |
| | NHSSTAFF11 | NHS Staff Survey - KF15. Fairness and effectiveness of incident reporting procedures | 0.63 | 0.63 | No evidence of risk |
| | NHSSTAFF16 | NHS Staff Survey - KF21. % reporting good communication between senior management and staff | 0.22 | 0.27 | No evidence of risk |

| Section | ID | Indicators | Observed | Expected | Risk? |
|---|---|---|---|---|---|
| Staffing | ESRSIC | Composite risk rating of ESR items relating to staff sickness rates | - | - | No evidence of risk |
| | ESRReg | Composite risk rating of ESR items relating to staff registration | - | - | No evidence of risk |
| | ESRTO | Composite risk rating of ESR items relating to staff turnover | - | - | Risk |
| | ESRSTAB | Composite risk rating of ESR items relating to staff stability | - | - | Risk |
| | ESRSUP | Composite risk rating of ESR items relating to staff support/ supervision | - | - | No evidence of risk |
| | ESRSTAFF | Composite risk rating of ESR items relating to ratio: Staff vs bed occupancy | - | - | No evidence of risk |
| | FLUVAC01 | Healthcare Worker Flu vaccination uptake | 0.51 | 0.48 | No evidence of risk |
| Qualitative intelligence | WHISTLEBLOW | Whistleblowing alerts | - | - | Elevated risk |
| | GMCconcerns | Serious Education Concerns | - | - | Elevated risk |
| | Safeguarding | Safeguarding concerns | - | - | No evidence of risk |
| | SYE | Your Experience | - | - | No evidence of risk |
| | NHSchoices | NHS Choices | - | - | No evidence of risk |
| | P_OPINION | Patient Opinion | - | - | No evidence of risk |
| | CQC_COM | CQC complaints | - | - | No evidence of risk |
| | PROV_COM | Provider complaints | - | - | No evidence of risk |

University Hospitals of Leicester NHS Trust

Appendix of indicators used in the composite mortality indicators

| Section | ID | Indicators | Risk? |
|---|---|---|---|
| Cardiological Conditions and Procedures | HESMORT24CU | In-hospital mortality: Cardiological conditions | No evidence of risk |
| | MORTAMI | Mortality outlier alert: Acute myocardial infarction | No evidence of risk |
| | MORTARRES | Mortality outlier alert: Cardiac arrest and ventricular fibrillation | No evidence of risk |
| | MORTCABGI | Mortality outlier alert: CABG (isolated first time) | No evidence of risk |
| | MORTCABGO | Mortality outlier alert: CABG (other) | No evidence of risk |
| | MORTCASUR | Mortality outlier alert: Adult cardiac surgery | No evidence of risk |
| | MORTCATH | Mortality outlier alert: Coronary atherosclerosis and other heart disease | No evidence of risk |
| | MORTCHF | Mortality outlier alert: Congestive heart failure; nonhypertensive | No evidence of risk |
| | MORTDYSRH | Mortality outlier alert: Cardiac dysrhythmias | No evidence of risk |
| | MORTHVD | Mortality outlier alert: Heart valve disorders | No evidence of risk |
| | MORTPHD | Mortality outlier alert: Pulmonary heart disease | No evidence of risk |
| Cerebrovascular Conditions | HESMORT21CU | In-hospital mortality: Cerebrovascular conditions | No evidence of risk |
| | MORTACD | Mortality outlier alert: Acute cerebrovascular disease | No evidence of risk |
| Dermatological Conditions | HESMORT35CU | In-hospital mortality: Dermatological conditions | No evidence of risk |
| | MORTSKINF | Mortality outlier alert: Skin and subcutaneous tissue infections | No evidence of risk |
| | MORTSKULC | Mortality outlier alert: Chronic ulcer of skin | No evidence of risk |
| Endocrinological Conditions | HESMORT29CU | In-hospital mortality: Endocrinological conditions | No evidence of risk |
| | MORTDIABWC | Mortality outlier alert: Diabetes mellitus with complications | No evidence of risk |
| | MORTDIABWOC | Mortality outlier alert: Diabetes mellitus without complications | No evidence of risk |
| | MORTFLUID | Mortality outlier alert: Fluid and electrolyte disorders | No evidence of risk |

| Section | ID | Indicators | Risk? |
|---|---|---|---|
| Gastroenterological and Hepatological Conditions and Procedures | HESMORT27CU | In-hospital mortality: Gastroenterological and hepatological conditions | No evidence of risk |
| | MORTALCLIV | Mortality outlier alert: Liver disease, alcohol-related | No evidence of risk |
| | MORTBILIA | Mortality outlier alert: Biliary tract disease | No evidence of risk |
| | MORTGASHAE | Mortality outlier alert: Gastrointestinal haemorrhage | No evidence of risk |
| | MORTGASN | Mortality outlier alert: Noninfectious gastroenteritis | No evidence of risk |
| | MORTINTOBS | Mortality outlier alert: Intestinal obstruction without hernia | No evidence of risk |
| | MORTOGAS | Mortality outlier alert: Other gastrointestinal disorders | No evidence of risk |
| | MORTOLIV | Mortality outlier alert: Other liver diseases | No evidence of risk |
| | MORTOPJEJ | Mortality outlier alert: Operations on jejunum | No evidence of risk |
| | MORTPERI | Mortality outlier alert: Peritonitis and intestinal abscess | No evidence of risk |
| | MORTTEPBI | Mortality outlier alert: Therapeutic endoscopic procedures on biliary tract | No evidence of risk |
| | MORTTEPLGI | Mortality outlier alert: Therapeutic endoscopic procedures on lower GI tract | No evidence of risk |
| | MORTTEPUGI | Mortality outlier alert: Therapeutic endoscopic procedures on upper GI tract | No evidence of risk |
| | MORTTOJI | Mortality outlier alert: Therapeutic operations on jejunum and ileum | No evidence of risk |
| Genito-Urinary Conditions | HESMORT31CU | In-hospital mortality: Genito-urinary conditions | No evidence of risk |
| | MORTUTI | Mortality outlier alert: Urinary tract infections | No evidence of risk |
| Haematological Conditions | HESMORT28CU | In-hospital mortality: Haematological conditions | No evidence of risk |
| | MORTDEFI | Mortality outlier alert: Deficiency and other anaemia | No evidence of risk |
| Infectious Diseases | HESMORT26CU | In-hospital mortality: Infectious diseases | No evidence of risk |
| | MORTSEPT | Mortality outlier alert: Septicaemia (except in labour) | No evidence of risk |
| Conditions Associated With Mental Health | HESMORT33CU | In-hospital mortality: Conditions associated with Mental health | Not included |
| | MORTSENI | Mortality outlier alert: Senility and organic mental disorders | No evidence of risk |
| Musculoskeletal Conditions | HESMORT36CU | In-hospital mortality: Musculoskeletal conditions | No evidence of risk |
| | MORTPATH | Mortality outlier alert: Pathological fracture | No evidence of risk |
| | MORTSPON | Mortality outlier alert: Spondylosis, intervertebral disc disorders, other back problems | No evidence of risk |

| Section | ID | Indicators | Risk? |
|---|---|---|---|
| Nephrological Conditions | HESMORT30CU | In-hospital mortality: Nephrological conditions | No evidence of risk |
| | MORTRENA | Mortality outlier alert: Acute and unspecified renal failure | No evidence of risk |
| | MORTRENC | Mortality outlier alert: Chronic renal failure | No evidence of risk |
| Neurological Conditions | HESMORT34CU | In-hospital mortality: Neurological conditions | No evidence of risk |
| | MORTEPIL | Mortality outlier alert: Epilepsy, convulsions | No evidence of risk |
| Paediatric and Congenital Disorders and Perinatal Mortality | HESMORT32CU | In-hospital mortality: Paediatric and congenital disorders | Risk |
| | MATPERIMOR | Maternity outlier alert: Perinatal mortality | No evidence of risk |
| Respiratory Conditions and Procedures | HESMORT25CU | In-hospital mortality: Respiratory conditions | No evidence of risk |
| | MORTASTHM | Mortality outlier alert: Asthma | No evidence of risk |
| | MORTBRONC | Mortality outlier alert: Acute bronchitis | No evidence of risk |
| | MORTCOPD | Mortality outlier alert: Chronic obstructive pulmonary disease and bronchiectasis | No evidence of risk |
| | MORTPLEU | Mortality outlier alert: Pleurisy, pneumothorax, pulmonary collapse | No evidence of risk |
| | MORTPNEU | Mortality outlier alert: Pneumonia | No evidence of risk |
| Trauma and Orthopaedic Conditions | HESMORT37CU | In-hospital mortality: Trauma and orthopaedic conditions | No evidence of risk |
| | MORTCRAN | Mortality outlier alert: Craniotomy for trauma | No evidence of risk |
| | MORTFNOF | Mortality outlier alert: Fracture of neck of femur (hip) | No evidence of risk |
| | MORTHFREP | Mortality outlier alert: Head of femur replacement | No evidence of risk |
| | MORTHIPREP | Mortality outlier alert: Hip replacement | No evidence of risk |
| | MORTINTINJ | Mortality outlier alert: Intracranial injury | No evidence of risk |
| | MORTOFRA | Mortality outlier alert: Other fractures | No evidence of risk |
| | MORTREDFB | Mortality outlier alert: Reduction of fracture of bone | No evidence of risk |
| | MORTREDFBL | Mortality outlier alert: Reduction of fracture of bone (upper/lower limb) | No evidence of risk |
| | MORTREDFNOF | Mortality outlier alert: Reduction of fracture of neck of femur | No evidence of risk |
| | MORTSHUN | Mortality outlier alert: Shunting for hydrocephalus | No evidence of risk |

| Section | ID | Indicators | Risk? |
|---|---|---|---|
| Vascular Conditions and Procedures | HESMORT23CU | In-hospital mortality: Vascular conditions | No evidence of risk |
| | MORTAMPUT | Mortality outlier alert: Amputation of leg | No evidence of risk |
| | MORTANEUR | Mortality outlier alert: Aortic, peripheral, and visceral artery aneurysms | No evidence of risk |
| | MORTCLIP | Mortality outlier alert: Clip and coil aneurysms | No evidence of risk |
| | MORTOFB | Mortality outlier alert: Other femoral bypass | No evidence of risk |
| | MORTPVA | Mortality outlier alert: Peripheral and visceral atherosclerosis | No evidence of risk |
| | MORTREPAAA | Mortality outlier alert: Repair of abdominal aortic aneurysm (AAA) | No evidence of risk |
| | MORTTOFA | Mortality outlier alert: Transluminal operations on the femoral artery | No evidence of risk |

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John Adler
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23 October 2013

Dear Mr Adler

**Wave 2 acute hospital inspection programme: January-March 2014**

I have now been the Chief Inspector of Hospitals at CQC for three months and we have carried out six acute trust inspections using the new approach that I outlined when I was appointed, with a further 12 scheduled to be inspected by Christmas.

On Thursday (24 October) I will be publishing a list of 19 acute trusts that we will inspect between January and March 2014. This will be the second wave of inspections using this new model and will let us build on the learning and improvements we have made during the 18 inspections in 'wave 1'.

**We will be inspecting your trust using the new CQC model as part of this second wave.** My colleagues will be in touch within the next fortnight regarding what this means in practical terms and with dates for our planned inspection. I wanted to let you know about your inclusion in 'wave 2' and thought it would be helpful if I gave you an overview of what this new model entails.

The new inspection teams will be large (over 20 people) and will be headed by a senior NHS clinician or executive, working alongside senior CQC inspectors. The teams include professional and clinical staff and other experts, including trained members of the public ('experts by experience'). Many of these are volunteers who came forward when I launched my new approach in July.

The teams will spend at least two full days at the trust inspecting every site that delivers acute services, and eight key service areas: A&E; acute medical pathways including the frail elderly; acute surgical pathways; critical care; maternity; paediatrics; end of life care and outpatients. The teams will look at other services where necessary, and for some trusts in 'wave 2' we will be testing methodology to look at community services provided by acute trusts.

The inspections are a mixture of announced and unannounced and may include inspections in the evenings and weekends, when we know people can experience poor care. Our inspection teams make better use of information and evidence to direct resources where they're most needed. Our analysts have developed new triggers to guide the teams on when, where and what to inspect. Before they inspect, the teams assess a wide range of

quantitative data, including information from our partners in the system, and information from the public.

Each inspection will provide the public with a clear picture of the quality of care in their local hospital, exposing poor and mediocre care and highlighting good and excellent care. We will look at whether the trust and each of the core services are safe; effective; caring; responsive to people's needs and well-led.

I will decide whether hospitals are rated as outstanding; good; requires improvement; or inadequate. If a hospital requires improvement or is inadequate, I will expect it to improve. Where there are failures in care, I will work with my colleagues at Monitor and the NHS Trust Development Authority to make sure that a clear programme is put in place to deal with the failure and hold people to account.

In the first wave of inspections we are piloting ratings at three of 18 trusts. For the second wave every trust will get a rating. Your inclusion in this wave means my inspection of care services at your trust will include ratings of each of the eight core services, and of the trust overall. By the end of 2015 my teams will have inspected and rated all acute hospitals in this way. You can find out more details on our website – visit www.cqc.org.uk and search for 'new acute hospital inspection model'.

I have made my choices for this second wave of inspections based on our assessment of risk; as follow-ups to the Keogh reviews carried out earlier this year; or depending on where trusts are in the Foundation Trust pipeline (we have considered the views of Monitor and the NHS Trust Development Authority). CQC is publishing details of its 'intelligent monitoring' of NHS trusts tomorrow alongside details of our second wave of acute inspections. You will have received our analysis for your trust and this will be made public on your page on our website tomorrow.

You will receive a follow up from CQC explaining in more detail what this will mean for you and your trust, including the dates on which we intend to inspect. Your CQC regional director should be able to answer general questions about the new model in the meantime, or you can contact Matthew Trainer (London regional director, who is overseeing the national delivery of this programme) at matthew.trainer@cqc.org.uk.

Thank you in advance for your co-operation, and I look forward to working with you in the near future.

Yours sincerely,

**Professor Sir Mike Richards**
**Chief Inspector of Hospitals**

Appendix D

# Care Quality Commission announces next phase of hospital inspections

**24 October 2013**

**CQC's new hospital inspection programme enters its second phase in January, with 19 acute trusts named today as the next trusts to be inspected using larger, expert teams that include professional and clinical staff and trained members of the public. These will be the first trusts to be given ratings by CQC.**

The first phase of inspections started in September. By December 2015, CQC will have inspected every NHS Trust. Each inspection seeks to answer five questions about services: are they safe, caring, effective, well-led and responsive to people's needs? Inspectors will then make a judgement about the quality and safety of the care people receive there. Care will be rated as outstanding, good, requiring improvement or inadequate.

The acute trusts to be included in the second phase have been selected for a number of reasons: they may receive an inspection because they are showing as higher risk in our new intelligent monitoring system. They may show as having an intermediate risk that allows us to test the intelligent monitoring tool or they may be aspirant foundation trusts that Monitor have asked us to look at. We will, as we promised, also be following up on trusts inspected by Sir Bruce Keogh.

**The next wave of inspections will cover University Hospitals of Leicester NHS Trust (Central)**

Our new way of inspecting makes better use of intelligent monitoring and expert inspection to assess performance. The selection of acute trusts for inspection has been informed by CQC's new intelligent monitoring tool developed by the regulator's analysts. Together with local information from partners and the public, intelligent monitoring helps us to decide when, where and what to inspect.

CQC's Chief Inspector of Hospitals, Professor Sir Mike Richards said: "As a doctor, I liken intelligent monitoring to a screening test; our inspection combined with intelligent monitoring provides the diagnosis, following which we make a judgement, which will in turn lead to action.

"Our intelligent monitoring helps to give us a good picture of risk within trusts, showing us where we need to focus our inspections. We aim to publish the results at regular intervals. They will provide the basis for constant contact with NHS hospitals and other NHS organisations, and may lead to inspections in response to particular issues."

As well as providing us with guidance on who we should inspect first, this helps us identify and respond more quickly to hospitals where there is a risk that people might not be receiving safe, effective, high quality care.

The intelligent monitoring is based on 150 indicators that look at a range of information including patient experience, staff experience and statistical measures of performance. The indicators relate to the five key questions CQC will ask of all services. The indicators are used to raise questions, not to make judgements about the quality of care. CQC's own considered judgements take the results of our intelligent monitoring and reports from other organisations into account and, importantly, what our inspectors find during inspections.

We have used the intelligent monitoring for acute trusts to help select the next acute trusts to be inspected. For mental health and community services, we have chosen a range of organisations to help us test and develop our models for integrated mental health services regulation and assessment of services delivered in the community. This will also advance our approach to how best to use intelligent monitoring for these services.

We are also today publishing the results of our intelligent monitoring for each acute trust. We will update and refine this information as we gain greater insight and receive more feedback about the quality and safety of care in trusts. We want trusts to use the information to help them improve their performance.

The intelligent monitoring tool has been welcomed by Professor the Lord Darzi of Denham, who said: There is a huge amount of data available about our health services, but to be useful it needs to be focused on those indicators that give the clearest picture of the quality of care. The intelligent monitoring tool helps CQC make best use of the data so it can look more deeply at issues of concern. It is an important development."

Dr Jennifer Dixon, Chief Executive of the Health Foundation and CQC Board member said: "It makes sense to use the wealth of routinely available data in the NHS to try to spot patterns which might identify or predict poor quality care for patients. The intelligent monitoring tool can never by itself be a crystal ball, but it is a great start and will surely develop over time."

**The next wave of inspections will cover the following trusts (listed in alphabetical order).**

## Acute trusts

### From the Band 1 of our intelligent monitoring

- Aintree University Hospital NHS FT (North)
- Heatherwood and Wexham Park Hospitals NHS FT (South)
- Homerton University Hospital NHS FT (London)
- Leeds Teaching Hospital NHS Trust (North)
- Northampton General Hospital NHS Trust (Central)
- Royal Berkshire NHS FT (South)

- **University Hospitals of Leicester NHS Trust (Central)**

### Foundation Trust aspirants

- Hull and East Yorkshire Hospitals NHS Trust (Band 2) (North)
- Oxford University Hospitals NHS Trust (Band 3) (South)
- Royal Cornwall Hospitals NHS Trust (Band 5) (South)
- St George's Healthcare NHS Trust (Band 6) (London)

### Keogh inspection follow ups

- Basildon and Thurrock University Hospitals NHS FT (Band 1) (Central)
- Blackpool Teaching Hospitals NHS FT (Band 2) (North)
- Buckinghamshire Healthcare NHS Trust (Band 1) (South)
- Dudley Group NHS FT (Band 4) (Central)

### Intermediate trusts

- East Kent Hospitals University NHS FT (Band 3) (South)
- Lewisham and Greenwich NHS Trust (Band 2) (London)
- Peterborough and Stamford Hospitals NHS FT (Band 6) (Central)
- University Hospitals of Morecambe Bay NHS FT (Band 5) (North)

## Mental health trusts/community health services

- Bridgewater Community Healthcare NHS Trust – FT applicant (Community - North)
- Central Essex Community Services (Provider) – Social Enterprise (Community – Central)
- Coventry and Warwickshire Partnership NHS Trust – FT applicant (Mental Health - Central)
- Derbyshire Community Health Services NHS Trust – FT applicant (Community - Central)
- Devon Partnership NHS Trust – FT applicant (Mental Health - South)
- Dudley and Walsall Mental Health Partnership NHS Trust, MH – FT applicant (Mental Health - Central)
- Solent NHS Trust – FT applicant (Combined - South)
- SW London and St George's Mental Health NHS Trust – FT applicant (Mental Health – London)

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Leicestershire Partnership NHS
NHS Trust

F

| TRUST BOARD PAPER - 31 OCTOBER 2013 | |
|---|---|
| **Title** | **Leicestershire Partnership Trust's Quality Improvement Programme** |

**Executive Summary**

**Introduction**

The Trust was issued with two warning notices by the Care Quality Commission in July 2013 and a 30 day plan to address immediate actions related to care planning and discharge planning was enacted, as reported previously to this Board.

**Outcome of the Risk Summit**

Due to the escalation of concerns about the Trust's adult mental health services a Risk Summit was convened on August 29 where local stakeholders and agencies came together to share their concerns with the Trust. Actions arising from the summit included:

1) The Trust was required to produce a Quality Improvement Programme to provide assurance that the necessary improvements to the safety and care of patients in the Trust's adult mental health services were being undertaken and could be sustained into the future.

2) The Trust was required to design and produce a regular SITREP (operational) report so that the Trust and commissioners could jointly examine staffing, bed occupancy and other operational matters on a daily/weekly basis for additional assurance, particularly with respect to patient safety.

3) That an Oversight and Assurance Group be formed to hold the Trust Board to account collectively

**Progress on Risk Summit Actions**

The SITREP was immediately designed with commissioners and has now been operating for 2 months.

The Oversight and Assurance Group was also immediately put into place and meets every two weeks convened by the NHS Trust Development Authority (TDA).

It was agreed that the Trust would develop the Quality Improvement Programme (QIP) collaboratively during September and October with a view to approval of the programme plan by the Oversight and Assurance Group and the Trust Board by the end of October.

The aim of this document is to provide a single, consolidated and coordinated plan of action to address the risks and issues raised, showing the timeframes for improvements to be made, how improvements will be measured, who is responsible for the respective elements of the programme and how the Trust will be held accountable for delivery internally and externally of the overall programme.

**The Development of the Quality Improvement Programme**

Over the last 8 weeks the QIP has been developed in partnership with a wide range of stakeholders including our leadership team, our clinical and operational staff, the NHS Trust Development Authority, local clinical commissioning groups, local authorities and their scrutiny committees, local Healthwatch, local service user groups, their advocates and voluntary sector organisations. A copy of the engagement plan is attached at Appendix A

The Trust is extremely grateful to all parties who have engaged in this intensive piece of work and for the opportunity to discuss the issues we have faced in an honest and transparent way throughout. The overall format of the QIP has been recommended by the Trust Development Authority.

**Measuring Achievement**

A feature of the QIP is the inclusion of specific metrics so that improvement can be evidenced over time, and where applicable a trajectory for improvement will be developed to show the scale and pace of change we are aiming for.

Some of the metrics already have established baselines and mechanisms for data collection. Others are new areas of focus or represent new ways of working, and therefore require the development of baseline information and additional mechanisms for collecting and analysing data. The programme indicates timescales for this work where appropriate.

In terms of governance arrangements, the delivery of the QIP will be governed internally via a new Quality Improvement Programme Board reporting directly into the Trust Board. Delivery will be assured by the Oversight and Assurance Group which was formed following the Risk Summit and which will hold the Trust Board to account externally for delivery.

The Oversight and Assurance Group is external to the Trust and chaired by the NHS Trust Development Authority (TDA).

The Oversight and Assurance Group is established for the period of time that the Trust's position is escalated to the TDA and will determine at which stage the Trust will be de-escalated with respect to the assurance achieved on the Quality Improvement Programme.

The role of the Oversight and Assurance Group is therefore as follows:

- Approve the Quality Improvement Programme

- Hold the Trust Board to account and assure the delivery of the programme externally
- Determine which specific actions from our programme are the ones that they wish to see achieved in order that we can be de-escalated; following which, the programme will continue to be assured by the Trust Board and its local commissioners, e.g. as business as usual.

**Cultural Change**

It is important to stress that much of this programme is about cultural change, including some important changes in professional practice and clinical leadership that have a direct impact on the safety, effectiveness and experience of care in the adult mental health unit (and elsewhere in the Trust).

We have also listened carefully to feedback from service users, voluntary sector groups, advocacy groups, councillors, and service users about where further cultural changes are needed from their perspective.

While these changes can and will be the subject of audit against key metrics in terms of quantitative measurement, the Trust is keen to ensure that equal emphasis is given to qualitative and softer measures of improvement.

The overall experience of staff and patients in the planning, delivery and experience of care is where we wish to see the greatest impact of these cultural changes. We expect to see this translated into improved public confidence in the quality of the Trust's services, and that there are tangible improvements in our leadership, accountability and transparency.

**Extending the programme across other aspects of the Trust's Business and Services**

While the QIP focuses primarily on adult mental health services, we have identified a number of thematic areas of the plan where action will be immediately extended across other clinical divisions.

We have also reflected in depth, as an organisation and as a Board, on the lessons learned from the July CQC report, and the events leading up to this at the Trust, along with various other aspects of the escalation period we have experienced. We are very aware of the impact this has had on our patients, staff, stakeholders and the public in general. Our discussions with local scrutiny committees have focused heavily on these matters.

Our overall approach to quality assurance and risk management is being fundamentally reviewed as a result of reflecting on lessons learned, including for example the introduction of improved early warning systems for our clinical services and a review of our approach to regulatory assurance, being led by our Chief Nurse.

**It is the Trust's ambition to use the QIP as an important stepping stone on our quality improvement journey. Through the QIP and work in hand to refresh our**

**quality strategy we must go well beyond "recovery" and aim again for excellence in line with our organisational vision.**

We recognise there are expectations internally and externally about demonstrating a stepped change in the pace of our actions and the impact they are having, but we also need to sustain improvement for the medium and longer term. The timescales we have set out in the QIP therefore intend to strike a balance between these two requirements.

Although the QIP will be the subject of the external Oversight and Assurance Group for the remedial period (e.g. until we are de-escalated by the TDA), the Trust will continue to develop and deliver its quality improvement plan on a rolling programme of work. The Quality Improvement Programme will therefore:

- Become business as usual
- Cut across all clinical services
- Remain top priority
- Be highly visible form ward to board.

We will continue to be open, honest and transparent about our progress and welcome all challenge and feedback on any aspect of our care and services at any time.

**Sharing our Learning**

Our experience may be valuable to other Trusts who face similar challenges in delivering sustainable high quality mental health care, especially given the escalating pressure this month on the overall capacity and quality of mental health care nationally and the introduction of the new CQC inspection regime.

We will actively share what we have learned for the benefit of other Trusts locally, regionally and nationally.

We are also responding to the new Chief Inspector of Hospital's national engagement about the methodology for assessing community and mental health trusts under the new CQC Inspection regime

**Recommendations**

The Trust Board is asked to:

- Approve in principle the Quality Improvement Programme and associated metrics subject to the approval of (and any amendments required) by the Oversight and Assurance group
- Approve the LPT governance arrangements, including establishing the Quality Improvement Programme Board with effect from November 2013

| | |
|---|---|
| **Related Trust Objectives** | • We will continuously improve quality and safety with services shaped from user and care experience, audit and research.<br>• We will build our reputation as a successful, inclusive organisation, working in partnership to improve health and |

| | |
|---|---|
| | wellbeing. |
| **Risk and Assurance** | The delivery of the QIP will provide measurable improvements in quality assurance for the care and treatment of patients in the adult mental health service and other clinical services within the Trust. |
| **Legal implications/ regulatory requirements** | The delivery of the QIP will provide improved assurance that CQC standards can be maintained in the medium term. Failure to maintain CQC regulatory standards can lead to fines and/or deregulation of the affected services. |
| **Presenter** | Peter Miller, Chief Executive |
| **Author(s)** | LPT Executive Team<br>Judy McCarthy, Head of Strategic Programme Office<br>Will Legge, Chief Information Officer |

Leicestershire Partnership NHS
NHS Trust

# *"Quality Improvement Programme"*



## A programme to achieve sustainable high quality adult mental health services so the Trust and its stakeholders can be confident about the quality of care for local service users

October 2013

# Contents

## Quality Improvement Programme

# 1. Introduction

In response to concerns raised at the Risk Summit on 29 August 2013, the Trust has worked with a wide range of people to develop this Quality Improvement Programme.

The programme contains a comprehensive set of activities to address specific risks identified following an inspection by the Care Quality Commission in July 2013, and a number of other related risks and issues of concern that have been raised by local commissioners, local Healthwatch, NHS England and the Trust Development Authority. All these matters were discussed in depth at the Risk Summit and at the inaugural meeting of the Oversight and Assurance Group held on 11th September 2013.

The aim of this document is to provide a single, consolidated and coordinated plan of action to address the risks and issues raised, showing the timeframes for improvements to be made, how improvements will be measured, who is responsible for the respective elements of the programme and how the Trust will be held accountable for delivery internally and externally of the overall programme.



The programme has been developed from a number of concerns identified by stakeholders:-

- Governance
- Workforce and Leadership
- Quality Strategy
- Quality Assurance
- Clinical and Operational Effectiveness;
- Cultural Change
- Transparency
- External Regulation + Reviews

A programme management approach will be undertaken to deliver this programme and report on progress. A programme management approach is already established within the Trust and is currently being used to manage delivery of the other service improvements in our clinical divisions.

## Scope

A number of serious concerns were raised about the quality of the Adult Mental Health inpatient service at the Bradgate Unit by the Care Quality Commission in their report following an inspection in July 2013. The Trust immediately initiated urgent work to address the report findings including the implications of two warning notices issued to the Trust which related to discharge planning and care planning.

While the Trust focused initially on these matters in July and August 2013, the Trust has since performed an intensive piece of work in September and October to develop a medium term Quality Improvement Programme. While the focus for this has primarily been for our Adult Mental Health service, the programme also recognises that high quality, safe services must be sustained across all our clinical divisions.

The culture of quality improvement and quality assurance within the organisation clearly needs further development so that lessons learnt from our Adult Mental Health service are fully embedded and readily transferred across other areas of the Trust. The programme therefore includes how we will create a stronger platform for quality through our refreshed quality strategy and put in place a much better system to alert the Trust from “ward to Board” to any future risks to deterioration in quality care across all our services.

The Quality Improvement Programme therefore has a number of aims that apply across all our clinical services as illustrated in the box on page 5 below.

## AIMS

- Ensuring the most effective care is provided in a person centred manner
- Service users (and wherever possible those that matter most to service users such as their carers, family members, friends) are actively involved in the decisions regarding their care
- Improving the safety, communication and service user involvement in the discharge process
- Ensuring safe staffing levels and a skill mix that takes into account all the factors that affect the intensity of care and support needed to address individual care plans
- Improving the quality of physical health care on mental health wards
- Improving the ease of developing and using care plans as well as embedding care plans within the care process
- Enhancing the skills of staff in the assessment and effective management of risk
- Providing support and creating opportunities for staff to learn continuously from practice (near misses, serious incident investigation recommendations, service users feedback) and reduce clinical variability
- Improving the patient experience, healing nature and safety of the environment
- Ensuring treatment and recovery focuses on the wider determinants of health and wellbeing (employment, housing, finances, social isolation etc.)
- Care provided is able to accommodate the needs of the individuals with diverse needs and backgrounds

## Principles for Improving

This Quality Improvement Programme has been designed to embed the following principles:

1) **Rights** - the programme is underpinned by the statutory requirements placed on all Trusts by the NHS Constitution and Duty of Candour

2) **Planning** – the Trust has a clear, consolidated programme of work that collectively meets the needs of our service users, the Trust and all stakeholders/agencies.

3) **Service User and public participation** – service users, their advocates and public representatives have played an important role in developing this Quality Improvement Programme. Clinicians, directors and staff are working together on the "Quality Improvement Programme Board" with these stakeholders and will continue to do so throughout the delivery of the programme, and as "business as usual" within the Trust. In developing the improvement activities we have listened carefully to the views of service users, their advocates, local voluntary sector organisations, county and city councillors, and our own democratically elected shadow council of governors

4) **Listening to the views of staff** – the Trust is committed to improving staff experience and the levels of staff engagement and staff satisfaction. There are a number of established ways in which the Trust seeks the views of staff including formal consultative forums, the annual NHS staff survey and the Trust's local quarterly pulse surveys, staff support groups and the Trust's various feedback mechanisms which have been further strengthened this year by adopting to the "speak out safely campaign" which actively encourages staff to raise concerns about care quality. Staff views are also obtained through some of the mechanisms established to improve patient experience including the 'Changing your Experience for the Better' programme and Trust Board member visits to clinical areas. The Listening into Action (LiA) programme also brings staff together to share their thoughts and ideas and make improvements together. The Trust has already captured a large range of staff views through large engagement events, and is currently rolling out the programme to the first set of teams within the Trust and putting place the quick wins that have been prioritised.

