Leicestershire County Council

Meeting: **Health Overview and Scrutiny Committee**

Date/Time: **Wednesday, 11 June 2014 at 2.00 pm**

Location: **Sparkenhoe Committee Room, County Hall, Glenfield**

Contact: **Mrs. R. Palmer (0116 305 6098)**

Email: **rosemary.palmer@leics.gov.uk**

Membership

Mrs. J. A. Dickinson CC
Dr. T. Eynon CC
Dr. R. K. A. Feltham CC
Dr. S. Hill CC
Mr. W. Liquorish JP CC
Mr. J. Miah CC
Mr. M. T. Mullaney CC
Mr. J. P. O'Shea CC
Mr. A. E. Pearson CC

Please note: this meeting will be filmed for live or subsequent broadcast via the Council's web site at http://www.leics.gov.uk/webcast – Notices will be on display at the meeting explaining the arrangements.

AGENDA

Item		Report by
1.	Appointment of Chairman. To note that Dr S Hill CC was nominated as Chairman elect to the Health Overview and Scrutiny Committee at the County Council meeting held on 21 May 2014.	
2.	Election of Deputy Chairman.	
3.	Minutes of the meeting held on 12 March 2014.	(Pages 5 - 14)
4.	Question Time.	
5.	Questions asked by members under Standing Order 7(3) and 7(5).	
6.	To advise of any other items which the Chairman has decided to take as urgent elsewhere on the agenda.	

7.	Declarations of interest in respect of items on the agenda.		
8.	Declarations of the Party Whip in accordance with Overview and Scrutiny Procedure Rule 16.		
9.	Presentation of Petitions under Standing Order 36.		
10.	Progress Following Risk Summits and Outcome of CQC Inspection.	East Midlands Ambulance Service NHS Trust	(Pages 15 - 22)
11.	Report of the Scrutiny Review Panel on the Referral Pathway for Older People with Anxiety and Depression.	Scrutiny Review Panel	(Pages 23 - 38)
12.	Emergency Hospital Admission Avoidance from Care Homes.	West Leicestershire and East Leicestershire and Rutland CCG	(Pages 39 - 44)
13.	Perinatal Inpatient Mental Health Services in Leicestershire.	NHS England and West Leicestershire CCG	(Pages 45 - 58)
14.	Proposed Relocation of Child and Adolescent Mental Health Inpatient Services.	Leicestershire Partnership NHS Trust	(Pages 59 - 78)
15.	Performance Report.	Chief Executive and Greater East Midlands Commissioning Support Unit	(Pages 79 - 94)
16.	Date of next meeting.		

The next meeting of the Committee will be held on 10 September at 2.00pm.

17. Any other items which the Chairman has decided to take as urgent.

QUESTIONING BY MEMBERS OF OVERVIEW AND SCRUTINY

Members serving on Overview and Scrutiny have a key role in providing constructive yet robust challenge to proposals put forward by the Cabinet and Officers. One of the most important skills is the ability to extract information by means of questions so that it can help inform comments and recommendations from Overview and Scrutiny bodies.

Members clearly cannot be expected to be experts in every topic under scrutiny and nor is there an expectation that they so be. Asking questions of 'experts' can be difficult and intimidating but often posing questions from a lay perspective would allow members to obtain a better perspective and understanding of the issue at hand.

Set out below are some key questions members may consider asking when considering reports on particular issues. The list of questions is not intended as a comprehensive list but as a general guide. Depending on the issue under consideration there may be specific questions members may wish to ask.

Key Questions:

- Why are we doing this?
- Why do we have to offer this service?
- How does this fit in with the Council's priorities?
- Which of our key partners are involved? Do they share the objectives and is the service to be joined up?
- Who is providing this service and why have we chosen this approach? What other options were considered and why were these discarded?
- Who has been consulted and what has the response been? How, if at all, have their views been taken into account in this proposal?

If it is a new service:

- Who are the main beneficiaries of the service? (could be a particular group or an area)
- What difference will providing this service make to them – What will be different and how will we know if we have succeeded?
- How much will it cost and how is it to be funded?
- What are the risks to the successful delivery of the service?

If it is a reduction in an existing service:

- Which groups are affected? Is the impact greater on any particular group and, if so, which group and what plans do you have to help mitigate the impact?
- When are the proposals to be implemented and do you have any transitional arrangements for those who will no longer receive the service?
- What savings do you expect to generate and what was expected in the budget? Are there any redundancies?
- What are the risks of not delivering as intended? If this happens, what contingency measures have you in place?

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Agenda Item 3

Leicestershire County Council

Minutes of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Glenfield on Wednesday, 12 March 2014.

PRESENT

Dr. S. Hill CC (in the Chair)

Dr. T. Eynon CC	Mr. J. Miah CC
Dr. R. K. A. Feltham CC	Mr. M. T. Mullaney CC
Mr. S. J. Hampson CC	Mr. J. P. O'Shea CC
Mr. W. Liquorish JP CC	Mr. A. E. Pearson CC

In attendance.

Mr E F White CC, Cabinet Lead Member for Health
Mr Geoff Smith OBE, Healthwatch Representative
Caroline Trevithick, Chief Nurse and Quality Lead, WLCCG (minute 55 refers)
Dr Nick Willmott, Urgent Care Lead, WLCCG (minute 55 refers)
Rachel Bilsborough, Divisional Director, Community Health Services, LPT (minute 55 refers)
Jim Bosworth, Assistant Director – Commissioning, WLCCG (minute 58 refers)
Dr Satheesh Kumar, Medical Director, LPT (minute 58 refers)
Dr Dave Briggs, Managing Director, East Leicestershire and Rutland CCG (minutes 58 and 59 refer)
Stuart Baird, Interim Head of Communications and Engagement, ELR CCG (minute 58 refers)
Richard Mitchell, Chief Operating Officer, UHL (minutes 59 and 60 refers)
Rachel Overfield, Chief Nurse, UHL (minutes 59 and 60 refer)
Tim Sacks, Chief Operating Officer, ELR CCG (minute 61 refers)

47. Minutes.

The minutes of the meeting held on 22 January 2014 were taken as read, confirmed and signed.

48. Question Time.

The Chief Executive reported that no questions had been received under Standing Order 35.

49. Questions asked by members under Standing Order 7(3) and 7(5).

The Chief Executive reported that no questions had been received under Standing Order 7(3) and 7(5).

50. Urgent Items.

There were no urgent items for consideration.

51. Declarations of interest.

The Chairman invited members who wished to do so to declare any interest in respect of items on the agenda for the meeting.

Dr T Eynon CC declared a personal interest in all items on the agenda as a salaried GP.

52. Declarations of the Party Whip in accordance with Overview and Scrutiny Procedure Rule 16.

There were no declarations of the party whip.

53. Presentation of Petitions under Standing Order 36.

The Chief Executive reported that no petitions had been received under Standing Order 36.

54. Change to the Order of Business.

The Chairman sought and obtained the consent of the Committee to vary the order of business from that shown on the agenda.

55. Fit for Future: Community Health Services in Ashby.

The Committee considered a joint report of West Leicestershire Clinical Commissioning Group (WLCCG) and Leicestershire Partnership NHS Trust (LPT) which presented the options that were being formally consulted on in relation to the current review of community services in the Ashby. A copy of the report marked 'Agenda Item 14' is filed with these minutes.

The Chairman welcomed Caroline Trevithick, Chief Nurse and Quality Lead at WLCCG, Dr Nick Willmott, Urgent Care Lead at WLCCG and Rachel Bilsborough, Divisional Director for Community Health Services at LPT to the meeting for this item.

The Committee was of the view that any decision regarding community health services in Ashby should not be taken in isolation. It would be important to ensure that provision of community beds was maintained across West Leicestershire. Additionally, the Committee was keen to see patients being cared for in their own homes where possible.

The changes to community health services in Ashby would be implemented on a phased basis. It was expected that the new Ashby Health Centre, which was currently at the provisional planning stage, would be in operation next year.

RESOLVED:

(a) That Option 2 as set out in paragraphs 22 – 25 of the report be supported in principle, subject to the comments now made;

(b) That officers be requested to produce a formal response to the consultation on Community Health Services in Ashby, based on this Committee's discussions, and forward it to West Leicestershire CCG.

56. Better Care Fund Update.

The Committee considered a report of the Chief Executive which provided an update on the work in progress to finalise the Better Care Fund Plan for Leicestershire for submission to the Department of Health by April 4th 2014. A copy of the report marked 'Agenda Item 8' is filed with these minutes.

The Chairman welcomed Mr E F White CC, Cabinet Lead Member for Health, to the meeting for this item. Mr White spoke in support of the Plan and confirmed that he was satisfied that the County Council would meet the deadline for submitting the Plan to the Department of Health.

The Committee noted the comments of Healthwatch, a copy of which is filed with these minutes. At the invitation of the Chairman, Geoff Smith OBE, Healthwatch representative, emphasised the need for the Better Care Fund Plan to have a communications and engagement strategy.

The Committee welcomed the proposed review of the whole pathway for frail elderly care. It was also hoped that any recommendations arising from the Scrutiny Review of the referral pathway for older people with anxiety and depression would be picked up through delivery of the Better Care Fund Plan.

RESOLVED:

That the update on the work in progress to finalise the Better Care Fund Plan for Leicestershire for submission by April 4th 2014 be noted.

57. Performance Report

The Committee considered a report of the Chief Executive and Director of Public Health which provided an overview of the performance framework across the health and wellbeing sector in Leicestershire and an overview of current performance. A copy of the report marked 'Agenda Item 9' is filed with these minutes.

The Committee noted the comments of Healthwatch, a copy of which is filed with these minutes.

The Health and Wellbeing Strategy priority to provide appropriate housing and adaptations to enable the frail elderly to live longer in their own homes was currently partly delivered by the District Councils. However, there was a proposal in the Better Care Fund Plan called the 'Housing Offer to Health' which would identify partnership solutions to help people live in their own homes for longer. A brief overview of performance of this offer, in the context of delivery of the Better Care Fund Plan, would be included in future performance reports to this Committee.

The Committee was pleased to note that the target for increasing the number of children and adults who were a healthy weight was rated 'green'. It was noted that the target for chlamydia diagnoses was unlikely to be met due to the low prevalence in Leicestershire.

RESOLVED:

(a) That the progress made to date in developing the performance framework alongside reporting arrangements to support the Committee's role;

(b) That the performance summary, issues identified this quarter and actions planned in response to improve performance be noted.

58. Quality Oversight Group for Leicestershire Partnership NHS Trust.

The Committee considered a report from East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG) and West Leicestershire Clinical Commissioning Group (WLCCG) which provided an update on the work of the Assurance Oversight Group for Leicestershire Partnership Trust (LPT) and their progress to date on their Quality Improvement Plan. A copy of the report marked 'Agenda Item 10' is filed with these minutes.

The Chairman welcomed Dr Dave Briggs, Managing Director for ELRCCG, Jim Bosworth, Assistant Director for Commissioning at WLCCG and Dr Satheesh Kumar, Medical Director at LPT to the meeting for this item.

In Dr Briggs introduced the report and outlined developments that had taken place since it was written. There had been a meeting of the Assurance Oversight Group during the previous week and improvements had been seen in the numbers of qualified nurses being appointed. In addition, the dashboard metrics were now complete and would in future provide a comprehensive picture of quality across in-patient services, ward process and crisis response home treatment. There was still variation in the quality across the Bradgate Unit but it was hoped that this would be resolved during the next three months, especially as the impact of increased staffing was felt.

It was noted that the ratio of qualified to unqualified staff on a ward had been changed recently and that LPT now had 60% qualified staff on a ward. LPT acknowledged that its previous arrangement had not been sufficient to ensure quality of care.

Concern was expressed that LPT did not always resolve complaints in a timely fashion. The Committee was assured that LPT took individual complaints seriously. More generally, themes arising from complaints were used as one of a number of tools to assess the quality of care.

RESOLVED:

(a) That the work of the Assurance Oversight Group for Leicestershire Partnership Trust and the progress to date of their Quality Improvement Plan be noted;

(b) That the Scrutiny Commissioners be requested to consider establishing a Scrutiny Review Panel to consider NHS complaints and their impact on the quality of services.

59. Review of Effectiveness of Emergency Care over Winter.

The Committee considered a presentation from the University Hospitals of Leicester NHS Trust (UHL) and its commissioners which provided a summary of winter performance and the effectiveness of emergency care over winter. A copy of the slides forming the presentation is filed with these minutes.

The Chairman welcomed the following officers to the meeting for this item:-
Dr Dave Briggs, Managing Director, East Leicestershire and Rutland CCG;

Stuart Baird, Interim Communication and Engagement Manager, East Leicestershire and Rutland CCG;
Richard Mitchell, Chief Operating Officer, UHL;
Rachel Overfield, Chief Nurse, UHL.

Arising from discussion the following points were raised:-

(i) The Committee welcomed the partnership approach to resolving problems with the flow of patients through the Emergency Department. Each partner had a role to play to make improvements to the system. It was noted that there were still issues to address with the East Midlands Ambulance Service to encourage them to treat more patients themselves or convey them to a less intensive setting than the Emergency Department.

(ii) Concern was expressed that the opening hours of the Emergency Frailty Unit at the Leicester Royal Infirmary had been reduced. The Committee was assured that a full reinstatement of the unit was planned and that the Clinical Commissioning Groups were working with UHL to provide better services for frail elderly people. UHL had recruited more consultant geriatricians and it was intended that in the future the unit would be open seven days a week.

(iii) Concern was expressed that the times when there was most difficulty in achieving the 4 hour target in the Emergency Department coincided with school holidays and that the root cause could therefore be staffing issues. It was acknowledged that staffing had been an issue during the October half term but that since then staffing had been at a safe level during all school holidays. The reasons for poor performance during February related to the sustained period of increasing admissions which had left admissions at a critical level from the end of January.

(iv) UHL had been operating at full capacity for the past six months. In winter, the number of emergency beds was increased with a corresponding decrease in elective beds whereas in summer there were more elective beds available. The occupancy rates were lower in the summer but the same number of beds was available. In order to respond to seasonal changes, UHL now forecasted activity to ensure that the bed base was fit for purpose.

(v) There were a number of reasons for delayed transfers of care. A small number were attributable to social care, mainly when a domiciliary care package was needed. Other reasons included waiting for decisions on NHS Continuing Healthcare Funding and for a rehabilitation bed. A number of new approaches had been put in place including a closer relationship between community hospitals and social care.

(vi) Concern was expressed that increasing the flow through UHL would lead to increased costs to social care. It was noted that the Better Care Fund Plan included the transfer of funds to social care to protect the current level of spend. The Better Care Fund Plan also included proposals to reduce the demand on acute services. It was acknowledged by all partners that the best outcomes for patients would be achieved if robust reablement plans were in place so patients were made self-reliant and no longer dependent on health or social care services.

RESOLVED:

That the performance of the University Hospitals of Leicester NHS Trust during winter 2013/14 be noted.

60. Update on Current Issues.

The Committee considered a report from the University Hospitals of Leicester NHS Trust (UHL) which provided an update on the following issues:-

- Never Events 2009-2014;
- Hospital-acquired pressure ulcers;
- Nursing and medical staff and the use of agency staff;
- Cancelled operations;
- Emergency Department performance;
- Financial position;
- Care Quality Commission (CQC) inspection.

A copy of the report marked 'Agenda Item 12' is filed with these minutes.

The Chairman welcomed Richard Mitchell, Director of Operations and Rachel Overfield, Chief Nurse to the meeting for this item.

The Committee noted the comments of Healthwatch, a copy of which is filed with these minutes.

Arising from discussion the following points were raised:-

Never Events

(i) The recording of Never Events reflected an increasing recognition of human error. A tool was used which enabled UHL to identify if an error was procedural, systemic or human error. If it was the latter, a decision could also be taken to identify if it was a competency issue, intentional or caused by distraction. Appropriate action could then be taken.

(ii) The number of Never Events occurring at UHL was similar to, if not less than, other Trusts of a comparable size and complexity. UHL had put checklists in place to prevent Never Events and compliance with their use had increased dramatically, although it was acknowledged that further improvements could be made.

Staffing Issues

(iii) The Committee was pleased to note that UHL successfully recruited the majority of nurses who were trained in Leicestershire and that staff turnover and sickness levels were low. UHL struggled to recruit nurses from other parts of the UK, hence the recent, successful, recruitment drive in Spain, Portugal and Ireland. Overseas nurses were welcomed by UHL because of the challenge they bought to traditional systems and processes.

(iv) It was likely to take a further 12 months before a sufficient number of nurses had been recruited by UHL. In the meantime, agency and bank staff would continue to be employed to ensure that staffing was at a safe level. UHL were considering ways to reduce the cost of agency staff. It was noted that some nurses chose to be employed by agencies as it suited their lifestyle.

(v) UHL offered an attractive recruitment packages to nurses, for example enabling them to gain experience in a research or education setting as well as in a clinical setting. All NHS Trusts were recruiting nurses and it was felt that UHL's package of support to staff would help with retention.

(vi) The safety of services was a priority which meant that existing staff might have to move wards to fill gaps. However, where possible, UHL would seek to ensure that staff were not moved out of their speciality and would not have to move if they did not wish to. Systems of support for existing staff were in place, such as being able to talk to the Chief Nurse and the Listening to Action staff engagement programme.

Financial Position

(vii) There was an increasing level of confidence that the financial deficit would not increase before the end of the financial year. UHL would be required to pay back the loan from the Trust Development Authority although the terms of repayment had not yet been agreed. UHL would be required to break even within three years.

(viii) UHL was identifying themes such as theatres and outpatients which would enable clinical teams to identify where savings could be made. Leicester, Leicestershire and Rutland had been identified nationally as a 'challenged' health economy which meant that external consultants would work with key stakeholders to identify ways of making health services sustainable.

CQC Inspection

(ix) It was noted that UHL had received the draft report from the CQC the previous day and had a week to comment on factual accuracy. A quality summit would be held on 26th March and it was expected that the report would be published on 27th March.

RESOLVED:

(a) That the Never Events that have taken place at UHL, the root causes and the organisational actions which have been implemented be noted;

(b) That the actions being taken by UHL in the prevention and management of avoidable pressure ulcers be noted;

(c) That the monitoring arrangements for the use of agency staff and the recruitment plans in place to reduce spend be noted;

(d) That the current position with regard to cancelled operations be noted;

(e) That the financial position of UHL be noted;

(f) That the current status of the CQC inspection report be noted.

61. Urgent Care (Minor Injuries and Minor Illness) Review and Public Consultation.

The Committee considered a report from the East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG) which identified the proposed options for future

delivery of urgent care services and invited the Committee to provide a formal comment as part of the public consultation. A copy of the report marked 'Agenda Item 13' is filed with these minutes.

The Chairman invited Tim Sacks, Chief Operating Officer at ELRCCG to the meeting for this item.

The Committee noted the comments of Healthwatch, a copy of which is filed with these minutes.

