Bradgate Unit Position Statement

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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