5) **Openness and transparency** – all possible information and intelligence relating to the quality of the care provided to our patients has been and will continue to be made available to our partners and stakeholders including our Shadow Council of Governors, local Clinical Commissioning Groups, local Healthwatch, Patients' Panel, Staffside representatives, the Care Quality Commission (CQC), the General Medical Council (GMC), Health Education East of England (HEEoE), the NHS Trust Development Authority (NTDA) and NHS England. The Trust continues to be open to expertise from outside of the Trust and welcomes this advice and expertise. The Trust Board recognises its role in promoting this work and being held accountable. The Trust Board continues to challenge itself and take on board feedback from all parties on the type, quantity and quality of information shared in the public domain whether via our public meetings, website, newsletters, media, social media and other routes.

6) **Cooperation between organisations** – this programme has been built around strong cooperation between all of the different organisations that make up the local health and care system, placing the interests of service users first at all times.

7) **Leadership** - this programme recognises the development needs of clinical and managerial leaders within the Trust and has been designed so that improvements can be made in the management culture of the organisation from ward to Board, with the Board promoting a leadership style built on service user centred values.

# 2. Background

## Context

On 30 July 2013 the Trust was served with two Warning Notices, in line with the CQC Enforcement Policy, against the Bradgate Mental Health Unit registered location. In addition the unit was also judged as non-compliant with three Outcomes resulting in three Compliance actions against Outcomes 7, 14 and 16.

| | | |
|---|---|---|
| **Outcome 4** | **Care and welfare of people who use services** | **Warning Notice** |
| **Outcome 6** | **Cooperating with other providers** | **Warning Notice** |
| Outcome 7 | Safeguarding people who use services from abuse | Compliance Action |
| Outcome 14 | Supporting workers | Compliance Action |
| Outcome 16 | Assessing and monitoring the quality of service provision. | Compliance Action |



The inspection report was published on 20 August and is available on the CQC web site. The report and Enforcement notices were shared at the Trust public Board meeting on Thursday 29 August 2013.

An action plan was sent to the CQC on Wednesday 4 September 2013 and on Thursday 5 September 2013 and Friday 6 September 2013 requests were received for the provision of further information.

On Monday 9 September 2013 the CQC returned to the unit to review progress against the two Warning Notices.

## The population and communities we serve

The following characteristics summarise the population we serve.

- A catchment population of approximately one million people living within the city of Leicester and the surrounding counties of Leicestershire and Rutland.
- In common with the national pattern, more boys are born than girls; however as women tend to live longer, the ratio of males to females is approximately 50:50.
- Our local catchment area falls within the boundaries of NHS Midlands and East, in which we play an active role in the provision of specialist services on a wider regional basis.
- We relate to three local authorities, seven district and borough councils, and three Clinical Commissioning Groups.
- The City of Leicester and counties of Leicestershire and Rutland bring together a rich mix of urban, suburban and rural districts, diverse in cultural heritage and ethnicity.
- The total Leicester City population as at 2012 is 331,606 which represents an 18% increase since 2001.
- Deprivation is a significant issue for many of our citizens. Almost half of our population is highly disadvantaged. Of the 152 local authority areas in the UK, Leicester has the 20th most deprived population, with almost half of these people living in the fifth most deprived areas in England.
- Rutland residents and the majority of the population in South Leicestershire have above average levels of affluence compared to the rest of England. However, there are pockets of relative deprivation concentrated mainly in urban areas.
- The majority of the population who live in Leicestershire County and Rutland are white British (91% and 97% respectively)[1], whilst Leicester City has a more diverse population than England overall, with approximately 50% from Black and minority ethnic groups (BME). The majority of Leicester's BME population are South Asian, with 37% from Indian background.[1]
- There are also a significant populations from other countries such as Eastern Europe, who also represent diversity, but are not represented in BME statistics.
- In addition, the population figures are not well established for other vulnerable groups such as asylum seekers and those with protected characteristics under the equalities act, such as lesbian, gay, bi sexual and transgender people.
- A large number of students live in Leicester, and therefore there is a youthful population with almost half aged under 29, and that number is increasing. There is a higher proportion of people in the older adult categories in Leicestershire County and Rutland.

[1] 2011 figures from Office for National Statistics

- The populations of both the City and Counties are forecast to increase by 2015. There will be significant growth in the 0 – 14 age group and those of working age in Leicester City with lower, albeit significant growth, in the over 65s. This pattern is counter to that seen in the Counties where the major growth is in the over 65 age groups.

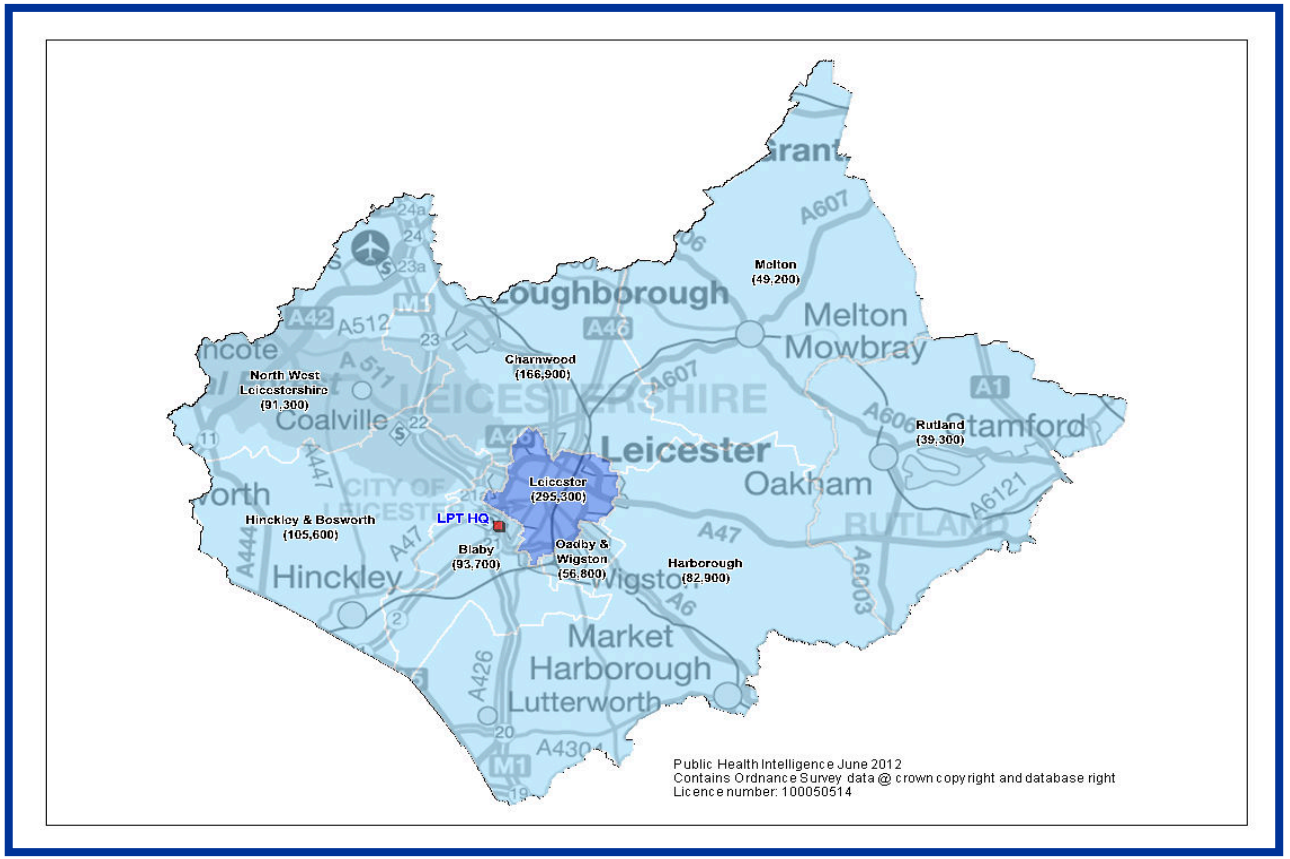
## Our commissioners

Our services are commissioned primarily by the three Clinical Commissioning Groups of Leicester, Leicestershire and Rutland, authorised in 2012, these are:

- West Leicestershire
- East Leicestershire and Rutland
- Leicester City
- Some of the Trust's services are also commissioned on a regional/national basis through specialist commissioning

The counties of Leicestershire and Rutland are generally more affluent and less ethnically diverse, with demography older than the national average. There are approximately 680,000 people living mainly in suburban areas and market towns, with pockets of deprivation and approximately 12% of people living in isolated rural villages.

## Area Map


Loughborough
Melton
(49,200)
Melton
Mowbray
Charnwood
(166,900)
North West
Leicestershire
(91,300)
Coalville
LEICESTERSHIRE
Leicester
Leicester
(295,300)
Oakham
Rutland
(39,300)
Stamford
LPT HQ
Hinckley & Bosworth
(105,600)
Hinckley
Blaby
(93,700)
Oadby &
Wigston
(56,800)
Harborough
(82,900)
Market
Harborough
Lutterworth
A607
A46
A512
A42
A47
A426
A6
A1
A6003
A6121
A4304
M1
Public Health Intelligence June 2012
Contains Ordnance Survey data @ crown copyright and database right
Licence number: 100050514

## Health and Care Economy

We operate primarily within the health and social care economies of LLR and work with three corresponding local authorities and seven district councils.

### Local Authorities:

- Leicester City Council
- Leicestershire County Council
- Rutland County Council

### District Councils:

- Blaby District Council
- Charnwood Borough Council
- Harborough District Council
- Hinckley and Bosworth District Council
- Melton Borough Council
- North West Leicestershire District Council
- Oadby and Wigston Borough Council



## The Service User's Perspective

The ability to listen to what matters to people who use and experience our services, and the views of those who matter most to them (e.g. carers, friends, family) and to act on this feedback is the Trust's method of demonstrating its values being turned into action. Demonstrating that we have listened and made changes also underpins our dedication to being an open and transparent organisation.

The Friends and Family Test (FFT) is a national tool based on the commercial Net Promoter Score Test and is a tool used for providing a simple, headline metric, which when combined with a follow up question and triangulated with other forms of feedback, can be used across services to drive a culture of change, recognising and sharing good practice. The overall aim of the process is to identify ways of improving the quality of care and experience of the service users (and those who matter most to them) using NHS services in England

The Trust is participating in a national pilot to roll out the FFT to other services outside of the acute sector, which is the main area of NHS care where the test is currently formally applied and reported. We are feeding back our experience of using this test with our service users in community and mental health services, and have been giving our views of how the test may need adapting in these settings. As part of this we are also working with local commissioners and we have agreed that a further roll-out of the FFT across priority services would provide useful information to the Trust in line with its plans to introduce the 'Changing Your Experience for the Better' programme across all clinical areas. The FFT is used in that context as a baseline and improvement measurement, alongside feedback data from the customer services team (from complaints, concerns and compliments) and through the Trust's Staff Listening into Action Engagement Programme, staff pulse surveys and the annual staff survey.

# 3. Governance



The Trust has a number of systems and processes in place to provide assurance to the Trust Board and other key stakeholders about the governance of the organisation. These include a committee structure, a risk management system and strategy, a comprehensive risk register and an escalation framework to ensure Trust Board members are aware of all risks to the successful delivery of the organisations key strategic objectives.

In order to place focus on this programme of work a Quality Improvement Programme Board will be established within the Trust. This will be chaired by the Chief Operating Officer, (or Medical Director and Chief Nurse in their absence), and will consist of representatives from each of the divisions. Terms of reference and membership for the Quality Improvement Board are being finalised by early November, and will be published on our website as soon as possible. The first meeting of the Quality Improvement Programme Board will take place in November.

As part of the assurance process, the Quality Improvement Programme Board will develop a risk register to ensure where progress is not being made as quickly as expected, mitigating actions are put in place.

The Quality Improvement Programme Board will be held to account by the Trust Board who will receive the minutes of the Programme Board and the risk register on a monthly basis.

The Quality Improvement Programme Board will provide assurance to the Trust Board, on a monthly basis, regarding the delivery of the programme, including highlighting any risks to delivery and the mitigating actions being taken to ameliorate those risks.

The Quality Improvement Programme Board activities will also be considered by the Trust's existing Quality Assurance Committee (http://www.leicspart.nhs.uk/Library/QAC_TOR.pdf

The Oversight and Assurance Group is external to the Trust and chaired by the NHS Trust Development Authority. The Oversight and Assurance Group is set up for the period of time that the Trust's position is escalated to the NHS Trust Development Authority and will determine at which stage the Trust will be de-escalated with respect to the assurance achieved on the quality improvement programme. The role of the Oversight and Assurance Group is therefore as follows:

- Approve the programme of work assure the delivery externally
- Determine (during November 2013) which specific actions from our programme are the ones that they wish to see achieved in order that we can be de-escalated - following which the programme will continue to be assured by the Trust Board and its local commissioners, e.g. as business as usual.



The programme will be signed off and closed when all actions have been delivered and the Trust Board, in conjunction with key stakeholders, have received adequate assurance that the programme has been completely delivered and the improvements are sustainable.

However the Trust Board will adopt the Quality Improvement Programme approach and roll it out to other areas of the Trust. When this happens, our progress will be very clear and transparent both in terms of the completion of the programme of work shown in this document and the addition/roll out to other areas of our business, with regular reports via our public Trust Board meetings.

Also our engagement and communication about our Quality Improvement Programme will continue throughout the delivery of this programme of work and into any extension into other areas of the Trust's work. Therefore local scrutiny committees, local VCS organisations, health and wellbeing boards, service user groups, our council of governors, and many others will continue to be closely engaged in our progress and will continue to shape our future aspirations.

# Governance Structure

# 4.Programme Baselines

| Ref | Theme | Metric | Target | Baseline | Timescale | Lead |
|---|---|---|---|---|---|---|
| 1 | Crisis Support (CRHT) | Delivery of CRHT against operational framework (by audit) | 100% | Action plan in place to establish baselines | 01/02/2014 | Chief Operating Officer |
| 2 | Crisis Support (CRHT) | Adherence to the new CRHT shift handover protocol being implemented by January 2014 | 100% | New initiative; baseline to be established | 01/02/2014 | Chief Operating Officer |
| 3 | Crisis Support (CRHT) | SitRep for CRHT implemented and achieving tolerance levels across staffing metrics | 80% | New initiative; SitRep to be designed and implemented with Commissioners | 01/05/2014 | Chief Operating Officer |
| 4 | Pre-Admission | Transmission of complete care information with out of area placement providers upon placement within 24 hours | 100% | New initiative; based on checklist implementation | 01/02/2014 | Chief Operating Officer |
| 5 | Pre-Admission | Bed Occupancy level | 85% | 91.8% @ Sept 2013 | 31/03/2014 | Chief Operating Officer |
| 6 | Pre-Admission | Delayed Transfer of Care | ≤ 7.5% | 5.7% @ Sept 2013 | 01/11/2014 | Chief Operating Officer |
| 7 | Pre-Admission | Average Length of Stay | 30 days | 34.6 days @ Sept 2013 | 03/06/2014 | Chief Operating Officer |
| 8 | Pre-Admission | Number of out of area placements | ≤ 20 | 26 @ 17.10.13 | 30/03/2014 | Chief Operating Officer |
| 9 | Admission | Number of MDT assessment templates completed on admission (by audit) | 100% | New initiative; baseline to be established | 01/05/2014 | Medical Director |
| 10 | Admission | Number of service users (and wherever possible those that matter most to service users such as their carers, family members, friends) involved in their care planning (by audit) | 100% | 71% @ Sept 2013 | 01/02/2014 | Chief Nurse |
| 11 | Admission | Number of admissions seen by a senior doctor within 48 hours (by audit) | 100% | New initiative; baseline to be established | 01/03/2104 | Medical Director |

| Ref | Theme | Metric | Target | Baseline | Timescale | Lead |
|---|---|---|---|---|---|---|
| 12 | On-going care on the In-patient Unit | Adherence to service user leave protocols (by audit) | 100% | Action plan in place to establish baselines | 01/05/2014 | Chief Nurse |
| 13 | On-going care on the In-patient Unit | Number of service users offered advocacy where clinically appropriate (by audit) | 80% | New initiative; baseline to be established | 31/12/2013 | Chief Nurse |
| 14 | On-going care on the In-patient Unit | Number of staff with current valid therapeutic observation of patients training | 85% | 90.1% @ Aug 2013 | 01/12/2013 | Director of HR & OD |
| 15 | On-going care on the In-patient Unit | Number of scheduled weekly ward rounds attended by nurse and doctor versus plan | 100% | 100% @ 21/10/13 | 01/02/2014 | Medical Director |
| 16 | On-going care on the In-patient Unit | Number of service users (and wherever possible those that matter most to service users such as their carers, family members, friends) involved in their care planning (by audit) | 100% | 71% @ Sept 2013 | 01/02/2014 | Chief Nurse |
| 17 | Discharge | Number of care plans reflecting discharge planning (by audit) | 90% | 59% @ Sept 2013 | 01/02/2014 | Chief Nurse |
| 18 | Discharge | Number of service users (and wherever possible those that matter most to service users such as their carers, family members, friends) involved in their discharge planning (by survey) | 80% (*Set at 80% in recognition of those people who decline to be involved)* | 67% @ Dec 2012 | 01/11/2014 | Chief Nurse |
| 19 | Discharge | Continuity of care from the same consultant/community worker | 80% | New initiative; baseline to be established | 01/04/2014 | Chief Operating Officer |
| 20 | Staffing | 60:40 skill mix qualified / unqualified ratio achieved on the Bradgate Unit | 100% | New initiative; recruitment trajectory in place | 01/05/2014 | Chief Operating Officer |
| 21 | Staffing | 5 / 5 / 3 staffing levels achieved on the Bradgate Unit | 100% | 100% @ 17/10/13 | 01/11/2013 | Chief Operating Officer |
| 22 | Physical Healthcare | Number of care plans reflecting physical healthcare needs where identified (by audit) | 100% | 90% @ Sept 2013 | 01/05/2014 | Chief Nurse |
| 23 | Physical Healthcare | Number of physical healthcare assessments undertaken versus admissions (by audit) | 100% | 92% @ Sept 2013 | 01/05/2014 | Chief Nurse |

| Ref | Theme | Metric | Target | Baseline | Timescale | Lead |
|---|---|---|---|---|---|---|
| 24 | People with Personality Disorder | Number of Bradgate Unit staff with current valid personality disorder training, against plan | 80% | Training commences Nov 2013; baseline data captured from 1st cohort Nov 2013 | 01/11/2014 | Medical Director |
| 25 | Risk Assessment | Complete risk assessment documentation present in care record for current episode of care | 100% | 92% @ Sept 2013 | 01/03/2014 | Chief Nurse |
| 26 | Risk Assessment | Number of staff with current valid risk assessment training | 80% | 92.1% @ Sept 2013 | 01/05/2014 | Chief Nurse |
| 27 | Handover | Adherence to In-patient handover protocol (by audit) | 100% | New initiative; baseline to be established | 01/01/2014 | Chief Nurse |
| 28 | Continuous learning & staff support | Number of debriefing sessions versus number of violent incidents and Serious Incidents reported | 100% | New initiative; baseline to be established | 01/01/2014 | Chief Nurse |
| 29 | Continuous learning & staff support | Attendance rate of MDT learning forums against Terms of Reference | 80% | New initiative; baseline to be established | 01/01/2014 | Medical Director |
| 30 | Continuous learning & staff support | Number of MDT learning forums held versus plan | 100% | New initiative; baseline to be established | 01/01/2014 | Medical Director |
| 31 | Improvement of the environment | Adherence of staff to seclusion process and policy (by audit) | 100% | Action plan in place to establish baselines | 01/05/2014 | Medical Director |
| 32 | Improvement of the environment | Adherence of all seclusion environments to national standard | 100% | Baseline will be set by environmental audit | Dependent upon scale of work | Chief Operating Officer |
| 33 | Improvement of the environment | Number of ligature assessments undertaken in the Bradgate Unit | 100% | All In-patient wards completed | 01/12/2013 Non In-patient areas | Chief Operating Officer |
| 34 | Improvement of the environment | Improvement in PLACE survey results | 90% | PLACE baselines (Sept 2013):<br>• Cleanliness: 87.37%<br>• Condition, appearance and maintenance: 75.12%<br>• Privacy, dignity and wellbeing: 81.96%<br>• Food and hydration: 84.79% | Dependent upon scale of work and 2014 PLACE assessments | Chief Operating Officer |

| Ref | Theme | Metric | Target | Baseline | Timescale | Lead |
|---|---|---|---|---|---|---|
| 35 | Equality | Documented consideration of Equality & Diversity patient needs in care plan | 100% | 87%@ Sept 2013 | 01/05/2014 | Chief Nurse |
| 36 | Equality | Number of staff trained in Equality & Diversity Training | 80% | 96.1%@ Sept 2013 | 01/11/2014 | Director of HR & OD |

# Governance

## Improving the acute care pathway

## Crisis Support (CRHT)

Aim – enhanced level of crisis support

| Theme | Mapped to | Action | Supporting Action | Lead | Timescale |
|---|---|---|---|---|---|
| *Improving the response, efficiency and quality of assessment and support provided to patients with acute mental health problems* | **Keogh area of improvement:**<br>- *Patient experience*<br>- *Safety*<br>- *Workforce*<br>- *Clinical and operational effectiveness*<br>- *Leadership & governance* | **1. Thematic analysis of Serious Incidents within CRHT.**<br>a. Implement the recommendations from the thematic review of serious incidents | | Chief Nurse | 31/03/2014 |
| | **SI 133782 actions 2 and 3 commission internal review of handover between shifts in AMH SPA and review delegation of tasks between SPA and Acute Assessment and Home Treatment**<br><br>**Keogh area of improvement:**<br>- *Clinical and operational effectiveness*<br>- *Leadership & governance* | **2. Office based co-ordinator on each shift to ensure safe allocation of work and hand over between shifts**<br>a. Documented protocol for CRHT handover<br>b. Initial role description for the co-ordinator | Assess the quality of the allocation of cases by co-ordinators | Chief Operating Officer | 01/02/2014 |
| | | | Develop a trajectory to improve the allocation of cases by co-ordinators to the appropriate level of staff/skill mix (qualified or unqualified) | Chief Operating Officer | 01/02/2014 |
| | | | Develop a trajectory for measuring improvements in handover effectiveness | Chief Operating Officer | 01/02/2014 |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | |
| | **Keogh area of improvement:**<br>- *Safety*<br>- *Clinical and operational effectiveness*<br>- *Workforce* | **3. Provide routine assurance information against current service model/staffing.** | Implement a SitRep report for CRHT | Chief Operating Officer | 01/05/2014 |
| | **Keogh area of improvement:**<br>- *Patient experience*<br>- *Safety*<br>- *Workforce*<br>- *Clinical and operational effectiveness*<br>- *Leadership & governance* | **4. Co-produce a longer term service model, based on a more detailed diagnostic with the CCG's** | An agreed new service model with commissioners<br><br>Implement new service model | Chief Operating Officer | 31/03/2014 |
| | **Keogh area of improvement:**<br>- *Patient experience*<br>- *Safety*<br>- *Clinical and operational effectiveness* | **5. Refresh/agree between AMH and commissioners the definitions of risk levels and thresholds for CHRT assessment within the agreed timeframes within the triage process. (2hrs, 4 hrs, 72hrs – may need to revisit these time spans especially the 4-72hrs)** | | Medical Director | 01/05/2014 |

| CRHT Baselines | | | | | | |
|---|---|---|---|---|---|---|
| **Ref** | **Theme** | **Metric** | **Target** | **Baseline** | **Timescale** | **Lead** |
| 1 | Crisis Support (CRHT) | Delivery of CRHT against operational framework (by audit) | 100% | Action plan in place to establish baselines | 01/02/2014 | Chief Operating Officer |
| 2 | Crisis Support (CRHT) | Adherence to the new CRHT shift handover protocol being implemented by January 2014 | 100% | New initiative; baseline to be established | 01/02/2014 | Chief Operating Officer |
| 3 | Crisis Support (CRHT) | SitRep for CRHT implemented and achieving tolerance levels across staffing metrics | 80% | New initiative; SitRep to be designed and implemented with Commissioners | 01/05/2014 | Chief Operating Officer |

| Pre-admission<br>To ensure a speedy and well-co-ordinated process for admission | | | | | |
|---|---|---|---|---|---|
| **Theme** | **Mapped to** | **Action** | **Supporting Action** | **Lead** | **Timescale** |
| *Improving the quality of care and patient safety throughout the process of the admission* | **Keogh area of improvement:**<br>- *Patient experience*<br>- *Safety*<br>- *Clinical and operational effectiveness* | **1. Address the bed capacity position for AMH patients**<br>a. Review bed capacity/configuration and ward configuration to achieve sustainable occupancy levels<br>b. Implement solutions by agreement with commissioners | Set a baseline and trajectory for sustainable occupancy levels underpinned by benchmarking data | Chief Operating Officer | 31/12/2013 |
| | | | Set baseline and trajectory for ALOS | Chief Operating Officer | 31/12/2013 |
| | | | Set baseline and trajectory for DTOC | Chief Operating Officer | 31/12/2013 |
| | | | Set baseline and trajectory for reducing out of area placements | Chief Operating Officer | 31/12/2013 |
| | | | *DN: Additional metrics will be developed in line with the actions that come out of the review such as the availability and uptake of alternatives to admissions such as step up and step down beds/access to suitable housing solutions/crisis house etc.* | | |
| | **Keogh area of improvement:**<br>- *Patient experience*<br>- *Safety*<br>- *Clinical and operational effectiveness*<br>- *Leadership & governance* | **2. Streamline admission and gate keeping to avoid duplication**<br>a. Adhere to the assessment protocol<br>b. Set a standard for the time between agreement to admit and admission taking place<br>c. Checklist of core information to be provided between admitting team and inpatient team including 'out of area' placements | Measure adherence to the admit time standard | Chief Operating Officer | 01/02/2014 |
| | | | Measure the reduction in the duplication of assessments between different parts of the AMH team | Chief Operating Officer | 01/02/2014 |
| | **Keogh area of improvement:**<br>- *Patient experience*<br>- *Safety*<br>- *Clinical and operational effectiveness*<br>- *Leadership & governance* | **3. Ensure robust process in place for sharing of information/contact with out of county providers** | Set trajectory for the percentage completeness of transmission of the information within 24 hours (with agreed valid exceptions) for admitting service users within LLR and 'out of area' | Chief Operating Officer | 01/02/2014 |

| Pre-admission Baselines | | | | | | |
|---|---|---|---|---|---|---|
| **Ref** | **Theme** | **Metric** | **Target** | **Baseline** | **Timescale** | **Lead** |
| 4 | Pre-Admission | Transmission of complete care information with out of area placement providers upon placement within 24 hours | 100% | New initiative; based on checklist implementation | 01/02/2014 | Chief Operating Officer |
| 5 | Pre-Admission | Bed Occupancy level | 85% | 91.8% @ Sept 2013 | 31/03/2014 | Chief Operating Officer |
| 6 | Pre-Admission | Delayed Transfer of Care | ≤ 7.5% | 5.7% @ Sept 2013 | 01/11/2014 | Chief Operating Officer |
| 7 | Pre-Admission | Average Length of Stay | 30 days | 34.6 days @ Sept 2013 | 03/06/2014 | Chief Operating Officer |
| 8 | Pre-Admission | Number of out of area placements | ≤ 20 | 26 @ 17.10.13 | 30/03/2014 | Chief Operating Officer |

| Admission<br>To ensure a thorough assessment and development of a good quality care plan | | | | | |
|---|---|---|---|---|---|
| **Theme** | **Mapped to** | **Action** | **Supporting Action** | **Lead** | **Timescale** |
| *Improving the quality and effective-ness of clinical care in the first 72 hours of Inpatient stay* | **Keogh area of improvement:**<br>- *Patient experience*<br>- *Safety*<br>- *Clinical and operational effectiveness*<br>- *Leadership & governance* | **1. Develop a multi-disciplinary assessment template and process** | | Medical Director | 01/02/2014 |
| | **The results of the AMH Inpatient Survey is being presented on 28 October –action plan will follow**<br><br>**Keogh area of improvement:**<br>- *Patient experience*<br>- *Safety*<br>- *Clinical and operational effectiveness* | **2. Those most important to the individual (e.g. carer, family or friends) involvement**<br>a. Pilot introduction of entry and exit questionnaires for service users (and wherever possible those that matter most to service users such as their carers, family members, friends) to test experience of care levels of engagement (e.g. exit questionnaires to assess – *were your needs met?)*<br>b. Admission checklist to capture specific actions and data wherever possible for those that matter most to service users such as their carers, family members, friends) engagement<br>c. Contact GP to advise patient admitted and LPT to extract relevant patient information from the GP within 24 hours (service user summary/discussion where possible) | Measure adherence to admissions checklist in relation to wherever possible those that matter most to service users such as their carers, family members, friends), engagement and GP contact<br><br>The wards will complete a *Triangle of Care* self-assessment in order to establish a baseline and understand the potential gaps for the involvement and communication with those most important to the individual (e.g. carers, family or friends).<br><br>Following the self- assessment, actions will be identified and support will be provided in order to address any areas of weakness by the Trust's Patient Experience team. | Medical Director | 01/05/2014 |

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|---|---|---|---|---|---|
| | **Keogh area of improvement:**<br>- *Patient experience*<br>- *Safety*<br>- *Clinical and operational effectiveness* | **3. Seen by senior doctor within the first 48 hours** | Set baseline and trajectory to achieve 100% of admissions being seen by a senior doctor within 48 hours | Medical Director | 01/03/2014 |
| | **Appleby action plan action 9.1 – Access and Community Services Interface Meeting to review information sharing**<br><br>**Keogh area of improvement:**<br>- *Patient experience*<br>- *Safety*<br>- *Clinical and operational effectiveness*<br>- *Leadership & governance* | **4. Sharing information between community and Inpatient team**<br>a. Develop an operating protocol for sharing information with community services (inpatient and named nurse and CPN regular contact) | | Medical Director | 01/05/2014 |

| Admission baselines | | | | | | |
|---|---|---|---|---|---|---|
| **Ref** | **Theme** | **Metric** | **Target** | **Baseline** | **Timescale** | **Lead** |
| 9 | Admission | Number of MDT assessment templates completed on admission (by audit) | 100% | New initiative; baseline to be established | 01/05/2014 | Medical Director |
| 10 | Admission | Number of service users (and wherever possible those that matter most to service users such as their carers, family members, friends) involved in their care planning (by audit) | 100% | 71% @ Sept 2013 | 01/02/2014 | Chief Nurse |
| 11 | Admission | Number of admissions seen by a senior doctor within 48 hours (by audit) | 100% | New initiative; baseline to be established | 01/03/2104 | Medical Director |

| On-going care on the Inpatient Unit<br>To improve the quality of inpatient care | | | | | |
|---|---|---|---|---|---|
| **Theme** | **Mapped to** | **Action** | **Supporting Action** | **Lead** | **Timescale** |
| *Ensuring the most effective care is provided in a person centred manner.*<br><br>*Patient, and wherever possible, carers / family are actively involved in the decisions regarding their care* | **CQC Action Plan – Outcome 4, no. 2**<br>**Review of patient involvement in care plans**<br><br>**Keogh area of improvement:**<br>- *Patient experience*<br>- *Clinical and operational effectiveness*<br>- *Leadership & governance* | **1. Service user led care**<br>a. Demonstrate improvements in service user(and wherever possible those that matter most to service users such as their carers, family members, friends) involvement in care planning | Measure service user, (and wherever possible those that matter most to service users such as their carers, family members, friends) satisfaction and experience through; | Chief Nurse | 01/02/2014 |
| | | | • the entry and exit questionnaires | Chief Nurse | 01/02/2014 |
| | | | • impact of VCS ward forums | Chief Nurse | 01/02/2014 |
| | | | • regular audit of care plans/discharge plans | Chief Nurse | 01/02/2014 |
| | **Quality Schedule LR 2**<br><br>**Keogh area of improvement:**<br>- *Patient experience*<br>- *Safety*<br>- *Clinical and operational effectiveness*<br>- *Leadership & governance* | **2. Redefine and monitor the daily ward reviews**<br>a. Review the process and template used | | Medical Director | 01/02/2014 |

| | | | | | |
|---|---|---|---|---|---|
| | **Keogh area of improvement:**<br>- *Patient experience*<br>- *Safety*<br>- *Clinical and operational effectiveness* | **3. One to one sessions for service users**<br>a. Ensure service users are<br>• Seen weekly by a senior doctor<br>• Receive a 1:1 session with a junior doctor<br>b. Ensure service users<br>• Receive two 1:1 sessions per week with their named nurse | | Medical Director | 01/02/2014 |
| | **Appleby action plan action 7.2 – Review of clinical psychology provision to wards**<br><br>**Keogh area of improvement:**<br>- *Patient experience*<br>- *Safety*<br>- *Clinical and operational effectiveness* | **4. Review the provision of psychological therapy on the wards**<br>a. Define and agree the model of psychological therapy we are aiming for across the inpatient areas and benchmark<br>b. Consider models from elsewhere<br>c. Agree how much improvement can be generated by improved nurse skill mix on the wards and what represents additional investment | Measure achievement of agreed levels of support against a trajectory | Chief Operating Officer | 31/03/2014 |
| | **Appleby action plan action 6.1 – development of prompt cards for observation**<br><br>**Keogh area of improvement:**<br>- *Patient experience*<br>- *Safety*<br>- *Workforce*<br>- *Clinical and operational effectiveness* | **5. Training and education for nursing staff and health care workers in undertaking therapeutic observation of service users**<br>a. Review the therapeutic observation policy<br>b. Ensure comprehensive training plans in place | Measure effectiveness through clinical supervision | Medical Director | 01/11/2014 |