Arising from discussion, the following points were raised:-

(i) The Committee indicated its support for Option 3, which would introduce standardised opening hours for all services except the Oadby Urgent Care Centre. It was explained that the opening hours for the Urgent Care Centre would be different due to the high levels of demand. To reduce the opening hours of the Oadby Urgent Care Centre in line with other urgent care services in East Leicestershire would increase the pressures on the Emergency Department and Primary Care. The funding received from NHS England would allow the Urgent Care Centre in Oadby to be open from 8am until 9pm.

(ii) The public consultation was seeking views on potentially moving the Urgent Care Centre from Oadby to Wigston. Members expressed concern that the transport links between Oadby and Wigston were poor.

(iii) Concern was expressed that smaller GP surgeries might struggle to provide good quality urgent care. The Committee was assured that, in order to deliver urgent care services, each surgery was required to demonstrate its competency. The Committee was also pleased to note that training was also being organised for primary care staff, in particular for practice nurses who were likely to be the urgent care leads. The training ranged from a three day course to a day a week for six months and was being part funded by the CCG.

(iv) X-ray services would be available in Oakham, Market Harborough and Melton Mowbray during weekday opening hours. They would be available for patients referred by the local GP practices. The cost of introducing x-ray services for the Oadby Urgent Care Centre was prohibitive, although ultrasound and ECG services would be available.

RESOLVED:

(a) That Option 3 as set out in paragraph 23 of the report be supported;

(b) That officers be requested to produce a formal response to the consultation on urgent care services in East Leicestershire and Rutland, based on this Committee's discussions, and forward it to East Leicestershire and Rutland CCG.

62. <u>Anne Mitchell.</u>

The Committee joined the Chairman in congratulating Anne Mitchell on her retirement and thanking her for the fantastic support that she had provided over the past 10 years. She had been a tremendous asset to the Committee.

63. Geoff Smith OBE.

The Committee noted that this was the last meeting Geoff Smith OBE would be attending as Healthwatch representative and joined the Chairman in thanking him for his work to assist the Committee.

64. Date of next meeting.

It was noted that the next meeting of the Committee would be held on 11 June 2014 at 2.00pm.

2.00 - 4.40 pm CHAIRMAN
12 March 2014

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Agenda Item 10

East Midlands Ambulance Service NHS Trust

HEALTH AND OVERVIEW SCRUTINY COMMITTEE: 11 JUNE 2014

REPORT OF EAST MIDLANDS AMBULANCE SERVICE NHS TRUST

PROGRESS FOLLOWING RISK SUMMITS AND OUTCOME OF CARE QUALITY COMMISSION INSPECTION

Purpose of the Report

1. The purpose of the report is to:

   - Provide an honest, open and transparent report about the current issues, progress and challenges that face East Midlands Ambulance Service NHS Trust (EMAS).

   - Outline the two recent "Risk Summits" required of the Trust and the outcomes from these, explaining the approach being taken by EMAS in the short and medium term to ensure service provision is sustainably improved for all users and the very positive progress achieved to date.

   - Outline the findings from the recent Care Quality Commission (CQC) inspection of the Trust and the actions being taken to address the identified areas of shortfall/non-compliance.

   - Demonstrate public accountability and set out how the Trust is working to restore confidence in its services.

Overview of the recent "Risk Summits"

2. The non-delivery of core service performance and quality standards by EMAS through the first half of 2013 gained sufficient attention and concern that NHS England required the Trust to attend a "Risk Summit" in October 2013. The Risk Summit was attended by the relevant commissioning bodies responsible for the EMAS contract plus NHS England, The Trust Development Authority (TDA) and the CQC.

3. With the appointment of a new CEO, Sue Noyes, a focused recovery plan was developed and approved by the same agencies, following the Risk Summit. EMAS term this the "Better Patient Care" plan. This plan has been mobilised and implemented Trust Wide and is monitored through a PMO office and a dedicated Board that meets weekly, chaired by the CEO.

4. A copy of the plan can be found at - http://www.emas.nhs.uk/ under the tab 'Our Services'.

5. The core workstreams within the plan are:

   - Responding to our Patients
   - Our People
   - Our Leadership
   - Clinical Effectiveness
   - Patient Safety and Experience
   - Our Money
   - Our Estate, IT and Fleet
   - Our Communications

6. Following implementation of the Better Patient Care plan, fortnightly progress reviews were conducted with the agencies who attended the Risk Summit, this continued until a second Risk Summit was convened in February 2014.

7. The second Risk Summit was attended by all organisations that had attended the original summit.

8. Progress against the Better Patient Care plan was further reviewed at this second Risk Summit and key performance interrogated. The EMAS Executive Director team attended all review meetings.

9. Following this meeting the substantial progress made by EMAS against the Better Patient Care plan and the approved trajectory of further improvement provided sufficient surety that the monitoring of EMAS was reduced to a monthly frequency and has remained so since. The meeting chair complimented EMAS on the very positive progress made and felt this needed to be recognised, this view was also supported by the lead commissioners and the CQC.

10. The business improvement achieved at this point enabled this phase of the Better Patient Care Quality Improvement Plan, focused on organisational recovery, to progress to the second phase of the programme, reflecting the finalised strategic objectives for the organisation and delivering the required actions in 2014/15 to maintain strong performance, consolidate activities to ensure performance is achieved sustainably and all aspects of the plan remain managed through the same governance and accountability process.

11. The first review meeting this financial year, with the TDA, held on 19 May 2014 was very positive and EMAS was commended on the continued positive progress made to date and since 01 April in continuing further to improve organisational performance.

12. Patient care measured through the key performance indicators of response time (Red 1/Red 2 and Red 19 and all 4 Green performance measurements) were delivered above target for the Trust in April 2014. The Trust also ended April with a small financial surplus, recognising the on-going success of the Better Patient care plan and management rigour.

13. For Leicester, Leicestershire and Rutland (LLR) two of the Red performance indicators were achieved (Red 2 and Red 19). The Red 1 target was not delivered, this showed an underperformance at 74.54%, the target is 75%.

14. Other key points of note arising from the Better Patient Care Plan:

- A new and expanded team of Executive Directors, approved by the TDA, has been recruited to the Trust; all will be in post by mid-July 2014.

- A revised local management structure has been introduced to focus more on local delivery, partner and cooperative working and resolution of issues arising. An Assistant Director of Operations was appointed for LLR on 16 December 2013, to lead the Leicestershire element of the Better Patient Care plan.

- The “Estates Programme” has been temporarily paused to allow the Trust to focus on delivery of patient care and performance. Work is continuing only at a planning/options level pending further direction from the EMAS Board.

- Staff engagement and recruitment has seen greater emphasis, being mobilised through an NHS initiative termed “Listening into Action” that is being led by our CEO.

- Staff recruitment and the workforce plan is fully committed for the current financial year with new staff joining the service in April, June, July, September, October and March 2015.

- Investment in 46 new “front line” vehicles has been committed by the Trust this year to improve fleet reliability and age profile. Delivery of these vehicles is expected in Quarter 3 of 2014. Further vehicles will be approved for procurement in 2015/6 to reflect the on-going renewal process and capital investment programme.

- Partner initiatives with CCGs, County Council, University Hospitals of Leicester (UHL) and voluntary bodies are in place and being further explored linked to the “Better Care Fund” and in particular providing more appropriate and targeted care in the right setting, not necessarily the Emergency Department. This has so far resulted in LLR achieving the highest “non-conveyance” rate, at 37%, for patients in the East Midlands ensuring care is delivered in the most appropriate setting.

- Quality, Patient Safety and Clinical Effectiveness and the data used to measure these criteria have all been reviewed and revised in addition to being externally audited by Price Waterhouse Coopers. This work has shown substantial progress in the reduction of patient complaints and investigations.

- The financial position for the Trust, year ending 31 March 2014, showed a break even position after agreement from commissioners for the reinvestment of fines imposed.

- 2014/15 is the first year in the five year planning cycle (2014/15). Our focus this year is very much on delivering and maintaining performance levels and ensuring a transition that achieves performance in a sustainable way and places great emphasis on engaging with and supporting our staff.

- All NHS Trusts are required to produce strategic plans by 20 June 2014. These plans are collected through the production of a five-year Integrated Business Plan (IBP) and Long Term Financial Model (LTFM) that respond to the substantial challenges faced by the NHS. We will be demonstrating that we have:

  i. undertaken strategic analysis and thinking to enable resilient planning for the future;
  ii. plans in place which demonstrate sustainability of services;
  iii. plans that are financially viable;

- The very positive progress across the eight facets of the Better Patient Care Plan continue and provide on-going service improvement month on month and are allowing EMAS to build a stronger organisation for future service delivery in Leicestershire.

15. A full report on the Better Patient Care Plan, can be located at http://www.emas.nhs.uk/ document reference PB.14.0132.4 Better Patient Care Next Stage of Development Report May 2014.

Overview of the CQC Visits January and February 2014

16. The Care Quality Commission (CQC) carried out a routine annual inspection of the Trust in January and February 2014. The CQC inspected six outcomes. These are listed below with the CQC's judgement:

- Outcome 4 Care and welfare of people who use services - Action needed
- Outcome 8 Cleanliness and Infection Control - Standard met
- Outcome 10 Safety, availability and suitability of equipment - Action needed
- Outcome 13 Staffing - Action needed
- Outcome 14 Supporting workers - Action needed
- Outcome 17 Complaints - Standard met.

17. The main areas of concern the CQC has identified are as follows:

- response standards were not being met;
- lack of staff resources;
- coverage of shifts;
- availability of vehicles;
- equipment availability;
- equipment checks on vehicles were not always carried out;
- lack of performance appraisals in some areas;

- low staff morale; and
- lack of time for management duties.

Key actions being taken to address outcome 4

- Operations Management Structure
- Recruitment of frontline staff
- Tactical management arrangements 24/7
- EOC resources – dispatcher secondments and agency nurses
- Dispatch Protocols
- Service Delivery Model, EOC Strategy, Fleet Strategy
- Arrangements for forecasting demand
- Dynamic System Status Plan
- Reduce conveyance and on-scene times
- Divisional performance management regime

Key actions being taken to address outcome 10

- Fleet Strategy
- Use of technology to determine vehicle requirements
- Fleet Wave system to manage vehicle and equipment availability
- Integration of existing systems to match daily vehicle needs
- Review Make Ready arrangements to improve vehicle availability
- Revise Safer Ambulance Checklist
- Regular reporting on vehicle requirements vs actual availability

Key actions being taken to address outcome 13

- Recruitment Plan for 2014/15
- Use of VAS/PAS, bank staff and overtime to cover vacancies
- Career development routes – Technician to Paramedic and ECA to Paramedic
- Manage abstractions at 28% through sickness management and revised Education Programme
- Improvements to sickness absence management
- Review supplementary contracts which affect core rotas
- Post implementation review of 2013/14 operational management restructure including management time vs operational response

Key actions being taken to address outcome 14

- Recruit to Team Leader and Clinical Team Mentor vacancies
- Post implementation review of 2013/14 operational management restructure including management time vs operational response to ensure time for appraisal and supervision
- New appraisal system
- Appraisal training update
- Targets for completion of appraisal and clinical supervision – at least 75% of available staff to have an appraisal in 2014/15

18. The full CQC report can be found at http://www.emas.nhs.uk/ document reference PB.0101.2 CQC Inspection Report Final Published Version April 2014.

19. The Better Patient Care improvement programme which the Trust is currently implementing will address a number of the weaknesses. Action has already been taken which has resulted in improvements since the inspection.

20. The Trust responded to the CQC on 07 May 2014, setting out the actions, noted above, and associated timescales for addressing concerns and ensuring compliance with the four standards which the CQC determined that the Trust had not met.

21. A report including this response and the detailed actions which the Trust will take to address all weaknesses in the report, not just those relating to the standards not met, will be presented to the Trust Quality and Governance Committee. That Committee will continue to monitor compliance with all of the CQC standards.

22. The actions required to address the issues identified by the CQC and any other actions required to ensure compliance on other standards not reviewed at the recent inspection, will be incorporated into the Better Patient Care Programme, where they are not already included.

23. The Better Patient Care Programme Board is responsible for monitoring progress against those actions. The Programme Board reports to each meeting of the Trust Board and therefore the Board will receive information on progress and any areas of concern through that mechanism.

Public accountability and working to restore confidence in services

24. As a Trust, and with the support and challenge of partner and external agencies previously mentioned, EMAS has had to address some very difficult issues over the last nine months and confront a number of failings from Board to front line, but has made significant recognised improvement across all areas of the service.

25. The two “Risk Summits” were seen as watersheds for the Trust and all staff understand that the Better Patient Care Plan is not just an immediate action plan but one that will and must deliver continual sustained improvement.

26. Now that the Trust has moved beyond the second Risk Summit and seen substantial positive progress against the Better Patient Care Plan, momentum in wider involvement and engagement is expanding and EMAS is being embraced as a partner organisation that can and does play a significant role within the health care community in Leicestershire.

27. The Trust is active with HealthWatch and has formed an EMAS HealthWatch Task Group to look at and action initiatives in response to local needs.

28. Engagement with both Urgent Care Board (UCB) and Urgent Care Working Groups is well established and representation and participation is regular and inclusive.

29. Work on unique initiatives with partner organisations such as CCGs, the Integration Executive, Local Resilience Forum (LRF) and others are on-going in support of the improvements necessary for the wider Leicestershire health economy.

30. Pro-active work on hospital delays with UHL staff have shown improvement, but there is a lot more work to do in this area. UHL will be presenting an action plan on this to the UCB during June 2014.

31. New Executive Director appointments to strengthen the EMAS senior management team have been made and a new local operational area management structure will be embedded by the end of July 2014 to strengthen local accountability in the delivery of the Better Patient Care plan and further enhance visibility.

32. External expert and consultant support, advice, critique and audit has been sourced and the results of this work and findings shared with commissioners to ensure the EMAS plan is robust and sufficiently focussed to deliver the required outcomes. Commissioner feedback on this has been very positive and supportive through their attendance at all relevant Board and Working Group meetings.

33. Continuing proactive engagement across stakeholders, public and staff engagement has been identified for future work, this will include: -

    - Station and Quality visits
    - ECHO (interactive online platform)
    - Listening into Action 'pulse check'
    - Staff opinion survey
    - Healthwatch organisations, Health & Wellbeing Boards and Overview & Scrutiny Committees (OSCs)

    - Listening into Action events are building the Trust priorities and vision
    - Planned engagement between now and 20 June:
        - Commissioners
        - OSCs
        - Healthwatch
        - Trade Unions (Partnership Forum)
        - CEO – team brief/ bulletin

34. Whilst absolutely understanding the organisation must continue to focus on delivery of key performance targets, EMAS is starting to further look to the

future as part of its five year strategic plan and what its service model and provision should look like to:

- ensure it has a sustainable future;
- its role in an integrated health and social care system; and
- ensuring the healthcare economy as a whole remains sustainable, supporting the management of patients at home, in primary care and the community where most appropriate.

35. Our Board stands accountable for the impact the current position of the Trust has had on public confidence. Through being completely open and honest in our communication and engagement in these matters concerning the progress and substantial improvements we are making, the population of Leicestershire can be assured of the commitment to deliver Better Patient Care.

Sources of reference data and information

- All sources of information and data referred to in this report can be found on the EMAS Trust website www.emas.nhs.uk.

Officer to Contact

Paul St Clair
Assistant Director of Operations
Leicester, Leicestershire and Rutland

Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 11 JUNE 2014

FINAL REPORT OF THE SCRUTINY REVIEW PANEL ON THE REFERRAL PATHWAY FOR OLDER PEOPLE WITH ANXIETY AND DEPRESSION

Introduction

1. This report sets out the conclusions and recommendations arising from the Scrutiny Review Panel investigation into the referral pathway for older people with anxiety and depression.

Recommendations

2. The recommendations of the Panel are located within the body of the report. For ease of reference, they are also set out below:-

   (a) The Panel welcomes the arrangements already put in place to prevent older people from developing common mental health disorders and suggests that consideration be given to the following:-
   - Screening of people in residential care for common mental health problems and the development of a residential care based initiative to respond to any identified need;
   - Joining up community based initiatives with primary care services including the Improving Access to Psychological Therapies (IAPT) service;
   - Identifying a GP practice in Leicestershire to pilot the 'community services desk' in conjunction with VAL.

   (b) Recognising the barriers that exist, the Panel recommends that an awareness-raising campaign be undertaken using the following channels:-
   - Books on Prescription;
   - First Contact;
   - Libraries;
   - GP Surgeries;

   and that the success of this be measured through increased access to books on prescription and other community wellbeing services.

(c) That Patient Participation Groups (PPGs) be asked to undertake an audit of the accessibility of services provided by their GP surgery to older people with mental health problems and to support the surgery to act upon the findings of the audit accordingly.

(d) That Clinical Commissioning Groups be encouraged to work with the voluntary sector to identify community transport opportunities which would enable services to be more accessible and that wherever possible services are provided in accessible, local venues.

(e) The Panel recognises that the majority of common mental health disorders should be addressed in primary care and in order for this to happen on a successful and consistent basis, recommends the following:-

- That the Leicester, Leicestershire and Rutland Mental Health and Wellbeing Strategy Group be asked to consider ways of strengthening the role of primary care in treating mental health conditions and positioning primary care as the initial point of contact, early management and onward referral of patients as appropriate;
- That all organisations coming into contact with older people, in particular social workers, be encouraged to ask questions about their mental health and wellbeing and where appropriate refer them to their GP or the IAPT service;
- That voluntary sector organisations be encouraged to use outcome measures for wellbeing so that GPs can be confident in referring patients to them;
- That the use of online self-management programme for anxiety and depression be increased;
- That consideration be given to training volunteers to act as therapeutic friends and supplement the delivery of the IAPT service;
- That primary care practitioners be encouraged to consider social prescribing when treating older people suffering from anxiety or depression where appropriate;
- That GPs and IAPT therapists be asked to consider the aftercare of patients, specifically with regard to helping service users plan for the future and signposting them to community based services.

(f) That organisations providing specialist care for long term conditions be encouraged to take into account the potential mental health needs of patients and to ensure that there are appropriate links between their services and those provided in primary care.

(g) That all health and social care programmes intending to address mental health issues adopt an agreed set of patient-reported outcome measures.

Scope of the Review

3. The Joint Strategic Needs Assessment (JSNA) identified that depression is the most common mental health problem in older people and is associated with social isolation, long term physical health problems, caring roles and living in residential care. The JSNA found that access to relevant services for people aged over 65 was an issue which would merit further exploration. The Scrutiny Commissioners, when appointing the Panel, considered that scrutiny activity in this area was timely as it would address the JSNA recommendation and feed into the development of the delivery plan for the JHWS priority of improving mental health and wellbeing.

