Leicestershire County Council

Meeting: **Health Overview and Scrutiny Committee**

Date/Time: **Thursday, 12 September 2013 at 4.00 pm**

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

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

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

Membership

Dr. S. Hill CC (Chairman)

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

AGENDA

Item		Report by
1.	Question Time.	
2.	Questions asked by members under Standing Order 7(3) and 7(5).	
3.	To advise of any other items which the Chairman has decided to take as urgent elsewhere on the agenda.	
4.	Declarations of interest in respect of items on the agenda.	
5.	Declarations of the Party Whip in accordance with Overview and Scrutiny Procedure Rule 16.	
6.	Presentation of Petitions under Standing Order 36.	

7. Bradgate Mental Health Unit

   (a) Report of Leicestershire Partnership NHS Trust. (Pages 5 - 46)

   (b) Report of the Care Quality Commission. (Pages 47 - 50)

8. Date of next meeting.

   The next meeting of the Committee is scheduled to take place on 27 November 2013 at 2.00pm

9. 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 7a

Leicestershire Partnership NHS
NHS Trust

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 12 SEPTEMBER 2013

REPORT FROM LEICESTERSHIRE PARTNERSHIP NHS TRUST

BRADGATE MENTAL HEALTH UNIT

Purpose of the Report

1. The purpose of this report is to:

   - Provide an honest, open and transparent report about the current issues and challenges affecting Leicestershire Partnership Trust.
   - Outline the specific findings, implications and immediate actions taken following the Care Quality Commission (CQC) visit at the Bradgate Mental Health Unit in July.
   - Explain the approach the Leicestershire Partnership Trust is taking in the medium term to assure high quality sustainable care for local mental health service users, and all our other services users.
   - Demonstrate public accountability and set out how the Trust is working to restore confidence in its services.

Overview of CQC Visit July 2013

2. The Bradgate Adult Mental Health Unit was inspected by the CQC on 4 and 17 July 2013.

3. The CQC found two areas of major concern and three moderate areas of concern and on 30 July, Leicestershire Partnership Trust was issued with two warning notices with respect to the two major areas of concern, which related to care planning and discharge planning.
http://www.leicspart.nhs.uk/Library/PRCQCresponse30July.pdf

Warning Notices	
Outcome 4	Care and welfare
Outcome 6	Cooperating with other providers
Moderate areas of concern	
Outcome 7	Safeguarding people who use services from abuse
Outcome 14	Supporting
Outcome 16	Assessing and monitoring the quality of service provision.

4. In line with usual practice, the CQC report arising from this visit was initially issued in draft form to the Trust for checking for factual accuracy.

5. The Trust's response to the draft report and our response on receipt of the warning notices were made within the CQC's required timescales.

6. The report was published on the CQC website on 28 August. Direct link to the CQC report: http://www.cqc.org.uk/sites/default/files/media/reports/RT5KF_The_Bradgate_Mental_Health_Unit_INS1-711321412_Scheduled_22-08-2013.pdf

   For further information about the inspection regime please see the CQC website home page www.cqc.org.uk)

7. The Trust is required to submit a further response to the CQC by 4 September which will address the three areas of moderate, such as seclusion facilities and access to interpreters.

8. The Trust is required to show sufficient progress to address the issues raised in the warning notices within a 30 day period.

9. A follow up inspection will be undertaken by the CQC which we anticipate will be in the early part of September; however this will be an unannounced event.

10. Should the Trust fail to demonstrate sufficient improvement in the two areas that relate to the warning notices, further sanctions may follow in line with the CQC regulatory framework. These can include applying a significant fine and could ultimately affect the ability of the Trust to provide certain services.

The Response of the Trust

11. The Trust has taken this report extremely seriously and acknowledges that the provision of high quality care planning and discharge planning is a fundamental part of providing safe, effective and person-centred care to all patients in all our services.