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|---|---|---|---|---|---|
| | **CQC (MHA) Ashby Ward action plan, action 4 Review of recording section 132 including access to IMHA**<br><br>**Keogh area of improvement:**<br>- *Patient experience*<br>- *Clinical and operational effectiveness* | **6. Improving access to Advocacy**<br>a. Implement standard service user information boards in every ward, and supplement with scrolling digital display | Measure how often we reiterate the information via MHA processes for those detained and for informal patients via Therapeutic Liaison Workers | Chief Nurse | 01/11/2014 |
| | **CQC (MHA) Ashby Ward action plan, action 5 pilot revised section 17 form**<br><br>**Keogh area of improvement:**<br>- *Patient experience*<br>- *Safety*<br>- *Clinical and operational effectiveness* | **7. Service user leave**<br>a. Establish a clearer protocol for escorting and home leave | Measure leave cancellation rates and the reason for cancellation | Chief Nurse | 01/11/2014 |

| On-going care on the in-patient unit Baselines | | | | | | |
|---|---|---|---|---|---|---|
| **Ref** | **Theme** | **Metric** | **Target** | **Baseline** | **Timescale** | **Lead** |
| 12 | On-going care on the In-patient Unit | Adherence to service user leave protocols (by audit) | 100% | Action plan in place to establish baselines | 01/05/2014 | Chief Nurse |
| 13 | On-going care on the In-patient Unit | Number of service users offered advocacy where clinically appropriate (by audit) | 80% | New initiative; baseline to be established | 31/12/2013 | Chief Nurse |
| 14 | On-going care on the In-patient Unit | Number of staff with current valid therapeutic observation of patients training | 85% | 90.1% @ Aug 2013 | 01/12/2013 | Director of HR & OD |
| 15 | On-going care on the In-patient Unit | Number of scheduled weekly ward rounds attended by nurse and doctor versus plan | 100% | 100% @ 21/10/13 | 01/02/2014 | Medical Director |
| 16 | On-going care on the In-patient Unit | Number of service users (and wherever possible those that matter most to service users such as their carers, family members, friends) involved in their care planning (by audit) | 100% | 71% @ Sept 2013 | 01/02/2014 | Chief Nurse |

| Discharge<br>To improve the safety, communication and patient involvement in the discharge process | | | | | |
|---|---|---|---|---|---|
| **Theme** | **Mapped to** | **Action** | **Supporting Action** | **Lead** | **Timescale** |
| *Improving the safety, communication and patient involvement in the discharge process* | **CQC Action Plan – Outcome 6, no. 2 (b) and (d) Discharge care plan and discharge planning meetings**<br><br>**Keogh area of improvement:**<br><br>- *Patient experience*<br>- *Safety*<br>- *Clinical and operational effectiveness*<br>- *Leadership & governance* | **1. Improved discharge care plan**<br>a. Further improve the discharge care plan documentation<br>b. Implement discharge care plan documentation<br>c. Set date for a pre-discharge meeting at the 1st MDT and inform/invite service user (and wherever possible those that matter most to service users such as their carers, family members, friends) community team and relevant stakeholders. Discharge care plan to be finalised in this meeting<br>d. Establish a discharge communication protocol<br>e. Establish a revised discharge summary by agreement with GPs and implement the new process | Monitor the implementation and the professional effectiveness via an updated discharge tool and service user satisfaction exit questionnaires and GP satisfaction via GP feedback/survey | Chief Nurse | 01/02/2014 |
| | **CQC Action Plan – Outcome 6, no. 2 (d), (e), (g) Planning meetings, liaison with social care managers and social workers**<br><br>**Keogh area of improvement:**<br>- *Patient experience*<br>- *Safety*<br>- *Clinical and operational effectiveness*<br>- *Leadership & governance* | **2. Achieve much more detailed earlier engagement with social workers on care planning, risk assessment and discharge planning with social care needs identified as early as possible.**<br>a. Design new protocol for county and city hospital social workers covering the Bradgate Unit | Evidence of social work involvement in MDT meetings | Chief Nurse | 01/02/2014 |
| | | | Evidence in care plans and discharge plans of social work involvement and impact of actions taken | Chief Nurse | 01/02/2014 |

| Discharge Baselines | | | | | | |
|---|---|---|---|---|---|---|
| **Ref** | **Theme** | **Metric** | **Target** | **Baseline** | **Timescale** | **Lead** |
| 17 | Discharge | Number of care plans reflecting discharge planning (by audit) | 90% | 59% @ Sept 2013 | 01/02/2014 | Chief Nurse |
| 18 | Discharge | Number of service users (and wherever possible those that matter most to service users such as their carers, family members, friends) involved in their discharge planning (by survey) | 80% (*Set at 80% in recognition of those people who decline to be involved)* | 67% @ Dec 2012 | 01/11/2014 | Chief Nurse |
| 19 | Discharge | Continuity of care from the same consultant/community worker | 80% | New initiative; baseline to be established | 01/04/2014 | Chief Operating Officer |

# Additional Specific Actions

## Staffing

| Theme | Mapped to | Action | Supporting Action | Lead | Timescale |
|---|---|---|---|---|---|
| *Ensuring safe staffing level that takes account of all acuity factors* | **Keogh area of improvement:**<br>- *Patient experience*<br>- *Safety*<br>- *Workforce*<br>- *Clinical and operational effectiveness*<br>- *Leadership & governance* | **1. Develop a phased approach and implement a SitRep for AMH in conjunction with commissioners with agreed thresholds and triggers which incorporate acuity, staffing/skill mix and bed occupancy metrics**<br><br>a. SitRep commenced in the Bradgate Unit August 2013;<br>i. Agreement to regularity of reporting<br>ii. Agreement to metrics<br>iii. Agree the escalation actions that will be taken by the Trust to address any operational issues arising from the SIT REP<br>b. Roll out SitRep to other parts of AMH (e.g. CRHT)<br>c. Move to a new skill mix of staff (60/40 ratio) | Recruitment plan | Chief Operating Officer | 01/05/2014 |

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|---|---|---|---|---|---|
| | **Keogh area of improvement:**<br>- *Patient experience*<br>- *Safety*<br>- *Workforce*<br>- *Clinical and operational effectiveness*<br>- *Leadership & governance* | **2. Roll-out SitRep to other inpatient areas in other divisions** | Early warning dashboard development for other divisions | Chief Operating Officer | 01/05/2014 |

**Staffing Baselines**

| Ref | Theme | Metric | Target | Baseline | Timescale | Lead |
|---|---|---|---|---|---|---|
| 20 | Staffing | 60:40 skill mix qualified / unqualified ratio achieved on the Bradgate Unit | 100% | New initiative; recruitment trajectory in place | 01/05/2014 | Chief Operating Officer |
| 21 | Staffing | 5 / 5 / 3 staffing levels achieved on the Bradgate Unit | 100% | 100% @ 17/10/13 | 01/11/2013 | Chief Operating Officer |

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| Physical Health Care | | | | | |
|---|---|---|---|---|---|
| **Theme** | **Mapped to** | **Action** | **Supporting Action** | **Lead** | **Timescale** |
| *Improving the quality of physical health care on mental health wards* | **Keogh area of improvement:**<br>- *Patient experience*<br>- *Safety*<br>- *Clinical and operational effectiveness*<br>- *Leadership & governance* | **1. Review the admission assessment protocol/proforma including the input of senior medical staff in assessing and meeting physical health needs**<br>a. Review the proforma<br>b. Prepare a mandatory checklist for essential investigations | Check compliance and quality of information through auditing the admission documents | Medical Director | 01/05/2014 |
| | **Wellbeing Strategy audit action 2 Medical and Nursing directors to consider requirement for LPT wellbeing co-ordinator role**<br><br>**Keogh area of improvement:**<br>- *Patient experience*<br>- *Safety*<br>- *Clinical and operational effectiveness*<br>- *Leadership & governance* | **2. Use existing MDT proforma to discuss physical health need and management during weekly ward rounds** | Check compliance through auditing undertaken by Senior Matrons | Medical Director | 01/05/2014 |

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|---|---|---|---|---|---|
| | **Appleby action plan action 5.1 – recruitment of RGN Action 5.2 – introduction of Track and Trigger**<br><br>**CQC Action Plan – Outcome 4, no. 3 As above**<br><br>**SI 132244 action plan action 1 and 6 as above.**<br><br>**Keogh area of improvement:**<br>- *Patient experience*<br>- *Safety*<br>- *Workforce*<br>- *Clinical and operational effectiveness*<br>- *Leadership & governance* | **3. Implement a training programme for mental health nursing staff to include specific physical health assessment needs, skills and care delivery**<br>a. Recruit to the post of Physical Health Nurse<br>b. Develop training package on physical health assessment and management; facilitated by Physical Health Nurse | Monitoring of training attendance | Chief Nurse | 01/05/2014 |

**Physical health care Baselines**

| Ref | Theme | Metric | Target | Baseline | Timescale | Lead |
|---|---|---|---|---|---|---|
| 22 | Physical Healthcare | Number of care plans reflecting physical healthcare needs where identified (by audit) | 100% | 90% @ Sept 2013 | 01/05/2014 | Chief Nurse |
| 23 | Physical Healthcare | Number of physical healthcare assessments undertaken versus admissions (by audit) | 100% | 92% @ Sept 2013 | 01/05/2014 | Chief Nurse |

| People with Personality Disorder | | | | | |
|---|---|---|---|---|---|
| **Theme** | **Mapped to** | **Action** | **Supporting Action** | **Lead** | **Timescale** |
| *Improving the skills of staff in managing people with personality disorder* | **Appleby action plan action 7.1 – progress with personality disorder care pathway**<br><br>**Keogh area of improvement:**<br>- *Patient experience*<br>- *Safety*<br>- *Workforce*<br>- *Clinical and operational effectiveness*<br>- *Leadership & governance* | **1. Implement rolling programme of training** | Personality Disorder audits of care plans for evidence of improvements to quality of the care plan for people with Personality Disorder; measure also via exit survey with service users | Medical Director | 01/11/2014 |
| | **Keogh area of improvement:**<br>- *Safety*<br>- *Clinical and operational effectiveness*<br>- *Leadership & governance* | **2. Strengthen the existing reflective practice groups to have a greater focus on case studies and lessons learned** | Staff satisfaction with the sessions every 6 months and monitor levels of attendance | Medical Director | 01/11/2014 |

| | | | | | |
|---|---|---|---|---|---|
| | **Keogh area of improvement:**<br>- *Safety*<br>- *Clinical and operational effectiveness*<br>- *Leadership & governance* | **3. Strengthen the complex case reviews to focus on lessons learned and changes to practice** | Staff satisfaction with the sessions every 6 months and monitor levels of attendance | Medical Director | 01/11/2014 |

| People with Personality Disorder Baselines | | | | | | |
|---|---|---|---|---|---|---|
| **Ref** | **Theme** | **Metric** | **Target** | **Baseline** | **Timescale** | **Lead** |
| 24 | People with Personality Disorder | Number of Bradgate Unit staff with current valid personality disorder training, against plan | 80% | Training commences Nov 2013; baseline data captured from 1st cohort Nov 2013 | 01/11/2014 | Medical Director |

| Care Plans | | | | | |
|---|---|---|---|---|---|
| **Theme** | **Mapped to** | **Action** | **Supporting Action** | **Lead** | **Timescale** |
| *Improving the ease of developing and using care plans as well as embedding care plans within the care process* | **Keogh area of improvement:**<br>- *Patient experience*<br>- *Safety*<br>- *Clinical and operational effectiveness*<br>- *Leadership & governance* | **1. Review the care plan format to improve documentation and streamline for ease of use** | Test the effectiveness of the new format via staff feedback and patient feedback | Chief Nurse | 01/02/2014 |
| | **Keogh area of improvement:**<br>- *Patient experience*<br>- *Safety*<br>- *Workforce*<br>- *Clinical and operational effectiveness*<br>- *Leadership & governance* | **2. Provide bespoke training and development via supervision to individuals to improve the quality of care planning** | | Chief Nurse | 01/02/2014 |
| | **Keogh area of improvement:**<br>- *Patient experience*<br>- *Safety*<br>- *Clinical and operational effectiveness*<br>- *Leadership & governance* | **3. On-going monitoring of care plans using the existing audit and cycle identified for all Bradgate unit care plans** | | Chief Nurse | 01/02/2014 |

| Risk Assessment | | | | | |
|---|---|---|---|---|---|
| **Theme** | **Mapped to** | **Action** | **Supporting Action** | **Lead** | **Timescale** |
| *Enhancing the skills of staff in the assessment and effective management of risk* | **Appleby action plan action 10.1 – Integritas training**<br><br>**CQC Action Plan – Outcome 14, no. 3 (e) and Outcome 16, no. 1 (c)**<br>**As above**<br><br>**Keogh area of improvement:**<br>- *Patient experience*<br>- *Safety*<br>- *Workforce*<br>- *Clinical and operational effectiveness*<br>- *Leadership & governance* | **1. Deliver an enhanced MDT interactive risk management training programme (this complements the existing mandatory rolling programme ref the Morgan risk tool)** | Regularity of sessions and attendance levels | Chief Nurse | 01/05/2014 |
| | | | The implementation of the agreed risk management approaches into supervision | Chief Nurse | 01/05/2014 |
| | | | Measure effectiveness also via sampling supervision notes | Chief Nurse | 01/05/2014 |
| | | | Measure also via evidence from MDT reviews and use of risk assessment | Chief Nurse | 01/05/2014 |
| | | | Measure via the routine risk assessment audits via care plans | Chief Nurse | 01/05/2014 |

| | | | | | |
|---|---|---|---|---|---|
| | **Keogh area of improvement:**<br>- *Patient experience*<br>- *Safety*<br>- *Workforce*<br>- *Clinical and operational effectiveness*<br>- *Leadership & governance* | **2. Enhance clinical leadership to risk management training through named individuals** | Measure the effectiveness of the agreed risk management approach via supervision | Medical Director | 01/05/2014 |
| | | | Names individuals identified and evidence through their job plans to be able to conduct the role | Medical Director | 01/05/2014 |
| | **Keogh area of improvement:**<br>- *Patient experience*<br>- *Safety*<br>- *Workforce*<br>- *Clinical and operational effectiveness*<br>- *Leadership & governance* | **3. Review and strengthen the peer review approach for consultant's practice; ensure there is a systematic approach across AMH with clear standards including risk management**<br>a. Identify, agree and implement appropriate audit tool | | Medical Director | 01/05/2014 |

**Risk assessment Baselines**

| Ref | Theme | Metric | Target | Baseline | Timescale | Lead |
|---|---|---|---|---|---|---|
| 25 | Risk Assessment | Complete risk assessment documentation present in care record for current episode of care | 100% | 92% @ Sept 2013 | 01/03/2014 | Chief Nurse |
| 26 | Risk Assessment | Number of staff with current valid risk assessment training | 80% | 92.1% @ Sept 2013 | 01/05/2014 | Chief Nurse |

## Hand Over

| Theme | Mapped to | Action | Supporting Action | Lead | Timescale |
|---|---|---|---|---|---|
| *Checking and searching procedure to be clear and consistent. Guided with intelligence on risk posed by the patient* | **Appleby action plan action 2.2 – review of handover policy**<br><br>**Keogh area of improvement:**<br>- *Patient experience*<br>- *Safety*<br>- *Clinical and operational effectiveness*<br>- *Leadership & governance* | **1. Harmonise, review and improve the protocol which includes all aspects of handover (e.g. ward to ward handovers; shift to shift, internal/external; daily review) with clear diagrams/flow charts to assist staff to follow systematic processes**<br>a. Implement training programme | | Chief Nurse | 01/01/2014 |

## Hand Over Baselines

| Ref | Theme | Metric | Target | Baseline | Timescale | Lead |
|---|---|---|---|---|---|---|
| 27 | Handover | Adherence to In-patient handover protocol (by audit) | 100% | New initiative; baseline to be established | 01/01/2014 | Chief Nurse |

| Embedding a system for continuous learning & Staff support | | | | | |
|---|---|---|---|---|---|
| **Theme** | **Mapped to** | **Action** | **Supporting Action** | **Lead** | **Timescale** |
| *Providing support and create opportunities for staff to learn continuously from practice (near misses, SI investigation recommendations, patient feedback) and reduce clinical variability* | **Keogh area of improvement:**<br>- *Safety*<br>- *Workforce*<br>- *Clinical and operational effectiveness*<br>- *Leadership & governance* | **1. Review and strengthen the policy for staff support, including for violence, aggression and Serious Incidents** | | Chief Nurse | 01/01/2014 |
| | **Keogh area of improvement:**<br>- *Workforce*<br>- *Clinical and operational effectiveness*<br>- *Leadership & governance* | **2. Identify and provide additional training for specific staff who can lead debriefing sessions** | Include database of key people and their training, the number of sessions they have led, along with feedback from staff who have attended those sessions | Chief Nurse | 01/01/2014 |
| | **Keogh area of improvement:**<br>- *Patient experience*<br>- *Safety*<br>- *Workforce*<br>- *Clinical and operational effectiveness*<br>- *Leadership & governance* | **3. Develop a MDT forum for reviewing lessons learned ref. professional practice** | Measure resulting changes in practice and other actions taken | Medical Director | 01/01/2014 |

| | | | | | |
|---|---|---|---|---|---|
| | **Keogh area of improvement:**<br><br>- *Patient experience*<br>- *Safety*<br>- *Workforce*<br>- *Clinical and operational effectiveness*<br>- *Leadership & governance* | **4. Utilise all available data such as staff feedback, service user experience, professional practice and Serious Incident thematic review to implement new mechanisms for disseminating lessons learned**<br>a. Develop and implement ward level scorecards<br>b. Develop and implement early warning data sets | | Medical Director | 01/05/2014 |

| Continuous learning & staff support Baselines | | | | | | |
|---|---|---|---|---|---|---|
| **Ref** | **Theme** | **Metric** | **Target** | **Baseline** | **Timescale** | **Lead** |
| 28 | Continuous learning & staff support | Number of debriefing sessions versus number of violent incidents and Serious Incidents reported | 100% | New initiative; baseline to be established | 01/01/2014 | Chief Nurse |
| 29 | Continuous learning & staff support | Attendance rate of MDT learning forums against Terms of Reference | 80% | New initiative; baseline to be established | 01/01/2014 | Medical Director |
| 30 | Continuous learning & staff support | Number of MDT learning forums held versus plan | 100% | New initiative; baseline to be established | 01/01/2014 | Medical Director |

| Improvement of the Environment | | | | | |
|---|---|---|---|---|---|
| **Theme** | **Mapped to** | **Action** | **Supporting Action** | **Lead** | **Timescale** |
| *Improving the patient experience, healing nature and safety of environment* | | **1. Ward environment**<br>a. PLACE results are available for each inpatient area – recommendations to be actioned<br>b. Cleaning schedule to be reviewed with manager of Domestic Services to ensure that cleaning requirements are met | FM metrics in the Interserve contract<br>PLACE action plan implementation | Chief Operating Officer | 01/05/2014 |
| | **Appleby action plan action 8.1 – review of ligature risk assessments**<br><br>**CQC Action Plan – Outcome 16, no. 3 (f) (g)**<br><br>**CQC (MHA) Ashby Ward action plan, action 7** | **2. Ward environment – patient safety**<br>a. Review Ligature assessment policy<br>b. Ligature risk assessment – review to be completed for each ward using new tool from Ligature Risk Policy (approved March 2013)<br>*NB: the ligature risk assessment review referred to here will be completed across Bradgate by end of October with report to QAC.*<br>c. Refurbishment of bathrooms to the 4 old wards to remove already identified ligature risks (already in 13/14 Capital programme and awaiting commencement date of work)<br>d. Structural solutions to minimise patients with high risk absconding – SALTO system, additional CCTV, intercoms and additional security doors to be installed throughout the Bradgate site including Glenvale area | Staff satisfaction with environment | Chief Operating Officer | 01/05/2014 |
| | | | | Chief Operating Officer | 30/11/2013 |
| | | | | Chief Operating Officer | 30/11/2013 |

| | | | | | |
|---|---|---|---|---|---|
| | | – Capital works approved and work has commenced<br>e. Review of current fencing – business case to be developed following recommendations | | Chief Operating Officer | 31/12/2013 |
| | **CQC Action Plan – Outcome 7, no. 1 (d) (e)**<br>**Review of seclusion rooms and resulting building work**<br><br>**1 (g)**<br>**Review of Seclusion Good Practice Group**<br><br>**Keogh area of improvement:**<br>- *Patient experience*<br>- *Safety*<br>- *Clinical and operational effectiveness*<br>- *Leadership & governance* | **3. Seclusion**<br>a. Review of all seclusion rooms to ensure fit for purpose<br>b. Costs to be obtained for air conditioning to seclusion rooms<br>c. Seclusion Group – this group is to be chaired by a clinician and purpose of the group will be to ensure that seclusion practice is monitored and that best practice is being adhered to as per the seclusion policy – this group is already in place and a lead clinician has been identified as Chair – the Chair of the Seclusion Group will write the annual seclusion report which is submitted to the SCQG | Feedback on the seclusion room changes from staff and service users | Chief Operating Officer | 01/05/2014 |
| | | | Evidence of improvements to privacy and dignity including those relating to single sex accommodation arrangements | Chief Operating Officer | 01/05/2014 |

| Improvement of the environment Baselines | | | | | | |
|---|---|---|---|---|---|---|
| **Ref** | **Theme** | **Metric** | **Target** | **Baseline** | **Timescale** | **Lead** |
| 31 | Improvement of the environment | Adherence of staff to seclusion process and policy (by audit) | 100% | Action plan in place to establish baselines | 01/05/2014 | Medical Director |
| 32 | Improvement of the environment | Adherence of all seclusion environments to national standard | 100% | Baseline will be set by environmental audit | Dependent upon scale of work | Chief Operating Officer |
| 33 | Improvement of the environment | Number of ligature assessments undertaken in the Bradgate Unit | 100% | All In-patient wards completed | 01/12/2013 Non In-patient areas | Chief Operating Officer |
| 34 | Improvement of the environment | Improvement in PLACE survey results | 90% | PLACE baselines (Sept 2013):<br>• Cleanliness: 87.37%<br>• Condition, appearance and maintenance: 75.12%<br>• Privacy, dignity and wellbeing: 81.96%<br>• Food and hydration: 84.79% | Dependent upon scale of work and 2014 PLACE assessments | Chief Operating Officer |

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| Equality<br>Meeting the needs of individuals with Diverse needs | | | | | |
|---|---|---|---|---|---|
| **Theme** | **Mapped to** | **Action** | **Supporting Action** | **Lead** | **Timescale** |
| *Care provided is able to accommodate the needs of the individuals with diverse needs and backgrounds* | **CQC Action Plan – Outcome 14, no. 1 (b) (d)**<br><br>**Keogh area of improvement:**<br>- *Patient experience*<br>- *Workforce*<br>- *Clinical and operational effectiveness*<br>- *Leadership & governance* | **1. To improve overall staff awareness of the needs of service users by revising the equality and diversity training so that this has a focus on the assessment of the protected characteristics and how care is planned and delivered with these in mind** | | Director of HR & OD | 01/11/2014 |
| | **CQC Action Plan – Outcome 14, no. 1 (a)**<br><br>**CQC (MHA) Thornton Ward action 6 staff to ensure use of interpreters**<br><br>**Keogh area of improvement:**<br>- *Patient experience*<br>- *Workforce*<br>- *Clinical and operational effectiveness* | **2. Ensure appropriate provision and access to language and communication support to enable service user communication, including translation services** | | Chief Nurse | 01/05/2014 |

| Equality Baselines | | | | | | |
|---|---|---|---|---|---|---|
| **Ref** | **Theme** | **Metric** | **Target** | **Baseline** | **Timescale** | **Lead** |
| 35 | Equality | Documented consideration of Equality & Diversity patient needs in care plan | 100% | 87%@ Sept 2013 | 01/05/2014 | Chief Nurse |
| 36 | Equality | Number of staff trained in Equality & Diversity Training | 80% | 96.1%@ Sept 2013 | 01/11/2014 | Director of HR & OD |

| Effective governance<br>Supporting effective governance of the Trust | | | | | |
|---|---|---|---|---|---|
| **Theme** | **Mapped to** | **Action** | **Supporting Action** | **Lead** | **Timescale** |
| *Ensuring the adequacy of Ward to Board mechanisms to support effective governance of the Trust* | **Keogh area of improvement:**<br>- *Clinical and operational effectiveness*<br>- *Leadership & governance* | **1. Establish a Board Assurance and Escalation Framework that describes the effective ward to board reporting mechanisms to ensure effective governance of the Trust** | | Chief Nurse | 31/12/2013 |
| | **Keogh area of improvement:**<br>- *Clinical and operational effectiveness*<br>- *Leadership & governance* | **2. Review the organisational risk management strategy to ensure there is effective ward to board reporting and management of risks across the Trust** | | Chief Nurse | 31/12/2013 |
| | **Keogh area of improvement:**<br>- *Patient experience*<br>- *Safety*<br>- *Workforce*<br>- *Clinical and operational effectiveness*<br>- *Leadership & governance* | **3. Implement the priority areas from the Trust's analysis of the Francis Report** | Board Analysis of Francis Report<br><br>Thematic actions agreed in Q2<br><br>Progress report in Q3 (October Board Report)<br><br>Annual Review Q4 | Chief Executive Officer | February 2013<br><br>June 2013<br><br>October 2013<br><br>February 2014 |

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Leicestershire Partnership NHS
NHS Trust

# QUALITY IMPROVEMENT PROGRAMME (QIP)
# CORPORATE ENGAGEMENT PLAN

**Appendix A**

| Key for RAG Rating | |
|---|---|
| | Action not commenced |
| | Action On-going and to time |
| | Action Completed |
| | Action has missed deadline |

| Communications & Reputation Management<br>Director with lead responsibility:<br>Director of Business Development | | | |
|---|---|---|---|
| **Patient, Carers & Service Users** | **Who** | **By When** | **Progress/Assurance** |
| Contact patient and carer groups with information and reassurance | Chief Nurse | Complete | An initial meeting was organised with service users at Network for Change on 13/09/13 in response to group concern. |
| "*Changing your experience for the better*" – review recent comprehensive results from service user focus groups within AMH | Chief Nurse | Complete | A meeting was organised for 17/09/13 inviting voluntary and community sector organisations to provide them with information regarding the CQC findings, Trust actions and to hear from them about any concerns they may have.<br><br>Patient experience team and AMH Divisional Director have undertaken a thematic review of these findings to support development of Quality Improvement programme. |

| External Stakeholders | Who | By When | Progress/Assurance |
|---|---|---|---|
| Forwarding draft CQC report (July inspection) to lead commissioner | Chief Operating Officer | Complete | Completed 08/08/13 |
| Share response with the CCGs electronically before 15/8/13 | Chief Nurse | Complete | Completed 15/08/13 |
| Meeting with Local Health Watch | Chief Nurse | | LPT Chairman met with Local Health Watch representatives on 17/09/13<br><br>Letter from Local Health Watch to Acting CEO in August reference CQC update. Letter from Local Health Watch to CEO in October and meeting on 30/10/13 |
| Commissioner awareness, involvement and support for the immediate and medium term actions: set up an extraordinary exec team meeting with commissioners | Director of Finance | Complete | Commissioner meeting held 15/8/13. |
| MP Briefings | Acting CEO | Complete | Regular appointments in place. All MPs offered a telephone call updating them on the position ref July inspection. All MPs receive monthly LPT stakeholder briefings |
| Immediate initial meeting with TDA to brief on CQC and FT. | Acting CEO and Exec team | Complete | Constructive meeting held with TDA on 13/8/13<br>Actions incorporated into Immediate Action Plan and Quality Improvement Programme where applicable.<br>Further meeting with TDA on 2/9/13. |
| Meetings with CCGs to further develop QIP Plan and metrics | Chief Nurse | Complete | Meetings held 24/9/13 and 03/10/13 to confirm and challenge content of the latest version of the QIP and discuss proposed metrics.<br>On-going TDA input via Oversight & Assurance Group and monthly IDM meetings |

| Local Authorities, Scrutiny Committees and Health and Wellbeing Boards | Who | By When | Progress/Assurance |
|---|---|---|---|
| Briefing sessions offered to overview and scrutiny committees x3 | Director of Business Development | 2/8/13 | All scrutiny officers contacted, this led to:-<br>• Leicestershire County Council; Medical Director and Chief Operating Officer attended to present report on 12/9/13<br>• Follow up meeting at Leicestershire County Council on 27/11/13 (CEO, Chief Nurse and Medical Director) to present update report.<br>• Leicester City; Acting CEO and Director of Business Development attended to present report on 3/9/13 and Chairman, Medical Director and Director of Business Development attended to present update report on 15/10/13<br>• Rutland County Council; Director of Business Development and Chief Nurse attended and presented report on 26/9/13<br><br>The Chair of the Leicestershire County and Rutland Adult Safeguarding Board was invited to the Leicestershire County Council scrutiny meeting on September 12; we suggested the same approach for Leicester City. |
| Generic Report produced for Scrutiny Committees that can be adapted over time/to address specific council queries. | Director of Business Development | 21/8/13 | Report completed and submitted initially for Leicester City deadline for papers (21/8) |
| Briefing sessions to be offered to safeguarding adults boards locally x 2 | Director of Business Development | Complete | Incorporated into scrutiny plans above |
| Briefing sessions offered to the chairs of the three local health and wellbeing boards | Director of Business Development | 10/08/13 | Acting CEO office contacted all three Chairs to offer individual briefings as needed.<br><br>Acting CEO briefing meeting held with Councillor Ernie White on 21/8/13.<br><br>Chairman meeting Councillor Rory Palmer on 30/10/13 |

| Internal Communications | Who | By When | Progress/Assurance |
|---|---|---|---|
| Statement on the receipt of the full CQC report<br>Statement on increasing independence of SI investigations | Director of Business Development | Complete | Complete – combined and issued via staff briefing and stakeholder briefing on 7/8/13 |
| Statement to clarify suicide numbers – for Chair and CEO | Chief Nurse | Complete | Issued to CEO and Chair on 6/8/13. Further detail and refinements made to data analysis by Chief Nurse by 20/8 |
| Communications forward planner showing reputational issues and mitigation plans | Director of Business Development and Head of Communications | Complete | Complete - shared at Senior Management Team on 5/8/13<br>Updated for Executive Team meeting on 12/8/13 and then updated bi-weekly and presented at Executive Team meetings and Senior Management Team meetings. |
| Communications forward events planner and channel of good news stories | Director of Business Development and Head of Communications | Complete | Forward planner in place and managed proactively via divisional communications leads. |
| Cascade of CQC report (July inspection) through AMH | Chief Operating Officer and Divisional Director | Complete | Cascaded.<br>Medical Director confirmed all appropriate clinical staff have received it personally. |
| On-going staff communication to reinforce Trust Board's support and report our progress | Acting CEO & Chair through communications | Complete | Special editions of team brief on CQC Report (July inspection) through July and August |
| Acting Chief Executive initial meeting with AMH Consultants at Bradgate Unit | Acting Chief Executive | Complete | Acting Chief Executive held constructive meeting with AMH Consultants on 9/8/13. Medical Director to lead on taking forward the key issues raised which focused on what is preventing good quality care from their perspective. |

| | | | |
|---|---|---|---|
| Issue CQC report to other Divisional Directors and discussion/action on:<br>• thematic review of CQC report by other divisions<br>• additional divisional communications/leadership on patient safety and record keeping<br>• identification of other areas of CQC risk (Oakham House/Agnes Unit) where record keeping/case note improvements and other interventions are needed | Director of Business Development/Chief Operating Officer | Complete | Discussed with Divisional Directors who are progressing actions accordingly.<br><br>COO follow up via fortnightly Ops team and monthly Executive Performance Reviews with Divisions<br><br>Initial Thematic review complete and reported to Senior Management Team on 19/8/13 |
| Briefing arrangements for lead governor/governor communications | Board Secretary | Complete | Acting CEO met with staff governors 29/8/13. Chairman/Lead Governor considered extra-ordinary Council of Governors meeting. Lead Governor receiving all stakeholder briefings and regular updates from the Chairman. Council of Governors briefed at their July and October meetings |
| Trust Board and CQC Report/Response | Acting Chief Executive | Complete | Complete: Response shared with Trust Board at 29/8/13 meeting/development session. Paper presented to Trust Board in public session 29/8/13 including immediate action plan, warning notices and full CQC report. |
| Weekly briefing for Board to be shared with Matrons across all divisions | Chief Nurse | On-going | |
| **Other Communications actions** | **Who** | **By When** | **Progress/Assurance** |
| Small suite of initial public facing products on the Trust, patient safety and other activities/profile.<br><br>Review of ward information packet at the Bradgate Unit | Medical Director, Chief Operating Officer and Head of Communications | On-going | Initial topics agreed w/c 12/8/13. Initial products by 30/8/13, then rolling programme.<br><br>Refreshed service user ward information packet draft being reviewed by communications and VCS during October |
| Annual General Meeting on 7/09/13 | Acting Chief Executive | Complete | Meeting to finalise arrangements 15/8/13. Communications plan for CQC July inspection report publication finalised 22/8/13 including AGM aspects |

| | | | |
|---|---|---|---|
| Co-ordination ref publication of CQC Report and associated communications including handling for Trust Board and Risk Summit on 29/8/13. | Chief Nurse and Director of Business Development | Complete | LPT Communications plan developed and enacted 27-30 August in relation to the publication of the CQC report<br>Communications handling plan developed and enacted for the Trust Board meeting. Coverage by BBC East Midlands Today, Leicester Mercury and BBC Radio Leicester.<br><br>Co-ordination of communications following the Risk Summit being led by Area Team. LPT fully engaged in this process and issued a further staff and stakeholder briefing w/c 2/9/13. |
| Weekly stakeholder update to core communications stakeholder list | Director of Business Development and Head of Communications | Complete | To review regularly at 3 and 6 weeks.<br>First bulletin 31/7/13; second bulletin 08/8/13; third bulletin 12/8/13 & 13/8/13<br>(Now monthly as before) |
| **Continuing engagement – October 2013 onwards** | **Who** | **By When** | **Progress/Assurance** |
| Engagement with Senior Leadership Group (approx. 150 people) on the Quality Improvement Programme | CEO | | Meeting arranged for 27/11/13 |
| New Ward Forums at Bradgate Unit, inclusive of patients, VCS and Ward Staff | Chief Operating Officer, Chief Nurse and Medical Director | | Ward Forums are in the process of being arranged/re-established |
| Communications plan for the publication of the September CQC inspection Report | Director of Business Development | | Communications plan in place |
| On-going VCS engagement | Director of Business Development and Head of Patients Experience | On-going | Post the September briefing, a further VCS engagement follow up session was held on 22/10/13 to gather feedback on the draft Quality Improvement Programme with the next session planned for 12/11/13 |
| Trust Board engagement | CEO | On-going | Board development sessions 25/7/13 in relation to the July inspection CQC report. Board development sessions held 29/8/13, 26/09/13 and 31/10/13 with continual focus on quality assurance and transparency |

Leicester City Council

# Leicester City: Improving Oral Health

## Purpose of the report

The purpose of the report is to brief the Health and Overview Scrutiny Commission on the:

- oral health needs of children in Leicester City
- NHS reforms and dentistry
- development of the Oral Health Promotion Strategy for preschool children

## Background

Dental health for children in Leicester City is worse than the national and regional averages as well as when compared against all local authority comparators. The most common oral diseases, tooth decay and periodontal (gum) disease can both cause pain and infection as well as eventual tooth loss. This discomfort often results in lost sleep and disruption to family life, leading to time of work and school. Acute dental infection can cause swelling and severe pain. Extensive treatment can still be stressful, especially for the very young. This can lead to children being referred to hospital for dental extractions under general anaesthesia (GA). Such procedures expose children to unnecessary risk of complications which should be prevented.