4. The following outcomes for the Review were identified by the Scrutiny Commissioners:-

   (i) To understand the referral pathways for older people with anxiety and depression and identify any areas where access or service provision could be improved;

   (ii) To understand the quality of services provided to older people and the outcomes for users regarding anxiety and depression;

   (iii) To examine the partnership arrangements currently in place and make recommendations for improved integration in the light of examples of best practice;

   (iv) To identify ways of increasing the potential for older people suffering from more than one medical condition to access appropriate support for anxiety and depression.

Membership of the Panel

5. The following members were appointed to serve on the Panel.

Mrs R Camamile CC	Dr T Eynon CC
Mr J Kaufman CC	Mr D Jennings CC
Mr W Liquorish CC	

Mrs R Camamile CC was appointed Chairman of the Panel.

Conduct of the Review

6. The Panel met on four occasions between 13 January and 6 March and over that period:-

   (i) Received detailed information on the findings of the Joint Strategic Needs Assessment, recommendations in the Joint Health and

Wellbeing and other appropriate evidence relating to anxiety and depression in older people;

(ii) Considered the pathways currently in place for older people suffering from anxiety and depression, including the Improving Access to Psychological Therapies (IAPT) service;

(iii) Considered case studies setting out the patient experience of the identification and diagnosis of anxiety and depression and the associated referral pathways;

(iv) Received details of the scope of current partnership arrangements.

7. The Panel was supported in its review by the following officers and is indebted to them for their contributions:-

Lorraine Austen	Head of Service, Leicestershire Partnership NHS Trust (LPT)
Dr Dave Briggs	Managing Director, East Leicestershire and Rutland Clinical Commissioning Group (CCG)
Jim Bosworth	Associate Director of Contracting, West Leicestershire CCG
Peter Caunt	Service Director, Good Thinking Therapy
Dr Samantha Hamer	Clinician, LPT
Ivan Liburd	Policy Officer, Healthwatch Leicestershire
Dr Mike McHugh	Medical Consultant in Public Health
Dr Noel O'Kelly	Clinical Director, LPT
Ian Redfern	Head of Service, Adult Mental Health, Leicestershire County Council
Ben Smith	Health Policy Officer, Voluntary Action LeicesterShire (VAL)
Jude Smith	Deputy Clinical Director, LPT
Dr Erik Van Diepen	Consultant Psychologist, LPT

8. The Panel is particularly grateful to VAL and Healthwatch Leicestershire for their investigation into service user experience. A copy of the report setting out their findings is appended to this report.

Background

9. Good mental health and emotional wellbeing are as important in older age as in any other time of life. Many people fear growing older, and assume that old age is depressing and distressing, characterised by loss and disability, offering little to look forward to. But the reality is that older people are as capable as younger people of enjoying life, taking on challenges and coping with life's difficulties.

10. The chief difference between older people and other age groups is that older people are more likely to have experienced events associated with poorer mental health, such as having to deal with a decline in physical health or bereavement. The term 'resilience' is often used to describe our ability to recover from difficult or stressful situations and it has been suggested that our resilience is also likely to influence our wellbeing in later life.

11. Although the majority of older people remain in good mental health, mental health problems in older adults are common; present in perhaps 40% of GP attendees, 50% of general hospital patients and 60% of care home residents.

Definition of common mental health disorder

12. The term ‘common mental health disorder’ Includes depression, generalised anxiety disorder (GAD), panic disorder, phobias, social anxiety disorder, obsessive-compulsive disorder (OCD) and post-traumatic stress disorder (PTSD).

13. *Depression* is characterised by low mood, emotional, cognitive, physical and behavioural symptoms. Symptoms typically include poor sleep, reduced appetite, tearfulness, irritability and social withdrawal. Marked anxiety can frequently co-exist with depression.

14. *Generalised anxiety disorder (GAD)* features excessive anxiety and worry, often accompanied by restlessness, fatigue, difficulty concentrating, irritability, muscle tension and disturbed sleep. GAD often occurs simultaneously with depression and this can make accurate diagnosis problematic.

15. *Panic disorder* results in either intermittent apprehension, and panic attacks in relation to particular situations or spontaneous panic attacks with no apparent cause. Patients often take action to avoid being in particular situations in order to prevent those feelings, which may develop into conditions such as agoraphobia which is anxiety about being in places or situations from which escape might be difficult.

16. *Obsessive-compulsive disorder (OCD)* involves the presence of either obsessions or compulsions, but commonly both fear of contamination from dirt, germs, viruses, body fluids etc., fear of harm, obsessions with religious, sacrilegious or blasphemous thoughts, sexual thoughts and repetitive behaviours or mental acts that the person feels driven to perform e.g. checking (for example, gas taps).

17. *Post-traumatic stress disorder (PTSD)* develops in response to one or more traumatic events e.g. acts of interpersonal violence, severe accidents, disasters or military action. The most characteristic symptoms of PTSD are

re-experiencing symptoms including flashbacks in which the person acts or feels as if the event is recurring.

18. *Social anxiety disorder* also referred to as social phobia, is characterised by an intense fear in social situations that results in considerable distress and in turn impacts on a person's ability to function effectively in aspects of their daily life.

Prevention

19. In order to prevent people from developing a common mental health disorder, such as anxiety or depression, they need to be supported to become more resilient. For older people, some particular risk factors have been identified which can make people more vulnerable to developing depression. These are as follows:-
    - Limited mobility, chronic pain, frailty or other mental/physical problems leading to loss of independence;
    - Physical illness;
    - Bereavement;
    - Social isolation;
    - Loneliness.

20. Another group of people at significant risk of developing anxiety or depression is older people who move into residential care. This is due to the scale of change in lifestyle. Although they are living with other people, it will not necessarily be a group of their choosing. They can also have difficulty coming to terms with the loss of their own home and independence.

21. There are a number of initiatives already in place in Leicestershire aimed at mitigating the risk factors and preventing older people from developing anxiety or depression. Organisations such as the County Council provide pre-retirement courses which advise people to keep active and form part of social groups to prevent feelings of social isolation and depression.

22. The Five Ways to Wellbeing are promoted across Leicestershire by the Culture, Health and Wellbeing Partnership; a partnership led by Leicestershire County Council and is supported by Leicester City Council and the Districts and Boroughs of Leicestershire County. The Five Ways to Wellbeing is a set of evidence-based public mental health messages aimed at improving the mental health and wellbeing of the whole population. They were developed by nef (the new economics foundation) in 2008 and are as follows:-
    - Connect with people around you;
    - Be active;
    - Take notice of your surroundings, people etc;
    - Keep learning;

- Give e.g. as a volunteer, share your knowledge and experiences etc.

23. A range of social activities aimed at promoting positive mental health are organised by libraries; these can help to reduce feelings of social isolation and depression. Libraries can also support people to self-manage their mental health, for example through the books on prescription service, which makes available cognitive behavioural therapy self-help books. These can provide very effective help and treatment for a range of common emotional and mental health problems. The main libraries in Leicestershire have wellbeing collections which include specific, evidence-based books.

24. The Panel feels that it is important that community-based initiatives, such as those in libraries, are linked to primary care services. The Panel was pleased to hear that Voluntary Action Leicestershire (VAL) is currently piloting a 'community services desk' at a GP surgery in Leicester. This has been developed with the Patient Participation Group and will be managed by volunteers who will be able to provide advice and guidance and direct people to the appropriate voluntary sector group for support. Further detail is included in the appended report which sets out the findings of Healthwatch and VAL's investigation into patient experience.

25. More recently, the Better Care Fund Plan, a pooled budget aimed at improving the integration of health and social care in Leicestershire, has been developed. One of the workstreams in the Plan is the Unified Prevention Offer which will include specific work to raise awareness of mental health and target the most vulnerable. The Plan will also consider how to join up data systems to enable all health and social care services involved in the care of a patient to access the same records.

26. Within residential care homes, consideration is being given to whether residential homes should target known needs or whether there is a benefit to a general screening programme for services in residential care. Both Leicestershire Clinical Commissioning Groups have a care home project which aims to capture both the physical and mental health needs of patients. The Panel suggests that any screening activity would need to be linked to an effective intervention, such as providing basic Cognitive Behavioural Therapy training for some staff in residential care so that they were able to respond to identified need.

<u>Recommendation</u>

(a) The Panel welcomes the arrangements already put in place to prevent older people from developing common mental health disorders and suggests that consideration be given to the following:-
    - Screening of people in residential care for common mental health problems and the development of a residential care based initiative to respond to any identified need;

- Joining up community based initiatives with primary care services including the Improving Access to Psychological Therapies (IAPT) service;
- Identifying a GP practice in Leicestershire to pilot the 'community services desk' in conjunction with VAL.

Access to Services

27. A number of barriers have been identified which can prevent older people suffering with anxiety or depression from accessing services. These can be summarised as follows:-

Patient factors:

- feelings of shame
- stigma and fear
- distrust of healthcare services
- masking and normalising of symptoms (especially mental health symptoms)
- lack of knowledge about mental health symptoms or services
- lack of support or encouragement to access healthcare services from families and community
- a belief in spirituality and self-reliance as a means of overcoming healthcare problem
- somatisation (when mental and emotional problems present as physical ill-health)
- limited language and communication proficiency, resulting in communication problems (including hearing and speech problems)
- cultural factors, such as the lower levels of awareness of problems such as depression in black and minority ethnic communities

Practitioner-level factors:

- poor communication with patients and the wider community
- poor attitude to patients
- stereotyping of individuals by practitioners
- minimisation or poor recognition of mental health symptoms.
- have time constraints in their surgeries that prevent them from diagnosing mental health problems effectively
- consider that depression is an inevitable consequence of ageing and fail to see the value of treating it;
- recognise symptoms of depression or anxiety but fail to recognise that they can be treated with psychological therapies;
- attribute mental health problems to someone's reactions to physical health problems, such as diabetes, Parkinson's disease, arthritic pain, stroke, cardiac or thyroid disorders etc., and so do not consider them suitable for treatment;

- believe that treating physical health problems is a higher priority than treating mental health problems, and consequently do not refer patients to psychological therapy services;
- mistakenly believe that psychological therapies do not work for older people;
- prioritise referring younger people with depression and anxiety to services providing psychological therapies; and/or
- not have the skills to identify and manage mental health problems in older people.
- inadequate assessments arising from limited information about a range of issues (for example, cultural background)

System and service-level factors:

- poor allocation of services and poor quality of services
- poor communication between services
- lack of flexibility in healthcare systems and practices to take into account individuals' cultural beliefs
- use of standard procedures and practices that are unfamiliar or unexplained to vulnerable individuals
- transportation issues
- poor appointment systems

28. The stigma around mental health problems might create a barrier for some older people, particularly those in close-knit rural communities. These people are less likely to talk to other people about how they are feeling. In addition, older people may not have the words to enable them to identify their symptoms as the language of psychology is not common to older people.

Recommendation

(b) Recognising the barriers that exist, the Panel recommends that an awareness-raising campaign be undertaken using the following channels:-

- Books on Prescription;
- First Contact;
- Libraries;
- GP Surgeries;

and that the success of this be measured through increased access to books on prescription and other community wellbeing services.

(c) That Patient Participation Groups (PPGs) be asked to undertake an audit of the accessibility of services provided by their GP surgery to older people with mental health problems and to support the surgery to act upon the findings of the audit accordingly.

(d) That Clinical Commissioning Groups be encouraged to work with the voluntary sector to identify community transport opportunities which would

enable services to be more accessible and that wherever possible services are provided in accessible, local venues.

Strengthening the Role of Primary Care

29. The majority of common mental health disorders should be treated in primary care. GPs can make an initial assessment of a mental health condition, provide good advice and initial support, arrange referrals to other treatments and services, such as psychological therapies and counselling and, if necessary, prescribe medication such as anti-depressants where appropriate. However, the Panel noted that there is some lack of consistency in the service offered by GPs. Those with a special interest in mental health were generally confident in identifying and diagnosing common mental health conditions. Where mental illness manifested itself through physical symptoms it was more difficult for a GP to make a correct diagnosis.

30. The correct diagnosis of mental health conditions is a particular issue for older people with long term conditions, who are more likely to suffer from anxiety and depression, but less likely to identify their symptoms correctly.

31. The GP appraisal process does not provide a way of ensuring consistency in the treatment of mental health conditions across primary care. It does not assess whether GPs are confident in dealing with mental health conditions unless the GP has been identified by the practice as a mental health lead. Under appraisal and revalidation requirements there are no specific requirements for GPs to attend training courses specifically for mental illness. The requirement is that they show evidence of keeping up to date in relation to their role as doctors. If they have a lead role, or identify mental health training as a learning need, this can be added to their personal development plan but it is not a requirement under any legislation.

32. The Panel is pleased to note the creation of a new Leicester, Leicestershire and Rutland Mental Health and Wellbeing Strategy Group. This group would have a significant part to play in strengthening the role of GPs in dealing with common mental health conditions through training and through facilitating development of clear pathways of care with the primary care team as the hub. However, it is not just GPs in primary care who should be able to help older people with anxiety or depression, help should be available from across the whole range of primary care services. In particular, practice nurses supporting patients with other chronic conditions ought to be checking their mental health regularly as well.

33. The Panel is pleased to note that East Leicestershire and Rutland Clinical Commissioning Group has developed a holistic care template which includes trigger questions that will result in a care co-ordinator referring patients to their GP for treatment of anxiety or depression. However, this was only in place for patients with specific long term conditions.

34. Self-management is an important aspect of treatment of anxiety and depression. This can be improved by access to online education sources, similar to the DESMOND (Diabetes Education and Self-Management for On-going and Newly Diagnosed) programme which supports people with type 2 diabetes to manage their own condition. Voluntary Sector organisations also have a key role to play, for example through forming partnerships with GP surgeries. It might be useful to develop a quality mark for voluntary sector groups so GPs feel confident when referring patients to them.

Improving Access to Psychological Therapies (IAPT) Service

35. The IAPT service provides psychological therapies for patients over the age of 16 years with depression and anxiety in a range of community venues, including GP surgeries. The service follows the recommendations set by the National Institute for Health and Care Excellence (NICE) providing evidence based psychological therapies. There are two types of practitioners:-
    - Psychological Wellbeing Practitioners (PWPs), offering assessments, guided self-help and psycho-educational groups;
    - High intensity therapists offering a range of psychological therapies including Cognitive Behavioural Therapy, Interpersonal Psychological Therapy, Dynamic Interpersonal Therapy and Counselling.

    The service was provided by Good Thinking Therapy until 31 March 2014, from 1 April 2014 Nottingham Healthcare NHS Trust are providing the service.

36. Many older people express a preference for talking therapies and there is a considerable body of research evidence that indicates that talking treatments are just as effective in addressing anxiety and depression in older people as other age groups. NICE guidance on the treatment of anxiety and depression makes no variation in its recommendations relating to age. The national data for IAPT indicates that there is no difference in recovery rates for those aged over 64 years and locally recovery rates for older people are better than average. There is also a trend towards older people being more likely to complete a full course of treatment than other age groups.

37. Despite IAPT services being open to all adults there is considerable under representation of older people amongst the population accessing IAPT. The following are nationally recognised barriers for older people accessing the IAPT service:-
    - Historically the IAPT service was primarily for working age adults which may lead care professionals to forget that IAPT is an all age service;
    - Perception that talking therapies are not relevant for older persons;
    - Physical barriers such as mobility or sensory impairment;

- Poor understanding of the issues relating to the treatment of the older person.

38. Locally, the following initiatives have been put in place to help older people access the service:-
    - All PWPs have been trained in the treatment of Long Term Conditions and Older Persons Feb to April 2013;
    - High Intensity Therapists are trained by experienced Older Persons Psychologists who are involved in adaptations to therapy to make therapy more accessible;
    - An Older Persons Champion has been appointed;
    - Cognitive Behaviour Therapy training across the county includes components addressing Long Term Conditions.

39. From mid-April 2014 'Mindfulness' will also be available in Leicestershire. 'Mindfulness' is a way of paying attention to the present moment, using techniques like mediation, breathing and yoga. It helps people become more aware of their thoughts and feelings so they can manage them rather than being overwhelmed by them. GP surgeries not providing 'Mindfulness' will need to have arrangements in place to signpost service users to patient transport schemes. It was also felt that volunteers could be trained as 'therapeutic friends' to support 'Mindfulness' by working with the service user and helping them to think of things other than their illness, a type of distraction therapy.

40. Another area that needs developing is aftercare. There is a lack of structured aftercare for service users whose IAPT sessions had been completed. There was a role for therapists and GPs in helping the service user to plan for the future and signpost them to other services, such as those provided by the voluntary sector.

<u>Recommendations</u>

(e) The Panel recognises that the majority of common mental health disorders should be addressed in primary care and in order for this to happen on a successful and consistent basis, recommends the following:-
    - That the Leicester, Leicestershire and Rutland Mental Health and Wellbeing Strategy Group be asked to consider ways of strengthening the role of primary care in treating mental health conditions and positioning primary care as the initial point of contact, early management and onward referral of patients as appropriate;
    - That all organisations coming into contact with older people, in particular social workers, be encouraged to ask questions about their mental health and wellbeing and where appropriate refer them to their GP or the IAPT service;

- That voluntary sector organisations be encouraged to use outcome measures for wellbeing so that GPs can be confident in referring patients to them;
- That the use of online self-management programme for anxiety and depression be increased;
- That consideration be given to training volunteers to act as therapeutic friends and supplement the delivery of the IAPT service;
- That primary care practitioners be encouraged to consider social prescribing when treating older people suffering from anxiety or depression where appropriate;
- That GPs and IAPT therapists be asked to consider the aftercare of patients, specifically with regard to helping service users plan for the future and signposting them to community based services.

Secondary Care

41. Common mental health disorders should not be treated in secondary care except in rare circumstances. The Panel is pleased to note that, as with all age groups, only a very small proportion of older people suffering with anxiety or depression have a condition sufficiently serious to require secondary care intervention. Leicestershire Partnership NHS Trust (LPT) provides services for older people with severe anxiety or depression which cannot be treated elsewhere. It specialises in providing support for service users with complex conditions, such as having two or more chronic medical conditions.

42. LPT provide a stepped model of care in which the patients' needs are met by the service that provides the most appropriate intensity of care at that time. Patients can step up or step down into services as their needs change. The Panel emphasises the importance of ensuring patients are treated at the right level according to their needs, including being discharged to primary care when appropriate. Services are provided through outpatient clinics which patients are referred to by their GP. More serious conditions are referred to the Community Mental Health Team (CMHT) which provides on-going care through multi-disciplinary teams. The CHMT has a community intensive service which is between community services and hospitals, and a care home in-reach team. There is also an urgent service which can support patients for up to 72 hours whilst a care pathway is developed and a liaison service with UHL for patients with both physical and mental needs. The stepped model of care is illustrated as follows:-

43. One area where involvement is appropriate is in the rehabilitation programme for people with long term conditions. LPT has designed a pulmonary rehabilitation programme which focuses on education and exercise and also includes a session on recognising anxiety and depression. A heart failure rehabilitation programme is due to start soon using the same model.