12. The feedback from the July CQC visit has shown considerable inconsistency in the application of good practice in care planning and discharge planning, in particular with respect to recording the associated documentation in clear and systematic ways.

13. While some wards demonstrate good practice in both the planning of care and discharge arrangements and documenting this, others have not demonstrated good practice in one or both aspects, or have been unable to demonstrate this consistently.

14. A Trust Board meeting was held on 31 July to investigate the position and an extraordinary Trust Board meeting was held in public on August 29 where the Trust formally received the CQC report, reported on progress in addressing

the warning notices, and responded to a number of questions from members of the public.
Board papers can be viewed at http://www.leicspart.nhs.uk/_Aboutus-Trustboardmeetings2013-August2013.aspx.

15. We also issued this statement:
http://www.leicspart.nhs.uk/Library/AMH_025_13CQCreport.pdf

Extract from the statement:

Sue Noyes, LPT Acting Chief Executive, and David Chiddick, LPT Chair, said: "We are very disappointed by the report and are very sorry for the failings identified by the CQC. We fully accept the CQC findings, recognise the severity of this situation and are being transparent in all aspects of its response. This latest CQC visits reinforces that, while several wards have maintained good performance, this performance has not been consistently maintained across all wards at the unit."

Issues, Concerns and Progress in Adult Mental Health Services 2012 / 13

a) Issues and Concerns

16. There have been a number of related issues that have affected the Bradgate Unit's overall performance and quality assurance over the past two to three years. Cumulatively this has led to escalating public concern along with more intensive commissioner and media scrutiny. The issues and concerns have broadly included:

- The independent Professor Louis Appleby review into patient suicides between 2010 and 2012 - the report considered thematic findings from a number of patient related Serious Incident investigations in the inpatient services.
- Associated coroner cases / rulings.
- Findings from previous CQC and Mental Health Act inspections.
- Monitor's decision to defer the Trust's FT application in December 2012 due to insufficient assurance on the Trust's quality governance framework (materially affected by the Bradgate Unit's trend in serious incidents at that time).
- A recent File on Four radio documentary examined serious incidents in mental health inpatient settings (using LPT as an example) and considered if independent investigations should be the policy in the future.

b) Progress in 2012

17. In August 2012 as part of the development of the Trust's overall five year business plan, the Trust Board approved a comprehensive service

development initiative for adult mental health services which aimed to drive up the quality of care across the pathway from inpatients to community settings (Appendix A).

18. These developments include the continuing capital programme to relocate inpatient wards from the Towers hospitals into new modern accommodation at the Bradgate Unit.

19. In November 2012 the Board received the findings of Professor Louis Appleby's independent review. This review considered a number of inpatient suicides in the adult mental service between 2012 and 2012. As a result of this review the Trust put in place a quality improvement plan to address the thematic findings of this review.

20. Professor Appleby's report and the individual incident investigations highlighted themes such as the quality of communication, record keeping, handover and risk assessments by staff at the Bradgate Unit which were contributing factors in some of the serious incidents (SIs) within the Unit.

21. The weblink below takes you to the Professor Louis Appleby report. There is also a link at this page to the latest progress report given at our Quality Assurance Committee in August 2013.
http://www.leicspart.nhs.uk/_CommitmentstoCare-LouisApplebyreportandLPTsresponse.aspx

22. Along with the planned service developments and the actions to address the Louis Appleby report findings the Trust has increased staffing resource on the wards as follows;

- 2012/13 investment of £650k to increase the staffing levels ratio to 5:5:3
- 2013/14 additional investment of £810k to fund the skill mix change to a 60:40 split of qualified/unqualified staff; with the full year effect of an increase of £1.3m (£300k for the therapeutic liaison workers to improve the type and availability of therapeutic activities for inpatient service users)

c) Progress in 2013

23. To understand the effectiveness of the actions taken in response to the Professor Louis Appleby report, and compliance with CQC standards and outcomes, a series of internal quality assurance visits were made to all adult mental health wards in January and February by members of the Trust Board and the Trust's quality team.