The causes of poor oral health include:

- **Poor diet and nutrition**: High intake of sugar, fizzy and acidic drinks
- **Poor oral hygiene**: Failure of self-care e.g. regular tooth brushing and flossing
- **Fluoride**: The lack of exposure to fluoride
- **Tobacco and alcohol**: Smoking increases the risk of periodontal disease and is one of the main causes of oral cancer. Smoking combined with alcohol can lead to a 30 times greater risk of oral cancer. Smokeless tobacco also increases the risk of oral cancer
- **Injury**: The health of teeth can be compromised by traumatic injury. Those who play contact sport are at particular risk

Poor oral health occurs more often in vulnerable groups, as evidenced below:

- Leicester is the 20th. most deprived local authority in the country with 35.3% of children and young people between 0-19 years living in poverty. Studies show that those from lower socio-economic groups are likely to have the highest levels of dental decay and consequently worse oral health.
- Epidemiological data has shown that the prevalence of dental decay is also much higher in Asian heritage children. This is of particular relevance to Leicester City with a high BME population.

Further points of note:

- Looked after children can miss out on dental check-ups and treatment because they are often relocated.
- People with disabilities and complex health needs are at greater risk of dental disease. It is important that preventative work and access to services are appropriate for this group of vulnerable people.

In 2009, the National Institute for Health and Clinical Excellence (NICE) recognised dental neglect as a type of child neglect. The recommendations relate to two types of dental neglect:

- persistent failure by parents/carers to obtain dental treatment for a child's dental decay
- the possibility of child maltreatment or oral injury.

The consequence of untreated dental diseases for children can be significant. Not only do many children affected experience pain and discomfort, they can lose sleep, confidence and it can restrict their play activities and affect their readiness for nursery and school.

## Oral health needs of children in Leicester City

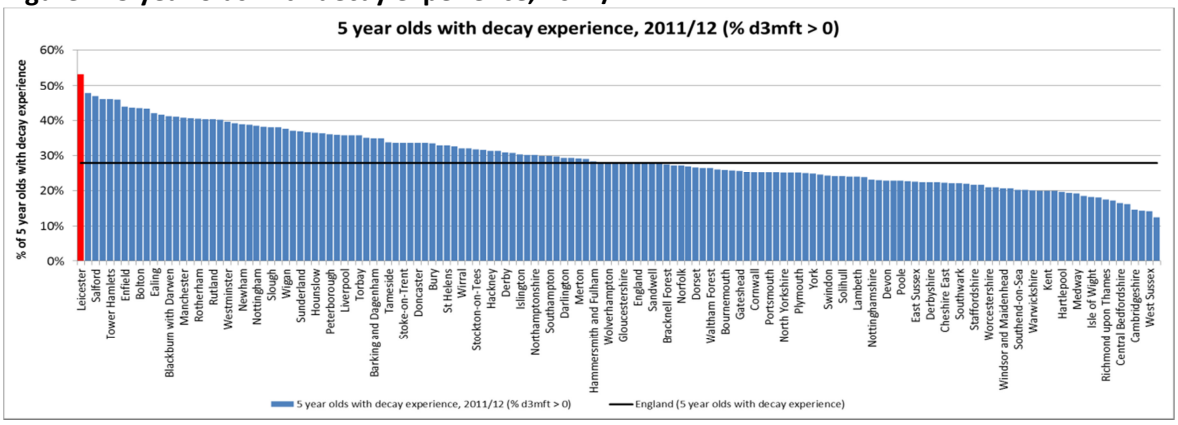
- Five year old children living in Leicester have the highest experience of dental decay observed in England.

- The 2012 results show an increase in the proportion of children with dental decay in Leicester from 48.7% in 2008 to 53.2% in 2012, equating to a percentage point increase of 4.5%.

- At age 5, children normally have 20 primary teeth. On average, 5 year old children in Leicester had just under 4 teeth (3.88) that were decayed, missing or filled.

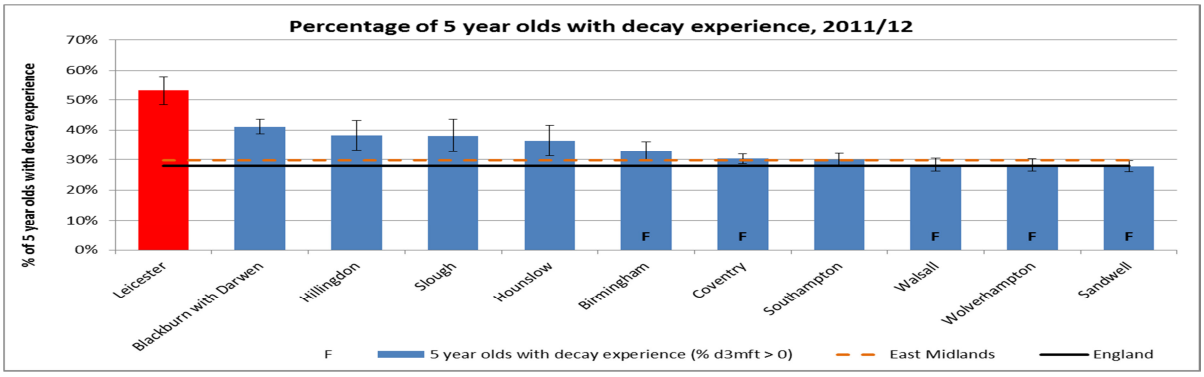
- The average number of decayed, missing or filled teeth in the whole sample taken in Leicester (including the 46.8% who were decay free) was 2.06. This was more than double the national rate of 0.94.

**Figure 1: 5 year olds with decay experience, 2011/12**




When comparing the results against local authority comparators, the results reveal wide variation in the amount and severity of dental decay: the areas with poorer oral health tend to be those where the public water supplies are not fluoridated.

**Figure 2: Amount of dental decay in 5 year olds, 2011/12**



The association between social deprivation and tooth decay is undisputed. These key determinants need to be considered when addressing improvement in oral health and in future service planning. Many families with young children on lower incomes face a number of challenges; some parents find it very difficult to promote good oral health due to affordability of fruit and vegetables as well as toothpaste and toothbrushes; for many it is not the norm to access preventative services in the absence of painful illness and also a lack of information and poor communication about services can be a barrier.

The oral health of young children is an accurate mirror to the quality of their diet, parenting and living conditions in general. Poor oral health is a timely indicator of sub-optimal diet and parenting in early life. Poor baby feeding practices, weaning habits, lack of hygiene and diets high in sugar lead not only to poor dental health but also to higher risks of obesity, diabetes, cardiovascular disease and some cancers in later life. Poor oral health can also lead to a restriction to a child's ability to eat, speak and socialise.

## NHS reforms and dentistry

In April 2013, NHS England became responsible for commissioning NHS dental services at a local level (Leicestershire and Lincolnshire Area Team). There is a commitment from the Department of Health to introduce a new NHS dental contract. This is to replace the current contract which is based on treatment activity. The new NHS dental contract will be based on patient registration, capitation and quality to evaluate dentists on the consistency and impact of the services they provide. Performance will be determined by compliance with quality and safety standards and will be informed by patient experience. It is proposed that dentists will be expected to complete a consistent oral health needs assessment on every patient and adhere to a preventive care pathway approach. Contracts will be measured by a Dental Quality and Outcomes Framework (DQOF), based on clinical outcomes and clinical effectiveness, patient safety and patient experience.

At the same time, local authorities were given Public Health responsibilities which includes dental public health services. There is also an oral health indicator of 5 year old children in the Public Health Outcomes Framework. The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012 state that each local authority shall provide or make arrangements to secure the provision of:

- Oral health promotion programmes
- Oral health surveys which facilitate:
    - The assessment and monitoring of oral health needs
    - The planning and evaluation of oral health promotion programmes
    - The planning and evaluation of the arrangements for provision of dental services as part of the health service
    - The monitoring and reporting of the effect of water fluoridation programmes (where applicable)

The Regulations also further state that the local authority shall participate in any oral health survey conducted or commissioned by the Secretary of State.

## Development of the Oral Health Promotion Strategy for preschool children

The Leicester City Child Poverty Commission reports that more than 26,000 Leicester children (over a third of those in the City) are growing up in poverty. Recommendation 43 from the Commission states that:

- The Health & Wellbeing Board, the NHS Commissioning Board and other partners should work actively to promote oral health ensuring access and take up of preventative dental care for all children across the city.

The City Mayor's Delivery Plan 2013/14 has also stated that a partnership action plan to improve children's dental health should be developed.

The Children's Trust Board has also included the improvement of oral health as one of it's priorities in the Children and Young People's Plan.

Progress to date:

- An Oral Health Summary Needs Assessment has been undertaken for Leicester City.
- Non-recurrent funding of £490k has been allocated to improving oral health.
- A project manager for the oral health initiative has been appointed.
- The Oral Health Promotion Partnership Board was established on the 17th. September, 2013. The purpose of the Board is to develop and deliver an oral health promotion strategy for preschool children in the first instance. The Strategy is currently in draft and it is anticipated that this will be finalised by the end of Dec 2013. The intended outcomes are to:
  - Improve oral health
  - Reduce oral health inequalities
  - Improve access to NHS dental services

Dr. Jasmine Murphy
Consultant in Public Health
Leicester City Council
October 2013

| APPENDICES | | |
|---|---|---|
| 1. | Joint Strategic Needs Assessment Oral Health chapter | http://www.leicester.gov.uk/your-council-services/social-care-health/jsna/jspna-reports/ |
| 2. | Dental Health survey results of 5 year old children 2011/12 | LMB - 5 yr olds.docx |
| 3. | DRAFT Terms of Reference for Oral Health Promotion Partnership Board | Leicester City Oral Health Promotion Part |

# Oral Health Promotion Strategy 2014-2017: Pre-school children

This is a DRAFT document which was taken to the first meeting of the Oral Health Promotion Partnership Board on the 17th. September, 2013. The Board is led by Leicester City Council – Public Health. Membership of the Board includes NHS England – Area Team (primary care dental contracting and also Health Visiting), Local Dental Network, Leicester City Clinical Commissioning Group, Public Health England, Health Education England (LETB), Leicester City Council Children's Services (Early Years, Workforce, Learning Services) and Healthwatch. This document provides the initial discussion points as a 'starter for ten' for strategic partners to consider in order for the final strategy which emerges to be supported and endorsed by all.

**CONTENTS** **PAGE**

## Purpose

This document should be read in conjunction with the JSNA chapter on Oral Health, which is available at http://www.leicester.gov.uk/your-council-services/social-care-health/jsna/jspna-reports/. The oral health promotion strategy outlined in the main body of this document is a strategic planning process to improve oral health of preschool children living within Leicester City. However, it is also intended that further strategies across the life-course will be attached as an appendix to this document as they are written and agreed by the Board. While prevention is key, provision of high quality accessible dental services is also fundamental. The tackling of oral health is complex and inextricably bound up with issues of culture, lifestyle and deprivation.

## Introduction

Poor oral health, as with general health, is more common in individuals from areas of relative deprivation. The wider determinants of health such as poverty, poor housing, access to food, access to services, education and unemployment impact on oral health as they do on general health.

Non-communicable diseases (NCD) have overtaken infectious diseases as the main cause of premature death in developed countries. The four most prominent NCDs are cardiovascular diseases, diabetes, cancer and chronic obstructive pulmonary diseases. A core of modifiable risk factors is common to these diseases that account for a large proportion of the cases. These risk factors include diet and obesity, alcohol and smoking. These risk factors also account for a high proportion of oral diseases. Alcohol and tobacco (either smoked or chewed) are major risk factors for oral cancer and periodontal (gum) disease. A diet high in sugar (including fizzy drinks) leads to dental decay and tooth erosion.

Health promotion strategies can be aimed at the whole population and at specific groups or individuals at risk of disease. The risk of suffering from many chronic diseases can be reduced by action to reduce smoking prevalence and alcohol consumption as well as improvement in diets. These approaches will impact on the prevalence and severity of oral diseases too. In addition, the use of fluoride will reduce the prevalence of tooth decay. This first strategy focuses on preschool children with the ethos of giving every child the best start in life. The strategy will use both the whole population and the risk approach to health promotion and will attempt to address some of the common risk factors as well as fluoride for disease prevention.

## Contextual Evidence

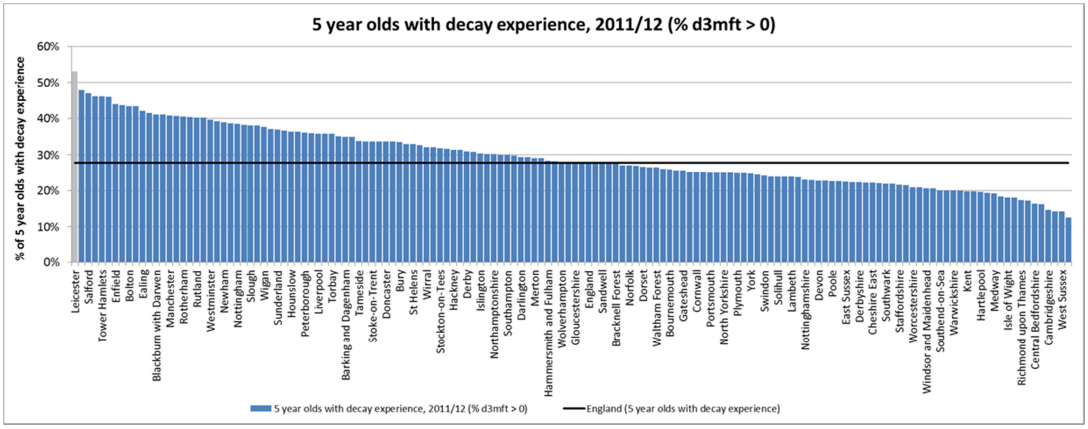
- Five year old children living in Leicester have the highest experience of dental decay observed in England.

- The 2012 results show an increase in the proportion of children with dental decay in Leicester from 48.7% in 2008 to 53.2% in 2012, equating to a percentage point increase of 4.5%.

- At age 5, children normally have 20 primary teeth. On average, 5 year old children in Leicester had just under 4 teeth (3.88) that were decayed, missing or filled.

- The average number of decayed, missing or filled teeth in the whole sample taken in Leicester (including the 46.8% who were decay free) was 2.06. This was more than double the national rate of 0.94.

**Figure 1: 5 year olds with decay experience, 2011/12**




When comparing the results against local authority comparators, the results reveal wide variation in the amount and severity of dental decay: the areas with poorer oral health tend to be those where the public water supplies are not fluoridated.

**Figure 2: Amount of dental decay in 5 year olds, 2011/12**

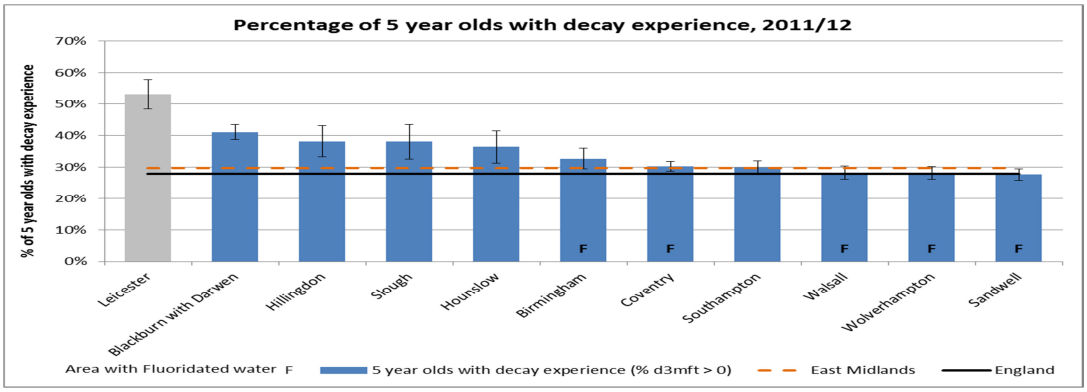
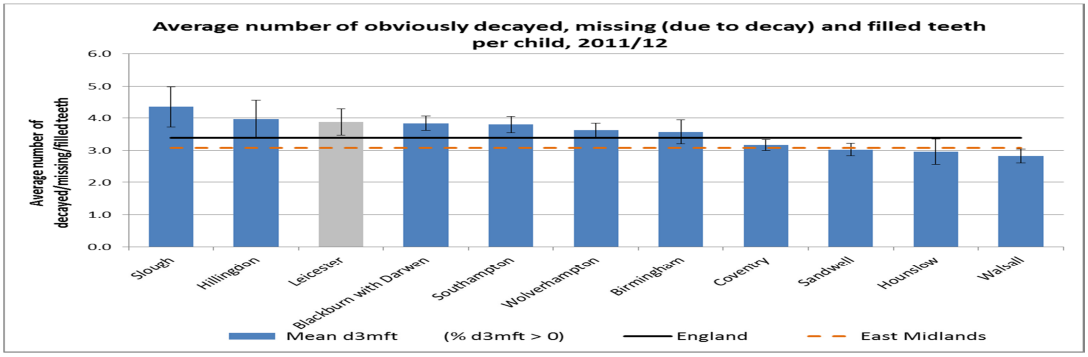



**Figure 3: Severity of dental decay in 5 year olds, 2011/12**




The most common oral diseases, tooth decay and periodontal disease can cause pain and infection as well as eventual tooth loss. This discomfort often results in lost sleep and disruption to family life, leading to time off work and school. Acute dental infection can cause swelling and severe pain. Extensive treatment can still be stressful, especially for the very young. This can lead to children being referred to hospital for dental extractions under general anaesthesia (GA). Such procedures expose children to unnecessary risk of complications which should be prevented.

The causes of poor oral health include:

- **Poor diet and nutrition**: High intake of sugar, fizzy and acidic drinks
- **Poor oral hygiene**: Failure of self-care e.g. regular tooth brushing and flossing
- **Fluoride**: The lack of exposure to fluoride
- **Tobacco and alcohol**: Smoking increases the risk of periodontal disease and is one of the main causes of oral cancer. Smoking combined with alcohol can lead to a 30 times greater risk of oral cancer. Smokeless tobacco also increases the risk of oral cancer
- **Injury**: The health of teeth can be compromised by traumatic injury. Those who play contact sport are at particular risk

Poor oral health occurs more often in vulnerable groups, as evidenced below:

- Leicester is the 20th. most deprived local authority in the country with 35.3% of children and young people between 0-19 years living in poverty. Studies show that those from lower socio-economic groups are likely to have the highest levels of dental decay and consequently worse oral health.
- Epidemiological data has shown that the prevalence of dental decay is also much higher in Asian heritage children. This is of particular relevance to Leicester City with a high BME population.

Further points of note:

- Looked after children can miss out on dental check-ups and treatment because they are often relocated.
- People with disabilities and complex health needs are at greater risk of dental disease. It is important that preventative work and access to services are appropriate for this group of vulnerable people.

In 2009, the National Institute for Health and Clinical Excellence (NICE) recognised dental neglect as a type of child neglect. The recommendations relate to two types of dental neglect:

- persistent failure by parents/carers to obtain dental treatment for a child's dental decay
- the possibility of child maltreatment or oral injury.

The consequence of untreated dental diseases for children can be significant. Not only do many children affected experience pain and discomfort, they can lose sleep, confidence and it can restrict their play activities and affect their readiness for nursery and school.

## Aim

The aim of this strategy is to support coordinated activity across Leicester City to improve oral health, reduce oral health inequalities and lay solid foundations for good oral health throughout life.

## Objectives

- Optimising exposure to fluoride
- Gain multi-partnership support in order for **everyone** to play a role in improving oral health
- Improve preventive and routine dental attendance
- Improve parental skills on caring for children's oral health

## Target

The prevalence of tooth decay across the population is seen as a key measure, both in assessing oral health status and the prospects for future oral health. Therefore, changes in the proportion of 5 year old children free of dental decay should be used as a monitor of oral health improvement. The Department of Health set a national target in 1994 which was not met locally. It is therefore proposed that Leicester City strives to meet this national target that was set by 2018:

- 5 year old children should have no more than 1 tooth with decay
- 70% of 5 year olds should have no decay

FOR FURTHER DISCUSSION

## Rationale

The improvement in oral health for preschool children living in Leicester City involves the contributions from a wide range of agencies and groups, and is not the sole responsibility of one single organisation. The strategy should therefore adopt a multi-sectored strategic approach directed at both local and national levels.

Any intervention considered should be tailored to each sector of the community being served. It has been recommended that oral health education programmes should focus on the prenatal and early post-natal period as women tend to be more susceptible to public health messages. This in turn could help to ensure that healthy behaviours are established in early childhood. Every community living in Leicester City should be targeted to receive appropriate oral health education, as low levels of knowledge rather than negative attitudes may be putting them at high risk.

Water fluoridation is a very cost effective method for reducing the risk of caries especially within deprived communities. There are no water fluoridation schemes in Leicester City and this should be pursued in the longer term. In the short term, the wide distribution of fluoride toothpastes on a regular basis should be considered. The cost of toothpaste can be a barrier for low income communities and therefore the removal of VAT may be advantageous. The provision of low cost and affordable toothbrushes and toothpastes can also be stocked for sale at Children's Centres, along with supervised tooth brushing sessions at Early Years settings.

It has been reported that decay prevalence is higher in young children who brush their own teeth than those where an adult helps and therefore encouraging supervision by an adult until the child has the manual dexterity to brush effectively is encouraged. Supervised tooth brushing sessions at Children's Centres and Early Years settings could be implemented.

Facilitating access to early and regular dental care is as crucial as providing a greater availability of non-pharmacological techniques for anxious preschool children in order to reduce the demand and requirement for dental GA. Referral guidelines should be formalised in order to reduce referrals for GA and this should be monitored closely. Furthermore, professionally applied topical fluoride varnish applications should be encouraged for all preschool children.

All front line staff have ready access to parents/carers with preschool children and are therefore an ideal group to collaborate with. The need to recognise oral health within mainstream health and care policies is vital as a common risk factor approach to disease prevention could provide a more effective means to promoting oral health. There is also a

need to ensure that the under-served population groups are fully integrated into the community health strategy with active involvement stimulating a sense of belonging and community spirit, thereby increasing social capital within a community.

## Strategy

The oral health promotion strategy for preschool children living in Leicester City is structured around the five principles of the Jakarta Charter (World Health Organisation 1997):

- **Promote social responsibility for health**
  - Encourage advertisements for healthy foods
  - Campaign for the removal of VAT on fluoride toothpastes
  - Lobby for more retail outlets to provide total sweet free checkouts (especially at toddler eye level)
  - Ensure oral health input into infant feeding guidelines
  - Introduce dietary guidelines on reducing sugar consumption for preschool children
  - Encourage the increase in the provision of fluoride varnish applications from three years of age
  - Raise awareness of dental neglect within child protection
  - Pursue support for water fluoridation

- **Increase investments for health development**
  - Ensure oral health promotion messages are consistent and evidence based
  - Conduct oral health workshops for all front line staff including early years settings
  - Incorporate oral health input into early years training programmes provided in the City
  - Develop educational oral health programmes for parenting classes
  - Use social marketing methods to promote oral health messages within a range of settings
  - Re-commence a '*Brushing for Life*' scheme in Children's Centres
  - Provide training to the local dental profession on non-pharmacological behaviour management techniques for preschool children
  - Increase local dental profession's awareness/understanding of oral health issues affecting different sectors of the community
  - Ensure local dental profession receive training in Delivering Better Oral Health
  - Develop general health promoting knowledge and skills of the dental team
  - Establish an accreditation process for early years settings that offer healthy food/snack policies and daily supervised tooth brushing
  - Establish an accreditation process for NHS dental practices providing a child friendly preventative focus
- **Consolidate and expand partnerships for health**
  - Develop networks to facilitate oral health promotion within general health promotion
  - Develop multiple access points to dentistry through building effective links with all (multi-agency) front line staff
  - Ensure the provision of oral health information and signposting to all pregnant women by midwives

- Introduce oral health advice at four month developmental check by health visitors – distribute toothbrushes and toothpastes at this universal contact
- Build relationships between accredited NHS dental services and Neighbourhood Advisory Boards, Children's Centres and early years settings
- Ensure data sharing agreements in place to identify and target those at high risk for dental decay
- Ensure the oral health needs of newly arrived children in the City are identified and met through collaborative working
- Ensure that a whole family approach to dental decay prevention is provided when one child has required a dental extraction under general anaesthesia
- Enhance involvement of midwives, family nurse partnerships, looked after children nurses, community nurses, community development workers, health visitors, school nurses, children centres staff, family support workers, early years staff (including childminders), foster carers, educational staff, community pharmacists and voluntary sector workers in promoting oral health
- Fully utilise the skill mix in the dental profession
- Encourage the prescribing, dispensing and sale of sugar-free medication to all pre-school children (particularly those on long term medication)
- Work intensively with those at higher risk of dental decay using a multi-agency approach

- **Increase community capacity and empower the individual**
  - Build community interest in oral health
  - Strengthen and develop strong community, commercial, voluntary, health and care partnerships
  - Support and promote Breastfeeding Friendly Places in the City
  - Introduce supervised tooth brushing sessions at Children's Centres and Early Years settings
  - Expand interpreter services for non-English speaking parents/carers
  - Ensure that the design of specific oral health resource packages are informed by community (including faith groups) participation and involvement
  - Distribute free toothbrushes and toothpastes to every child in the City by health visitors at universal points of contact: 4 months (to include weaning/drinking cups), 1 year and 2 years
  - Introduce the sale of affordable '*Brushing for Life*' packs at Children's Centres
  - Ensure that community and family support schemes tackle family lifestyle issues that could affect the health of the unborn and preschool child e.g. a household where parents use tobacco, take drugs, misuse alcohol.

- **Secure an infrastructure for health promotion**
  - NHSE-AT(Lincolnshire and Leicestershire) and Leicester City Council to work closely with other key organisations to ensure a coordinated and consistent approach towards improving oral health
  - Ensure information on accessing NHS dentistry is easily available to all sectors of the community including new residents to the City
  - Ensure access to NHS dentistry is equitable throughout Leicester City
  - Investigate appropriate incentives to encourage and support preventive approach to treating preschool children

- Dental attendance to be encouraged by Health Visitors at the 4-month visit
- Ensure that every child in the City attends a dental practice before their first birthday
- Amend the child health record (red book) to include dental questions
- Consider the cost-effectiveness of dental screening at early years settings in order to maximise uptake of services as a result
- Establish and maintain a single point of contact or dental 'portal' e.g. dental helpline
- Explore flexible models of service provision that match the needs of the population e.g. mobile units
- Investigate direct access to dental therapists, dental hygienists and dental nurses
- Ensure an improvement in the patient's experience of NHS dental services

## Evaluation

This strategy should form the basis by which oral health promotion interventions could be planned and outcomes measured. It could act as a basis of comparison across interventions, contributing to a knowledge base on effectiveness whilst assisting in the utilisation of limited resources. The selection of interventions will depend upon the evidence base, what is culturally appropriate and what is possible within the available resources. Both clinical outcomes as well as impact on oral health related quality of life measures need to be evaluated. It is essential that the evaluation developed is in accordance with the nature of each specific intervention.

It should be noted that there is currently little evidence on how best to evaluate oral health promotion interventions. The evaluation of oral health promotion is a complex and difficult task which has been generally underfunded and neglected. The WHO (1998) recommends that at least 10% of resources be allocated to the evaluation of interventions.

Process evaluation will be required throughout each intervention although assessment of the interventions as a whole will be required at completion. A core element of the implementation arrangements will be monitoring performance of the strategy to ensure progress and improvement and where necessary, to make adjustments.