44. The Panel supports LPT's intention to further develop the services it provides in the following ways:-

- increased access to physical health care in all clinical settings;
- increased integration of physical and mental health services for frail older people.

Recommendation

(f) That organisations providing specialist care for long term conditions be encouraged to take into account the potential mental health needs of patients and to ensure that there are appropriate links between their services and those provided in primary care.

(g) That all health and social care programmes intending to address mental health issues adopt an agreed set of patient-reported outcome measures.

Resources Implications

45. None specifically arising from this report.

Equal Opportunities

46. In the course of its investigation the Panel had focused particularly on the needs of socially excluded groups, including those identified as protected in the Equalities Act 2010.

Circulation under the Local Issues Alerts Procedure

47. None.

Background Papers

48. File containing the reports submitted to the Scrutiny Review Panel on the Referral Pathway for Older People with Anxiety or Depression.

Recommendations

49. ***The Health Overview and Scrutiny Committee is recommended to support the findings of the Panel and refer the conclusions to the Cabinet for its consideration;***

Mrs R Camamile CC
Chairman of the Panel

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NHS
West Leicestershire
Clinical Commissioning Group

NHS
East Leicestershire and Rutland
Clinical Commissioning Group

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 11th JUNE 2014

REPORT OF WEST LEICESTERSHIRE CLINICAL COMMISSIONING GROUP AND EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP

EMERGENCY HOSPITAL ADMISSION AVOIDANCE FROM CARE HOMES

Purpose of report

1. The purpose of this paper is to inform the Scrutiny Committee of the work undertaken by West Leicestershire Clinical Commissioning Group (WLCCG) and East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG) to avoid unnecessary hospital admissions from care homes and present the key commissioning activities and quality improvement initiatives introduced in 2013/14 and for 2014/15 to improve outcomes for frail older people. Key to avoidance of unnecessary hospital admissions has been the development towards integrated working with Leicestershire County Council, and collaborative working with independent contractors to foster a culture of continuous quality improvement for residents in care homes.

Policy Framework and Previous Decisions

2. Emergency hospital admissions have continued to rise inexorably and reversing this trend is an absolute priority for the NHS and the CCGs within their Operating Plans. Older people are the primary users of health services and emergency hospital admission increases with age. An estimated 55 per cent of emergency bed days are used by the over 75s and 25 per cent of all hospital admissions involve older people with 'ill-defined disease'.

3. Locally in Leicester, Leicestershire and Rutland (LLR), if you are over 65 and attend the Accident and Emergency Department you have a 1 in 3 chance of being admitted to hospital. Admission to secondary care often has adverse consequences for frail older people. Patients may acquire new health problems/harms for example Health care Associated Infections: MRSA, or C.-Difficile, malnutrition, pressure ulcers and falls. Patients with cognitive impairment may become more confused and distressed in strange and new surroundings. People at the end of life may spend their final hours in a strange busy ward where their needs may not be met and where they are not at home with friends and family.

4. Admissions to hospital are costly compared to primary care management; where the average admission costs £1500, compared to a GP visit costing about £100, or a

course of community nurse treatment costing £ 70-100. The National Institute of Clinical Excellence (NICE) have stated that a 10% drop in admissions would save the NHS £52 million per annum in England alone.

Background

5. Both WLCCG and ELRCCG have quality improvement programmes that aim to reduce inappropriate hospital admissions from care homes where it had been identified that across LLR 10% (33) of the 310 care homes admit more than 50% of their patient population (baseline data 11/12). In the County there are 210 care homes, of which 34 are nursing homes.

6. Increasingly, residents of care homes have severe physical disabilities and many have advanced cognitive frailty. The complex health problems and multiple health needs of these people include for example: dementia, depression, pain management, incontinence, pressure damage, nutritional risk, diabetes management and palliative care needs.

7. Within the context of increasing dependency, the CCGs have focused on how agencies can work together to ensure that the long-term care needs of older people is met and to avoid unnecessary hospitalisation - especially for the identified problems/issues that contribute to avoidable emergency hospital admissions of care home residents that include the following:
   - Nurses and carers in homes can lack the necessary skills, competence and confidence to offer the care their residents need, especially as older frail people have complex health problems and multiple health needs;
   - Incidents of falls are high in care homes;
   - Homes often work in isolation and there is lack of partnership working;
   - Many homes do not have advanced care planning or recognise the end of life stage, particularly in residents with dementia;
   - Communication and relationships with other agencies can be poor, for example with General Practice and acute care providers.

8. Through the CCGs contract quality review process for all people on Continuing Health Care (CHC) that is provided by the Greater East Midlands Commissioning Support Unit (GEM CSU) CHC Quality Team, commissioners are aware of the significant challenges that nursing homes are facing currently and that impact on quality of care and patient safety. These include: the inability to recruit registered nurses owing to many nurses now taking up employment within the NHS acute provider organisations owing to better pay and conditions, regular changeover of care home managers, and lack of sustainability of quality improvement and high quality care.

WLLCCG and ELRCCG Care Home Key Activities and Deliverables for 13/14

9. The CCG key activities and deliverables for emergency hospital avoidance in 13/14 have included the following:

   - **Identification of care homes that are outliers for hospital admissions**: To capture emergency admissions and have meaningful data based on actual residency of people in care homes (as other data is based on postcodes) to

inform commissioning and quality improvement, a bespoke system has been developed for WLCCG (the Exeter System) by GEM CSU Informatics. This system identifies admissions by: Care Home, by General Practice, Length of Stay and Primary Diagnosis. The data has been directing the focus of interventions, resources and timely response by the WLCCG specialist nursing support service and the Leicestershire County Council Quality Improvement Team, who are able to review all admissions with individual care homes and provide support and implement quality improvement initiatives for hospital avoidance. In addition, GPs are now able to receive this data on a monthly basis through the HERA system and where they have the ability to see individual patient information, in order to focus their interventions and undertake medical review for hospital avoidance.

This data has identified falls, urinary tract infection (UTI), and chest infections as the top primary diagnosis for admissions and therefore this information has facilitated the development of a comprehensive training programme to be developed and support tools for the care homes. This information has been shard across the 3 CCGs and where commissioners, linking with the Leicestershire Social Care Development Group have commissioned a training programme for across LLR for 14/15.

The WLCCG emergency admissions data it is already demonstrating a reduction in admissions Dec 13-Feb 14:

Dec 13	**Jan 14**	**Feb 14**
113	102	74

- ***Commissioned a specialist nursing support service for nursing homes:*** This service commissioned by WLCCG and provided by LPT aims to develop the capability and confidence of nursing and support staff to provide high quality care-through provision of education and training, nurse leadership, support and quality improvement. All 19 nursing homes in West Leicestershire have had individual profiling to identify their specific needs for training and quality improvement. Priority areas for training include: clinical, falls prevention, nutrition and hydration, tissue viability, avoidance of urinary tract infections (UTIs) and End of Life Care. The service lead has a key working relationship with the County Council Quality Improvement Team (QIT) lead nurse to ensure a coordinated and unified approach across both nursing and residential homes. The learning and evaluation of the service is being shared across the LLR CCGs and the County Council and for consideration of roll out of this service across the County.
- ***Developing integrated working with LCC and the Quality Improvement Team (QIT):*** Through the Better Care Together programme the CCGs Chief Nurses, and the County Council Adult and Communities Assistant Director are developing integrated working of their teams for quality improvement and safeguarding of adults. In particular, the Leicestershire County Council QIT are working with the WLCCG Head of Nursing for hospital avoidance and quality improvement in care homes.
- ***Established interprofessional learning;*** Nurses in nursing homes now have access to the WLCCG Practice Nurse Protected Learning Time sessions to enable shared learning for key topic areas that have include wound care, management of Long Term Conditions, End of Life Care and Dementia.

- ***Ensured a number of engagement activities and stakeholder events for Care Homes:*** The CCGs have held an number of events that have had representation from health, the County Council and the independent sector care homes to foster collaborative working through shared values for continuous quality improvement and care for frail older people.
- ***Developed communication tools and decision-making tools:*** The ***'***Check for Change Tool,' and the 'Falls Decision Tree,' and guidance have been developed for care homes by the CCGs and have been disseminated across LLR. Positive feedback has been received from the homes about the tools in terms of guidance and management of incidents of falls, and in particular that is providing confidence in the system and the collaborative working.
- ***Medicines Management Optimisation for care homes:*** Both WLCCG and ELRCCG have in post a pharmacist lead for care homes that is ensuring medicine optimisation, improving concordance and prevention of harms that include falls. The pharmacists have developed a care home 'Homely Remedy' protocol and issue a quarterly newsletter to care homes containing key advice and best practice in medicine management.
- ***General Practice: One Home-One General Practice Scheme;*** Key to good outcomes for patients is positive relationships and team working, which has been strengthened in the new specification and contract for GPs to provide high quality medical services for people in care homes. The scheme includes: weekly ward rounds, ensuring an anticipatory care plan is in place, on-going assessment and proactive monitoring of Long Term Conditions, medication review, effective handover/communication to care home staff through Multi-Disciplinary Team meetings, review of hospital admissions, and review of harms (pressure ulcers and falls.
- ***Direct access to GPs in-hours:*** The GP is the 'senior decision-maker' in hours and therefore in WLCCG all care homes have been provided with the GP back office telephone number for all urgent situations and to facilitate timely access to a doctor.
- ***End of Life care:*** Significant work has been undertaken by the CCGs to improve end of life care and choice of place of death. This work has included a series of training programmes provided by LOROS for the GP workforce, practice nurses and care homes staff, and ensuring joint working with GPs and care homes for DNAR (Do Not Attempt Resuscitation) and advanced care plans. An LLR initiative is currently in progress for sharing advanced care plans with the Out of Hours (OOH) provider and development of a new summary process generated from special patient notes to ensure other organisations receive effective communication to inform patient management for high quality end of life care.

WLCCG and ELRCCG Care Home Activities and Deliverables for 14/15

10. The activities and deliverables for hospital avoidance for 14/15 include the following areas:

    - ***Developing the crisis response and 'senior clinical decision maker,' in the out of hours period (OOHs):*** In light of an increase in emergency admissions from care homes during December 2013 and in order to understand the utilisation of OOHs services, and reasons for admission –WLCCG undertook an audit of 19 nursing homes in April 2014. Findings for the main reasons for admissions include: chest infection (requirement for Intravenous antibiotics),

End of Life Care and falls. Pathway issues included the current requirement for contacting NHS 111 in the event of an urgent situation and the fact that this could lead to a disposition/referral to emergency services. This has resulted in working with the local OOHs provider for direct access by care homes to the Health Care Professional line- in order to ensure that they can access a doctor for effective/timely medical management and hospital avoidance. ELRCCG have a robust programme in place for review of their interventions and quality improvements that focuses on care plans and their implementation and to ensure appropriateness of the plan for hospital admission avoidance.

- ***Dementia in-reach***; The CCGs have strengthened the service specification for dementia in-reach to support the care homes with people who have dementia and their complex and challenging behaviours to ensure it is a responsive service to meet demand.
- ***Information Technology*- WiFi** – Both CCGs have a programme for ensuring WiFi is installed in all care homes in order that GPs can access patient records and enter timely information to ensure effective communication, care planning and patient management
- ***Assistive Technology***: The CCGs are exploring and developing a range of assistive technologies for harms avoidance that includes falls and pressure ulcers, management of Long Term Conditions and for dementia care. Assistive Technologies will be piloted in a number of care homes to evaluate outcomes in the summer of 2014.
- ***Focus on falls prevention***: The CCGs have commissioned training programmes for care homes for falls prevention and have commissioned LPT to develop training packs. Work is currently in progress for review of the falls pathway and key to this work is partnership working working with EMAS, social services, secondary care and community health services therapists.

Clinical Leadership

11. To support the quality improvements and initiatives- clinical leadership has been essential and has been provided in the CCGs by GP clinical leads who are working as mentors for GPs and practice teams, particularly for End of Life Care. The CCG Lead Nurses have been integral to driving quality improvements and change, and championing collaborative working with the different agencies. Specialist nurses are providing leadership, support and training in a range of clinical areas for General Practice and the care homes.

Conclusions

12. Both WLCCG and ELRCCG have commissioned a number of services and quality improvement programmes for avoidance of unnecessary hospital admissions of frail older people.

13. The CCGs have recognised the potential for more integrated and collaborative working of the different agencies that include the NHS, Local Authority and the independent contractor-care homes, to enhance the quality of care of residents in the County. In particular, for the care home sector this includes developing confidence and trusting relationships, and skills and knowledge amongst care homes staff for delivery of high quality and safe care.

Recommendations

14. The Committee is requested to receive the contents of the report.

Officer to Contact

Patricia Ford; Head of Nursing
West Leicestershire Clinical Commissioning Group
Email: Patricia.Ford@WestLeicestershireccg.nhs.uk
Tel: 01509 567723

Agenda Item 13

NHS West Leicestershire Clinical Commissioning Group

NHS England

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 11TH JUNE 2014

REPORT OF NHS ENGLAND AND WEST LEICESTERSHIRE CLINICAL COMMISSIONING GROUP

PROVISION OF PERINATAL INPATIENT MENTAL HEALTH SERVICES IN LEICESTERSHIRE

Introduction

1. The purpose of this report is to update Leicestershire Health Overview and Scrutiny Committee on the provision of inpatient perinatal mental health services on Leicestershire, including details of the stakeholder event and recent actions..

2. This document is a culmination of the report detailed above with the outcomes of the stakeholder event held in October 2013 by NHS England and West Leicestershire Clinical Commissioning Group (CCG) and the Perinatal Next Steps Meeting held in January 2014.

3. The provider Leicestershire Partnership Trust gave notice to NHS England that it could not comply with the service specification, necessary quality standards or invest the finances required to bring the current service up to standard.

.Current Provision

4. Contracted for 13/14 are 15 beds across the East Midlands with three providers delivering Inpatient Perinatal Services.
   Derby has a six bedded unit
   Leicester has three beds
   Nottingham has a six bedded unit

Background

5. The level of demand, numbers of beds and quality of Inpatient Perinatal Provision has been a discussion point for the last 5 years or so. In 2009 and 2010 as part of the Lord Darzi Next Stage Review and Towards Excellence Reviews, Perinatal Inpatient provision was considered across the three units within region by partners and stakeholders for the East Midlands Specialised Commissioning Group (EMSCG).

6. The work undertaken looked at capacity and demand as well as quality and cost. In 2010, a report to the EMSCG Board identified that National evidence indicates there are 2 to 4 admissions per 1000 live births. This would give the East Midlands a need for 9 to 18 beds and for planning purposes, the mean of 13 beds has always been used.

7. Nice guidance refers to a unit being typically between 6 and 12 beds and regional clinical opinion supported a minimum unit having 6 beds but a single unit of 13 beds for women plus 13 babies was not clinically supported. Therefore based on NICE guidance and clinical opinion a two 6 bed model was deemed appropriate.

8. In the report to the EMSCG Board in July 2010, the Board were asked to determine:
    - Whether the minimum size for an inpatient unit is 6 beds.
    - Whether to change the number of units commissioned.
    - Whether the number of units should be capped or allow market dynamics and quality standards to determine the future configuration of inpatient services. Consideration to be given to the White Paper and the need to engage the public in any decision to reduce the number of units.
    - Whether the other two mental health Trusts in the East Midlands who did not provide inpatient services could be included as potential providers.

9. The Board concluded that the SCG should seek to ensure; quality and value for money for the services and progress through the service specification designation route.

10. At the request of NHS Leicester City, NHS Leicestershire County and Rutland and Leicestershire Partnership Trust an independent review of the Leicestershire Inpatient Perinatal Mental Health Service was undertaken by Dr Roch Cantwell, Consultant Perinatal Psychiatrist and Elaine Clark, Nurse Consultant in Perinatal Mental Health from Glasgow Perinatal Mental Health Service. The subsequent report highlighted the strengths of the service that the staff were enthusiastic and dedicated, but highlighted that most of them did not work full-time within the service. All staff had a clear commitment to

the service and a desire to see further enhancements to the benefit of patients and their families. The reviewers met with one inpatient, who spoke warmly of the care received and the professionalism and caring attitude of nursing and medical staff. They also stated that plans were being explored for identifying staff to work exclusively within the service, and for changes to the layout of the mother and baby beds to ensure improved quality of access and physical integrity.

11. However, the report highlighted a number of changes that were required and one of the most significant issues related to the physical location of the 3 beds which are adjoining a general adult unit, with access to the mother & baby beds being through that unit. The report also highlighted that the toilet and kitchen facilities needed upgrading. There was no dedicated nursery, baby food preparation and storage area or play area. The general view was that the physical provision of the inpatient service was not at a standard that was suitable for a Perinatal Mother and Baby Unit and there were essential changes that needed to be made regarding the physical layout, staffing, training and supervision, baby care and safeguarding and commissioning environment. The report concluded with 20 essential recommendations which included becoming a member of the Royal College of Psychiatrists' Perinatal Quality Network.

12. The contract for the Perinatal Inpatient Service was held with the PCT until the beginning of 12/13 when the contracting responsibility for this service transferred to the Specialised Commissioning Group and the introduction of a regional service specification. The contract financial value transferred on the same basis as previous years as a block contract.

13. The activity during 12/13 was a total of 265 days. The beds were not used for two months of the year and four months saw activity ranging from 8 to 18 days. However, during this time patients from Leicestershire were sent to other units when they presented as emergencies as the unit was unable to staff the unit at short notice or when in use for male patients.

14. The service did not meet the standards of the regional service specification during 12/13 or the Royal College of Psychiatrists Quality Network for Perinatal Mental Health Services Standards for Mother and Baby Units.

15. During contract negotiations for 13/14 the incoming national service specification requirements for specialised services was raised as a potential further challenge for the service. The national service specifications for Specialised Services have been developed as a product by NHS England's Clinical Reference Groups, one of which is for perinatal inpatient services. The Clinical Reference Group (CRG) covers specialised perinatal mental health services. The scope of the CRG is to ensure that these services provide a safe and secure environment for the care of seriously mentally ill

women and their infants and meet NICE and Royal College Standards. The CRG therefore established a specification that reflected the need for the service to be separate from other acute mental health admission facilities. To provide care for women with serious mental illness including postpartum psychosis, schizophrenia, bipolar illness and other serious affective disorders, as well as those with complex needs. Provide expert psychiatric care for the mother whilst at the same time ensuring the care of the infant and avoiding unnecessary separation of mother and baby.

16. The CRG has a voluntary Chair who is appointed for a three-year term and clinical members are drawn from the 12 Senate areas in England and are voluntary appointments. There are up to four patient and carer members and up to four professional/training organisations that are eligible to join the CRG membership. An accountable commissioner holds the managerial accountability for the work of the CRG; collaborating commissioners also hold an interest in the work of the CRG.