24. The Trust Board was able to see personally the good progress that was being made at this time. A CQC inspection in February also noted the improvements seen as a result of this work.

25. The leadership team at LPT acknowledges that the assurance taken at this time both internally and externally may have led to the view that these changes were progressing sufficiently, and would now be sustained.

d) Current Position July-August 2013

26. Given the outcome of the latest CQC report, LPT has recognised that the improvements initially made have either not been sustained, or not been consistently applied, across all our adult mental health wards during the first half of 2013, which is extremely disappointing, and for which the Board stands accountable.

27. The Board also acknowledges that our own assurance processes and early warning systems should have identified and tackled any slippage, rather than this becoming apparent via an external assessment.

Overview of the Immediate 30 Day Action Plan

28. The 30 day action plan has focused on an in-depth review of all care plans across the adult mental health wards at the Bradgate Unit, examining the quality of the care planning process and documentation using an audit tool with four core sections.

29. A team of staff have been released from other work to lead on this audit including two lead nurses and two lead consultants.

30. Each record has been audited and the respective named nurses, ward matrons and medical staff have been given specific feedback and actions to take to improve the quality of the care planning activities and documentation for each service user including discharge planning, physical health needs and risk assessment.

31. In addition other clinical divisions in the Trust have completed a thematic review of the findings of the CQC report. Care plans in other parts of the Trust are being scrutinised to examine where further improvements can be made, utilising the same tools and techniques as the adult mental health unit.

32. The new Medical Director and new Chief Nurse have been leading this work personally and holding clinical meetings on site at the Bradgate Unit every 48 hours to ensure staff and clinical leaders are fully supported in this work.

33. In doing so they are jointly building a picture of the cultural changes that are needed to improve clinical and professional leadership across the adult mental health division and the Trust as a whole.

34. They are working with the Chief Operating Officer, clinical and divisional directors to identify where improvements can be made to leadership, culture, policies, procedures, documentation, IT and environmental issues.

35. In particular they have been examining the root causes that prevent staff from delivering consistently high quality care. Initially this has been with respect to care planning / discharge planning / risk assessment / documentation / ward

rounds, in that this has been the focus of the first 30 days and the CQC warning notices. This is now broadening out to consider a wider range of organisational development issues which the Board will be discussing in September.

36. The 30 day action plan is attached at Appendix B and shows the detail of individual actions and their status.

37. This includes a range of measures to support staff from an HR and OD perspective including targeted stress management support and improving recruitment timescales, particularly for areas of clinical priority.

38. Improvements are also being made to environmental matters such as seclusion facilities based on the CQC report findings.

39. The action plan also shows the extent of the communications and engagement including internal and external briefings, and the Trust's on-going engagement with service users, voluntary sector, commissioners, the Trust Development Authority (TDA), Local Healthwatch, Overview and Scrutiny Committees, Chairs of Health and Wellbeing Boards, and the media.

40. A weekly report has been made during August to the Trust Board on the progress towards the completion of these actions, recognising that some areas have started within the 30 day plan but will continue to develop in the medium term.

Escalation of Concerns and the Impact on the Trust's Foundation Trust Application

41. On 13 August the Executive Team met with the Trust Development Authority to discuss the warning notices and the Trust's response.

42. This was a constructive meeting which included wider themes such the refresh of the Trust's Quality Strategy and the further work needed on the Trust's Quality Governance Framework to ensure sustainable high quality services.

43. The Executive Team also discussed with the TDA the impact of the CQC warning notices on the Trust's position in the FT pipeline and fed back the views of the Trust.

44. Board's assessment from their meeting on 31 July to withdraw from the Monitor application at this stage. The TDA agreed with the Trust's view, and a formal Board decision was subsequently recorded at the meeting in public on 29 August to withdraw our application. Board papers can be viewed at http://www.leicspart.nhs.uk/_Aboutus-Trustboardmeetings2013-August2013.aspx.