Examples of some of the proposed output measures:

- Proportionate increase in the advertisements for healthy foods locally
- Proportionate increase in retail outlets provided total sweet free check-outs in the City
- Proportionate increase in the provision of fluoride varnish applications in 3-5 year olds (2-4 times a year)
- Number of oral health parenting sessions provided, and uptake
- Number of '*Brushing for Life'* packs sold at Children's Centres
- Number of Children's Centres and early years settings accredited with healthy food/snack policies and daily supervised tooth brushing sessions
- Number of dental practices accredited providing a child friendly preventative focus
- Number (and %) of pregnant women living in the City attending an NHS dental practice
- % increase in 0-1 and 2-5 years living in the City attending an NHS dental practice

- Number of children attending DGA
- Number of children with repeat DGA
- Number of children whose siblings have required DGA
- Participation of accredited dental practices in clinical audit and peer review
- Number of oral health preventive sessions held in accredited dental practices
- Number of accredited dental practices linked to Neighbourhood Advisory Boards, Children's Centres and Early Years settings

Outcome measures:

- Children attending primary dental care who are decay free
- Changes to dental decay levels and prevalence in children through dental epidemiological surveys

**TO BE DEFINED**

In order to deliver on the strategy, additional resources may be required. It is important that oral health receives fair consideration with other priorities when additional funding becomes available either locally or nationally over the lifetime of this strategy. There also remains the issue of funding for oral health within established programmes for preschool children and opportunities to access external funding should also be exploited.

To achieve the goals set out within this strategy, it is necessary to facilitate the engagement of all partners in order to promote oral health improvement and acknowledge a shared responsibility to address oral health. The principal emphasis on oral health education should continue to be laid upon four key areas: diet, oral hygiene, water fluoridation and dental attendance.

Although oral health has dramatically improved overall in the last 20 years, oral health inequalities have widened with the most stark oral health inequalities being found in dental caries levels amongst preschool children. Any restructuring of dental services must therefore ensure that young children are given the highest priority for care. However, these actions alone cannot hope to result in meeting the objectives and a population-based strategy is therefore essential. Only one measure can provide such a dramatic improvement in dental health on a community basis and that is water fluoridation, which will benefit the whole population.

## Next Steps

Once the Strategy is agreed and endorsed by the Board, an Action Plan will be written with built-in deliverables and deadlines involving all partner agencies. The Action Plan will provide the process of mobilising the implementation of the Strategy by establishing and clarifying goals that are SMART (Specific, Measurable, Attainable, Realistic and Time-based) focused.

**Jasmine Murphy**
**Consultant in Public Health**

# Appendix H

## Leicester City: Oral Health Promotion Action Plan (DRAFT)

Jasmine Murphy
Consultant in Public Health
Leicester City Council

### Year 1 (April 2013 – March 2014)

| Tasks | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 1 | 2 | 3 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Publish Oral Health Needs Assessment | | | | | | | | | | | | |
| Recruit and appoint Project Manager | | | | | | | | | | | | |
| Project Manager starts post | | | | | | | | | | | | |
| Establish Oral Health Programme Board and agree Terms of Reference | | | | | | | | | | | | |
| Define and agree Oral Health Promotion Strategy | | | | | | | | | | | | |
| Design Oral Health Promotion leaflets | | | | | | | | | | | | |
| Pilot the distribution of Healthy Teeth, Happy Smiles resource (leaflets, toothbrush and toothpaste) | | | | | | | | | | | | |
| Develop evaluation and benchmarking tools | | | | | | | | | | | | |
| Develop dental health pathway | | | | | | | | | | | | |
| Equality Impact Assessment | | | | | | | | | | | | |
| Identify task and finish groups | | | | | | | | | | | | |
| Recruitment to task and finish groups | | | | | | | | | | | | |
| Consultation exercise on equitable access to NHS dentistry | | | | | | | | | | | | |
| Identify training needs of all front-line staff | | | | | | | | | | | | |
| Develop accreditation scheme for Dental Practices, Nurseries, Child-minders, Play groups, Children's Centres and Schools | | | | | | | | | | | | |
| Investigate feasibility of community fluoride varnish programme including modelling exercise | | | | | | | | | | | | |
| Procure services for web design and social media package | | | | | | | | | | | | |
| Procure oral health | | | | | | | | | | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| package/resources (toothbrushes, toothpastes, leaflets, weaning cups) | | | | | | | | | | | | |
| Procure social marketing research | | | | | | | | | | | | |
| Procure evaluation of project | | | | | | | | | | | | |
| Develop training packages for all front-line staff | | | | | | | | | | | | |
| Oral health input into infant feeding guidelines | | | | | | | | | | | | |

## Year 2 (April 2014 – March 2015)

| Tasks | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 1 | 2 | 3 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Develop local guidelines for reducing sugar consumption | | | | | | | | | | | | |
| Promote adverts for healthy foods | | | | | | | | | | | | |
| Lobby for sweet free checkouts | | | | | | | | | | | | |
| Continued development of training packages for all front line staff | | | | | | | | | | | | |
| Implement training of all front line staff | | | | | | | | | | | | |
| Core training embedded in professional development | | | | | | | | | | | | |
| Commence accreditation scheme for dental practices and early years settings | | | | | | | | | | | | |
| Commence oral health component in ante-natal parenting classes | | | | | | | | | | | | |
| Commence distribution of oral health resources by health visitors | | | | | | | | | | | | |
| Build partnership and links between accredited Dental Practices and nurseries, Children's Centres and schools according to Neighbourhood Advisory Board area | | | | | | | | | | | | |
| Commence supervised daily toothbrushing at Children's Centres (Cook and Eat sessions), nurseries and primary schools | | | | | | | | | | | | |
| Scope initiatives to build community interest | | | | | | | | | | | | |
| Develop oral health | | | | | | | | | | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| champion training package | | | | | | | | | | | | |
| Commence training members from different sectors of the community as oral health champions | | | | | | | | | | | | |
| Commence community fluoride varnish programme (if proven feasible) | | | | | | | | | | | | |
| Commence cross-cutting social marketing campaign | | | | | | | | | | | | |

### Year 3: (April 2015 – March 2016)

- Embed sustainability of programme

### Year 4: (April 2016 – March 2017)

- Embed sustainability of programme
- Evaluation and lessons learnt

October 2013

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Leicester City Council

Oral health for Overall health

Dr. Jasmine Murphy
(Consultant in Public Health)
Paul Akroyd
(Project Manager)

# What is oral health?

Health of the teeth and other oral structures which allows individuals to:

* Be free of pain and discomfort
* Eat efficiently
* Speak clearly
* Socialise without embarrassment
* Be free of life threatening disease

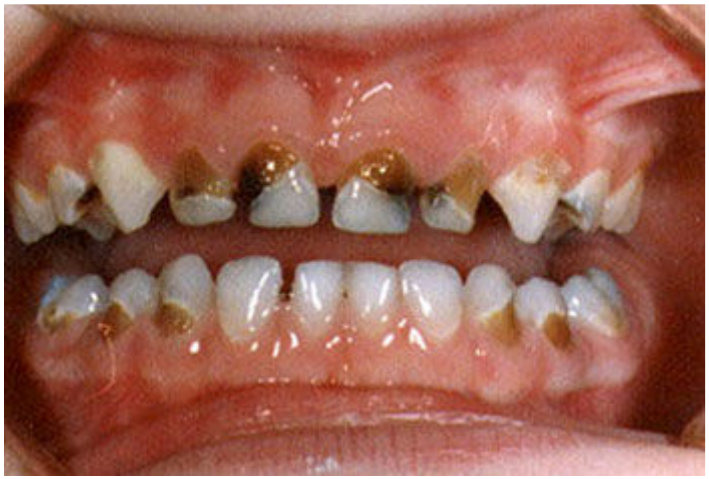
and contributes to individual

general well-being

# What are the main causes of poor oral health?

- **Poor diet and nutrition**: High intake of sugar, fizzy and acidic drinks
- **Poor oral hygiene**: Failure of self-care e.g. regular tooth brushing and flossing
- **Fluoride**: The lack of exposure to fluoride
- **Tobacco and alcohol**: Smoking increases the risk of periodontal disease and is one of the main causes of oral cancer. Smoking combined with alcohol can lead to a 30 times greater risk of oral cancer. Smokeless tobacco also increases the risk of oral cancer
- **Injury**: The health of teeth can be compromised by traumatic injury. Those who play contact sport are at particular risk

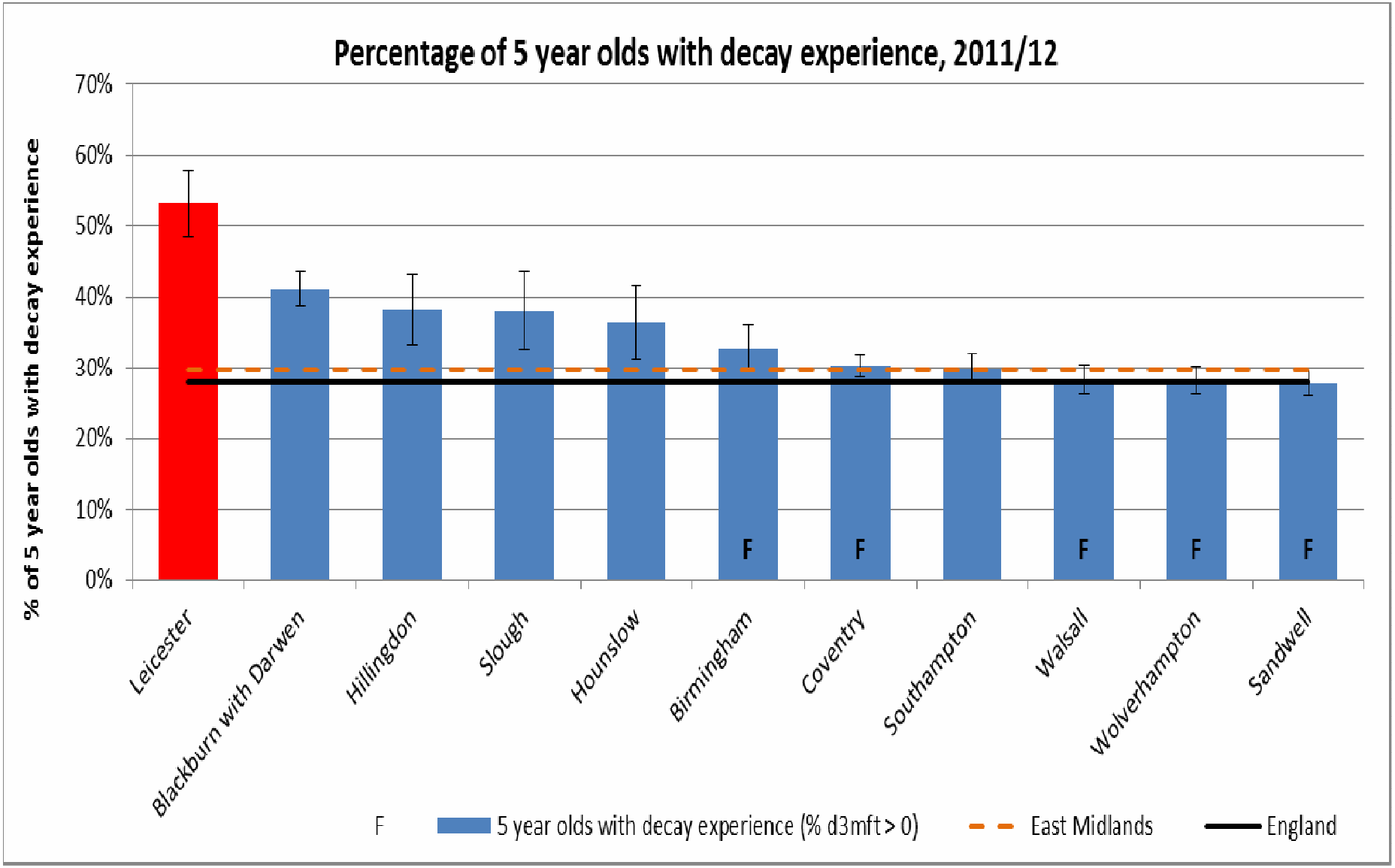
# What is the situation in Leicester?



- 5 year old children living in Leicester have the highest experience of dental decay observed in England

- The average number of decayed, missing or filled teeth for a five year old in Leicester is 2.06 which is more than double the national rate of 0.94

5 year olds with decay experience, 2011/12 (% d3mft > 0)
% of 5 year olds with decay experience
60%
50%
40%
30%
20%
10%
0%
Leicester
Salford
Tower Hamlets
Enfield
Bolton
Ealing
Blackburn with Darwen
Manchester
Rotherham
Rutland
Westminster
Newham
Nottingham
Slough
Wigan
Sunderland
Hounslow
Peterborough
Liverpool
Torbay
Barking and Dagenham
Tameside
Stoke-on-Trent
Doncaster
Bury
St Helens
Wirral
Stockton-on-Tees
Hackney
Derby
Islington
Northamptonshire
Southampton
Darlington
Merton
Hammersmith and Fulham
Wolverhampton
Gloucestershire
England
Sandwell
Bracknell Forest
Norfolk
Dorset
Waltham Forest
Bournemouth
Gateshead
Cornwall
Portsmouth
North Yorkshire
Plymouth
York
Swindon
Solihull
Lambeth
Nottinghamshire
Devon
Poole
East Sussex
Derbyshire
Cheshire East
Southwark
Staffordshire
Worcestershire
Windsor and Maidenhead
Southend-on-Sea
Warwickshire
Kent
Hartlepool
Medway
Isle of Wight
Richmond upon Thames
Central Bedfordshire
Cambridgeshire
West Sussex
5 year olds with decay experience, 2011/12 (% d3mft > 0)
England (5 year olds with decay experience)

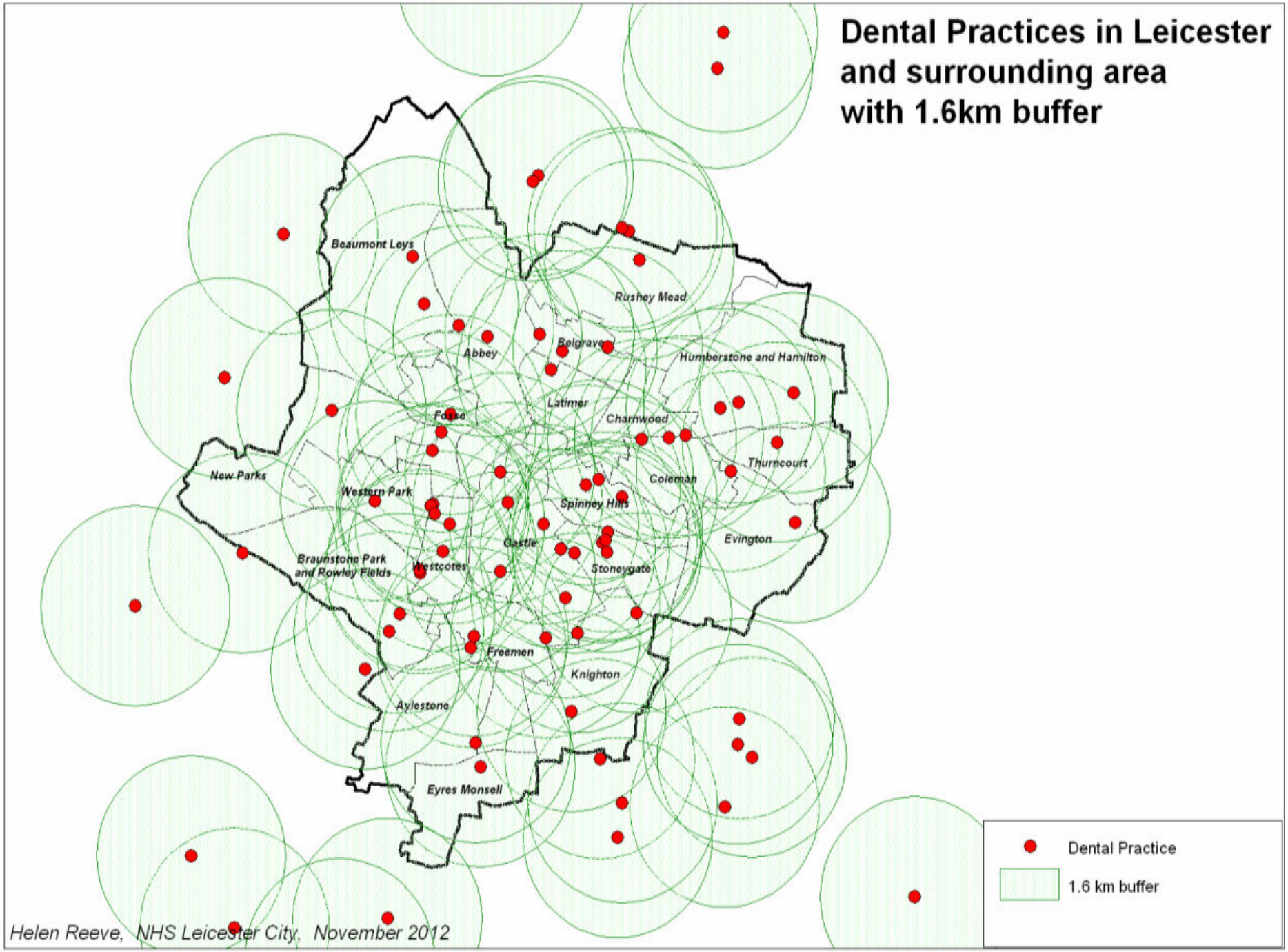

Percentage of 5 year olds with decay experience, 2011/12
% of 5 year olds with decay experience
70%
60%
50%
40%
30%
20%
10%
0%
F
F
F
F
F
Leicester
Blackburn with Darwen
Hillingdon
Slough
Hounslow
Birmingham
Coventry
Southampton
Walsall
Wolverhampton
Sandwell
F
5 year olds with decay experience (% d3mft > 0)
East Midlands
England

# Why is there a problem?

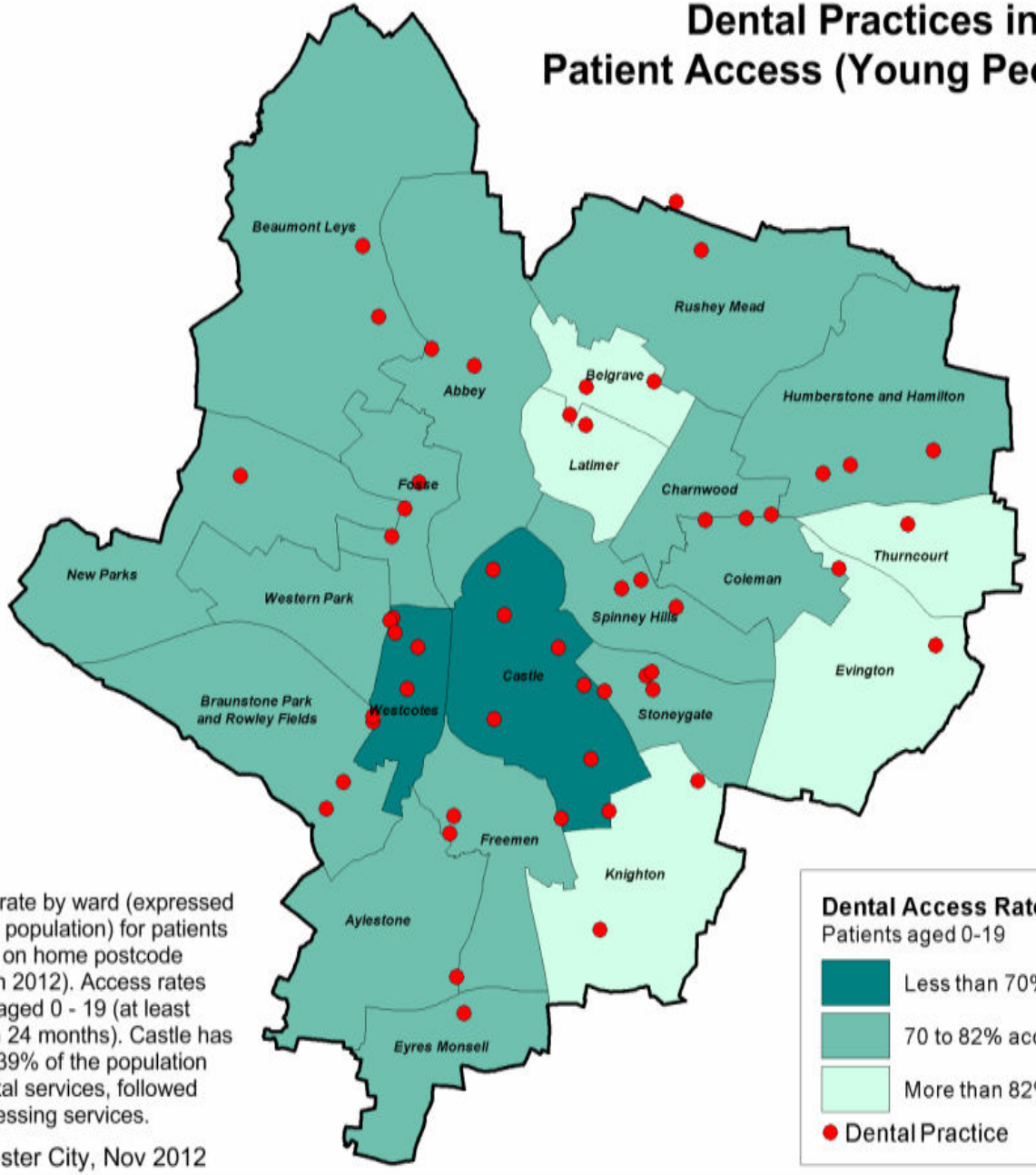
1. Most of the decay is mainly caused by children having unhealthy diets that are too high in sugary food and drinks.

2. Children need to clean their teeth; and parents need to help them gain these skills.

3. It's important that a child regularly visits the dentist.


Dental Practices in Leicester and surrounding area with 1.6km buffer
Beaumont Leys
Rushey Mead
Abbey
Belgrave
Humberstone and Hamilton
Latimer
Fosse
Charnwood
New Parks
Western Park
Thurncourt
Coleman
Spinney Hills
Castle
Evington
Braunstone Park and Rowley Fields
Westcotes
Stoneygate
Freemen
Knighton
Aylestone
Eyres Monsell
Dental Practice
1.6 km buffer
Helen Reeve, NHS Leicester City, November 2012

# Dental Practices in Leicester and Patient Access (Young People aged 0-19)




The map shows the access rate by ward (expressed as a percentage of the ward population) for patients resident in Leicester (based on home postcode between April 2010 to March 2012). Access rates are also shown for patients aged 0 - 19 (at least one visit to the dentist within 24 months). Castle has the lowest access rate with 39% of the population aged 15-19 accesssing dental services, followed by Westcotes with 52% accessing services.

Rowan Smith, NHS Leicester City, Nov 2012

**Dental Access Rate (%)**
Patients aged 0-19

- Less than 70% accessing services (2)
- 70 to 82% accessing services (10)
- More than 82% accessing services (10)
- Dental Practice

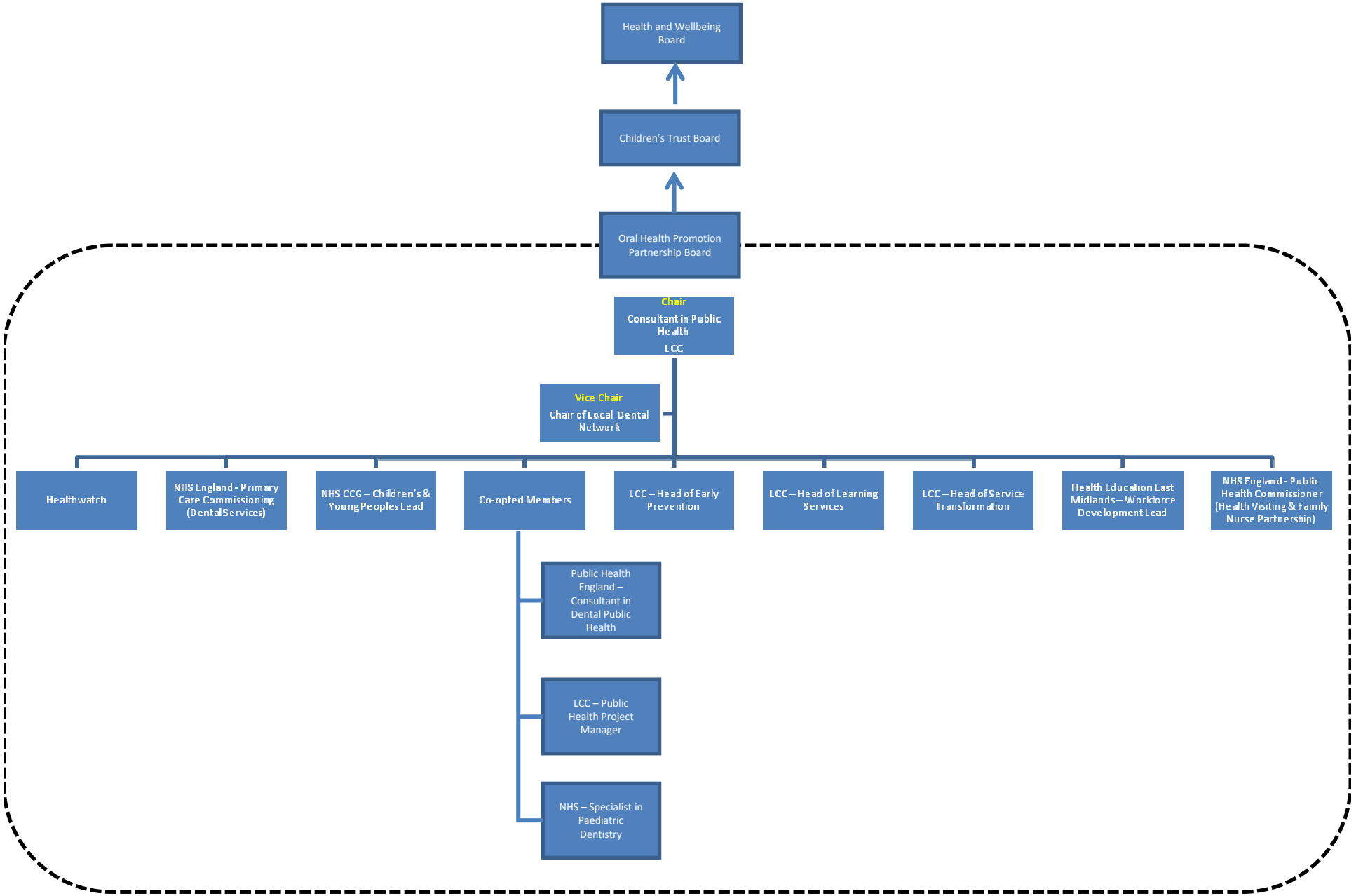
# What are we doing about it?

- Improving oral health: new responsibility for local government.

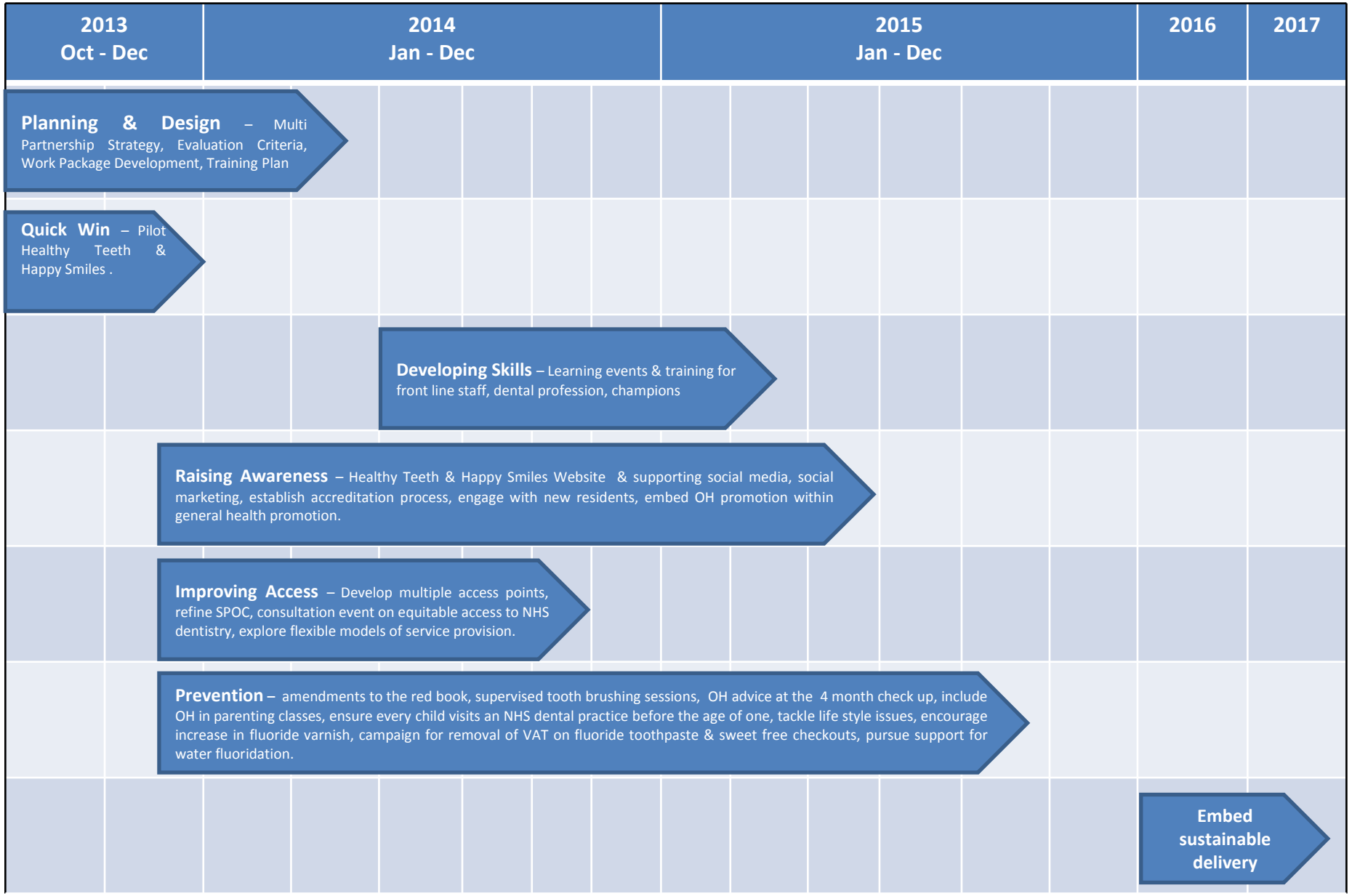
- Leicester City Council: leading on the development of some practical and sustainable solutions for the improvement of oral health in the city.