17. NHS England requires that all providers must be compliant with the national service specifications by 1 April 2014 and a derogation process has been put into place from 1st October 2013 to allow providers who may need time to become compliant.

18. There had been several meetings between NHS England and the provider about the requirements of the current 12/13 specification which they were not compliant with and the forth coming 13/14 specification. The provider did look at what it could do to meet the Royal College and specification requirements and submitted a full business plan to their Board on 28 March 2013. However, NHS England received formal notice on 30 April 2013 that the provider was giving 12 months' notice on the Inpatient Perinatal Service.

19. The provider stated that it had been recognised for some time that current provision did not meet minimum standards as set by the Royal College of Psychiatrists nor does it comply with the regional service specification. In order to address these issues a significant investment would be required to relocate provision into a stand-alone unit and they had undertaken extensive work to look at the options to support this. The outcomes of this work had been shared with the Specialised Commissioning Group (now NHS England) through a series of meetings. A summary of the work undertaken by the provider and its outcomes is detailed below.

20. The first option considered was a significant investment in relocating and expanding the current 3 bedded unit to provide the 4-6 beds necessary to deliver a clinically safe and financially viable service. This would require capital investment in the region of £1m to bring an existing ward up to the required standard alongside the recruitment of a dedicated staff team to provide the service on an on-going basis. Together these will result in an

annual running cost of c£800k per annum which measures against a current income of £134,772.

21. The provider recognised that the current contract price was below the East Midlands and national average of c£700 per occupied bed day (OBD), however the beneficial impact of the application of a higher price was not sufficient to increase income to a viable level, raising it from c£135k to c£189k, leaving a gap of £611k to be bridged.

22. The provider also said that alongside this and more critically, there is the issue of the apparent lack of demand locally for this service which is significantly below that expected in light of available epidemiological and demographic data. The current volume of referrals, including a minimal number from outside of Leicester, Leicestershire and Rutland (LLR), has equated to around 275 OBD for each of the last three years – an occupancy of around 30% of current capacity. They recognised that a small number of referrals will have been referred to other services in the East Midlands due to their on-going capacity issues; however, the volume of this is in single figures and is not sufficient to bridge the gap.

23. In light of this they had worked in partnership with the Specialised Commissioning Group (SCG) to look across the full Midlands and East region to assess any unmet need / inappropriate referrals that an expanded unit would be able to provide for, taking account of not only LLR but looking also at Northampton, Milton Keynes, east of England and adjacent CCGs in Coventry and Warwick. Despite this extensive catchment potential, and recognising sporadic referrals from each of the areas listed, they were unable to identify sufficient current demand to sustain a viable unit.

24. The provider said that it recognised that there may be the potential for the SCG and LPT to work together to stimulate the market in the south of the region. This would need a sustained programme of work over an extended period and, in absence of obvious unmet need, has no guarantee of success. The approach would need to increase demand to a level some 8 times the current volume and generate total income of circa £800k - around £611k more than contracted activity level at the expected tariff price. It seemed an unlikely outcome based on information available at present and is a risk that sits wholly with LPT, a position which will be exacerbated by the move to cost per case contracts due to take place from April 2013.

25. In view of the above, and following a discussion at the Trust Board, LPT found itself in a position where it felt the only option was to give notice on the future provision of this service, recognising that this gives an adequate period for the consultation and due process necessary for any service closure / relocation; a process that would need to include the wider health and social care community with full consultation and engagement of

colleagues in local authorities, University Hospitals of Leicester, CCGs and other LPT services.

Way forward

26. Since receiving written notice, NHS England has been liaising with LPT and the CCGs regarding the way forward and the need to ensure that the pathway to Inpatient Perinatal beds is clear and widely known by all stakeholders to ensure that women receiving effective treatment and admission when identified as appropriate by the Community Perinatal Service.

27. At the end of October, an Engagement Event was held and key stakeholders were invited to attend to look at the care pathway, to hear from a patient with experience of services and the other two regional units.

What does good look like?

28. The Joint Commissioning Panel for Mental Health (JCP-MH) (www.jcpmh.info) co-chaired by the Royal College of General Practitioners and the Royal College of Psychiatrists, bringing together leading organisations and individuals with an interest in commissioning for mental health and learning disabilities has written The Guidance for Commissioners of perinatal mental health services.

29. The guide highlights a number of areas including why Perinatal Mental Health Services are important to commissioners and provides guidance and key principles to “What does good look like?”

30. These key principles state that services:

- A good service requires a perinatal mental health strategy which includes a commissioning framework and service design for populations large enough to provide a critical mass for all the services required across a clinical pathway. This will require collaboration with providers and other commissioners.

- Services should be provided on the basis of the known epidemiology of perinatal conditions taking into account any special geographical or socio-economic features of the area to be covered.

- The delivered population should be the denominator for service planning and provision.

- Good perinatal mental health services will use an integrated care pathway drawn up and agreed by all stakeholders to ensure the timely access of women to the most appropriate treatment and service for their condition.

- All women should have equal access to the best treatment for the condition irrespective or where they live, their socioeconomic status, their ethnicity.

- Good perinatal mental health services should promote prevention, early detection and diagnosis and effective treatment.

- The right treatment should be evidence based, effective, personalised and compassionate. It should meet the needs of both mother and infant, respect the wishes of the mother wherever possible and compatible with the safety of the infant and promote optimal care and outcome for the infant.

- A good service should accommodate the cultural and religious practices for a newly delivered woman compatible with the health and safety of mother and infant.

- Good perinatal mental health services promote seamless, integrated, comprehensive care across the whole clinical pathway and across organisational and professional boundaries. This requires close working relationships and collaborative commissioning between mental health services and maternity services, children's services and social care, primary care and voluntary organisations.

- Good perinatal mental health services will ensure that no woman is needlessly separated from her infant and that she receives the appropriate support, care and guidance to safely care for her infant if she is mentally unwell. If she requires admission to a psychiatric unit, she must be admitted to a specialised mother and baby unit unless there are compelling reasons not to do so.

- Good perinatal mental health services should include an education and training programme which should be provided for non-specialists involved in the care of pregnant and postpartum women including general psychiatric teams, GPs, midwives, Health Visitors and IAPT workers to ensure the early identification of those at high risk:
    - early diagnosis
    - an understanding of the maternity context
    - the additional clinical features
    - and risk factors associated with perinatal disorders
    - the developmental needs of infants.

- Good perinatal services should be part of a clinical network. With so many different agencies and services, providers and differing commissioning arrangements in the pathway of care from early pregnancy through to the postpartum period, it is essential that systems are in place to maintain the integration and collaboration of these agencies. Part of the perinatal mental health strategy should include a managed (strategic) network made up of all stakeholders, including patients' representatives, to ensure the functioning of the whole service pathway and to allow for development and innovation as new evidence arises. A clinical network also has the important function of advising both commissioners and providers.

- Good perinatal mental health services will include a range of services including:
  - specialised inpatient mother and baby units
  - specialised community perinatal mental health teams
  - parenting and infant mental health services
  - clinical psychology services linked to maternity hospitals
  - specialist skills and capacity within:
    - maternity services
    - general adult services
    - IAPT
    - general practice and the extended primary care team
    - health visiting.

31. The guide says that a good specialised perinatal service should be organised on a hub-and-spoke basis so that inpatient mother and baby units to serve the needs of large populations are closely integrated with specialised community perinatal mental health teams provided by Mental Health Trusts in each locality.

Mother and baby units

32. A good mother and baby unit should be accredited by the Royal College of Psychiatrists' quality network and meet their standards. It should:
    - provide care for seriously mentally ill women or those with complex needs who cannot be managed in the community in late pregnancy and in the postpartum months
    - provide expert psychiatric care for seriously ill women whilst at the same time admitting their infants, avoiding unnecessary separation of mother and infant
    - offer advice, support and assistance in the care of the infant whilst the mother is ill, meeting the emotional and developmental needs of the infant

- provide a safe and secure environment for both mother and infant
- offer timely and equitable access such that mothers are not admitted to general adult wards without their baby prior to admission
- be closely integrated with specialised community teams to promote early discharge and seamless continuity of care.

Specialised community perinatal mental health team

33. A good specialised community perinatal mental health team will be a member of the Royal College of Psychiatrists' quality network. It will assess and manage women with serious mental illness or complex disorders in the community who cannot be appropriately managed by primary care services. It should:
    - respond in a timely manner and have the capacity to deal with crises and emergencies and assess the patients in a variety of settings including their homes, maternity hospitals and outpatient clinics
    - have close working links with a designated mother and baby unit
    - manage women discharged from inpatient mother and baby units
    - work collaboratively with colleagues in maternity services (including providing a maternity liaison service) and in adult mental health services with women with prior or longstanding mental health problems.

34. A good community perinatal mental health service will offer pre-conception counselling to women with pre-existing mental health problems and those who are well but at high risk of a postpartum condition.

35. Since NHS England has developed a national service specification to ensure that all Perinatal Inpatient Units across the country are of the same standard and deliver the same quality and standard of care, the East Midlands CCG's and Perinatal Quality Network are working together to write a regional service specification for Community Perinatal Services. This will also ensure that all areas of the East Midlands are working towards a Gold Standard service for pregnant women and mothers with mental health problems. And no matter where a woman may become ill the quality and standard of support she receives will not depend upon the area, county or postcode where she resides or receives her treatment.

Perinatal Mental Health Event

36. On 31st October 2013 key stakeholders were invited to a half day event with Dr Margaret Oates CRG Clinical Lead and Karen Lockett Programme of Care Lead NHS England welcoming everyone in attendance. Mel Thwaites from West Leicestershire CCG and Ruth Sargent from NHS England set out the current position regarding the position regarding the Leicester Perinatal Services and pathway issues.

37. During the morning stakeholders heard first-hand about Jo's Story, a patient experience and journey whilst experiencing perinatal mental illness. Jo gave a frank and heart touching account about her illness, the importance of receiving the right care at the right time and what the care and support she received within a specialist perinatal unit meant to her and her family. The effect of Jo's presentation and her honesty about her illness had a significant impact upon all in the room. It reminded everyone of the importance of ensuring that women who need perinatal specialist provision that met the necessary quality and Royal College standards, should be able to do so in a timely and effective manner.

38. The morning moved into presentations by Dr Margaret Oates on the National and East Midlands Perinatal standards for both inpatient and community provision, followed by clinicians from the Mother and Baby units in Derby and Nottingham about the Inpatient Pathway and the importance of working with Community Perinatal Community Services.

39. Finally, before the round table discussions the way forward without the 3 beds being available after April in Leicester was discussed. The group then broke into round table discussions with a feedback session, opportunity to consider the next steps and have an open discussion.

40. The 'Round Table Discussions' session gave a chance to attendees to list 'What needs to happen to make access to inpatient services for work for Leicestershire patients?'. Each group was asked to feedback the top 3 issues from the discussion on each table.

41. The group discussion produced the following issues and resolves:

Potential Difficulties Faced:

- Staffing within the community team in Leicestershire
- Emergency team
- Distance of travel
- Impact on the whole region
- Not enough data collection
- Wider communication systems were needed
- Community team needed with involvement with patients
- Not enough time mobilise teams
- Need robust information sharing systems
- Child protection concerns and lack of data transfer systems
- Practicality of transfer - ambulance services? Costs of this?
- Limited or little community information
- Delays in access to units
- Bed capacity - stresses involved
- Crisis support - access to specialist support

What needs to be put in place?

- Need a complete pathway for perinatal to postnatal care
- Jointly commissioned service standards
- National bed management system
- Better training with wider breadth to include GPs, HV, and hospital staff
- Enhanced community perinatal service provision
- Mirror development pathways
- Need to alert wider pathway and model to all those involved with pregnant and new mothers
- Revisit thresholds for community teams
- Collaborative working between providers and commissioners
- Care of relatives as well as the patient
- Translation services for patients that do not speak English
- One regional service specification

How?

- Specialist service specification for perinatal services
- Finance
- Task and finish groups
- Oversight scrutiny groups
- Recruitment and development drive
- Use of technology i.e. Skype/ sure start/ communication between distances for patients
- Review process from the onset - to look at whether it's working
- GP engagement
- Consultations between LPT and commissioners
- Contract minimum data set
- Discharge maternity beds recording
- Set up working groups

42. One of the key outcomes from the event was the agreement that the East Midlands should adopt a regionally agreed service specification for CCG Community Perinatal Services. The East Midlands Perinatal Network had written a community service specification that would meet national and royal college guidelines. It would also ensure that any woman and baby requiring a specialist inpatient bed would have an effective and efficient smooth pathway to and from inpatient provision.

43. A meeting was held in January with representatives from the CCG, UHL and NHS England. This meeting discussed the outcome of the engagement event and identified a number of key actions to be addressed. These included:

- NHS England to email LPT to confirm that there has been no change in the provider's position about ceasing the service on 30 April 2014.
- NHS England Clinical Network to write to CCG Mental Health Leads requesting that locally adopted data monitoring is undertaken to identify pregnant women accessing adult mental health inpatient beds and IAPT provision.
- Leicestershire, Northamptonshire and Milton Keynes CCG Mental Health Leads asked to confirm whether they have comments on the regional perinatal community service specification.
- Confirmation of regional perinatal community service specification version.
- Task group established to develop clinical protocol guidance for referrals for perinatal inpatient admissions and two meetings held by end of February. Involving LPT; community nurses; GP; obstetric and other associated representation and focus group input.
- Patient focus group established to assist with above.

44. The Strategic Clinical Network for NHS England is running the focus groups to assist with the clinical protocol guidance for referrals with women who have used both Leicester inpatient and community services and some who had gone out of area which will be completed by the end of March.

45. During this time, the three CCG across Leicester Leicestershire and Rutland have also been reviewing the current community provision. This review has acknowledged that the current community service required improvements and in view of this commissioners have worked with clinicians to develop a new model.

46. The proposed new model is based on national recommendations and aims to increase the current capacity.

47. This team would work in conjunction with regional in-patient Mother and Baby Units to provide alternatives to admission and to provide treatment and support for women following discharge after an in-patient stay.

48. This proposal is being discussed as part of the contract negotiations with LPT.

49. It is hoped that the new model will be phases in from 1st April and work is now underway to agree local and regional clinical referral pathways.

50. NHS England will automatically direct any request for an inpatient perinatal bed to the two regional perinatal units in the East Midlands until the community referral pathway is finalised and in circulation.

Officer to Contact

Tina Smith
Mental Health Commissioning Manager
NHS England Leicestershire and Lincolnshire Area Team

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Agenda Item 14

Leicestershire Partnership NHS
NHS Trust

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 11TH JUNE 2014

REPORT OF LEICESTERSHIRE PARTNERSHIP TRUST

PROPOSED RELOCATION OF CAMHS INPATIENT SERVICE

Purpose of report

1. The purpose of this report is to describe to members of the Committee the proposal to temporarily relocate the specialist inpatient child and adolescent mental health service (CAMHS), currently based at Oakham House on the Towers site, to ward 3 at Coalville Hospital.

Policy Framework and Previous Decisions

2. Provision of a tier 4 inpatient CAMHS unit within Leicester, Leicestershire and Rutland is not a statutory requirement. Commissioners of health services within the Leicestershire and Lincolnshire Area Team of NHS England are required to ensure sufficient suitable provision is available across the region or further afield to meet the specialist mental health needs of the population. The Committee has not been involved in previous decisions in relation to this subject.

Background

3. Oakham House accommodates up to 10 young people between the ages of 11 - 18 who have mental health issues. The unit provides assessment, treatment and diagnosis of a range of conditions including, psychosis, depression, anxiety related disorders, eating disorders and learning disability associated with mental health. The unit admits around 70 young people a year from a few days up to several weeks.

4. Oakham House is currently located in Northfields and Humberstone area of Leicester City. A decision was taken by LPT's Board in 2010 to sell this building as part of the sale of the Towers Hospital site. Maintaining the service in the Oakham House building at the Towers site, was considered to be clinically unfavourable due to the isolation from any other inpatient provision. The terms of the sale specify that Redrow Homes take over the Oakham House land from the end of March 2015 and the Trust was unable to acquire any extension to this timeline from the developer.

5. An options appraisal was considered in 2012 which explored utilising existing sites in LPT or building new. The latter was supported by the Board and an outline business case was developed setting out the plans for a new single storey building on the Bradgate site in Glenfield. This secured Trust Board approval in 2013 and progressed to a full business case, which was developed during 2013. The indicative Guaranteed Maximum Price however exceeded the affordable envelope by over 3 million and contingency arrangements have therefore been developed to create more time to explore clinically and financially viable longer term solutions.

Proposals/Options

6. Two possible alternative temporary sites were looked at by architects, planners and the clinical leaders for the inpatient service. One of these sites was judged to be the most clinically suitable being an established inpatient facility. It was also immediately ready to upgrade and seen to offer a good layout to keep our young people safe and well cared for.

7. It is therefore proposed that our inpatient unit moves to ward 3 at Coalville Hospital. In the meantime LPT will continue to explore a longer term plan for the unit that delivers improved facilities for privacy and dignity, and more space for therapeutic and educational activities.

8. Refurbishment work, to make the ward brighter, fit for purpose and clinically safe, will commence in July 2014 and be completed in time for staff and our young people to move in by the end of March 2015. This will include a modular extension that will be joined to Ward 3 to accommodate the school for the unit, and more therapeutic space.

Consultation

9. We have launched a period of engagement from Tuesday 27th May until Friday 27th June to present the reasons for the choice of re-location and gain stakeholder views.

Resource Implications

10. Ward 3 at Coalville Hospital was previously a ward for older people and requires some refurbishment and alteration to make it suitable for younger patients. LPT are committed to upgrading this ward so that it is a more welcoming, brighter and safer environment. Infrastructure work is needed around the sleeping bays to install toilets and privacy screens. A modular extension will be attached to the ward to create space for the school and additional treatment areas. This will cost around £2million and will provide a better environment for any future use of the ward once a long term solution for the service is agreed.

Timetable for Decisions

11. We are seeking views from service users, commissioners and partners on the proposal between the 27th May and the 27th June. Subject to this feedback, and in the absence of another viable alternative, then work will commence on 15th July to prepare the ward ready for its new occupants in March 2015.

Conclusions

12. We are seeking the views and support from the Committee to progress this temporary arrangement to enable tier4 inpatient CAMHS to continue to be provided locally whilst alternative longer term plans are developed.

Background papers

The relocation of CAMHS inpatient services engagement documents are available at:

http://www.leicspart.nhs.uk/OakhamFeedback

Officer to Contact

Name and Job Title: Helen Thompson, Divisional Director
Telephone: 0116 2983118
Email: Helen.thompson@leicspart.nhs.uk

List of Appendices

Relevant Impact Assessments

Equality and Human Rights Implications

Due regard analysis attached (Appendix A)

Communication and Engagement

Engagement paper (Appendix B)

Appendix A

Leicestershire Partnership NHS
NHS Trust

Due Regard Equality Analysis

Initial Screening Template

*A full Due Regard (Equality Analysis) makes sure that any negative impacts have been considered and ways to minimize the impact are specified.