45. On 15 August the Trust also met with representatives from all 3 local clinical commissioning groups to discuss the CQC report, the warning notices, the Trust's response and the wider cultural and organisational issues that were

being uncovered in examining the root causes of the variability of care quality and record keeping across the Bradgate Unit.

46. Due to the escalation of concerns by a range of external agencies, the Trust Development Authority, NHS England, Local Clinical Commissioning Groups, the CQC and Local Healthwatch invited the Trust to attend a Risk Summit on 29 August. A statement about the summit can be found at Appendix C.

47. Members of the Trust Executive Team are also visiting all three council's scrutiny committees in September and we welcome the opportunity to discuss these matters with the respective committees.

48. We are approaching this in an open and transparent way and welcome all feedback, challenge and support, and will be pleased to follow up with any additional information and activities as needed following discussion with the respective committees.

Sustaining Improvement and Delivering High Quality Care in the Medium and Longer Term

49. As a Trust, and with the support and challenge of the external agencies as described above, we have had to address some very difficult issues over the past month and confront head on a number of failings from Board to ward.

50. This is seen as a watershed for the Trust and everyone understands that this is not just about an immediate action plan for the 30 days, nor is it just about the services within the Bradgate Unit or our mental health division. Our priority is that high quality clinical care is sustained and that everyone can be more assured and confident of the care provided by the Trust.

51. An outcome of the Risk Summit is that we will now be working closely with a core external group representing local CCGs, Local Authorities, Local Healthwatch and the TDA, who will be holding the Trust Board to account for the medium term improvements that are required.

52. Now that we have moved beyond the initial 30 day actions, our next steps will primarily be focused on cultural change and bringing patient centred values into the forefront of the organisation, building on the positive work we have already begun through the Listening into Action programme with our staff and our "Changing your Experience for the Better" programme for service users.

53. The Board and wider leadership team will continue to understand all the underlying issues that could prevent our staff from delivering consistently high standards of care and discussions with clinical staff in recent weeks are already starting to produce a different conversation than has been historically the case.

54. In particular our new Medical Director, Chief Nurse and new Chief Executive will be working across the Trust focusing on changes to clinical and professional leadership, assessing the processes and policies that impact

both positively and negatively on operational and clinical delivery from staff and service user perspectives, improving our internal quality assurance arrangements, embedding a fundamental cultural change throughout all our clinical divisions from the front line to the Board.

55. With all our stakeholders including patients and commissioners, we will be reviewing the adult mental health care pathway, and sense checking our existing plans to ensure we are making the best possible changes for the future. We will also be improving data flows and analysis about how we measure and assure care quality from ward to Board.

56. We have also made a commitment to bringing more independent scrutiny into patient care related serious incidents and we will be working with a range of stakeholders over the coming months to see how this can best be achieved

57. We have already appointed Professor Hilary McCallion, lately Chief Nurse of South London and Maudesley NHS Foundation Trust to lead two inquiries into recent suicides in the community; and undertake a thematic review of suicides in the community over the past two years.

58. We are also seeking additional external advice, support, research and scrutiny from a range of perspectives in order to uncover, understand and address concerns from all angles to gain valuable insight and bring best practice from elsewhere into Leicester, Leicestershire and Rutland.

59. Our Board stands accountable for the impact the current position of the Trust has had on public confidence and we are being completely open and transparent in our communication and engagement on these matters.