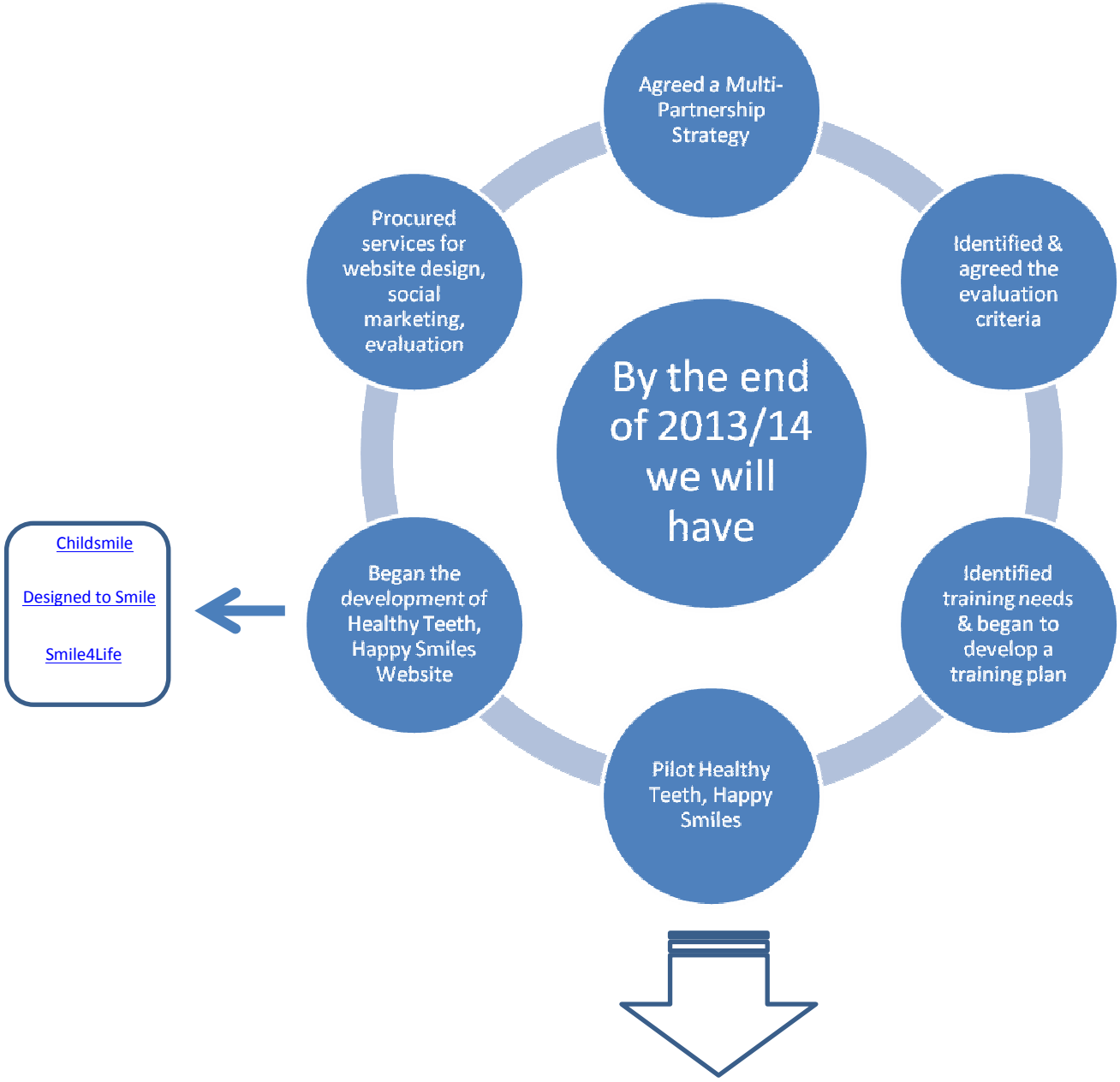
- Working in partnership across agencies to ensure that improving oral health is everyone's business.

# Oral Health Promotion Partnership Board - Governance



# Oral Health Promotion Strategy 2014-2017 – High Level Timeline




By the end of 2013/14 we will have
Agreed a Multi-Partnership Strategy
Identified & agreed the evaluation criteria
Identified training needs & began to develop a training plan
Pilot Healthy Teeth, Happy Smiles
Began the development of Healthy Teeth, Happy Smiles Website
Procured services for website design, social marketing, evaluation
Childsmile
Designed to Smile
Smile4Life

# Healthy Teeth, Happy Smiles !


- 3000 packs to be distributed by Health Visitors over 6 months at the universal 4 months check.
- 4300 packs to be distributed to every child in reception class in LCC maintained schools.
- 4000 packs to be distributed to every child in Year 3 in LCC maintained schools.

Appendix J

Leicester City Council

**LEICESTER CITY HEALTH AND WELLBEING BOARD**

**8TH OCTOBER 2013**

| | |
|---|---|
| **Subject:** | **Update on the Progress of the Joint Health and Wellbeing Strategy** |
| **Presented to the Health and Wellbeing Board by:** | **Deb Watson** |
| **Author:** | **Adam Archer** |

**EXECUTIVE SUMMARY:**

This report presents information on progress in delivering the Joint Health and Wellbeing Strategy: 'Closing the Gap'.

Responsibility for ensuring effective delivery of the strategy has been devolved to the Leicester City Joint Integrated Commissioning Board (JICB). This is the first bi-annual progress report to the Health and Wellbeing Board. It serves two related purposes: providing assurance that actions identified in the strategy are being delivered and/or flagging up any potential risks to delivery; and, reporting on the performance indicators set out in Annex B of the strategy.

The approach adopted is to provide relatively high level monitoring of the strategy, acknowledging that both the actions and performance indicators in the strategy are subject to separate monitoring and reporting through the governance arrangements of those partner organisations coming together through the Health and Wellbeing Board.

It is clearly too early to form any judgement as to whether the delivery of the strategy is making an impact on the health and wellbeing of the city's residents, but there are no major causes for concern identified in this report.

**RECOMMENDATIONS:**

The Health and Wellbeing Board is requested to:

(i) Note progress on the delivery of the Joint Health and Wellbeing Strategy;

(ii) Identify any areas of concern that require further reporting or remedial action from the JICB;

(iii) Comment on the style and content of this report, identifying any improvements that could be made to future reports from the JICB.

# Update on the Progress of the Joint Health and Wellbeing Strategy

Report on behalf of the Leicester City Joint Integrated Commissioning Board

## 1. Introduction

This reports presents information on progress in delivering the Joint Health and Wellbeing Strategy: 'Closing the Gap'.

The strategy, adopted in April 2013 and covering the period 2013 to 2016, is based on the Joint Strategic Needs Assessment (JSNA). Its overall aim is to reduce health inequalities, and it has five strategic priorities:

- Improving outcomes for children and young people
- Reducing premature mortality
- Supporting independence for older people, people with dementia, long term conditions and carers
- Improving mental health and emotional resilience
- Addressing the wider determinants of health through effective use of resources, partnership and community working

For each priority a number of focus areas are identified, and the strategy includes key performance indicators to measure progress.

This is the first bi-annual progress report to the Board. It serves two related purposes: providing assurance that actions identified in the strategy are being delivered and/or flagging up any potential risks to delivery; and, reporting on the key performance indicators set out in Annex B of the strategy.

The approach adopted is to provide relatively high level monitoring of the strategy, acknowledging that both the actions and key performance indicators in the strategy are subject to separate monitoring and reporting through the governance arrangements of those partner organisations coming together through the Health and Wellbeing Board.

## 2. Progress on implementing the actions in the Health and Wellbeing Strategy

The overall approach we have taken to monitoring progress against the actions set out on the strategy has been 'light touch' – in order to give a board overview of progress, and in keeping with the high level and extensive scope of the strategy itself.

Each of the five strategic priorities of the strategy consists of a number of sub-sections. Strategic priorities 1 to 4 contain 15 sub sections in all, and we have asked key contacts for those sub sections to provide a progress statement

and RAG rating on each one. For Strategic Priority 5: *Focus on the Wider Determinants of Health,* there is just one statement for the priority as a whole, to reflect the more enabling and cross-cutting nature of this priority.

In total therefore there are 16 statements of progress, together with RAG ratings, set out at ***Appendix 1***.

To produce each statement, a contact person was identified for each of the areas. That person was asked to liaise with key colleagues to:

- refer to the text of the Joint Health and Wellbeing Strategy for their sub-section;
- report on progress with taking forward the actions in that section, as at September 2013, particularly referring to the bullet points listed under *What we plan to do*;
- make the progress statement short and succinct;
- focus particularly on any key achievements in the context of the strategy or any areas that are on significantly at risk of not being delivered (ie red rated); and
- provide a RAG rating for progress on work in that sub-section.

Overall, the RAG ratings that contact people gave to the 16 areas were:

| | | |
|---|---|---|
| **Green** | Good progress is being made and there are no significant problems | 10 |
| **Amber** | Some risk that actions may not be delivered but this risk will be managed | 6 |
| **Red** | Serious risk of one or more actions not being delivered | 0 |

3. <u>Monitoring the key performance indicators in the Health and Wellbeing Strategy</u>

The majority of performance indicators in the strategy are outcome measures. They are designed to provide evidence that the actions identified in the strategy (and indeed the wider efforts of partners under the Board's "call to action") are having the desired impact, or not, as the case may be.

The indicators do not have specific targets, but rather reflect the ambition of the strategy to improve on the current positions for all our priorities.

At this early stage in the delivery of the strategy there is limited information available on which to make a judgement as to whether this improvement is happening.

Of the 24 indicators, 2 are reported biennially, 11 annually, 9 quarterly, 1 has no fixed reporting pattern and 1 is a placeholder (not yet being collected). Of the biennial and annual indicators, there has been no data published since the adoption of the strategy. However, in some cases we now have more up-to-date data than the baseline ("most recent position") published in the strategy. For 6 of the quarterly indicators data has been published for Quarter 1 of 2012/13.

Over time more data will be available and it will be possible to provide more meaningful reports with increasingly useful trend analysis. For some indicators benchmark data will be available which can be incorporated in future reports if the Board would find this helpful.

A table showing the current position

Given these caveats, a summary of the current position on the 24* indicators in the strategy is (the full report on the indicators is set out in ***Appendix 2*** of this report):

| | | |
|---|---|---|
|  | Performance has improved from the baseline in the strategy | 8 |
|  | Performance is the same as the baseline in the strategy, no data has been published since the baseline, or there are data quality issues | 11 |
|  | Performance has worsened from the baseline in the strategy | 6 |

* Although there are 24 indicators, 'obesity in children' has sub-indicators for 'reception' and 'year six', hence the ratings in the above table total 25.

*Appendix 1*

# Implementing the actions in Closing the Gap: Leicester's Joint Health and Wellbeing Strategy 2013-16

## Progress: September 2013

### Strategic Priority 1: Improve outcomes for children and young people

| Sub section | 1.1 Reduce Infant Mortality |
|---|---|
| Key contacts | Jo Atkinson, Public Health Consultant, LCC |

Leicester's current rate of infant mortality (6.4/1000) is significantly higher than the national rate (4.4/1000). The rate has reduced from a previous 3 year average of 7/1000. This is encouraging, however, the numbers are small therefore the reduction is not statistically significant.

A "Health in Infancy" event was held in October 2012 aiming to harness the capacity of a range of staff and volunteers to tackle infant mortality. A small grant was allocated to each neighbourhood area to fund small projects aimed at reducing infant mortality. "Health in Infancy" champions were appointed and have worked with their Neighbourhood Area Boards to develop and deliver on action plans. A further event is planned for December to showcase projects, share good practice and discuss next steps.

On a wider city level, a range of initiatives and services are in place and being further developed to tackle the risk factors for infant mortality. The infant feeding strategy is being revised, the key aim of which is to improve breastfeeding rates. Hospital and community based staff (including health visitors and children's centres) have received comprehensive training in supporting women to breastfeed. UHL and LPT are near to the completion of stage 2 of the UNICEF baby friendly programme (assessment November). A maternal obesity pathway has been developed to support women with weight management during pregnancy, which is being operationalized in October. A social marketing campaign is currently running locally aiming to increase the proportion of women booking for pregnancy before 12 weeks.

| RAG: Green | Good progress is being made and there are no significant problems. |
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| Sub section | 1.2 Reduce Teenage Pregnancy |
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| Key contacts | Jasmine Murphy, Consultant in Public Health, Leicester City Council |
| | Liz Rodrigo, Public Health Principal, Leicester City Council |
| | David Thrussell, Head of Young Peoples Service, Leicester City Council |

1. Coordination – Discussions are currently taking place between public health and youth services about the function of the coordinator and its synergy with the Early Help offer.
2. Access to contraception – All young people's services will be maintained with plans for further improvement in the recently commissioned Integrated Sexual Health Service which will be commencing 1st Jan 2014
3. Relationship and Sex Education – Review of position to take place for Q3
4. Educational attainment and Raising Aspirations – Leicester is continuing to perform well

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| with attainment. There are some concerns about NEET and under 18 conception data rising which is being investigated. | |
| **RAG: Amber** | Some risk that actions may not be delivered but this risk will be managed. |

| **Sub section** | **1.3 Improve readiness for school at age five** |
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| **Key contacts** | Nicola Bassindale, Early Prevention Service, Leicester City Council |

Progress on the planned actions for this priority is as follows:

**Action: Improving data systems to enable us to identify children at risk of achieving poor outcomes and who have delayed development at an early age, enabling us to target learning support to those who need it most.**
Work has progressed to ensure that the data held by DataNet is accessed directly by Children's Centre Teachers to pick up trends and identify children at risk of poorer outcomes at Foundation Stage, enabling them to target work with individual children and families and make contact through schools who have a greater proportion of children falling into the bottom 20%. Children's Centre staff provide individual support to children and promote and enable parents to get involved in their child's learning. Learning plans are developed and progress is tracked to evidence the impact of targeted support towards improving outcomes. The percentage of children achieving the 'expected' or 'exceeding' level of development across the 3 prime areas of learning at Foundation Stage (Leicester's measure of 'ready for school') has increased from 64% in 2012 to 65.7% in 2013.

**Action: Improving our partnership working to improve the quality, quantity and take up of family orientated preventative health and wellbeing initiatives for children living in our most deprived areas.**
The integrated model of services delivered through Children's Centres (located in the most deprived areas of the city) enables LCC and Health services to work closely together through formal liaison meetings and day to day working to identify families that may benefit from specific interventions aimed at improving learning and health outcomes. The two year old development check is now carried out jointly by Health Visitors and Children's Centre staff, enabling issues to be identified earlier and actions planned to address emerging learning or health concerns. Staff working directly with families also pick up on health-related issues and work with partners to develop and target preventative health and wellbeing initiatives to families, focusing on areas such as reducing obesity through healthy eating and 'grow your own' projects, improving health and reducing infant mortality through supporting breast feeding and reducing smoking in pregnancy, etc.

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| **RAG: Green** | Good progress is being made and there are no significant problems. |

| **Sub section** | **1.4 Promote healthy weight and lifestyles in children and young people** |
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| **Key contacts** | Jo Atkinson, Consultant in Public Health, LCC<br>Steph Dunkley, Public Health Principal, LCC |

- The National Child Measurement Programme provisional results for 2012/13 are expected in December 2013. Uptake of the programme has been very high this year.
- The review of the obesity strategy and Leicester Sports Partnership Trust's action plan are currently taking place. There are plans for consultation with stakeholders and the public regarding the revision of the obesity strategy late 2013/early 2014. A revised strategy

will be published in 2014.

- Active Travel initiatives continue to be supported. In 2012/13, over 1000 pupils were trained in Scootability and active travel to school continues to be promoted in city schools. The programme of neighbourhood cycling events, led-rides and Sky ride all contribute towards increasing levels of cycling in both adults and children.
- As of March 2013, 73 schools have engaged with the Healthy Schools programme and received training and support. 27 have identified a priority area - the chosen priorities are healthy weight (17), emotional health (15), teenage pregnancy/RSE (3) and smoking (3).
- The Food Routes programme continues to run in primary schools encouraging a whole school approach to healthy eating, including cooking skills courses for children and their families.
- The "Playing for health" programme continues to run in the majority of primary schools this academic year led by the professional sports clubs. This offers whole classes a 5 week multi-skills programme led by sports coaches in curriculum time.
- Child weight management programmes are due to start running in October until end March. This service is currently out to tender with a start date of 1st April 2014 for provision of the new service.

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| **RAG: Amber** | Some risk that actions may not be delivered but this risk will be managed. |

**Strategic Priority 2: Reduce premature mortality**

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| **Sub section** | **2.1 Reduce smoking and tobacco use** |
| **Key contacts** | Rod Moore, Public Health, Leicester City Council |

The Tobacco Control Coordination Group has completed the CleaR self-assessment audit to help strengthen leadership and influence for the tobacco control agenda. This includes the continued Step Right Out Campaign to reduce exposure to second hand smoke in homes and cars, where a recent independent evaluation has shown that among the sample consulted the Step Right Out campaign is achievable for those signing up and motivates the majority of individuals who previously allowed smoking in their home and car, to stick to the pledge to keep them smokefree.

Work has also continued to promote smoking cessation with communities, hospitals, primary care, maternity services and others. The achievement of quits at 4 weeks is lower than in previous years and is thought to reflect a change in approach to quitting brought about by e-cigarettes which is being experienced nationwide.

A recovery plan is in place and the issue of e-cigarettes will be further considered by commissioners. The service continues to make smoking cessation available to young smokers, though the service is finding it less easy to engage with schools on prevention than in previous years which will be addressed in the coming months. Leicester is hosting a national event looking at the issues of Shisha smoking on 17 October 2013.

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| **RAG: Amber** | Some risk that actions may not be delivered but this risk will be managed. |

| Sub section | 2.2 Increase physical activity and healthy weight |
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| Key contacts | Jo Atkinson, Consultant in Public Health, LCC<br>Steph Dunkley, Public Health Principal, LCC Leicester City Council |

- The review of the obesity strategy and Leicester Sports Partnership Trust's action plan are currently taking place. There are plans for consultation with stakeholders and the public regarding the revision of the obesity strategy late 2013/early 2014. A revised strategy will be published in 2014.
- Active Travel initiatives continue to be supported including cycle training, neighbourhood events, led-rides and the work –based cycle challenge. The Walking for Health Programme waits confirmed funding to appoint a co-ordinator and redevelop the local scheme which is currently very limited.
- The Lifestyle Referral hub has been piloted in 14 GP practices, a roll-out across all practices in the city is planned for 2014.
- Adult weight management services continue to be provided across the city, particularly targeting those areas and groups with the highest level of need. Consultation on weight management services will take place as part of the revision of the obesity strategy.
- The Active Lifestyle Scheme has seen a dramatic increase in demand and is overachieving targets following the introduction of scheme becoming free of charge.
- The "have one on us" campaign has been running across the city with the initial focus being diet and physical activity. A full social marketing programme is in the process of being developed.
- The health trainer service (one to one lifestyle advice) continues to operate in the most disadvantaged areas of the city. An evaluation of the service has been undertaken with very positive results in terms of outcomes and value for money. Re-procurement of the service will commence late 2013.

| RAG: Amber | Some risk that actions may not be delivered but this risk will be managed. |
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| Sub section | 2.3 Reduce Harmful Alcohol Consumption |
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| Key contacts | Julie O'Boyle, Consultant in Public Health LCC<br>Mike Broster, Licensing LCC<br>Chief Inspector Donna Tobin-Davies, Leicestershire Police<br>Karly Thompson, Divisional Director East Midlands Ambulance Service<br>Paul Hebborn, Leicestershire Fire and Rescue Service<br>Priti Raichura, Public Health Principal LCC<br>Justine Denton, LCC Trading standards |

The Alcohol Harm Reduction Delivery Group is a multi-agency partnership group focused on reducing harm related to alcohol. This group of partners are in the process of launching a new alcohol harm reduction strategy for the city. The strategy focuses on five main themes:

- Promoting a culture of responsible drinking
- Protection of children young people and families from alcohol related harm
- Improved health and wellbeing through early identification and recovery focussed treatment
- Promoting responsible selling of alcohol
- Reducing alcohol related crime disorder and anti-social behaviour

Activities undertaken include:

Co-ordinated alcohol awareness campaigns involving all partners including;

- Freshers week (both universities)
- Alcohol awareness week
- Dry January

Training of 1,000 front line staff to deliver alcohol brief interventions.

Targeted social marketing campaign aimed at the 7 wards with the highest rates of alcohol related harms.

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| **RAG: Green** | Good progress is being made and there are no significant problems. |

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| **Sub section** | **2.4 Improve the identification and clinical management of cardiovascular disease, respiratory disease and cancer** |
| **Key contacts** | Sarah Prema, Leicester City Clinical Commissioning Group |

- Between April and August 2013 11,140 NHS Health Checks have been undertaken against an Area Team target of 12,400 (by 31st March 2014) and a local target of 31,725 (by the end of March 2014). Of the 11,140, 1,917 patients have had conditions detected and a management plan put in place.
- General Practice staff have received training and development in the management of Diabetes through the EDEN project.
- Public Health is currently finalising proposals to expand the lifestyle referral hub which will give health professionals a one stop-shop for patients who need lifestyle interventions such as exercise and diet advice.
- New national campaign "blood in your pee" is due to be launched in the Autumn.
- New service to be implemented in October 2013 to case find patients who have COPD, it is anticipated that this will identified over 600 new patients by the 31st March 2014.
- Telehealth and health coaching is supporting 50 patients to manage their conditions better and reduce emergency admissions to hospital. This pilot is due to be increase to 100 patients over the next few months.

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| **RAG: Green** | Good progress is being made and there are no significant problems. |

**Strategic Priority 3: Support independence**

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| **Sub section** | **3.1 People with long term conditions** |
| **Key contacts** | Sarah Prema, Leicester City Clinical Commissioning Group |

- Work is commencing in the Autumn to further develop co-ordinated health and social care services.
- New service, Intensive Community Support Service, commencing in October 2013 to support people coming out of hospital in their own home.
- Plans are being developed to inform the plan for utilisation of the health transformation budgets, this will include prevention services.

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| **RAG: Green** | Good progress is being made and there are no significant problems. |

| Sub section | 3.2 Older People |
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| Key contacts | Bev White, LCC |

- Work is progressing on developing reablement and enablement pathways which will support older people to maintain or regain their independence.

- Work has begun to develop a Strategy for Older People which will take a holistic approach to the coordination and delivery of culturally appropriate high quality services across health, social care, housing and other relevant organisations. This will also consider how we can increase the participation of older people in neighbourhoods to increase social inclusion and general wellbeing.

| RAG: Green | Good progress is being made and there are no significant problems. |
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| Sub section | 3.3 People with Dementia |
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| Key contacts | Bev White LCC |
| | Wendy Pearson – LC CCG |

The Joint LLR Dementia Strategy continues to be implemented with many of the actions moving into a delivery stage:

- A memory assessment pathway has been developed and a shared care protocol is being finalised
- An integrated crisis response service has been developed and its success is being monitored
- A suite of information for carers, people with dementia and professionals has been developed and is about to be published
- The implementation of carers' assessments is a priority in the carer's strategy
- Work continues to ensure that re-ablement and intermediate care pathways are appropriate for people with dementia and facilitate early discharge back into the community.
- The provision of appropriate, high quality support services and assistive technology continue to be rolled out
- Awareness of dementia and the availability of services within specific communities continues to be promoted via Memory Cafes and Dementia Friends sessions
- Dementia champions have been recruited, trained and a network developed to ensure that the care delivered in hospitals is of the highest quality; a similar programme for residential and nursing homes is in development.

| RAG: Green | Good progress is being made and there are no significant problems. |
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| Sub section | 3.4 Carers |
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| Key contacts | Mercy Lett-Charnock, LCC |

- A Carers Joint Specific Strategic Needs Assessment, "The Needs of Carers in Leicester" has been produced. This will be reviewed over time but already identifies issues for carers in the City that support services can focus on in order to improve outcomes for carers. This information will inform future developments.
- The numbers of carers assessments undertaken has increased from 1,233 in 2011/12 to

1,810 in 2012/13.

- In 2012/13 824 carers were provided with a carers personal budget (this is approximately 45% of those receiving a carers assessment) and the opportunity continues to be promoted in order to enable carers to access personalised support that best meets their needs.
- A carers break scheme is in development with the voluntary sector already delivering additonal breaks as part of a pilot exercise to inform the longer term work.
- A significant commitment has been given to helping to identify carers and to support them through the provision of information and advice during the last year and in addition to the voluntary sector services provision, a new information leaflet to help early identification of carers has been produced with and for carers.
- Carers have also been invovled in the development of the LCC carers website. Specific information including a carers personal budget leaflet has been developed in response to carer feedback and a newsletter is produced specifcally for carers to help them access relevant training and services.
- A carer training programme has been developed within the City Council which has delivered training to an additional 123 people during the last year, to help them undertake their role.
- An interagency pilot has been underaken to improve the pathways into services for young carers, to ensure they are identified and are able to fulfil their potential in terms of education and leisure.
- GP's have been invovled in carer awareness along with practice manager staff to ensure an improved service for carers and better identification.

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| **RAG: Green** | Good progress is being made and there are no significant problems. |

**Strategic Priority 4: Improve mental health and emotional resilience**

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| **Sub section** | **4.1 Promote the emotional wellbeing of children and young people** |
| **Key contacts** | Jasmine Murphy, Consultant Public Health, Leicester City Council |
| | Mark Wheatley, Public Health Principal, Leicester City Council |

The approach currently being developed in Public Health focuses on the following areas:

- Healthy Schools
- School Nursing Service
- CAMHS chapter in the forthcoming Joint Specific Needs Assessment on Mental Health in Leicester
- Collaboration with the CCG in providing public health information and advice

The CCG with the local authority commissions Child Mental Health Training for staff delivering Tier 1 CAMHS services (universal services). The training service offers a wide range of courses, using experienced and practising professionals & clinicians, to deliver relevant content with a specific focus on children and adolescents. A two day event on 'Working Together in Child Mental Health and Promoting Mental Health' offers training for Tier 1/Primary care staff and managers for the statutory and voluntary sectors who come into contact or work with children and young people as part of their role. In addition to the 2 day course, more specialised one-day events on different types of child mental health problems/disorders are organised, incorporating a multi-agency approach similar to the 2

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| day courses. Topics include Attachment, Anger, Anxiety, Self-Harm, Depression, Attention Deficit-Hyperactivity Disorder, Eating Problems and Autism. | |
| **RAG: Amber** | Some risk that actions may not be delivered but this risk will be managed. |

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| **Sub section** | **4.2 Address common mental health problems in adults and mitigate the risks of mental health problems in groups who are particularly vulnerable.** |
| **Key contacts** | Yasmin Surti, Lead commissioner Mental Health LCC |
| | Julie O'Boyle, Consultant in Public Health LCC |
| | Mark Wheatley, Public Health Principal LCC |

We aim to improve self-reported wellbeing in Leicester, focusing on the following areas:

Suicide

- We have worked with strategic partners across Leicestershire to develop and launch a suicide prevention strategy.
- We have worked to raise awareness of the issue of suicide and available support services with the public through an interagency event to mark world suicide prevention day
- We have commissioned training for front line staff aimed at raising awareness and reducing stigma associated with suicide

Mental Health Needs Assessment

- We are working with key stakeholders, including service commissioners and mental health service providers to produce a specific needs assessment on mental health in Leicester City Council
- The findings from the needs assessment will be reported via the JSNA project board to the Health and Wellbeing Board
- The findings of the needs assessment will inform the refresh of the Joint Commissioning Strategy for Mental Health in the City

Mental Health Promotion

- We have worked with key partners to develop a Mental Health Promotion Strategy
- We aim to use the strategy to coordinate an approach to improve the mental and emotional wellbeing of people win Leicester
- We will raise awareness of the 5 Ways to Wellbeing; embedding them across City Council Departments, encouraging wider engagement and participation in them among individuals, families, communities and organisations as a means improving mental health and wellbeing in Leicester
- We have established a Mental Health Partnership Board whose representation includes service users, carers and key statutory and third sector partners in order to raise the awareness of the issues and good practice and to influence local developments

Self-reported wellbeing has not been routinely measured, but will be included in the next Citizen's survey.

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| **RAG: Green** | Good progress is being made and there are no significant problems. |

| Sub section | **4.3 Support people with severe and enduring mental health needs** |
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| **Key contacts** | Sarah Prema, Leicester City Clinical Commissioning Group |
| The CCG is currently undertaking a scoping exercise of mental health services to inform future commissioning intentions. | |
| **RAG: Green** | Good progress is being made and there are no significant problems. |

**Strategic Priority 5: Focus on the wider determinants of health**

| **Key contacts** | Sue Cavill, Public Health, LCC |
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| A programme of activity has begun to revisit the council's partnership boards to share with them the agreed Joint Health and Wellbeing Strategy and explore how this can be incorporated into their planning.<br>Additionally, there is a programme of visits back to the community and seldom heard groups who were consulted during the development of the strategy. Again, the strategy is being shared with them and their feedback invited about how they can be involved in taking forward the objectives.<br>The Deputy City Mayor is leading work on further plans to help improve community engagement in implementing the strategy and assessing the equality impacts of decisions. | |
| **RAG: Amber** | Some risk that actions may not be delivered but this risk will be managed. |

| ‘Closing the Gap’: Leicester’s Health and Wellbeing Strategy – 2013/16 Indicators | | | | | |
|---|---|---|---|---|---|
| **Improve outcomes for children and young people** | | | | | |
| Indicator | Reporting frequency | Baseline as published in strategy | Latest data as at September 2013 | Direction of travel | Notes |
| Readiness for school at age 5 | Annual | 11/12 – 64% | 12/13 – 66% |  | |
| Breastfeeding at 6-8 weeks | Quarterly | 11/12 – 54.9% | 12/13 – 55.1%<br>13/14 Q1 – 57.9% |  | Q1 based on local figures |
| Smoking in pregnancy | Quarterly | 11/12 – 12.7% | 12/13 - 14.2% |  | Performance may be affected by change in data collection methodology in 12/13.<br>Publication of 13/14 Q1 data delayed. |
| Conception rate in under 18 year old girls | Annual | 2011 – 30.0 | - |  | 2012 data due to be published in Feb 2014 |

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|---|---|---|---|---|---|
| Reduce obesity in children under 11 (bring down levels of overweight and obesity to 2000 levels, by 2020) | Annual | Reception:<br>10/11 – 10.6% | Reception:<br>11/12 – 11.1% |  | |
| | | Year 6:<br>10/11 – 20.6% | Year 6:<br>11/12- 20.5% |  | |

| **Reduce premature mortality** | | | | | |
|---|---|---|---|---|---|
| Indicator | Reporting frequency | Baseline | Latest data | Direction of travel | Notes |
| Number of people having NHS Checks | Quarterly | 11/12 – 8,238 | 12/13 – 24,048<br>13/14 Q1 – 7,089 |  | |
| Smoking cessation: 4 week quit rates | Quarterly | 11/12 – 2,806<br>(1,153 per 100,000 adult pop.) | 12/13 – 2,763<br>13/14 Q1 - 604 |  | |
| Reduce smoking prevalence | No regular pattern | 2010 – 26%<br>(Lifestyle survey)<br>10/11 – 23.4%<br>(Household survey) | - |  | Lifestyle survey may be undertaken in 2014 |

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|---|---|---|---|---|---|
| Adults participating in recommended levels of physical activity | Annual | Oct 10/Oct 11 – 27.8% | Oct 11/Oct 12 – 32.7%<br>Apr 12/Apr 13 – 31.7% |  | |
| Alcohol-related harm | Quarterly | 11/12 – 6,283 (1,992 per 100,000 pop.) | 12/13 – 6,404 (2,038 per 100,000 pop.) |  | |
| Uptake of bowel cancer screening in men and women | Annual | 11/12 – 43% | - |  | No further data currently available |
| Coverage of cervical screening in women | Annual | 11/12 – 74.7% | - |  | 12/13 data published on 24th October2013 |
| Diabetes: management of blood sugar levels | Annual | 11/12 – 62% | - |  | 12/13 data published on 29th October 2013 |
| CHD: management of blood pressure | Annual | 11/12 – 88.3% | - |  | 12/13 data published on 29th October 2013 |
| COPD: Flu vaccination | Annual | 11/12 – 92.3% | - |  | 12/13 data published on 29th October 2013 |

| Support independence | | | | | |
|---|---|---|---|---|---|
| Indicator | Reporting frequency | Baseline | Latest data | Direction of travel | Notes |
| People with Long Term Conditions in control of their condition | Annual | 11/12 – 81.24% | - |  | 12/13 data available, but trying to resolve technical problems |
| Carers receiving needs assessment or review and a specific carers service or advice and information | Quarterly | 11/12 – 18.8% | 12/13 – 26.5%<br>13/14 Q1 – 7.6% |  | |
| Proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement /rehabilitation services | Quarterly | 11/12 – 77.2% | 12/13 – 83.8%<br>13/14 – 89.5% |  | |
| Older people, aged 65 and over, admitted on a permanent basis in the year to residential or nursing care per 100,000 population | Quarterly (cumulative) | 11/12 – 608.9 | 12/13 – 735.27<br>13/14 Q1 – 141.8 |  | Performance dipped in 12/13 however Q1 data for 13/14 shows improvement |

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| Dementia - Effectiveness of post-diagnosis care in sustaining independence and improving quality of life | N/A | N/A | - |  | Placeholder measure in ASCOF, planned to be effective from 14/15 onwards |
| Carer-reported quality of life | Biennial | 9/10 – 8.7 | 12/13 – 7.1 |  | Next survey 14/15 |
| The proportion of carers who report that they have been included or consulted in discussion about the person they care for. | Biennial | 9/10 – 70% | 12/13 – 63.5% |  | |

| **Improve mental health and emotional resilience** | | | | | |
|---|---|---|---|---|---|
| Indicator | Reporting frequency | Baseline | Latest data | Direction of travel | Notes |
| Self-reported well-being - people with a high anxiety score | Annual | 11/12 – 41.2% | - |  | Sub-national analysis of 12/13 data will be published in October 2013 |
| Proportion of adults in contact with secondary mental health services living independently with or without support | Quarterly | 11/12 – 68.1% | 12/13 – 32.2%<br>13/14 Q1 -41.5% |  | Data quality issues with this indicator are being explored – not possible to make a judgement on direction of travel |

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Leicester
City Council

**Health and Wellbeing Scrutiny Commission**

**26 November 2013**

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**Briefing on Health Visiting and Family Nurse Partnership**

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## 1. Purpose of Report

The purpose of this report is to provide a briefing regarding the commissioning of health visiting services and the Family Nurse Partnership (FNP) in Leicester.