Due Regard Screening Template

Section 1	
Name of activity/proposal	Temporary Relocation of CAMHS Inpatient Service
Date Screening commenced	March 27th 2014
Directorate / Service carrying out the assessment	Families Young People and Childrens Division
Name and role of person undertaking this Due Regard (Equality Analysis)	Helen Thompson Divisional Director; Kamy Basra Communications Manager.
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: To continue to provide clinically safe inpatient CAMHS services to the regional population (11-18 years) following the sale of the current building.	
OBJECTIVES: • To secure appropriate accommodation to enable the continuation of the CAMHS inpatient service provided by Leicestershire Partnership Trust to young people across the Midlands and East Region. • To move the service temporarily to Coalville Hospital's ward 3 by the end of March 2015. • To create time and a greater opportunity to identify the type of space we can affordably use to best support the young people in our care. • To work closely with our patients, families, staff and partners to explore options for future sustainable provision.	
PURPOSE: • We are seeking views from service users, commissioners and partners on the proposal. Subject to this feedback, and in the absence of another viable alternative, then work will commence on 15th July to prepare the ward ready for its new occupants in March 2015.	

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Section 2		
Protected Characteristic	**Could the proposal have a positive impact Yes or No (give details)**	**Could the proposal have a negative impact Yes or No (give details)**
Age	Yes. It is widely accepted that young people aged 11 – 18	Yes. Based on the 65 young people that used the Oakham

	should be treated in age appropriate environments and not in adult units. The refurbishment will be tailored around this age group. The number of beds remains the same and LPT's commitment to providing this service as locally as possible is unchanged. The new location will be closer to family homes for some county and regional residents.	House service in 2013/14, 29 would have to travel further than 5 additional miles to the new location in Coalville. This therefore may create difficulties for some family members to travel to the site, as compared with the current location. Assistance with transport costs is available through the NHS Healthcare Travel Cost Scheme (HTCS). The new facilities will provide educational provision for the young people attending the unit. There have been some concerns from stakeholders that the use of a modular extension (albeit physically integrated with the main ward) to accommodate classrooms is less favourable than the space available in the current building. It is unclear what the specific risks currently are around this new arrangement.
Disability	Yes. Provision in the new facility is similar to the current arrangements. There will be some County and regional families that will travel a shorter distance to the new building.	Yes. As described above, there is likely to be additional travel for families living within Leicester City and some areas of the County. Assistance with transport costs is available as described above.
Gender reassignment	No. Provision is the same as current facility	No. Provision is the same as current facility
Marriage & Civil Partnership	No. Provision is the same as current facility	No. Provision is the same as current facility
Pregnancy & Maternity	No. Provision is the same as current facility	No. Provision is the same as current facility
Race	Possibly. Seeking views through consultation around impact of additional travel	Possibly. Seeking views through consultation around impact of additional travel
Religion and Belief	No. Provision is the same as current facility	No. Provision is the same as current facility
Sex	No. Provision is the same as current facility	No. Provision is the same as current facility
Sexual Orientation	No. Provision is the same as current facility	No. Provision is the same as current facility

Appendix A

Other equality groups?	No. Provision is the same as current facility	No. Provision is the same as current facility

Section 3

Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.

Yes		No	
High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4.	**X**

Section 4

It this proposal is low risk please give evidence or justification for how you reached this decision:

The temporary solution offers the same number of beds on a hospital site which will be refurbished to ensure that it is young people friendly and clinically safe. Currently Oakham House is the only remaining service at the Towers site. The staff and building is therefore isolated from other mental health staff and inpatient services, whereas Coalville Hospital is an established inpatient site that offers a supporting infrastructure.
The key change is the location of the service and the associated travel implications for some of the families and staff that use the service.

Sign off that this proposal is low risk and does not require a full Equality Analysis:

Head of Service Signed: Helen Thompson
Date: Last updated on 12th May 2014

Appendix B

CAMHS inpatient engagement 27 05 2014

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Leicestershire Partnership NHS
NHS Trust

Relocation of CAMHS inpatient service

Engagement document

27 May 2014 to
27 June 2014

Leicestershire Partnership NHS Trust
Lakeside House
4 Smith Way
Grove Park
Enderby
Leicester LE19 1SS

www.leicspart.nhs.uk/OakhamFeedback

OakhamFeedback@leicspart.nhs.uk

Introduction

Leicestershire Partnership NHS Trust (LPT) is relocating the specialist inpatient CAMHS (child and adolescent mental health service) currently based at Oakham House on the Towers site. It is proposed that the service will move to Coalville Hospital's ward 3 by the end of March 2015, following the sale of the current building.

We are proud that the CAMHS inpatient service is seen as an invaluable resource across the East Midlands, dealing with some of the most vulnerable young people with acute mental health needs. The interim move to the well-equipped Coalville Hospital gives us more time and a greater opportunity to think creatively about the type of space we require to best support the young people in our care.

Helen Thompson
Divisional Director for Families, Young People and Childrens Services

Rida Elkheir
Clinical Director for Families, Young People and Childrens Services

Current service

The specialist inpatient service is currently provided in Oakham House, which accommodates up to 10 young people between the ages of 11 - 18 who have mental health issues *(info: average age is 15 years).* The unit provides assessment, treatment and diagnosis of a range of conditions including, psychosis, depression, anxiety related disorders, eating disorders and learning disability associated with mental health. The unit admits around 70 young people a year from a few days up to several weeks.

Why change is needed

In 2010 Leicestershire Partnership Trust sold Oakham House and the land as part of the Towers Hospital site sale. In 2011 options were identified and considered for the re-location of the unit. The Trust originally proposed to develop a new inpatient unit on the Bradgate site in Glenfield to replace the unit. However, it became clear after Christmas 2013 that despite various changes to these plans, the design of the new building was not affordable. LPT Board members were therefore unable to agree these plans without significant alterations and agreed for the unit to be moved into a temporary location prior to the transfer of the current Oakham House land to the new owners at the end of March 2015.

What is the proposed option?

Two possible alternative temporary sites were looked at by architects, planners and the clinical leaders for the inpatient service. One of these sites was judged to be the most clinically suitable. It was also immediately ready to upgrade and seen to offer a good layout to keep our young people safe and well cared for. It is therefore proposed that our inpatient unit moves to ward 3 at Coalville Hospital. In the meantime LPT will continue to explore a longer term plan for the unit that

delivers improved facilities for privacy and dignity, and more space for therapeutic and educational activities.

Refurbishment work, to make the ward brighter, fit for purpose and clinically safe, will commence in July 2014 and be completed in time for staff and our young people to move in by the end of March 2015. This will include a modular extension that will be joined to Ward 3 to accommodate the school for the unit, and more therapeutic space.

Why this is the best option

Currently Oakham House is the only remaining service at the Towers site as all other services have relocated. The staff and building is therefore isolated from other mental health staff and inpatient services, whereas Coalville Hospital is an established inpatient site that offers a supporting infrastructure.

Providing a safe and high quality service for our most vulnerable young people is our top priority. Coalville Hospital is regionally accessible and provides us with a safe and efficient temporary solution as we find a longer-term base.

The Hawthorne Centre is adjacent to the site, and has been providing mental health services for many years. It provides opportunities for mental health trained staff to support the CAMHS inpatient service when required.

This interim move gives us more time and a greater opportunity to think creatively about the type of space we require to best support the young people in our care. We will be working closely with our patients, families, staff and commissioners to explore longer term options.

Impact on service users

The regional inpatient service has admitted 65 young people in the last 12 months, with a very small number needing more than one admission *(Info: 70 admissions in 13/14 relating 65 young people; 96 admissions relating to 76 young people in 12/13).* Most come from Leicester, Leicestershire and Rutland, with 26% of young people coming from other areas in the region such as Derbyshire and Nottinghamshire.

Oakham House is 16 miles from Coalville Hospital; the change in location is recognised to be of concern for some of the people who use our service. Coalville Hospital has good access from the motorway, particularly for regional and county west patients, and the road networks to the city are also good. The hospital has well developed public transport connections to the city with a regular bus service which runs from Monday to Saturday. *(Info: buses run from St Margaret's 7.30am – 11pm every hour and take 48 mins to Coalville; no bus on Sunday).*

Looking at the patient data from last year, of the 65 young people that used

our service in 2013, 36 patients would either have had to travel the same distance or less, or no more than 5 miles extra to get to Coalville (9 young people). The remaining 29 patients would have had to travel further. Overall it seems that the county and regional families will benefit from the move, whilst city residents and those from the South East will have further to travel.

Impact on staff

The well-being of staff is a priority for the Trust and we acknowledge that some staff may have difficulty getting to this new site; however we are open to ways of helping staff travel to Coalville Hospital. As soon as agreement regarding the move is confirmed every individual will be supported to talk through and discuss the best options for them. We currently have a variety of vacant posts in the Trust and if staff are unable to travel to Coalville, alternative roles will be considered elsewhere.

Disruption will be minimised as much as possible, through good planning and individual conversations. Continuity of care will be sought by recruiting staff early to any vacancies that might result from the move and we are optimistic that we will be able to draw from a wider pool of people as the new location borders a number of different counties.

Estimated costs

Ward 3 at Coalville Hospital was previously a ward for older people and requires some refurbishment and alteration to make it suitable for younger patients. LPT are committed to upgrading this ward so that it is a more welcoming, brighter and safer environment. Infrastructure work is needed around the sleeping bays to install toilets and privacy screens. A modular extension will be attached to the ward to create space for the school and additional treatment areas. This will cost around £2million and will provide a better environment for any future use of the ward once a long term solution for the service is agreed.

What are the next steps?

We are seeking views from service users, commissioners and partners on the proposal. Subject to this feedback, and in the absence of another viable alternative, then work will commence on 15th July to prepare the ward ready for its new occupants in March 2015.

Making sure we consider equalities

A ‘due regard’ assessment in line with the Equality Act 2010, has been completed, which indicates that this option is unlikely to have a negative impact on people from the groups protected by this legislation. This means that the assessment covered issues such as age, race, gender, maternity, disability, marital or civil

partnership status, sexual orientation, and religion or belief. This assessment is available upon request.

About this engagement

If you would like to talk to someone about how this engagement exercise has been put together and delivered, please contact Kamy Basra, Communications Manager by emailing kamy.basra@leicspart.nhs.uk

How you can give us your views

You can provide your views by completing the attached form or fill it online at https://www.surveymonkey.com/s/OakhamFeedback; or email your views to OakhamFeedback@leicspart.nhs.uk.

We are also holding two public engagement events: –

12 June (9am – 10am/10am – 11am))
Oakham House
17 Herongate Road
Leicester
LE5 0AW

17 June (4pm – 5pm)
Coalville Hospital
Broom Leys Road
Coalville
Leicestershire
LE67 4DE

Register to attend one of these events online at: www.leicspart.nhs.uk/OakhamFeedback.

If you would like us to present this to your group or organisation please get in touch through the above email.

The deadline for feedback is 27 June.

Thank you…

Thank you for taking the time to read this document. We hope it gives you a clearer understanding of why we are proposing the temporary re-location of our children and young people's inpatient mental health service. We are proud to be able to offer this service to the local and regional population. By working together we can help this valuable service evolve, to meet the changing needs of our young people and remain a vital part of your NHS.

Relocation of CAMHS inpatient service: Questionnaire

You can attach additional sheets if you need more space.

Q1. Have you used or come into contact with the CAMHS inpatient service over the last 12 months?

☐ **Yes** ☐ **No**

Q2. About you – please tick which statement most reflects you.

☐ **I am a service user or relative of a service user**

☐ **I am a member of staff**

☐ **I am a professional that has referred to the service or worked with the service**

☐ **I am another type of stakeholder. Please specify** ……

Q3. What are your views on the proposal?

……
……
……

Q4. If you believe that there is a preferable alternative option that would allow the service to safely move by 31st March 2015 then please provide details below?

……
……
……

Q5. If you would you like to comment further on ways to improve the CAMHS inpatient service for the future, or have ideas for longer term solutions for providing this service, please share these comments here.

……

……

Please tell us about yourself **(strictly confidential)**

Leicestershire Partnership NHS Trust recognises and actively promotes the benefits of diversity and is committed to treating everyone with dignity and respect regardless of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation. To ensure that our services are designed for the population we serve, we would like you to complete the short monitoring section below. The information provided will only be used for the purpose it has been collected for and will not be passed on to any third parties.

Data Protection Statement - All information will be kept strictly confidential and in accordance with the Data Protection Act 1998 and associated protocols.

What is your postcode? The first four letters/numbers of your postcode will help us understand where services may need to be directed (we will not be able to identify your address from this)						
First part of postcode eg, LE12					I'd prefer not to say	

What is your date of birth?								
Please complete your date of birth – just the month and year	M	M	Y	Y	Y	Y	I'd prefer not to say	

Please (✓) the relevant box under each equality question.

Please (✓) the relevant box under each equality question.

What is your current relationship status? Please choose one option that best describes your relationship status:					
Single		In a relationship		Living with partner	
Married/Civil Partnership		Separated		Divorced/Dissolved Civil Partnership	
Widowed/Surviving Civil Partner		Other		I'd prefer not to say	

What is your gender/sex?					
Male		Female		I'd prefer not to say	

Have you gone through any part of a process (including thoughts or actions) to change from the sex you were described as at birth to the gender you identify with, or do you intend to? (This could include changing your name, wearing different clothes, taking hormones or having gender reassignment surgery)					
Yes		No		I'd prefer not to say	

What is your sexual identity/orientation? Please choose one option that best describes how you think of yourself:					
Heterosexual / Straight		Gay / Lesbian		Bisexual	
Other		I'd prefer not to say			

Do you look after, or give any help or support to family members, friends, neighbours or others because of either					
Long-term physical or mental-ill-health/disability		Problems related to old age		No	
I'd prefer not to say		Other, please describe:			

Are your day-to-day activities limited because of a health condition or illness which has lasted, or is expected to last, at least 12 months? (Please select all that apply)	
Vision (such as due to blindness or partial sight)	
Hearing (such as due to deafness or partial hearing)	
Mobility (such as difficulty walking short distances, climbing stairs)	
Dexterity (such as lifting and carrying objects, using a keyboard)	
Ability to concentrate, learn or understand (Learning Disability/Difficulty)	
Memory	
Mental ill-health	
Stamina or breathing difficulty or fatigue	
Social or behavioural issues (for example, due to neuro diverse conditions such as Autism, Attention Deficit Disorder or Aspergers' Syndrome)	
No	
I'd prefer not to say	
Any other condition or illness, please describe:	

What is your ethnic group? Please choose one option that best describes your ethnic group or background?	
White	
English/Welsh/Scottish/Northern Irish/British	

Irish	
Gypsy or Irish Traveller	
Any other White background, please describe:	
Mixed/multiple ethnic groups	
White and Black Caribbean	
White and Black African	
White and Asian	
Any other mixed/multiple ethnic background, please describe:	
Asian/Asian British	
Indian	
Pakistani	
Bangladeshi	
Any other Asian background, please describe:	
Black/African/Caribbean/Black British	
African	
Caribbean	
Any other Black/African/Caribbean background, please describe:	
Chinese	
Chinese	
Other ethnic group	
Arab	
Any other ethnic group, please describe:	
I'd prefer not to say	

What is your religion? Please choose one option that best describes your religious identity?					
No religion		Christian (including Church of England, Catholic, Protestant and all other Christian denominations)			
Buddhist		Hindu		Jewish	
Muslim		Sikh		Baha'i	

Jain		I'd prefer not to say			
Any other religion, please describe:					

What is your main language? Please choose one option used for communicating and interpreting information?					
English		Arabic		Bengali	
BSL (British Sign Language)		Chinese		Farsi	
Gujarati		Hindi		Pashtu	
Polish		Portuguese		Punjabi	
Slovak		Somali		Turkish	
Urdu					
Any other preferred language, please describe:					

The free postal address for your responses is as below (please return by 27 June 2014):
RSUL-LSXC-AGJU
Helen Thompson
Leicestershire Partnership NHS Trust
Lakeside House
4 Smith Way
Grove Park
Enderby
Leicestershire LE19 1SS

A summary of responses to the engagement will be available by 11 July on www.leicspart.nhs.uk or you can request it via email at communications@leicspart.nhs.uk or by post to the above address.

If you need this information in another language or format please telephone 0116 295 0994 or email: Patient.Information@leicspart.nhs.uk

Arabic
إذا كنت في حاجة إلى قراءة هذه المعلومات بلغة أخرى أو بتنسيق مختلف، يرجى الاتصال بهاتف رقم0116 295 0994أو إرسال بريد إلكتروني إلى: Patient.Information@leicspart.nhs.uk

Bengali
যদি এই তথ্য অন্য কোন ভাষায় বা ফরমেটে আপনার দরকার হয় তাহলে দয়া করে 0116 295 0994 নম্বরে ফোন করুন বা Patient.Information@leicspart.nhs.uk ঠিকানায় ই-মেইল করুন।

Traditional Chinese
如果您需要將本資訊翻譯為其他語言或用其他格式顯示，請致電 0116 295 0994 或發電子郵件至：Patient.Information@leicspart.nhs.uk

Gujarati
જો તમારે આ માહિતી અન્ય ભાષા અથવા ફોર્મેટમાં જોઇતી હોય તો 0116 295 0994 પર ટેલિફોન કરો અથવા Patient.Information@leicspart.nhs.uk પર ઇમેઇલ કરો.

Hindi
अगर आप यह जानकारी किसी अन्य भाषा या प्रारूप में चाहते हैं तो कृपया 0116 295 0994 पर हमें फोन करें या Patient.Information@leicspart.nhs.uk पर हमें ईमेल करें

Polish
Jeżeli są Państwo zainteresowani otrzymaniem niniejszych informacji w innym języku lub formacie, prosimy skontaktować się z nami telefonicznie pod numerem 0116 295 0994 lub za pośrednictwem poczty elektronicznej na adres: Patient.Information@leicspart.nhs.uk

Punjabi
ਜੇ ਤੁਹਾਨੂੰ ਇਹ ਜਾਣਕਾਰੀ ਕਿਸੇ ਹੋਰ ਭਾਸ਼ਾ ਜਾਂ ਫਾਰਮੈਟ ਵਿਚ ਚਾਹੀਦੀ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ 0116 295 0994 ਤੇ ਟੈਲੀਫ਼ੋਨ ਕਰੋ ਜਾਂ ਇੱਥੇ ਈਮੇਲ ਕਰੋ: Patient.Information@leicspart.nhs.uk

Somali
Haddii aad rabto in aad warbixintan ku hesho luqad ama nuskhad kale fadlan soo wac lambarka 0116 295 0994 ama email u dir: Patient.Information@leicspart.nhs.uk

Urdu
اگرآپ کو یہ معلومات کسی اور زبان یا صورت میں درکار ہوں تو براہ کرم اس ٹیلی فون نمبر 0116 295 0994 یا ای میل پر رابطہ کریں Patient.Information@leicspart.nhs.uk

Agenda Item 15

Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 11 JUNE 2014

JOINT REPORT OF THE CHIEF EXECUTIVE AND DIRECTOR OF PUBLIC HEALTH

PERFORMANCE REPORT

Purpose of report

1. The purpose of this report is to provide the Committee with an overview of the performance monitoring and assurance framework across the health and wellbeing sector relating to the County Council and its area, CCGs, providers and partnership organisations. It also includes an overview of current performance of the schemes within the Better Care Fund (BCF). Any comments made by the Committee will be reported to the Health and Wellbeing Board.

Policy Framework and Previous Decisions

2. In response to the national Local Area Agreement (LAA) programme, performance was previously monitored by the Budget and Performance Monitoring Scrutiny Panel. However, the demise of the LAA and central targets in recent years meant that performance reporting at scrutiny level was included in the review of Scrutiny and Overview Committees conducted in 2013.

3. New arrangements including the abolition of the Budget and Performance Monitoring Scrutiny Panel were approved by the Constitution Committee on 12 June 2013. Performance of the County Council's Public Health Department and the Health and Wellbeing Board is now reported on a quarterly basis to the Health Overview and Scrutiny Committee.

4. Following the Francis report, it has been identified that, as good practice, Health Overview and Scrutiny Committees should consider performance data on a regular basis as part of their overview role.

Current Performance Monitoring Arrangements.

5. Performance Monitoring is currently undertaken by the Health and Wellbeing Board on a quarterly basis. The new performance framework now includes a section on the delivery of the Better Care Fund schemes, the health elements of the new Strategic Plan for the County Council and provider and CCG performance as before.

6. The BCF priorities have been aligned to the Joint Health and Wellbeing Strategy (JHWS) priorities. The JHWS is the overarching plan to improve the health and wellbeing of children and adults in the county and to reduce health inequalities. The Strategy has the following priorities:-
   - Getting it right from childhood
   - Managing the shift into early intervention and prevention
   - Supporting the ageing population
   - Improving mental health and wellbeing

7. It was agreed at the JSNA Steering Board of the 18 February, 2014, that the dashboards for the Health and Wellbeing Board are split to provide a clearer summary of performance across the healthcare system including CCG's and local providers. Performance against the Better Care Fund indicators are also included. Reporting will be amended following the scheduled update to the Joint Health and Wellbeing Strategy (JHWS) and any changes to governance arrangements.

8. Public Health England have revised the methodology for calculating rates for a number of the health targets that we report on. From now, all new data published will be calculated using the new methodology and all historical data back to 2001 will also be refreshed. As the new data is made available all targets and reporting will be updated to reflect this.

Integration Executive Dashboard Appendix A

9. Dashboard appendix A to this report shows accumulated performance against the schemes and metrics within the Better Care Fund.

10. The Integration Executive reviewed and agreed the draft dashboard at its meeting on the 27 May, with an exception dashboard that accumulates the data for Health Scrutiny and Health and Wellbeing Board level. As the schemes are at an early stage of development, the report highlights Ambers and Reds as exceptions.

11. The presentation of the framework has been updated specifically to allow a clear line of sight between each scheme and the associated metric(s) so that an overall confidence rating can be applied to delivery against each metric, as well as tracking delivery of individual schemes to their individual key performance indicators (KPIs), project milestones and financial plans. The dashboard now includes red, amber, green (RAG) ratings against three categories:
    - Overall delivery to plan milestones
    - Finance
    - Impact on metrics.

12. A set of guidelines are presented at the top of the dashboard. These have been proposed for each RAG rating including a definition for not applicable (N/A). Where appropriate these definitions include thresholds as to the variance from target.

13. There is also a summary of the 6 BCF metrics and current data against them. Data is not yet available for the metrics but provided in this section are the proposed targets and the baselines published. The trend charts are examples only and as data is published these will be used to show a view of whether the data is fluctuating or following a consistent upward or downward trend over a period of time. The direction of travel arrow will show at a glance whether the indicator has improved from the previous data set, worsened or remained the same.

14. Each project lead has provided an initial status report to populate the performance framework for the first time as at 27th May. This shows the current status of each scheme, with some already established, some at scoping stage and some not due for implementation until 2015/16. Commentary on an exception basis (i.e. all RED and AMBER items) is included in the exception commentary section of the dashboard.

15. The Operational Group of the Integration Executive agreed at their meeting of 15 May that, as individual project briefs and business cases are developed for each scheme (with scheme level KPIs), there will also need to be a clear line of sight between these scheme level KPIs and the national metrics where applicable.

16. There is a need for clear definitions for measuring impact against the national metrics so that for example "what constitutes an avoided emergency admission within the 2 hour crisis response service" is a transparent, jointly agreed definition between partners. These definitions will be brought to the Integration Executive for approval as business cases are developed and approved. Building on the impact assessment workshop held in March, a further workshop for the operational group may be planned to support this work in due course.

17. Some schemes may not be able definitively to measure direct impact from the outset but will support the overall BCF plan as enablers. Enablers are detailed on the dashboard as N/A against the impact on metrics RAG at this stage. The framework is a live working document, so when schemes are project scoped they may change from enablers to show where they will have a direct impact, the KPIs proposed and how the impact on metrics has been assessed.

18. A number of issues are highlighted below:

Project	**Commentary**
Integrated Crisis Response Service	**Action Plan** Night time nursing off track. Revised deadline for phased implementation approach to be fully operational by September. Mitigations have been put in place for the delay. **Finance** This has led to a predicted underspend for the year of up to £250k.
Patient Transfer Minimum Data Set	**Action Plan** Workshops to clarify and confirm arrangements are now

	being organised**.** **Finance** The level of underspend will be determined by the outcomes of the workshops. At this stage it is anticipated that any underspend will roll into 2015/16.
Transitions	Actions previously agreed by the Primary Care Trust (PCT) are now being renegotiated due to organisational change. Progress overall on action plan is good but further progress is needed.

Corporate Strategy Dashboard Appendix B

19. Appendix B to this report is a dashboard summarising the performance against Health targets in the Corporate Strategy for Leicestershire County Council.

20. The strategy sections include Better Public Health, Better Mental Health, Better Physical Health and Improving Children and Young People's Health.

21. The indicators included in each section are listed in the additional information box and any RED exceptions are highlighted with performance commentary against them.

22. A number of issues are highlighted below:

Indicator	**Commentary**
% successful completion of drug treatment - non-opiate users (PHOF 2.15ii)	Drugs and alcohol indicator trends are generally positive. In terms of treatment completion rates, there is still some way to go to achieve the top quartile range compared to similar areas, but if progress is maintained this should be an achievable in the near future. The performance of criminal justice treatment services is weaker than community treatment services, and significant improvement is needed to get into the top quartile range.
Chlamydia diagnoses (rate per 100,000 15-24 year olds) (Leics) (PHOF 3.02ii)	The diagnosis rate overall is low compared to England average however the rate for non-genitourinary (GU) settings is close to England Average. Since coverage is significantly higher than England average this suggests a low prevalence in Leicestershire.
% mothers breastfeeding at 6-8 weeks	The **Breast Feeding 6-8 weeks prevalence target** remains problematic particularly in the West of the County where breast feeding rates are lowest. A new Breast Feeding Peer Support project 'TLC' has been commissioned for Hinckley and Bosworth and North West Leicestershire districts to support mothers to breastfeed. The Peer supporters are working with maternity services, community midwives, health visitors, GPs and children centre staff to ensure the signposting and referral of mothers to the peer supporters for support. A breast feeding awareness week is planned for June 2014 the theme is 'Fake vs Real'. The Infant

	Feeding page on the Leicestershire Partnership Trust (LPT) website continues to develop and the' Meals on Heels' phone app which provides an interactive map of breast feeding support is now available for android phones. The assessment for Baby Friendly Initiative (BFI) Stage 3 for UHL Maternity services and for Community Services is booked for later this year.

Provider and CCG Dashboard Appendix C

23. This dashboard summarises information on provider and CCG performance in the same format as previous reports.

University Hospitals Leicester (UHL) – October-December 2013 Performance

24. The indicators within the dashboards are reported at CCG level. Data reported at provider level does differ, and delivery actions indicate where this is a risk.

Indicator	Commentary
18 Weeks Referral to Treatment (Data is at CCG level) The referral to treatment (RTT) operational standards are 90% of admitted (to hospital) and 95% of non-admitted patients (out-patients) should start consultant-led treatment within 18 weeks of referral. In order to sustain delivery of these standards 92% of patients who have not yet started treatment should have been waiting no longer than 18 weeks	At February 2014, the 18 week target for admitted patients was not achieved. West Leicestershire (WL) CCG is reporting 87.7% and East Leicestershire and Rutland (ELR) CCG is at 88.4% against a target of 90%. The Planned Care Board has been set up to meet fortnightly and commenced on 21 April 2014. A suite of RTT reports are being developed looking to map all inter-related performance issues eg. Emergency pressures/cancelled operations, to provide "flash" reports and trend information. At subsequent meetings in May 2014, the Board was concerned with the level of slippage of the agreed remedial action plan (which focuses on specialty areas: ophthalmology; ENT, general surgery and orthopaedics) . The Board has received revised actions and trajectories, with UHL committed to achieving recovery of admitted in November 2014. Additionally CCGs are exploring other strategies to ensure patient choice of provider is promoted further and additional capacity is procured (especially for cataracts) ensuring CCGs deliver on their commitments to the NHS Constitution.
A and E - 4 Hour Waiting Time	As at 9 April 14, 88.77% of patients were seen within 4 hours in A&E against a target of 95%. Although there have been notable improvements in recovery rates ensuring that one day of poor performance is taking less than 2 days to recover, the overall performance has remains static since January 2014 position reported. There are significant numbers of patients waiting for beds each morning with slow discharges first thing and

	chasing the flow throughout the day to keep pace with the volume coming in. This position does improve now towards the end of the week. The Urgent Care Working Group continues to meet weekly to review delivery against plan. In addition a weekly meeting with the NHS England Area Team, Trust Development Authority (TDA), CCGs, UHL and LPT is continuing focusing on high impact interventions which have a direct impact on flow delivery.
Ambulance Handovers	At March 2014, 12.9% of handovers between ambulance and A&E took place in less than 30 minutes against a zero tolerance. This position has improved from 14% reported last quarter. To support ambulance flow, patient handover and communication, a Hospital Ambulance Liaison Officer has been based at the hospital between the hours of 8am and 12am since December and continued until the end of March, which has improved the position.
Delayed Transfers of Care (DTOC)	Delays are being reported as the number of patients discharged as a percentage of occupied bed days. As at 27/03/14, 4.43% were delayed against a national target of 3.5%. This position has remained static since reported last quarter. Actions continue to focus on earlier discharge, and have been included in the 2014/15 contract. Discharge is undertaken weekly and reported to the Urgent Care Working Group.
Cancer 62 day waits All patients should wait a maximum of 62 days from their urgent GP referral to the start of their appointment	At February 2014, W LCCG is achieving the 85% standard with ELR CCG reporting 84.6%. UHL have achieved 85% overall. Actions in place are continuing including a dedicated senior manager at UHL and on-the-day booking for CT scans at UHL and the use of PET scan capacity through a third party.
Cancelled Operations	At February 2014, 95.3% of patients were seen against a target of 95%. This is an improvement since reported last quarter. At the Contract Performance Meeting with UHL on 3rd April 2014, UHL requested to revisit trajectories. UHL are identifying non-bed capacity related reasons for cancellations which equate to approximately 40% of cancellations and are analysing reasons for breaches to be reported to Commissioners in May 2014.
Never Events	There have been a total of 3 Never Events reported by UHL for 2013/14. There was a 3rd Never Event report in February and this is currently under investigation.
Pressure Ulcers	Monthly progress reports continue to be received through the Clinical Quality Review Group (CQRG). Revised thresholds agreed and UHL have been within their revised threshold since November 2013 with one exception in January 2014. The Contract Query Notice was closed in April 2014. Monitoring will continue on a monthly basis for 2014/15 against agreed thresholds.

	The end of year position will be reported during May 2014.
Safety Thermometer The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and "harm free" care.	UHL's average for 2013/14 was at 94% against a target of 95% which remains in line with the national position

East Midlands Ambulance Service (EMAS)

25. Areas of concern are detailed below.

Ambulance Response Times	At March 2014, Category A (8 minutes) Red 1 for EMAS is 71.26% and Category A Red 2 is 77.46% against a target of 75% and Category A (19 minutes) EMAS is 93.82%. These positions have deteriorated slightly since last reported. Progress against the action plans is being monitored weekly through the Better Patient Care Programme Board at EMAS. Formal monitoring continues on a monthly basis through an Oversight Group led by the TDA and includes the Care Qualirt Commission (CQC), Commissioners and EMAS. Data is now available at CCG level. This is as follows for March 2014: • Red 1 – WL 63.49% & ELR 59.98% (Target 75%) • Red 2 – WL 64.84% & ELR 59.93% (Target 75%) • Cat 19 – WL 92.62% & ELR 89.48% (Target 95%)

Leicestershire Partnership Trust (LPT)

26. Areas of concern against 'Efficient Services' indicators are detailed below. Data and commentary are taken directly from the LPT published Board papers for May 2014.

% Occupancy Rate – Community	Performance for the month of April stands at 86.6% against the 93% or above target. Community wards with significantly lower bed occupancy during the month were Ashby General Ward (77.5%), Coalville Snibston Ward (79.9%), Melton Dalgleish Ward (87.6%) and Rutland Ward (87.8%).
Occupancy Rate – Mental Health	Performance against this indicator has increased by 3.5% with Mental Health Bed Occupancy for the month of April at 89.1% against the trust target of 85% or

	below. Performance for the divisions' stand at Adult Mental Health and Learning Disabilities (90.9%), Community Health Services (85.2%), and Families, Young People and Children (90.8%).
% Delayed Patients (Community	Performance has increased compared to March and reads as 1.03% for April 2014 against the target of 2.12% for the month.
% Delayed Patients (MH)	Performance against this indicator has decreased for the month of April to 7.2% from 6.6% but stays within the Monitor 7.5% target.
Total number of Home Treatment episodes carried out by Crisis Resolution team (year to date)	Current position as at April is 117 episodes for the year against a pro-rata target of 141 cases (80.7%).
Waiting times	The Trust performance in relation to waiting times continues to be variable and further discussions are underway with Commissioners with regard to the targeting of funds to reduce key areas. Divisional Business Managers and Divisional Directors continue to scrutinise performance and data quality specifically in relation to these areas to ensure the most effective service delivery and reporting.

27. Areas of concern against 'Quality – Safe Care' indicators are detailed below. Data and commentary are taken directly from the LPT published Board papers for January 2014.

Compliance with hygiene code	Podiatry services are currently negotiating a suitable timescale from Interserve for the appropriate works to be undertaken and all risks associated with this issue continue to be managed by the Podiatry manager. The building works on Welford and Kirby wards with regards to the facilities is under review to ensure suitable equipment is identified. The Senior Nurse Advisor for Infection Prevention and Control (IPC) is visiting the areas on 23rd May to undertake a full assessment and develop a remedial action plan with timescales.
Infection control – C Diff (MH and Community)	Monitor target reflects the annual de minimus limit set at 12 cases as set out in the Monitor Risk Assurance Framework and is monitored each quarter. The Commissioner threshold is set provisionally at 9 cases and is reported monthly as per the Quality Schedule for 2014/15. There was 1 case for April on Dalgliesh Ward.
Strategic Executive Information System (STEIS) – Serious Incident (SI) action plans implemented within timescales STEIS is the system	Performance against this indicator for the month of April is 70.0% from 47.1% in March. This indicator considers only those SI action plans that should have been completed by the latest month. SI's investigations must be closed within 60 working days. Only then are any action plans implemented, each SI action plan will have its own deadline. All divisions

used to report serious untoward incidents	performed at 100% except Adult Mental Health and Learning Disabilities (AMHLD), where performance has been hampered due to the volume of actions and investigations in progress.

CCG Performance

28. There are a number of indicators in the NHS Outcomes Framework that relate to emergency admissions, and the majority are performing well based on February 2014 position. The exception is children with lower respiratory tract infections per 100,000 population. WL CCG is reporting an increase in admissions per 100,000 population of 166.3 in 2013/14 against the 2012/13 baseline of 143.40 and ELR CCG reporting 182.2 in 2013/14 against 2012/13 baseline of 181.66.

29. Areas of concern are highlighted below:

Infection Control. Incidences of CDIFF and MRSA These have been reported for both WL & EL&R :	**MRSA** WL CCG: 5 incidences against zero tolerance ELR CCG: 3 incidences against zero tolerance MRSA Actions - Protocol in place for all MRSA BSI cases- in line with NHS England requirements all cases undergo a period of infection review (PIR) with all relevant stakeholders to identify any learning and ensure actions are in place to reduce the risk of re-occurrence. **CDIFF** WLCCG: 87 incidences against a nationally set objective of 88 ELR CCG: 89 incidences against a national objective of 74 CDIFF Actions – following a multidisciplinary meeting in January 2014 which was facilitated by the Area Team it was agreed to develop a Whole Health Economy action plan that joins together both acute and community actions.
WLCCG Reduction in Emergency Admissions from Care Homes	As at February 2014 FOT, there are 1563 admissions against a 645 baseline. There are a number of actions in place, which will help to focus and target interventions. A Dashboard has been sent to GPs to identify homes that refer emergencies to the acute sector in order for them to target their work. The CCG will identity homes with higher admissions to the acute sector as a result to deploy commissioned resources.
East Leicestershire CCG Increase in People Dying at Home	As at February 2014, the target was not achieved. The has been chosen as a local priority in 2014/15 and a business case is being developed to work with Macmillan Cancer Services to provide GP mentorship and palliative care clinical nurse specialist support. The focus of primary care delivery will be around advance care planning. Choice regarding “place of death” will be included within the care plan, linked to dialogue with the

	individual and/or carer.
East Leicestershire CCG Transient Ischaemic Attack - Increase in people who are scanned and treated in 24 hours	As at March 2014, 67.1% against 70% target. Performance has improved significantly with fluctuations being due to small numbers.
East Leicestershire CCG IAPT – Increase in People Moving to Recovery	As at February 2014, 51.4% of people were moving to recovery against a target of 52%. This position has improved during the year, and is slightly below the target.

Background papers

Leicestershire Partnership Trust Board Papers can be found at the following link:
http://www.leicspart.nhs.uk/_Aboutus-Trustboardmeetings2014-May2014.aspx

University Hospitals Leicester Trust Board meetings can be found at the following link:
http://www.leicestershospitals.nhs.uk/aboutus/our-structure-and-people/board-of-directors/board-meeting-dates/

Further information on the health system can be found in a previous report to the Shadow Health and Wellbeing Board March 2013:
http://politics.leics.gov.uk/ieListDocuments.aspx?CId=961&MId=3727&Ver=4

Recommendations

30. The Committee is asked to:

a) note the progress made to date in developing the performance framework alongside reporting arrangements to support the Committee's role;

b) note the performance summary, issues identified this quarter and actions planned in response to improve performance; and

c) comment on any recommendations or other issues with regard to the report.