## 2 Background

Following the closure of the PCT at the end March 2013, NHS England took over the commissioning of public health services for the under 5s including health visiting services and the Family Nurse Partnership (FNP). The national proposal is that from 1st April 2015, Local Authorities will become responsible for commissioning these services. The decision to delay the transfer of health visiting to local authorities was taken to ensure that the health visiting workforce was brought up to strength. NHS England is charged with increasing health visitor number by 2015. The health visiting and FNP services are currently commissioned from Leicestershire Partnership Trust (LPT).

## 2.1 Health Visiting

In 2011 the "Health Visitor Implementation Plan 2011-15 – A Call to Action" was published setting out the need to expand and strengthen health visiting services. A commitment was made nationally to an extra 4,200 health visitors by 2015. In Leicester, Leicestershire and Rutland this means there should be a total of 228.5 and in Leicester a total of 142 whole time equivalents by the end of March 2015. The challenge locally is significant with LPT needing to appoint an additional 80 WTE health visitors across Leicester, Leicestershire and Rutland, with the majority of these needed in Leicester City.

It is recognised that the start of life is especially important in laying the foundations of good health and wellbeing in later years. The period from prenatal development to age 3 is associated with rapid cognitive language, social, emotional and motor development. A child's early experience and environment influence their brain development during these early years, when warm, positive parenting helps create a strong foundation for the future. New evidence about neurological development and child development highlights just how important prenatal development and the first months and years of life are for every child's future.

The aim is to ensure that parents and children have access to the support they need to get off to the best possible start, with early intervention to ensure additional support for

those who need it, including the most vulnerable families. Intervening early, working with families to build on strengths and improve parenting confidence and, where required, referring early for more specialist help, including specialist mental health services, is the most effective way of dealing with health, developmental and other problems within the family. Health visitors, working in partnership with GPs, midwives, Sure Start Children's Centres and other local organisations, have a crucial role in ensuring that this happens. Getting this right can affect the child's physical and mental health and wellbeing, their readiness to learn, and their ability to thrive later in life. This matters for the child, their family, local communities, and our wider economy.

Health visitors are trained nurses or midwives with specialist training in family and community health and are key to meeting the needs of families. They are skilled at spotting early issues, which may develop into problems or risks to the family if not addressed, for example a parent struggling to cope or a child health issue which needs special attention. They are public health nurses trained to work at community, family and individual level. They lead and deliver the Healthy Child Programme (HCP),[1] which is designed to offer a core, evidence based programme of support, starting in pregnancy, through the early weeks of life and throughout childhood. At the same time they provide or are the gateway to other services which families may need.

Health visitor teams deliver a range of services at varying levels of intensity:

- **Universal services** provide the Healthy Child Programme to ensure a healthy start for children and families (for example immunisations, health and development checks), support for parents and access to a range of community services/resources.

- **Universal plus** gives a rapid response from the HV team when you need specific expert help, for example with postnatal depression, a sleepless baby, weaning or answering any concerns about parenting.

- **Universal partnership plus** provides ongoing support from the HV team plus a range of local services working together and with the family, to deal with more complex issues over a period of time. These include services from Sure Start Children's Centres, other community services including charities and, where appropriate, the Family Nurse Partnership.

### 2.2 Family Nurse Partnership

Family Nurse Partnership (FNP) is a preventive programme for vulnerable first time young mothers (i.e. aged under 20). It offers intensive and structured home visiting, delivered by specially trained nurses, from early pregnancy until the child is two. There is commitment nationally to increasing the number of families in the programme at any one time to 16,000 by 2015. FNP has a very clear evidence base based on over 30 years of extensive research. Three large scale randomized control trials have tested the programme with diverse populations in different contexts. These have shown a range of long term benefits for children and mothers over the short, medium and long term. FNP has one of the best evidence bases for preventive early childhood programmes, being identified by many rigorous evidence reviews as having the highest quality of evidence and best evidence of effectiveness.

## 3 The need for health visiting and FNP services

Leicester has a high birth rate (5,324 births in 2011), with a higher than average proportion of children aged 0-4. In Leicester in 2011 there were 24,400 children aged 0-4 (7.4% of the total population) compared to 6.3% nationally.

Many indicators of the health and wellbeing of children in Leicester are worse than the national average. Child poverty levels are significantly higher than the national average, the infant mortality rate (deaths under a year), the proportion of babies born at a low birth weight, childhood obesity and dental decay are all significantly worse than the national average.

## 4 Service Delivery – progress made locally

An assurance board meets quarterly to oversee progress on the health visitor implementation plan. A project plan and risk log has been developed which is reported on monthly within LPT and involves representation from all interested parties, including the local authority It is anticipated that the recruitment of student Health Visitors will meet the March 2014 trajectory and LPT are currently well ahead of the required levels needed to reach this target. The current recorded establishment across the whole of Leicestershire is just under 170 WTE with 23 newly qualified Health Visitors in addition to the total currently entering the workforce. A robust communication and media strategy has been established and key communication materials produced, which is aimed at promoting recruitment to health visiting roles and also promotes the health visiting service to families.

An assurance board also meets quarterly to oversee progress on the FNP in the city. As this is a licensed programme it is important that the service operates within the required licence and the assurance board is an important part of this. So far since the Leicester FNP launched at the end of 2011, 111 young mums have been recruited onto the programme from a total of 150 possible for recruitment out of 187 who were eligible for the programme (as at the end of August 2013). Most are recruited by the teenage pregnancy midwife. The team includes 6.4 WTE family nurses, management and admin support, the most recent full time nurse appointed this month and an additional part time nurse is currently being recruited to. The programme is currently at full capacity given the clients remain with the service until their child is 2 years old so the additional post should enable further clients to be taken on. Each full time nurse can hold a caseload of 25 clients. There is an annual review due for the FNP service in Leicester that will be carried out by the national team and is part of their licensing role and will ensure that the programme is fit for purpose from a quality improvement perspective.

The Leicester City Joint Integrated Commissioning Board (3 October 2013) has noted that there will be discussions regarding the likely direction of the health visiting service alongside existing and planned children's' services in the city, so that a direction of travel is developed for agreement by the Executive and partners as applicable.

## 5. Report Authors

Joanne Atkinson, Consultant in Public Health (Leicester City Council)
Dave Giffard,, Public Health Commissioning Manager (NHS England)
Rod Moore, Divisional Director of Public Health (Leicester City Council)

**22 October 2013**

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Leicestershire Partnership NHS
NHS Trust

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| REPORT TO THE TRUST BOARD – 31st OCTOBER 2013 | |
|---|---|
| **Title** | Update on the Trust response to the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis Inquiry) |

**Executive summary**

This paper aims to update the Trust Board on the work undertaken within the Trust against the five priority themes approved by the Trust Board at its July 2013 meeting (minute TB/13/256).

It identifies a number of key activities and actions that have either been delivered or are in progress, mapped to the five priority themes. As agreed at the July 2013 Board meeting the activity across the Trust in response to the detail of the Francis report recommendations should not be seen as a separate activity or initiative, and must be fundamental to our staff delivering our overarching vision for improving quality, integration and excellence.

More recently, Prof. Don Berwick, (world-renowned Patient Safety expert), undertook an Independent Review focusing on Patient Safety following the publication of the Francis Report. The Berwick Report, with a number of recommendations, was published on 6th August 2013.

Following the CQC visit to the Bradgate Mental Health Unit, the Trust has been developing a Quality Improvement Programme which includes the priority themes identified from the Francis Report. This paper must therefore be viewed in conjunction with the Quality Improvement Programme paper submitted to this meeting.

**Recommendations**

The Trust Board is recommended to:

- Review the progress highlighted within this report against the five priority themes identified by the Trust in response to the Francis Report.
- Support the next steps proposed.

| | |
|---|---|
| **Related Trust objectives** | The implications of this report relate to all our strategic objectives. |

| | |
|---|---|
| **Risk and assurance** | Increased risk to patient care and experience if findings and recommendations are not addressed. |
| **Legal implications/ regulatory requirements** | No legal implications identified. |
| **Presenting Director** | Dr. Satheesh Kumar, Medical Director |
| **Authors** | Richard Chester, Head of Patient Experience and Partnerships<br>Samantha Wood, Patient Experience & Partnerships Manager |
| *Disclaimer: This report is submitted to the Trust Board for amendment or approval as appropriate. It should not be regarded or published as Trust Policy until it is formally agreed at the Board meeting, which the press and public are entitled to attend. | |

Leicestershire Partnership NHS
NHS Trust

# TRUST BOARD – 31st October 2013

## Update on the Trust response to the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis Inquiry)

### Introduction/Background

1. The Trust Board received a report at its 28 February 2013 meeting presenting the recommendations of the Francis Report and confirming that a considered review of the findings had commenced within the Trust. The Board has previously reviewed the findings of the Francis Report and had approved five priority themes; these can be found in detail at Appendix 1 of this paper. The priority themes are:
    - A. *Openness / transparency*
    - B. *Listening*
    - C. *Working together*
    - D. *Capacity within teams*
    - E. *Clinical Leadership*

### Aim

2. This paper aims to update the Trust Board on the work undertaken, or in progress, within the Trust in response to the Francis Report and the key identified themes.

### Recommendations

3. The Trust Board is recommended to:

    Review the progress highlighted within this report against the five priority themes identified by the Trust in response to the Francis Report, and to support the next steps proposed.
    Support the next steps proposed.

### Discussion

4. The Quality Strategy and Workforce and Organisational Development Strategy are the two key vehicles for the delivery of the recommendations in the Francis Report. The Quality Strategy is currently being refreshed and updated in order to reflect the key findings of the Francis Report. A revised Workforce and Organisational Development Strategy will also be seen by Trust Board in due course.

## 5. Progress against the Priority Themes

### A. Openness and Transparency

The Trust has carried out a review of the way it shares information at a strategic level with patients, carers, and the Voluntary and Community Sector, and has taken the following steps:-

i. The Trust Board receives a regular report on all serious incidents enabling discussion within the public section of the monthly Trust Board meeting. This provides an opportunity for the public to ask questions, raise concerns and gain confidence from the way in which issues are discussed and debated, and to obtain first-hand experience of how key decisions are taken.

ii. The Trust has made, and continues to make, changes to the website to provide more open, clear and prominent information on key issues. There is also a much more conscious effort to make use of social networking communication channels such as Facebook, Twitter and YouTube. This provides a number of benefits:

- Social networking provides hot spots for debating issues, bringing together people and ideas that otherwise might not meet
- Networks are expanded with individuals and organisations/charities beyond boundaries such as accessibility and geography
- The Trust is enabled to provide balanced information to the public direct from source which is not subject to external editing. This is also then open to public scrutiny and challenge
- Collective thinking – social networks are an excellent method for connecting new ideas, a process which is open to everyone, bringing together experts by profession (staff) and experts by experience (patients, carers and families).

iii. The Trust has also set up a dedicated phone line for staff to report concerns. This is a confidential service for those who feels unable to raise a particular concern with their line manager or clinical supervisor.

iv. The Trust has established a clinical forum (known as the 'Clinical Cabinet') which is for staff to raise and discuss collective concerns. These discussions are reported to the Trust's Senior Management Team in order to enable swift escalation of any issues of concern.

### B. Listening

The Trust has made a significant commitment to 'listening' and to evidence that listening by removing the challenges that sometimes are perceived to block the making of decisions at the correct level of the organisation.

i. The Trust has signed up to a programme of work called 'Listening into Action', a programme tested in other NHS Trusts and proven to improve staff engagement and empowerment to take actions. As part of this programme, the Trust's Executive Team hosted five 'conversation' sessions with over 450 staff. Themes from this exercise have been identified and discussed at Senior Management Team and Trust Board. A number of actions for immediate implementation have been identified as well as actions for longer term development. Staff members are made aware of actions taken through regular staff newsletter briefings.

ii. The Trust has continued to roll out its 'Changing Your Experience for the Better' Programme which includes 'In Your Shoes' listening events, aimed at supporting staff to listen to patients on a one-to-one basis to better understand their perspective. The programme has already been rolled out across Adult Learning Disability Services, Child and Adolescent Mental Health Services, Adult Mental Health Services (currently looking at actions as a result of the listening work), and eventually throughout Community Hospitals. St Luke's Hospital has already completed the Programme, with Hinckley and Bosworth Community Hospital due to commence in late October 2013. Ward 1, St Luke's Hospital Stroke Unit was nominated for Team of the Year for their 'Enhancing the Patient Experience' Project, which has fundamentally changed the way they work as a team through listening to patients. The project has seen many benefits with a 30% reduction in complaints overall and a 250% increase in compliments received.

iii. Listening is also carried out through engaging much more closely with local Voluntary and Community Sector (VCS) organisations through regular 'Meet and Greet' sessions with the Chief Executive, and/or Executive Director, and through Division Specific meetings and events with Divisional staff.

iv. The Trust has also worked closely with the local Healthwatch organisations to ensure that it capitalises on the support that the Healthwatch network can bring and the support from engaging with local communities.

v. The Trust has engaged with a public opinion website called 'Patient Opinion'. Further information on how the Trust is listening to the patients can be found within the Quarterly Customer Care report.

**C. Working Together**

i. The Trust's approach to service developments is based upon the model of integrated care pathways, which focuses on an integrated team approach to meeting the needs of patients, and this is reflected in the Service Development Initiatives across the four Divisions.

ii. Enhancing multi-disciplinary team working is an important element of the Quality Improvement Programme (to be seen at Trust Board in October).

iii. The Trust is committed to working together with health and social care partners, an element of which is reflected in the Trust becoming a partner in the 'Better Care Together' Programme.

**D. Capacity within Teams (Safe staffing numbers)**

i. The Trust has invested in the improvement of the staffing in in-patient areas.

ii. Within the Bradgate Mental Health Unit, the Trust is working towards recruiting more qualified nurses, and staffing levels are monitored daily. The same approach is being rolled over to other areas.

iii. Staff number and the capacity of the teams to deliver good quality clinical care is part of the Quality Improvement Programme.

**E. Leadership**

i. Enhancing clinical leadership is an important part of the Trust Quality Improvement Programme. Professional leadership across the Trust is currently reviewed by the Lead Nurse and Medical Director.

ii. Clinical leadership within Community Hospitals has been further enhanced through the appointment of Advanced Nurse Practitioners. The appointment of two senior matrons within the Bradgate Unit has similarly enhanced the professional leadership within the Unit.

iii. The Workforce and Organisational Development Group, and the Human Resources Strategy focus on
   - Developing a culture where the workforce is engaged, committed and supported.
   - Supporting the application of high quality management and leadership practices

iv. The Trust has developed a Leadership Development Programme integrating training currently offered nationally, regionally, and how they relate to LPT's Leadership Development Framework.

## 6. Next Steps

a. Recommendations from the Berwick Report are discussed within Trust Board and Quality Assurance Committee, and actions mapped against the Quality Improvement Plan, Organisational Developmental plans, and the Quality Strategy. The Quality Strategy will be refreshed by December 2013.

b. Professional leadership across the Trust is being reviewed. The New Professional Leadership Plan for LPT will be agreed by January 2014.

c. Trust Board will receive assurance on the pace of progress regarding key areas through the Quality Improvement Programme, which will be reported to Trust Board monthly from December 2013.

d. Trust Board will receive further updates on the Priority Themes on a quarterly basis.

## 7. Conclusion

It is the aim of this report to provide highlights to the approach that the Trust has taken in reflecting the Francis Report in a meaningful and sustainable manner. It demonstrates how the Trust has identified clear areas for prioritization and is taking appropriate actions to progress these. However, there is a need to have ongoing discussion with patients, public, carers and staff in order to map progress as well as set future development needs. It is the recommendation of this report that quarterly update reports be presented to the Trust Board to ensure continual assurance is provided and to ensure that the focus is maintained.

**Appendix 1**

## Trust Priority Themes

A. *Openness / transparency*: There is an LLR wide commitment to working on this theme together. The work will include promoting openness as

    1. Openness as a value – building on the Trust values of RIQHTCARE - in particular, Honesty.
    2. Cultural change - achieving the cultural shift in being alert to issues of quality and patient safety for not only one's own work but also that of others.
    3. System facilitating openness – within the organisation as well as externally, for example, increased use of website.

B. *Listening*: To continue listening and really hearing from patients, public, carers and staff, ensuring what is heard is not forgotten; supported by the Patient, Public and Carer Reference Group

C. *Working together:* Working together with other professionals and staff, with patients and their carers and families, to ensure effective team working within the Trust. To develop and embed integrated care pathways as well as working with other organisations around us to bridge gaps in quality and patient safety.

D. *Capacity within teams*: Safe staff number and skill mix across all inpatient and community services.

E. *Clinical Leadership*: Leadership at all levels with a patient centred approach, innovative thinking and ownership of holistic approach needs embedding within the clinical teams and wider Trust business.

# Appendix M

**Report of the Mid Staffordshire Foundation Trust Public Inquiry – update against LCCCG action plan**

## Background

1. Following the publication of the report regarding the Mid Staffordshire NHS Foundation Trust Public Inquiry (February 2013) and the subsequent Department of Health (DH) response (March 2013) the LCCCG Governing Body identified four priority areas to be progressed (May 2013). This paper provides an update on those priority areas.

2. The report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (February 2013) identified numerous warnings which should have alerted the trust board and the wider NHS system to the problems that led to a catalogue of failures in care.

3. On the 26 March 2013 the Department of Health (DH) released "Patients First and Foremost: The initial Government response to the report of the Mid Staffordshire NHS Foundation Trust Public Inquiry." This report highlighted areas where further work would be commissioned during 2013 ( fig 1). A summary of the outputs of some of these reports can be found in Appendix A.

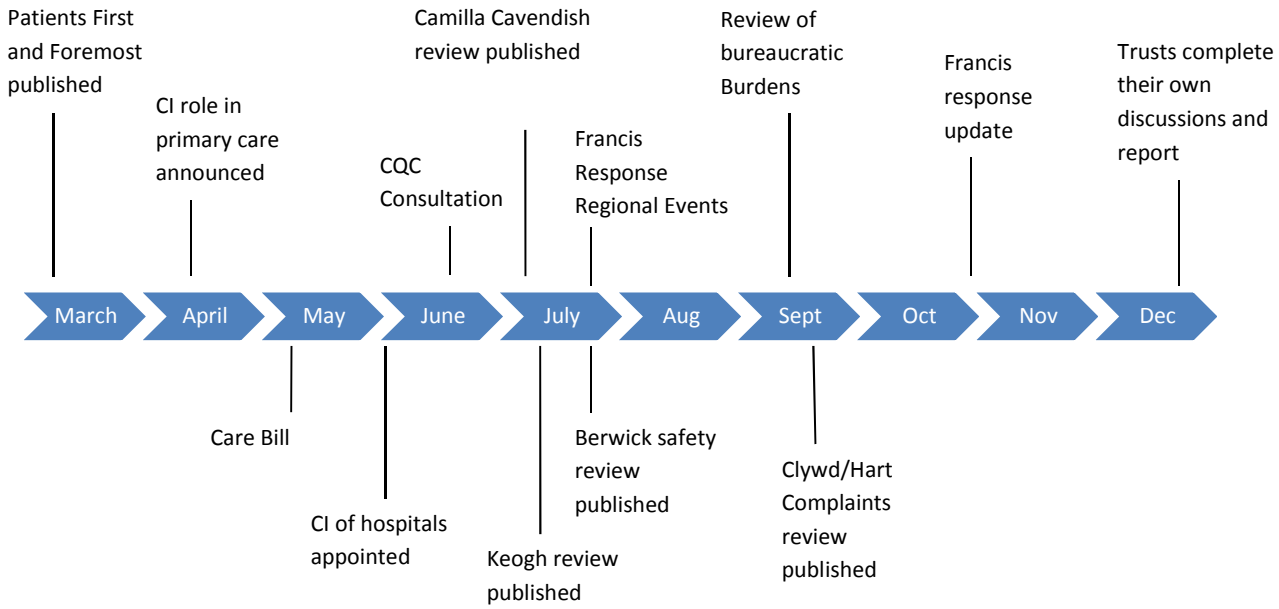
*Mid Staffordshire Foundation Trust Public Inquiry (2013)*

*What went wrong?*

- *Patients and families were not listened to*
- *Multiple warning signs not spotted or acted on*
- *Information not shared and inadequate action taken*

*The system failed in its most essential duty to protect patients*

**Figure 1:**



4. Professor Sir Mike Richards has been appointed at the Care Quality Commission (CQC) Chief Inspector of Hospitals (CI). The CI of Hospital will be responsible for assessing and judging how well hospitals put the quality of care and the interests of patients at the heart of everything that they do. He will provide the public with assurance that services are safe, effective, caring, well led and responsive to people's needs.

5. Professor Steve Fields has been appointed at the Chief Inspector of General Practice to lead the inspection and regulation of primary care services across the public, private and independent sectors. This will include launching a rating system for registered primary care providers and a drive to ensure that health and adult social services are more integrated. He will also work to champion the interests of people who use primary care medical services and makes judgments about the quality of care provided.

6. The findings from the recently published reports are being considered, as will future reports, in relation to implications for essential quality standards and specifically any amendments required for our contracting and quality monitoring arrangements with any of our providers. Three key reports available so far are:

**I. The Cavendish Review: An Independent Review into Healthcare Assistants and Support Worker in the NHS and Social Care Settings (July 2013)**

7. This report makes a number of recommendations on how the training and support of both healthcare assistants who work in hospitals and social care support workers who are employed in care homes and peoples own homes can be improved to ensure they provide care to a high standard.

8. NHS England, Health Education England and the Nursing and Midwifery Council are reviewing the implications of the report.

9. Locally, Leicestershire and Lincolnshire Area Team and Health Education East Midlands are coordinating a proposal to scope and deliver a programme of work to address the demand for a consistent and quality process for recruitment, training, management, development and support of the Health Care Support Workers/Health Care Assistants workforce. This is being taken to Leicester, Leicestershire and Rutland Local Education and Training Committee.

**II. Keogh Mortality Review: Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report (July 2013)**

10. This review looked at 14 acute trusts which were identified as having higher mortality rates than might have been expected over the past two years. Appendix A provides an outline of the problems identified.

11. One area of specific note is the learning from this review in relation to workforce requirements for providers and how organisations ensure that robust arrangements are in place for appropriate and safe staffing levels. As commissioners we are working closely with both UHL and LPT (via our contractual arrangements and quality monitoring)

to understand the staffing challenges they face and ensure robust arrangements are in place.

12. The learning from these reviews has been incorporated into the new CQC inspection regime (launched October 2013). University Hospitals of Leicester NHS Trust (UHL), one of our main service providers will be inspected in phase 1 of this process. All trusts will ultimately be inspected via this new format.
A pilot is underway to undertake similar inspections in non-acute trusts, but as yet no detail is available for this part of the inspection process.

> ***A promise to learn – a commitment to act, improving the Safety of Patients in the England (August 2013)***
>
> - *Placing the quality of patient care, especially patient safety, above all other aims*
> - *Engaging empowering and hearing patients and carers throughout the entire system and at all times*
> - *Fostering whole-heartedly the growth and development of all staff including their ability and support to improve the processes in which they work*
> - *Embracing transparency unequivocally and everywhere, in the services of accountability, trust and the growth of knowledge*

### III. The Berwick Report A promise to learn – a commitment to act, improving the Safety of Patients in the England (August 2013)

13. This report pledged further action to make the NHS the safest healthcare system in the world. It made 10 recommendations as outlined in Appendix A. The recommendations require a cultural change in thinking from everybody working in the NHS, with specific emphasis on openness and transparency.

14. A key point within this report for the CCG is that the patient and carer voice is an essential asset in monitoring the safety and quality of care. This is an area which the CCG has already identified as a priority area for development and action and is discussed later in this report.

15. In conclusion since the initial publication of the Report of the Mid Staffordshire Foundation Trust Public Inquiry, a number of national reviews / reports have been commissioned which will potentially influence improvements across a range of CCG activities. The CCG will take account of relevant report, findings and recommendations in all aspects of its work going forward.

**Leicester City CCG Priority Areas – Update in response to the Mid Staffordshire Foundation Trust Public Inquiry**

16. The CCG identified four areas to focus upon which were agreed at the Governing Body in May 2013. Progress against these four areas is detailed below.

**Priority one: Develop robust systems to ensure we are listening and engaging with patients and the public about current and future services and this feedback is acted upon.**

17. The CCG has considerable experience and expertise in engaging with patients and utilises a range of tools, techniques and technology to achieve a range of views, for example, toolkits and use of social media. The CCG has spent considerable energy on data collection and has much information to draw upon.

18. The CCGs already approved and has implemented a communications and engagement strategy (August 2012). We have taken the opportunity over the last couple of months to review this strategy and explicitly include our approach to gaining patient experience feedback along with proactive engagement. The updated strategy will incorporate the appropriate elements recommended within the Francis report related to patient experience. A first draft of this strategy is expected during December 2013 and will be accompanied by an implementation plan fro 2014.

19. The CCGs current engagement toolkit has also been reviewed. The toolkit provides best practice information and is a resource for CCG staff who undertakes engagement and consultation as part of their role. The availability of the toolkit has been promoted across the CCG and an on-line version is available on the intranet.

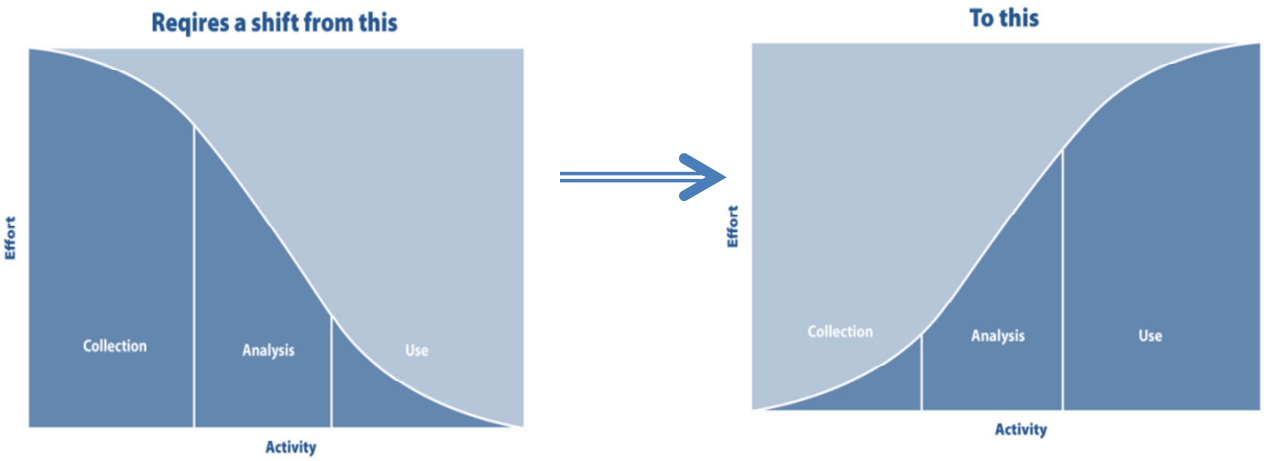
20. Patients are being encouraged to post their views on LCCCG NHS services online using social network sites such as Twitter and Facebook to identify opportunities to make improvements. This started in September 2013 and is on-going at the time of writing. Listening events have already taken place to gather feedback from patients, whether using interview via video or on hand written comment cards.

***UHL Patient Choices July 2013***

*"Gallbladder removal via keyhole... I was very hesitant going into hospital however I would like to say how fabulous the ward staff were, especially the Nurse, they were the most caring, professional individual I have ever met. Praise where praise is due!! The theatre staff were excellent as well, including the two recovery nurses. My consultant I would highly recommend, very compassionate and did a great job with extremely neat and tidy wounds.*
*Before my surgery I needed to contact the consultant and I spoke to their secretary who was very helpful and accommodating. Overall what a great visit. Thank you"*

21. A scoping exercise has been undertaken to identify what patient experience information is available to the CCG. This identified that the CCG has much information to draw upon. The task now is using this information consistently in our work to improve the quality of services we commission. To achieve this we need to create the shift from collection to analysis as depicted in in Figure 2 below. To enable this to happen the existing Nvivo software (a qualitative data analysis computer software package) has been selected to gather patient experience information in one place meaning that analysis can be undertaken of key themes which can then be used within the quality monitoring systems of commissioned services.

**Figure 2:**



22. To assist with this, the CCG capacity has been increased to systematically capture, analyse, act and report patient experience information. Working together with the engagement team the Quality Officer role (part of the Nursing and Quality team) was reviewed and amendments made to strengthen the patient experience aspect of the role. The role now includes explicit reference to monitoring external information on websites such as patient opinion, maintenance of the Nvivo database, analysing and reporting on the information. Interviews were held in July 2013 and the appointee commenced on 21 October 2013.

23. To conclude this section, there is evidence that information is collected and used by the CCG. To monitor and improve the quality of commissioned services and make a greater shift from patient experience data collection to acting on and using this information to improve services, the CCG has increased capacity and capability, and will utilise a range of resources, tools and technology to deliver the revised strategy and implementation plan. This will be supported by the updated engagement strategy and implementation plan.

**Priority two: Provide opportunities to listen and act as a result of feedback from professionals involved in care delivery.**

24. The CCG agreed to review and refresh General Practice based feedback mechanisms to ensure that issues related to patient care can be shared and acted upon promptly. The patient safety team were invited to and attended a LCCCG Locality Chairs meeting in April 2013 to discuss solutions for GPs to quickly and easily report incidents and to flag issues that do not require specific feedback but provide soft intelligence and paint a picture of the quality of care provision. SystmOne will be utilised and following system development a trial with one LCCCG practice and one practice within East Leicestershire and Rutland CCG started in October 2013. It is anticipated that roll out across LCCCG practices will commence later this year. Analysis of the themes and trends and learning for improvement will form part of the patient safety report to the CCG and also feed into the appropriate contracting teams for timely action and follow up.

25. Work has also been undertaken to raise awareness of how to raise concerns and procedures related to whistleblowing. This has been undertaken specifically with Practice Nurses at the Protected Learning Time, highlighting professional responsibilities and signposting to relevant policies and procedures. In addition the Area Team has established a Primary Care Medical Interface Group of which the CCG is an active member, one action is to develop simple flow sheet to make processed for raising concerns clear to all agencies ( this work is on-going).

26. In conclusion, work has been undertaken to ensure that there are mechanisms to feedback concerns within primary care. This includes General Practice based feedback of quality and safety concerns. Work is underway and following evaluation of a pilot this will be rolled out across all participating areas across the city .

**Priority three: Have robust and timely approaches to monitoring and measuring the quality of commissioned services and taking appropriate actions.**

27. A programme of unannounced visits to our main providers is in place. Desktop reviews using a range of data and intelligence inform these visits, including: quality contract performance, GP feedback, experience are performance metrics. Visits have taken place throughout the year to both UHL and LPT and further visits are planned later this year. This approach has been useful in validating the intelligence within the CCG and to provide further assurance about what is happening in practice regarding the quality and safety of care.

28. In order to provide a cohesive approach to the reporting of patient safety and quality the patient safety reports received by the CCGs were reviewed. These now contain a wider breath of information, with triangulation of all quality and safety functions managed by the patient safety team in one integrated report.

29. The Quality Team and Contracting Team updated current quality schedules following the publication of the Francis report. For example, the Duty of Candour, organisational response to the Francis report and workforce assurance are included within the contracts and are monitored as part of established processes. This will be further reviewed for 2014/15 contracts in light of additional developments and requirements.

30. Work has been undertaken to strengthen the quality monitoring process with the development of dashboards to act as an early warning mechanisms. The quality and safety dashboards cover areas of patient safety, patient experience and outcomes. Whilst this currently focuses on the main provider's plans will be developed to move towards increasing the spectrum of areas covered during 2014.