List of appendices

Officers to Contact

Mike Sandys
Director of Public Health, Leicestershire County Council
Tel: 0116 305 4239
Mob: 07730 583171
Email: mike.sandys@leics.gov.uk

Lisa Carter
Performance Manager, Leicestershire County Council

Tel: 0116 3053932
Email: lisa.carter@leics.gov.uk

Andy Brown
Performance & Business Intelligence Team Leader, Leicestershire County Council
Tel: 0116 3056096
Email: andy.brown@leics.gov.uk

Sarah Cooke
Head of Performance (Leicester & Lincoln)
Greater East Midlands Commissioning Support Unit
Tel: 0116 295 7272
Mobile: 07795126428
Email: Sarah.Cooke@gemcsu.nhs.uk

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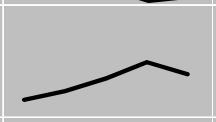
APPENDIX A - Health & Wellbeing Board Draft Dashboard

Better Care Fund

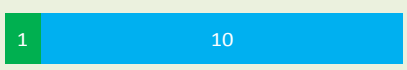
RAG Status Guidelines

Dimension	RAG Status	Guidelines
Action plan milestones	GREEN	Action plan development and/or milestones are on target / Service already in place
	AMBER	There are minor delays in the action plan milestones of up to 30 days
	RED	There are action plan milestones delayed more than 30 days / Action plan or project scope delayed
	N/A	Scheme not yet due to start (please provide a start date)
Finance	GREEN	Costs are on target
	AMBER	There is likely to be an overspend / underspend of up to 10% of the agreed budget
	RED	It is highly likely there will be an overspend / underspend greater than 10% of the agreed budget
	N/A	Budget not set for current financial year
Impact on metrics	GREEN	Assessed impact on primary metric(s) is on track
	AMBER	It is likely there will be a negative impact on the primary metric(s) of up to 10%
	RED	It is highly likely there will be a negative impact on the primary metric(s) greater than 10%
	N/A	This scheme is an enabler / Contribution to metrics not yet developed

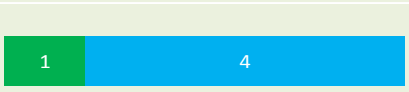
BCF Metrics

Metric	Target	Current data	Trend	Data RAG	DOT	Commentary
METRIC 1: Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	563.06	762.73		N/A	⇔	Data not yet available. Trend chart is an example only. Current data reflects the agreed baseline.
METRIC 2: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	93.86%	78.22%		N/A	⇔	Data not yet available. Trend chart is an example only. Current data reflects the agreed baseline.
METRIC 3: Delayed transfers of care from hospital per 100,000 population (average per month)	267.06	292.71		N/A	⇔	Data not yet available. Trend chart is an example only. Current data reflects the agreed baseline.
METRIC 4: Avoidable emergency admissions (composite measure)	113.08	124.12		N/A	⇔	Annual activity baseline = 9913 with a target of 9429 in 2018/19. Data not yet available. Trend chart is an example only. Current data reflects the agreed baseline.
METRIC 5: Patient / service user experience	~	~		N/A	⇔	In development.
METRIC 6: Injuries due to falls in people aged 65 and over	140.48	168.2		N/A	⇔	Data not yet available. Trend chart is an example only. Current data reflects the agreed baseline.

A Unified Prevention Offer for Communities — Exception information

JHWS Priority	Schemes	Schemes	Theme Lead	Exception commentary	Additional information
Managing the shift to early intervention and prevention	ACTION PLAN 		All projects are on track.		**Carers Service:** Carers consultation in progress. Report due to Cabinet Sept 14. Following outcome of consultation a new model will be produced. **Assistive Technology:** To become BAU. Project closure report due by July. New procurement complete, entering into 6 month transition period. Charging being introduced in Aug 14. **Local Area Co-ordination:** This scheme is in the planning stage and developing impacts on metrics 4 and 6 in particular. Business case due end of June.
	FINANCE 		All projects are on track.		
	METRIC 		All projects are on track.		

Integrated Urgent Response — Exception information

JHWS Priority	Schemes	Schemes	Theme Lead	Exception commentary	Additional information
HWBS 10: Planning for an ageing population	ACTION PLAN 	Integrated Crisis Response Service	Anne Walsh/ Yasmin Sidyot/ Caron Williams	Night time nursing off track. Revised deadline for phased implementation approach to be fully operational by Sept. Mitigations have been put in place for the delay.	**Integrated Crisis Response Service:** Records of data collected in place and can evidence elements of impacts on metrics. There are some data quality elements to be worked on, which may form part of the assessment. Co-location being trialled in Narborough, testing joint assessments and triaging. **Frail Older People Service:** Business case underway and will be completed by end June. **Expanded role of primary medical care:** In progress. Workshops being held. Paper to go to June Integration Exec
	FINANCE 	Integrated Crisis Response Service	Anne Walsh/ Yasmin Sidyot/ Caron Williams	Night time nursing has led to a predicted underspend for the year of up to £250k.	
	METRIC 		All projects are on track.		

Improved Hospital Discharge and Reablement — Exception information

JHWS Priority	Schemes	Schemes	Theme Lead	Exception commentary	Additional information
HWBS 11. Maximising independence	ACTION PLAN 	Patient Transfer Minimum Data Set	Caron Williams	Workshops to clarify & confirm arrangements are now being organised.	**Intermediate Care:** LPT contract 14/15 has been signed which includes Intermediate Care. **Strengthening Mental Health Discharge Provision:** Services in place. Hospital Social Workers attend twice weekly meetings to monitor DTOC numbers.
		Integrated Residential Reablement	Jackie Wright/ Caron Williams or Yasmin Sidyot	There is a task and finish group set up through the Urgent Care Working Group that is developing the 3 discharge pathways – defining the pathways will enable the development of the local reablement model. The group is an LLR task and finish group with representation from 3 CCGs and 3 LAs.	
	FINANCE 	Patient Transfer Minimum Data Set	Caron Williams	The level of underspend will be determined by the the outcomes of the workshops. At this stage it is anticipated that any underspend will roll into 2015/16.	
		Integrated Residential Reablement	Jackie Wright/ Caron Williams or Yasmin Sidyot	Delays in implementing the reablement model will result in an underspend of c£30k per month.	
	METRIC 	All projects are on track.			

Integrated, proactive care for those with long-term conditions				Exception information	
JHWS Priority	**Schemes**	**Schemes**	**Theme Lead**	**Exception commentary**	**Additional information**
HWBS 12. Management of long-term conditions	ACTION PLAN: 1, 10, 1	Continuing Healthcare		Operational workstream is led within the CCGs hosted contract team. Update to be provided to Integrated Exec July meeting.	**Pathway to Housing:** Measurements in place but not linked to outcomes as yet. Increasing amount of housing options and number of individuals supported to move into own housing. Reducing support packages during regular reviews. **Improving Quality in Care Homes:** QIT / Safeguarding. Measurements in place but not linked to outcomes. New safeguarding threshold tool introduced across LLR. A slow reduction in care home safeguarding investigations being identified. **IT Enablers:** Being led by LLR IM&T workstream. Feasibility work being completed by LCC on use of NHS number. Project brief
	FINANCE: 10, 2	All projects are on track.			
	METRIC: 9, 3	All projects are on track.			

Further Integration schemes				Exception information	
JHWS Priority	**Schemes**	**Schemes**	**Theme Lead**	**Exception commentary**	**Additional information**
	ACTION PLAN: 1, 4, 2	Transitions		Actions previously agreed by PCT are now being renegotiated due to organisational change. Progress overall on action plan is good but further progress is needed.	**Winterbourne View Concordat:** National JIP submitted on schedule. Plan now being implemented **Short Breaks:** Strategic aims agreed. Objectives being scoped. Business case & implementation plan being drawn up. **Transitions:** Emerging work around SEND agenda & EHCs. Working with partners in education & CYPS to develop systems to identify individuals earlier. This should help with management of the pooled budget. **Housing Offer to Health: Lightbulb project:** Paper to LCC CMT to discuss projects to pursue to secure transformational funding from DCLG for 2015/16. Expressions of interest for this to be completed by July 2014. **Housing offer to Health: Hospital Discharge Housing Enabler:** Job descriptions for Housing officers to work with LPT are in draft format. KPI's outlined to measure scheme effectiveness. These are being agreed.
	FINANCE: 1, 1, 5	Management of LD Pooled Budget		Risk of overspend to pooled budget. Financial modelling to be undertaken that will identify the extent of the potential overspend.	
	METRIC: 7	All projects are on track.			

KEY: R A G NA

APPENDIX B - Health & Wellbeing Board Corporate Dashboard

Better Public Health

Priority		Exception Information: Indicator	Exception Information: Exception commentary	Additional information
Reduce Health Inequalities and Increase Life Expectancy	3 2	Performance on track		This section includes the following indicators: 1. Slope index of inequality in life expectancy at birth (Males) (Leics) (PHOF 0.2iii) 2. Slope index of inequality in life expectancy at birth (Females) (Leics) (PHOF 0.2iii) 3. Life expectancy at birth (Males) (Leics) (PHOF 0.1ii) 4. Life expectancy at birth(Females) (Leics) (PHOF 0.1ii) 5. Take up of the NHS Health Check Programme – by those eligible
Reduce Premature Mortality from Respiratory and Cardiovascular Disease	2	Performance on track		This section includes the following indicators: 1. Under 75 mortality rate from all cardiovascular diseases (Persons per 100,000) (Leics) (PHOF 4.04i) 2. Under 75 mortality rate from respiratory disease (Persons per 100,000) (Leics) (PHOF 4.07i)
Reduce Cancer Mortality	3	Performance on track		This section includes the following indicators: 1. Under 75 mortality rate from cancer (Persons per 100,000) (Leics) (PHOF 4.05i) 2. % of eligible women screened - breast cancer (Leics) (PHOF 2.20i) 3. % of eligible women screened - cervical cancer (Leics) (PHOF 2.20ii)
Healthy Weight Adults	1	Performance on track		This section includes the following indicators: 1. % of adults classified as overweight or obese (Leics) (PHOF 2.12)
Reduce the Harm of Substance Misuse - Drugs and Alcohol	1 1 1	% successful completion of drug treatment - non-opiate users (PHOF 2.15ii)	Drugs and alcohol indicator trends are generally positive. In terms of treatment completion rates, there is still some way to go to achieve the top quartile range compared to similar areas	This section includes the following indicators: 1. % successful completion of drug treatment - opiate users (PHOF 2.15i) 2. % successful completion of drug treatment - non-opiate users (PHOF 2.15ii) 3. Admissions to hospital for alcohol related causes (rate per 100,000) (Leics) (PHOF 2.18)
Improved Sexual Health	1 1 1	Chlamydia diagnoses (rate per 100,000 15-24 year olds) (Leics) (PHOF 3.02ii)	The diagnosis rate overall is low compared to England average however the rate for non-genitourinary (GU) settings is close to England Average.	This section includes the following indicators: 1. Chlamydia diagnoses (rate per 100,000 15-24 year olds) (Leics) (PHOF 3.02ii) 2. People presenting with HIV at a late stage of infection - % of presentations (Leics) (PHOF 3.04) 3. Under 18 conceptions (rate per 1,000) (Leics) (PHOF 2.04)
Tobacco Control and Smoking Cessation	1 1 1	Performance on track		This section includes the following indicators: 1. Prevalence of smoking among persons aged 18 years and over (Leics) (PHOF 2.14) 2. Number of self-reported 4 week smoking quitters (Leics) 3. % of women smoking at time of delivery (Leics) (PHOF 2.03)

Better Physical Health

Priority		Exception Information: Indicator	Exception Information: Exception commentary	Additional information
Active Young People	1	Performance on track		This section includes the following indicators: 1. % of physically active adults (PHOF 2.13i)
Active Adults	1 1	Performance on track		This section includes the following indicators: 1. % of physically inactive adults (Leics) (PHOF 2.13i) 2. % of adults participating in one or more sports a week for 30 minutes or more (Leics)

Improving Children and Young Peoples Health

Priority		Exception Information: Indicator	Exception Information: Exception commentary	Additional information
Child Healthy Weight and Good Diet	1 2	Performance on track		This section includes the following indicators: 1. % of children with excess weight - 4-5 year olds (Leics) (PHOF 2.06i) 2. % of children with excess weight - 10-11 year olds (Leics) (PHOF 2.06ii) 3. % children aged 5 years with one or more decayed, missing or filled teeth
Breastfeeding and Maternity Support	1 1	% of mothers breastfeeding at 6-8 weeks	The **Breast Feeding 6-8 weeks prevalence target** remains problematic particularly in the West of the County where breast feeding rates are lowest.	This section includes the following indicators: 1. % of mothers initiating breastfeeding 2. % of mothers breastfeeding at 6-8 weeks

Better Mental Health

Priority		Exception Information: Indicator	Exception Information: Exception commentary	Additional information
Earlier Mental Health Detection and Treatment	4 1	Performance on track		This section includes the following indicators: 1. % of people with a low satisfaction score - self-reported well-being (Leics) (PHOF 2.23i) 2. % of people with a low happiness score - self-reported well-being (Leics) (PHOF 2.23iii) 3. % of people with a high anxiety score - self-reported well-being (Leics) (PHOF 2.23iv) 4. Excess under 75 mortality rate in adults with serious mental illness (Leics) (PHOF 4.9) 5. Suicide rate (Persons per 100,000) (Leics) (PHOF 4.10)
Earlier Detection/ Treatment of mental health problems in children	2	Performance on track		This section includes the following indicators: 1. Emotional health of looked after children - mean SDQ scores 2. Waiting times for assessment by Child & Adolescent Mental Health Services (CAMHS)
Effective Support for People with poor mental health	4	Performance on track		This section includes the following indicators: 1. Average length of stay in acute hospitals 2. Number of bed days commissioned from out of county hospitals 3. Delayed transfers of care (mental health service users) 4. % of adults in contact with secondary mental health services living in settled accommodation (ASCOF 1H)

KEY: R A G NA

APPENDIX C - Health & Wellbeing Board Corporate Dashboard

Providers

Supporting Indicators		Exception Indicators	
UHL		**Indicator**	**Comment**
Referral to Treatment	1 2 4	52 Week waiters	As at February 2014, there was 1 instance of a patient waiting over 52 weeks on a referral to treatment pathway against a zero tolerance
Diagnostic Waiting Time	2		Performance on track
ED Waiting Times	2	Emergency Dept. Waiting Time < 4 Hours Emergency Dept. Handovers between ED & Ambulance > 30 mins	As at 09.04.14, Accident and Emergency was 84.77%, against a target of 95% for patients to be admitted, transferred or discharged within 4 hours. At March 2013, 12.9% of handovers between ambulance and A and E took place in over 30 minutes against a zero tolerance
Delayed Transfer of Care	1	Delayed Transfers of Care - no. of patients as a % of occupied bed days	As at 27/03/14, 4.43% were delayed against a national target of 3.5%.
Cancer 62 Day Waiting Time (All Providers)	1 1		At February 2014, WL is achieving the 85% standard with EL&R CCG reporting 84.6%. This is an improvement on November 2013 position.
Hospital Quality	4 1	Never Events Pressure Ulcers (avoidable Grade 3 & 4) Pressure Ulcers (Grade 2) Safety Thermometer (% No Harms)	At March 2014 there had been 3 Never Events reported. At December there has been 55 avoidable pressure ulcers (Grade 3 and 4) against a zero tolerance. There have been 99 (Grade 2) against a zero tolerance. At March 2014, 94% of patients are harm free against a standard of 95%.
EMAS			
Ambulance Response Times	3		At March 2014, Category A (8 minutes) Red 1 for EMAS is 71.26% and Category A Red 2 is 71.46% against a target of 75% and Category A (19 minutes) EMAS is 93.82%.
LPT			
Efficient Services	1 1 4	Occupancy Rate - Community	The Community Occupancy rate performance has declined slightly and is reporting 86.6% at April 2014 against the 93% or above target.
Quality - Safe Care	1 1 3	STEIS - SI actions plans implemented within timescales	At April 2014, 70% of STEIS - SI action plans were implemented within timescales against a target of 100%.

CCG Indicators

Supporting Indicators		Exception Indicators	
West Leicestershire CCG		**Indicator**	**Comment**
Domain 2 Enhancing quality of life for people with Long Term Conditions	2		Performance on track
Domain 3 Helping people to recover from episodes of ill health or following injury	1 1	Emergency Admissions for children with Lower Respiratory Tract Infections (LRTI) per 100,000 population	Currently reporting 166.3 (FOT to Feb 14) against a 143.40 12/13 outturn, with a target of a reduction or 0% change from the previous year.
Domain 4 Ensuring that people have a positive experience of care	1 1		Performance on track
Domain 5 Treating and caring for people in a safe environment and protecting them from avoidable harm	1 1	Incidence of health associated infection MRSA	Reporting 5 incidences against a zero tolerance. Protocol in place for all MRSA BSI cases- in line with NHS England requirements.
Local CCG (West)	2 3	% reduction in emergency admissions from care homes. (No. of emergency admissions reported) % of people who enter psychological therapies	As at February 2014 FOT, there are 1563 admissions against a 645 baseline. There are a number of actions in place, which will help to focus and target interventions. As at February 2014, % of people entering psychological therapies was 13.7% against a target of 15%, this is an improvement on December 2013 results.
East Leicestershire & Rutland CCG			
Domain 2 Enhancing quality of life for people with Long Term Conditions	2		Performance on track
Domain 3 Helping people to recover from episodes of ill health or following injury	1 1	Emergency Admissions for children with Lower Respiratory Tract Infections (LRTI) per 100,000 population	Currently reporting 182.2 (FOT to Feb 14) against a 181.66 12/13 outturn, with a target of a reduction or 0% change from the previous year.
Domain 4 Ensuring that people have a positive experience of care	1 1		Performance on track
Domain 5 Treating and caring for people in a safe environment and protecting them from avoidable harm	2	Incidence of health associated infection MRSA Incidence of health associated infection CDIFF	Reporting 3 incidences against a zero tolerance. Protocol in place for all MRSA BSI cases- in line with NHS England requirements. As at March 2014 there were 89 incidences against a target of 74, this is an improvement on December 2013. Development of a Whole Health Economy action plan in underway
Local CCG (East & Rutland)	3 1 1	% increase in people dying at home % of people who have a stroke who are scanned & treated in 24 hrs % of people who enter psychological therapies	As at January 2014 results were 23.9% against a target of 30% As at March 2014 results were 67.1% against a target of 70% As at February 2014 results were 14.5% against a target of 15%, an improvement on December 2013

KEY: R A G NA