31. In conclusion, the CCG is enhancing and continues to strengthen approaches to monitoring and measuring quality and safety, which includes a programme of quality monitoring visits to providers of care and early warning systems in relation to quality and safety of care.

**Priority four: Supporting the local implementation of the Nursing and Midwifery Strategy (National Commissioning Board)**

32. The NHS England Area Team are supporting the Directors of Nursing (provider and commissioner) across Leicestershire and Lincolnshire to implement the Compassion in Practice - Nursing and Midwifery Strategy, with dedicated project management. They have prioritised a number of key areas / work programmes. These include:

- Recruiting, developing and supporting the bands 1-4 workforce
- Integrated working to deliver care closer to the home
- Review of metrics to assess quality
- Recruiting staff based on values and behaviours
- Flexible workforce planning
- Measuring culture and staff satisfaction

33. These work programmes are currently being further developed and will be finalised at the Directors of Nursing meeting in November.

34. To increase the nursing voice within the CCG one Practice Nurse Advisor has been appointed for each locality working 4 hours per month. Together they form the Practice Nurse Reference Group along with members of the nursing and quality team. The first meeting was held in July 2013. The terms reference for the group were agreed at the Executive Committee in August 2013 following which they were circulated along with meeting details and Practice Nurse Advisor details to CCG staff. Already the practice nurses have had an influence project delivery within the CCG and on the delivery and content of protected learning time (PLT) for the nurses, with good attendance and positive evaluation.

35. The quality monitoring templates used for visits by commissioners to LPT has been reviewed to take into account the nursing strategy. These will be used on the next visit and if successful we will then look towards utilising the same principles for UHL and other provider quality visits.

36. In summary the nursing input and professional voice within the CCG has enhanced and the use of existing forums such as PLT is being used effectively to raise both professional issues and CCG activities. The nursing strategy is being acted upon across LLR and has been incorporated into the quality schedule and quality monitoring visits.

***PLT: Practice Nursing Forum (Sept 2013)***

*"I have never been to this event as I am new in post. Great to meet other nurses and have access to this information"*

*"asthma/COPD session very good"*

*"providing useful information and tips - great to have an experienced advisor"*

*"Good to have information on the work of the Practice Nurse CCG group"*

*"Provide good timely updates on current and professional issues"*

**Conclusion**

37. A number of supplementary reports have been produced nationally following the publication of the Mid Staffordshire NHS Foundation Trust Public Inquiry (February 2013).

38. The CCGs local actions to the Francis report is an on-going process to take into account the findings of these reports.

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Appendix N

# Report to Scrutiny Commission

Health and Wellbeing Scrutiny Commission

26th November 2013

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## Response to the Review of 'Voluntary & Community Sector Groups who have raised concerns about Funding, Commissioning and Tendering issues

Report of the Director of Tracie Rees & Sarah Prema

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Leicester City Council

**Useful Information:**

- Ward(s) affected: ALL
- Report author: Mercy Letts-Charnock (Lead Commissioner for Early Intervention and Prevention
- Author contact details 252 6812

**1. Report**

1.1 The review, which commenced in November 2012, in response to concerns from the Voluntary and Community Sector (VCS) about funding cuts, tendering and commissioning processes, identified a number of actions. A response to these actions was provided by Adult Social Care (ASC) and the Leicester City Clinical Commission Group (CCG) as part of the review.

1.2 This report provides a further update of progress against the identified actions.

**(i) Some clarity about the basis upon which Leicester City Council (LCC) and Leicester City Clinical Commissioning Group engages with VCS.**

1.3 Further to the numerous examples of engagement that were provided in the review whereby the VCS had been actively engaged in the development of key strategic documents, including the Joint Strategic Needs Assessment, the Health and Well-Being Strategy, Mental Health, Learning Disabilities, Carer's, and Dementia strategies; and a number of forums where the VCS were active participants, Adult Social Care continues to work in this way with a commitment to engagement with the sector.

1.4 Key forums that provide engagement with the VCS are the Learning Disabilities Partnership Board; The forum for Older People; and the Carers Reference Group. Since the review the Adult Social Care Transformation Steering Group has ceased to run, but this has been replaced by a VCS Adult Transformation Group that is supported by LCC. The first meeting took place 22nd October, and Tracie Rees was in attendance along with other senior officers representing ASC. In addition the Mental Health Partnership Board had its first meeting on 23rd October, and this forum also engages with the VCS.

1.5 In addition to the specific engagement with Adult Social Care, the council has contracts in place with VCS providers for infrastructure support for the VCS and for representation and engagement with specific communities, and through the contractual requirements this acts as further engagement with the VCS. This support is the subject of a review which has just commenced with consultation on proposals running from 28th October until 17th January 2014. Health also contributes to this grant.

**(ii) Value for money from relationships with VCS, including positive partnerships, effective and efficient delivery of contracts, or no relationship where there is nothing to be gained from having one.**

1.6 Value for Money is addressed through commissioning reviews, whereby proposed service models will consider efficiency, effectiveness, and economy. This is always taken into consideration in our redesign processes. Through

the procurement process the weighting used to evaluate prospective service providers by the Council is considered as part of each exercise. Historically the 'standard' was 60% quality and 40% price. However, in recent procurement exercises the weighting has moved to 80% quality and 20% price; and has also included 90% quality and 10% price. As part of our commissioning processes we must consider the social impact of our proposals in line with The Public Services Social Value Act (2012), and therefore all commissioning proposals and associated tenders take into consideration the collective benefit to the community, beyond the monetary evaluation.
The relationship with the provider and the management of the contract is important to the Council and each provider has a named Contract Assurance Manager who leads for contract performance and quality assessment and also acts as a point of contact for providers during the contract period. Regular contract reviews are undertaken with the provider to look for how the service is performing to contract, celebrate good practice and if issues are found take early action where necessary.

1.7 The CCG has arrangements in place to manage voluntary sector grants, those Leicester City specific are managed by the CCG and those that are LLR wide are managed by East Leicestershire and Rutland CCG on behalf all three local CCGs.

**(iii) Fair, transparent and consistent approaches to VCS commissioning, procurement and funding arrangement across the council and lead commissioners**

1.8 The City Council works to a set of Contract Procedure Rules that outline the process that must be used and applies to all purchases, including the award of grants or funding to organisations in consideration for the provision of goods or services and where appropriate the Council can use grant funding approaches, rather than a full procurement exercise. Recent discussion has begun with Corporate Procurement regarding the most suitable approach. The Council commissions' services from VAL and Case-Da to support the local VCS in tender applications; this has been widely communicated to the sector.

**(iv) Some strategic alignment between the VCS and the city council in order to ensure that organisations are working towards similar outcomes.**

1.9 The VCS is always consulted in the development of strategies for ASC, giving them the opportunity to ensure there is strategic alignment, and that the desired outcomes are in sync.

**(v) Recognition of the value of VCS, through appropriate and fair remuneration, as many VCS groups are best placed with the knowledge, skills and support to provide quality and value for money services in Leicester.**

1.10 The value of the VCS is widely recognised. Including social impact within our commissioning and procurement processes translates this recognition, and provides opportunity for the VCS in tendering / procurement processes. There is some additional investment in the voluntary sector through ASC early

intervention and prevention, which demonstrates our commitment to this. In undertaking the review of Voluntary and Community Sector (VCS) preventative services, the sector was engaged via workshops (per service area) at the start of the review so that they could inform the service priorities which were then included in the final recommendations. This recognized the position the sector has in identifying gaps and barriers as well as good practice within their areas of expertise. The review has recommended procurement options that support the sector – including grant funding and consideration of accessible procurement options and support for the sector in preparing for procurement. This will enable the sector to be well placed to apply for or bid for future work.

1.11 There has been an ongoing dialogue between the Local Authority and the CCG about joint commissioning and the recommendations from the commissioning review of VCS preventative services. The proposals have been developed with Health partners fully informed about proposals and how they can in turn consider these when finalizing their own review proposals.

1.12 On 25th July the initial ASC VCS preventative service report was taken to an informal briefing meeting of the Executive and it was noted that it was important to engage with the sector when services were being re-commissioned.

**(vi) Recognition of the importance of keeping services local and valuing the contribution of local people as volunteers.**

1.13 In line with the Mayors pledge to implement new procurement processes in support of this, the commissioning and procurement processes that ASC utilize support this, with the inclusion of regard to social impact. A recent example of where a targeted approach to this has been successfully implemented is in the procurement of contracts for substance misuse. Through Voluntary Action Leicester/shire (VAL) the VCS was targeted to attract them to consider a consortium arrangement in support of the main community contract to deliver clinical services to adults with substance misuse problems in the community. As a result of this the successful tender was awarded to Leicestershire Partnerships Trust, supported by a consortium of 22 local VCS organisations.

**(vii) Some pooling of resources within the VCS, where appropriate and necessary.**

1.14 The VCS are encouraged to consider consortia arrangements, as the example of substance misuse contracts demonstrates.

**(viii) Improved training programmes to assist VCS in securing contracts to deliver services, especially for smaller organisations to compete for public sector contracts.**

1.15 The CCG and Leicester City Council commission procurement support for the VCS from VAL the Community Social Enterprise Development Agency. The Councils Planning and Economic Development Division also lead a project called ''selling to the public sector'' as part of the Councils initiative to help

local businesses to win Public Sector contracts with information tips and guidance available to Leicester based businesses. The review of infrastructure support will also consider the best model for the Council corporately to support the VCS in terms of training and development.

**(ix) Future Commissioning to include site visits to help commissioners understand the characteristics of an organisation, and future commissioning of contracts must not discount organisations that provide individualised care for marginalised groups. Contracts must allow for specialism and expertise to shine through.**

1.16 Commissioners do undertake site visits and these have also included visits from the Deputy City Mayor, Assistant City Mayor with the Lead for ASC and senior officers.

1.17 Commissioning is needs led, and where the needs assessment suggests that specialism is required this is reflected within the procurement process, and tender documentation and specifications will reflect this. Contracts for community based services are outcome focused with the aim of encouraging innovation and creativity in meeting these outcomes to be identified by the potential provider.

## 2. Recommendation(s) to scrutiny

2.1 To note progress against the findings

## 3. Supporting Information

3.1 None

## 4. Financial, legal and other implications

4.1 Financial implications

4.1.1 Awaiting Information

4.2 Legal implications

4.2.1 Awaiting information

4.3. Climate Change implications

| |
|---|
| 4.3.1 Awaiting information |

4.4 Equality Impact Assessment

| |
|---|
| 4.4.1 A separate EIA would be completed for any commission review. |

4.5 Other Implications

(You will have considered other implications in preparing this report. Please indicate any which apply?)

| |
|---|
| None |

**5. Background information and other papers:**

**6. Summary of appendices:**

**7. Is this a private report ? No**

**(If so, please indicate the reasons and state why it is not in the public interest to be dealt with publicly)**

# Scope and Interdependencies

## Introduction

1. The new Congenital Heart Disease (CHD) 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. Patients, clinicians and the public have been asked to advise on what services and conditions should be included in the scope of the new review. Approximately 40 responses were received (these will be made available to the Task and Finish Group in hard copy for reference).

3. NHS England originally proposed three categories (in scope; out of scope; to be determined). It was apparent from the responses received that not enough explanation had been given to respondents which had led to some misunderstanding of the concept of scope. It was also apparent that the reality is more complicated than a simple 'in' or 'out'. There are multiple, complex interdependencies, so this paper recommends a less binary, more nuanced approach that explains how the review relates to a range of other services and conditions, rather than simply declaring them to be either 'in' or 'out' of scope. At the same time, it is important to define the boundaries in such a way that there is a realistic prospect of completing the review and avoids mission creep.

4. A paper was written for the Clinical Advisory Panel summarising stakeholder responses. Members were also provided with the full original responses for reference. The panel met on 15 October 2013 and considered the scope of the review. This paper reflects that group's recommendations.

5. 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. Cross-border flows are significant and need to be taken into account. The NHS in each of the devolved administrations will therefore be asked to agree their relationship to the review and appropriate channels of communication.

## Summary recommendations

6. In summary the panel recommends that:

   **A.** The heart of the review should be the whole lifetime pathway of care for people with congenital heart disease, and specifically congenital heart disease services.

   **B.** There are a number of clinical conditions which while not CHD receive their care wholly or mainly from congenital heart services. The standards for services for these conditions should not be reviewed as part of the review (though the standards being developed may address aspects of the service). However, patients

who fall within this category use congenital heart services and should be able to participate in the review.

**C.** There are a number of services beyond congenital heart services that CHD patients may use. Some of these services are reliant on clinical support or backup from CHD specialists. The standards for these services should not be reviewed as part of the review. However, the use of these services by congenital heart disease patients should be considered by the review, including the definition of clinical pathways and referral routes. Any impact of changes recommended by the review on these services should be considered prior to decisions being taken and during implementation. Patients and specialists from these services should be able to participate in the review.

**Detailed recommendations**

7. Based on these principles, the Clinical Advisory Panel recommends that:

**In scope**

8. The heart of the review should be the whole lifetime pathway of care for people with congenital heart disease, and specifically congenital heart disease services. This means:

a) Improving the quality of care of people with suspected or diagnosed congenital heart disease (including those with congenital heart arrhythmias or arrhythmias in the context of congenital heart disease) along the whole patient pathway:

- Fetal and neonatal diagnosis of CHD
- Specialist obstetric care (including both care of women whose unborn child has suspected or confirmed CHD and care of pregnant women with CHD )
- Care for babies, children and young people
- Transition from children's services to adult services
- Care for adults
- End of life care

b) Cardiac and respiratory extracorporeal membrane oxygenation (ECMO) for children and young people.

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

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

**Interdependencies**

9. There are a number of clinical conditions which while not CHD receive their care wholly or mainly from congenital heart services. The standards for services for these conditions should not be reviewed as part of the review (though the standards being developed may address aspects of the service). However, patients who fall within this category use congenital heart services and should be able to participate in the review. This means:

    a) Children and young people with acquired heart disease
    b) Children and young people with inherited heart disease (for which a separate service specification has already been developed).

10. There are a number of services beyond congenital heart services that CHD patients may use. Some of these services are reliant on clinical support or backup from CHD specialists. The standards for these services should not be reviewed as part of the review. However, the use of these services by congenital heart disease patients should be considered by the review, including the definition of clinical pathways and referral routes. Any impact of changes recommended by the review on these services should be considered prior to decisions being taken and during implementation. Patients and specialists from these services should be able to participate in the review. This means:

    a) Neonatal, paediatric and adult intensive care unit (ICU) services, and transport and retrieval services.
    b) Other interdependent clinical services (for example other tertiary paediatric services).
    c) Mechanical circulatory support for adults including cardiac ECMO and VAD.
    d) Complex tracheal surgery.
    e) Heart transplant and bridge to transplant services for children and young people.
    f) Heart transplant for adults.

**Out of scope**

11. Adults with inherited heart disease
    It was recommended that this group be excluded from the review because these patients do not receive their care from congenital heart services.

12. Adult respiratory ECMO
    It was recommended that this service should be excluded from the review because it is not dependent on congenital heart services, and operates independently of ACHD services.

13. Local maternity services
    It was recommended that local maternity services should be excluded from the review. Rather, the review should include specialist cardiac obstetric care (see 7a) above).

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# The new Congenital Heart Disease review: 9th update – John Holden

14 October 2013 - 17:41

**Your feedback**

Thank you for your continued feedback, on the blog and elsewhere (our email address is england.congenitalheart@nhs.net). Amongst other things, you have

- reminded us we need to listen to the views of Healthwatch (local and national);
- expressed concern about the tight deadlines for commenting on papers;
- told us that some of the services we might consider "out of scope" of the review are in fact key to its outcome, and
- asked whether we are being even-handed in our dealings with each of the surgical centres, their supporters and representatives.

I'll deal with each of these in turn below.

**Healthwatch:** I've been discussing with Katherine Rake, Healthwatch England's CEO, how best NHS England can engage with Healthwatch on the new review of congenital heart disease. She has impressed on me that Healthwatch is much more than the national body, and that we should take full advantage of the opportunity presented by the experience and expertise in local Healthwatch groups. We both agree there needs to be an explicit opportunity for local Healthwatch to express their views and begin a dialogue; we'll say more about how we plan to achieve that shortly. In addition we've also asked Healthwatch England how they would like to be involved in our patient and public group: this is likely to be as observers. I will provide further updates in due course.

**Tight deadlines:** We've been criticised for publishing the Task & Finish Group papers only a few days before that Group met. I accept that it is in everyone's interests that we give as much notice as possible. In an ideal world, the papers would have been published earlier, but as ever, we are trying to strike a balance between making rapid progress, being as open as possible, and maximising opportunities for engagement. (For example, in allowing more time for everyone to feed in their comments on the Task & Finish Group paper on scope of the review (see below), we have reduced the time available for the members of the Clinical Advisory Panel to see this paper in advance of their meeting. Trade-offs like this are inevitable). Our timing was in accordance with our publication scheme (which commits to publishing the agenda and papers) and with the Task & Finish Group's own terms of reference. Of course we can always do better and we will try. But I don't accept some of the more strident criticism which implies we are manipulating the process, or even breaking the law. On the contrary: publishing the papers for the review's working groups, and inviting comment, is a practical example of our commitment to openness and transparency.

**Services outside the scope of the review:** Our Task & Finish Group provided an initial steer on scope, and we have received comments from stakeholders, all of which will help shape the discussion at our Clinical Advisory Panel (CAP) on 15 October. The paper on scope will be issued only shortly before the CAP meeting, reflecting the fact that we want to take account of the feedback we have received. CAP will make recommendations to help the Task and Finish Group to reach a decision. Some concerns have been expressed that if we define scope too narrowly we might close down an important line of discussion, or fail to make sense of the complex dependencies between services. In turn, so the argument goes, this might not only disadvantage certain groups, it may also favour some centres more than others, and so we are – deliberately or inadvertently – determining the outcome of the review. In fact, what we are doing is precisely the opposite – we are trying to ensure that the review strikes a sensible balance between scope which is too broadly defined, and therefore undeliverable in any meaningful timescale, versus scope which is too narrow, and inappropriately excludes patient groups who depend on CHD services. Even if we decide that a service is "out of scope" this does not simplistically mean that we will ignore it, as if it didn't exist. It means the review will not seek to determine how that service should be delivered, but we will take full account of the links to CHD services. So if the standards which are set for CHD require us to take account of those excluded services (for example requiring that they are co-located with CHD surgery) then we will ensure this is factored into our review's conclusions.

**Even-handed approach:** I hope it is clear from these remarks that we are striving to be sensible, consistent and even-handed in the way we go about this review, but in spite of this we are regularly challenged as to whether some action or inaction by NHS England reveals a preference for one centre or another. Here's my response to a selection of concerns from recent blogs –

- The reason NHS England's Dr Mike Bewick met the Leeds Charity CHSF was to discuss the review of surgical safety at Leeds, which has been ongoing since Easter. He is not involved in the national CHD review, and I am not involved in his work.
- The reason I have not met other Overview & Scrutiny Committees yet is because I took expert advice from the Local Government Association and the Centre for Public Scrutiny. They told me to prioritise the three OSCs who referred *Safe and Sustainable* to the Secretary of State. We are convening a meeting of council leaders for other areas to discuss how best to involve them.
- The fact that we want to work with the Children's Heart Federation, or Somerville Foundation, or British Heart Foundation, or CHUF, or CHSF, or Little Hearts Matter, etc., does not mean we are "taking sides". We will talk to anyone who can help us.
- The fact that some clinicians who have reached national prominence might know each other or have trained together is hardly surprising in a relatively narrow field of activity, in a country the size of ours. It is not evidence of collusion.

And so on. We don't have the time to mount a defence against every charge, or to dismantle complex conspiracy theories, so please don't assume that silence means agreement. Judge us by our actions, and please get involved in the review and help to shape it.

**Patients, families and their representatives**

Yorkshire and Humber Joint Health Overview & Scrutiny Committee have now published their draft minutes of the meeting I attended on 13 September. The minutes will remain in draft until they are formally approved by a future meeting of the Committee.

*******

On 9 October our Medical Director, Professor Sir Bruce Keogh, and Programme Director for the new review, Michael Wilson, attended a meeting of the All Party Parliamentary Group (of MPs and peers) in Committee Room W1 at the Houses of Parliament. For a list of attendees see here. Michael gave a short presentation which is available here.

We will produce a note of the meeting and post it on our webpage (with a link in the blog). It was not possible to answer all the Group members' questions in the time available at the meeting, so we have offered to provide written responses and we will also publish a link to those answers as soon as they are available.

*******

On Friday 25 October I will attend the meeting of the Joint Scrutiny Commission for Leicester, Leicestershire and Rutland in Leicester.

*******

We have set up a patient and public group, chaired by Professor Peter Weissberg (of the British Heart Foundation), to bring together representatives from every local and national charity with a direct interest in the review. The group's first meeting has been scheduled for November 12 in London. The full list of invitees is being finalised and will be available very shortly on **our web page.** If you think we've missed a group or organisation that should have been invited please let us know.

**Clinicians and their organisations**

The Clinical Advisory Panel (CAP), chaired by Professor Sir Michael Rawlins, meets in London on 15 October. Amongst other things CAP will consider the scope of the new CHD review, and provide a recommendation to the Board's Task and Finish Group on this. The agenda and papers are here. The final paper on scope will be added to our web page later and takes account of your feedback (following the publication of Task and Finish Group papers on 27 September).

The updated paper on scope which takes account of your feedback (following the publication of Task and Finish Group papers on 27 September) is now available.

*******

We have also set up a clinicians' group, chaired by Professor Deirdre Kelly (who also chaired the group developing additional standards for paediatric congenital cardiac care), to bring together representatives from every congenital heart centre, and other relevant clinicians. The group's first meeting will be held in London in November. The full list of organisations that have been invited to send representatives is attached here. If you think we've missed a group or organisation that should have been invited please let us know.

*******

We have set up a provider executives' panel, chaired by Chris Hopson (CEO of the Foundation Trust Network), to bring together the senior managers from those provider organisations most directly affected by the new CHD review. The panel's first meeting has been scheduled for November 19 in London. The full list of invitees is attached here. If you think we've missed a group or organisation that should have been invited please let us know.

**NHS England and other partners**

We now have a transcript of the discussion at our Board meeting on 18 July (the video has been online for some time).

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The minutes of the Board Task & Finish Group, which met on 30 September, will be available very shortly on **our web page.**

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Back in August I said that I was aiming to publish a blog every fortnight and I've roughly stuck to that plan, although I interrupted the cycle on 27 September to tell you about the papers for the Task & Finish Group. I am now back in a fortnightly routine and so future publication dates are likely to be on or around:

- Monday 28 October
- Monday 11 November
- Monday 25 November
- Monday 2 December
- Monday 16 December

# News

## The new Congenital Heart Disease review: 10th update – John Holden

28 October 2013 - 10:55

Not a big blog this week, it's half term so I'm off for a few days and just wanted to give you a quick update on what's happening.

**Your feedback**

There is no defining theme in the recent comments we've received on the blog and elsewhere. You have given us some really helpful views on the scope of the review, and you have asked questions about aspects of the process which are dealt with below. And finally you've reminded us (in classical French, and in more direct language!) that if we don't listen to people and learn from experience, then we can't expect to get things right.

Thank you for all your feedback. Please keep us on our toes, either by commenting on the blog or by emailing england.congenitalheart@nhs.net.

**Patients, families and their representatives**

At their meeting on 17 October, Michael Wilson briefed the NHS England Specialised Services Patient & Public Steering Group on the new review, including an update on the development of the communications and engagement plan.

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On 25 October I attended a meeting of the Joint Scrutiny Commission for Leicester, Leicestershire & Rutland in Leicester. Whilst in Leicester I also had a separate meeting with representatives of local Healthwatch.

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On 4 November I will attend the North East Regional Health Scrutiny meeting (the chairs of local government Overview and Scrutiny Committees), in Gateshead.

**Clinicians and their organisations**

When the last blog was published the detailed paper on the scope of the review, for consideration by our Clinical Advisory Panel, was not available. It was added to the blog later. In case you missed it, the paper on scope is attached again here, and reflects about 40 sets of comments we received during the period 27 September to 11 October. Minutes of the 15 October Panel will be published as soon as they are available.

******

Following discussion at the Panel on 15 October, the scope paper has now been rewritten to include a set of recommendations: you can read the revised paper here. It will be considered by Task and Finish Group (see below).

******

On 14 October Professor Deirdre Kelly chaired a meeting of a small working group overseeing the work on bringing together standards and addressing the issues raised by Sir Bruce Keogh. A note of that meeting will be published as soon as it is available.

******

At their meeting on 25 October, Michael Wilson briefed the CHD Clinical Reference Group on the new review, including an update on the scope of the review and the process for developing a service specification.

**NHS England and other partners**

Our Task and Finish Group met on 30 September, and the draft notes of that meeting are now available here. The minutes will be formally agreed at the next meeting of the Group, which is on Tuesday 29 October: the agenda and papers for the meeting are here. These papers include – at item 9 – the revised paper on scope (which I also attached separately above for ease of reference). We are asking the Task and Finish Group to make a decision on the scope of the new CHD review, based on these recommendations.

******

The first meeting of our Programme Board was on 21 October – the papers for that meeting are here. Minutes will be published as soon as they are available.

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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 for questions relating to the new CHD review which have been answered recently.

**DRAFT Summary Notes**

Meeting on Friday 25th October 2013 of Joint (Leicester, Leicestershire and Rutland) Health Scrutiny Committee to convene for the purpose of a private meeting with John Holden, Lead for NHS England Review Team.

Time & Venue: 1pm to 2.30pm in the Tea Room, Town Hall, Leicester, Leicester City Council.

Purpose of Meeting: To discuss how health scrutiny can be involved in the consultation process of this review.

## Attendees:

Councillors;

Councillor Michael Cooke,
-CHAIR of Health & Wellbeing Scrutiny Commission, Leicester City Council
Councillor Sarah Hill,
-CHAIR of Health Overview & Scrutiny Committee, Leicestershire County Council
Councillor Lucy Stephenson,
-CHAIR of People (Adults and Health) Scrutiny Panel, Rutland County Council
Councillor Baljit Singh
-Member of Health & Wellbeing Scrutiny Commission, Leicester City Council
Councillor Virginia Cleaver
-Member of Health & Wellbeing Scrutiny Commission, Leicester City Council
Councillor Stephen Hampson,
-Member of Health Overview & Scrutiny Committee, Leicestershire County Council

Invited:

- John Holden, Director of System Policy, NHS ENGLAND REVIEW TEAM

Officers:

- Deb Watson, Director of Public Health & Adult Social Care, Leicester City Council
- Rod Moore, Deputy Director of Public Health, Leicester City Council
- Anita Patel, Health Scrutiny Support Officer, Leicester City Council
- Anne Mitchell, Senior Policy Research Officer for Health, Leicestershire County Council

**SUMMARY NOTES:**

1) Councillor Cooke welcomed John Holden, on behalf of Leicester, Leicestershire & Rutland Health Scrutiny Chairs.

2) John provided an overview of the review and its remit. He explained that he is very hands-on and aims to keep the new review as open, transparent and accountable as possible, hence, his regular web blog to share information on progress.

3) Main points of information shared by John, as follows:

a) As per the IRP recommendations, (i) ECMO has been included in the scope of this new review, and (ii) both Children and Adult Heart Surgery (*from cradle to grave*) will be included in the scope of this review.

b) The revised scope for the review is now posted on the website.

c) The new review team have tried to understand and absorb the previous work done by the safe and sustainable team, as this work cannot be ignored.

d) Every person across England has the right to expect the same quality of service when being treated for heart surgery.

e) In looking at a patients' pathway of care, we do need to bear in mind that heart surgery can be just a small part of their pathway of care.

f) In measuring the heart surgery service, the important factors are clinical outcomes and the patient experience.

g) Quality engagement is a priority for the review team.

h) The review team are aiming to complete its work in June 2014, prior to that a focus on engagement work over this winter period.

i) The direction of travel for the review is:

*Phase 1* - Listen to people / this is the current stage
*Phase 2* - Engaging with people with our proposals to show what a good service should look like
*Phase 3* - Working towards an implementation stage with a range of options.

j) The review team recognises that there are changes in communities, demographics, population etc…..and will take these into account.

4) John assured councillors that the review team want to engage with local government and with health scrutiny committees across the country. John stated that a preference was to do this through a national scrutiny forum, however, now understands that this will not be possible.

5) John assured the councillors that they will continue to have a dialogue with the Local Government Association (LGA) and the Centre for Public Scrutiny (CfPS), however, would appreciate suggestions of how engagement can be best done?

6) John highlighted that the NHS England Area Directors will have a part to play in supporting this review e.g. for the enablement of formal engagement and consultation sessions.

7) Councillors suggested that as well as engaging with health scrutiny committees, wider engagement can be done via:

-Health & Wellbeing Boards
-Leaders and Executive of Councils
-Regional East Midlands Health Scrutiny Network
-NHS England Regional Area Director (David Sharp)

-Forum for Rural Councils (SPARS)

8) Councillors explained to John, their role and responsibilities, as elected members, in relation to listening to public opinions and views and the need to provide assurances to the people they represent.

9) Councillors urged the review team to better understand and take into account the social status of people in this review area. In particular, in relation to how people would react in situations of requiring surgery health care:
For example:
- financial constraints causing difficulties to travel for surgery and health care;
- the feeling of fear in situations of surgery combined with stress, money worries and family situations
- the feeling of guilt for those who are unable to access surgery health care easily.

10) Councillors echoed their support for the outstanding specialised service provided at Glenfield Hospital Heart Unit, which continues to treat patients locally, nationally and internationally.

11) Councillors reiterated that there is real need to understand the demographics and social status for the 3 areas of Leicester, Leicestershire and Rutland as each area is different.

12) John apologised for the potential tight deadlines upon health scrutiny in providing feedback and comments during this review.

13) John concluded by saying that he valued the discussions today and recognises the benefits of involving health scrutiny throughout this review.

14) Councillor Cooke, Councillor Hill and Councillor Stephenson, Chairs of Health Scrutiny, thanked John for taking time out to come to Leicester and for listening and explaining the review process.

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Health Scrutiny Support Officer
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Telephone: 0116 2298825

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Leicester City Council

# Appendix S

**DRAFT**

Briefing Report for members of the Health & Wellbeing Scrutiny Commission

26th November 2013

## Feedback from East Midlands Regional Health Scrutiny Network Meeting

### Purpose

This briefing report updates members of the commission on the issues discussed at the East Midlands Regional Health Scrutiny Network meeting on 21st October 2013.

### Report

This regional meeting was hosted by Nottingham City Council. Councillor Michael Cooke together with council representatives from the East Midlands region attended, plus Brenda Cook, Regional Advocate from the Centre for Public Scrutiny.

The main items discussed were:

a) The future for regional working on health issues

Agreed that it was beneficial to continue the Regional Network for Health Scrutiny working, as it is important to share knowledge on scrutinising common issues of interest e.g. EMAS.

b) Taking an overview of NHS complaints

In September 2013, the Centre for Public Scrutiny published its Briefing for Council Scrutiny about the Francis Report. CfPS guidance states that "*scrutiny is not a way to resolve individual complaints*", and that scrutiny "*should not ignore personal stories, but should have ways to test whether personal experiences are symptomatic of wider problems – amplifying the voices and concerns of the public where necessary to affect change*"

Agreed that Health Scrutiny Committees need to better understand the NHS complaints process and procedures, in order to take an overview of NHS complaints.

c) Future Regional Health Scrutiny Events

Brenda Cook reported that the Centre for Public Scrutiny plan to deliver 3 health scrutiny regional events in January 2014, one within each sub-region, i.e. West Midlands, East Midlands and East of England. Health scrutiny elected members and officers will be invited to attend.

These events will partly focus on a number of common themes that have been identified, such as:

a) The need to be clear about how to address substantial changes to health services and how the requirements will work in practice.

b) Developing relationships with national/regional partners (Monitor, CQC, NHS England, Public Health England)

c) Scrutiny of specialised services

d) Making scrutiny effective within current economic and resource pressures

**Councillor Cooke has offered for Leicester City Council to host the East Midlands event, which is planned to take place on 9th January 2014.**

Councillor Michael Cooke

Chair of Health & Wellbeing Scrutiny Commission