List of Appendices

Appendix A: August 2012 Trust Board Paper – Improving Acute Adult Mental Health In-Patient Care
Appendix B: Immediate CQC 30 Day Action Plan
Appendix C Outcome of the Risk Summit

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REPORT TO THE TRUST BOARD – 30 AUGUST 2012	
Title	Suicide and patient safety

Executive summary
Paper C on the public Trust Board agenda for 30 August 2012 provided an overview of the work in progress to provide assurance of actions to address themes arising from recent serious incidents (including suicides) within the adult mental health services of the Trust. Attached to this paper are the detailed action plans. Appendix A is a programme of work underway in the Adult Mental Health Division since November 2011 to improve acute in-patient care. The programme involves the implementation of a new acute care pathway; new care pathways as part of introducing payment by results (PbR); action to improve standards of care; workforce and leadership development; environmental improvements; significant service re-design. Appendix B is the corporate level action plan.
Recommendation
The Trust Board is recommended to review and comment upon the assurance actions.

Related Trust objectives	We will build our reputation as a successful, inclusive organisation, working in partnership to improve health and wellbeing. We will continuously improve quality, with services shaped from user experience, audit and research.
Risk and assurance	Failure to learn from and take action following serious incidents increases the risk profile for the Trust in respect of quality, clinical safety and reputation.(BAF risk reference 131)
Legal implications/ regulatory requirements	CQC compliance and statutory duty for quality (Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.
Presenting Director	Jackie Ardley, Director of Quality and Innovation/Chief Nurse
Author(s)	Jackie Ardley, Director of Quality and Innovation/Chief Nurse
*Disclaimer: This report is submitted to the Trust Board for amendment or approval as appropriate. It should not be regarded or published as Trust Policy until it is formally agreed at the Board meeting, which the press and public are entitled to attend.	

Leicestershire Partnership NHS
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APPENDIX V1

REPORT TO THE TRUST BOARD – 30 AUGUST 2012	
Title	Improving Acute Adult Mental Health In-Patient Care

Executive summary

This report was first presented to the Quality Assurance Committee on 21 August 2012 and it now includes operational and contextual information about the Adult Mental Health (AMH) Division's acute in-patient services to provide a comprehensive basis for the Board's discussion.

A programme of work to improve acute in-patient care has been underway in the AMH Division since November 2011 and it involves the implementation of a new acute care pathway; new care pathways as part of introducing payment by results (PbR); action to improve standards of care; workforce and leadership development; environmental improvements; significant service re-design.

The headline service changes are part of the Division's Service Development Initiative which attracted £1m transformational funding in 2012/13:

- Single point of access from September 2012
- Re-designed crisis resolution and home treatment service (CRHT) from September 2012
- Co-location of CRHT at the Bradgate Unit – completed by November 2012
- New acute care pathway – from January 2013
- Recovery College – from January 2013

Trends in recent very serious incidents and the narrative verdicts in two Coroner's cases has led to fresh consideration of the wider determinants of standards of care such as: staffing levels, leadership, staff attitude, handover and communication, care planning, risk assessment/management and so on. A number of immediate actions to remind ward staff of their responsibilities and improve critical operational processes such as ward handover have been taken. A staffing review is starting in August which will include staffing levels, ward management, clinical leadership and also make proposals on ward configuration by October 2012. Proposals from the review will be included in a planned management of change process due to commence in October.

The Trust's centre of excellence programme is delivering improvements in ward environments but in the light of recent events the Division will improve ward access/egress systems; examine the potential for greater use of CCTV and improve recreational areas.

Work to improve acute in-patient care is an on-going programme which has now

been enhanced in response to very serious incident trends and the recent Coroner's verdicts. The Division is systematically addressing the determinants of standards of care.
Recommendation
The Board endorses the programme of work being undertaken in the Adult Mental Health Division to improve acute in patient care.

Related Trust objectives	We will continuously improve quality, with services shaped from user experience, audit and research.
Risk and assurance	Ensuring effective systems, procedures and staff are in place to deliver good standards of care.
Legal implications/ regulatory requirements	Care Quality Commission
Presenting Director	Paul Miller Divisional Director Adult Mental Health and Learning Disability
Author(s)	Paul Miller Divisional Director Adult Mental Health and Learning Disability
*Disclaimer: This report is submitted to the Trust Board for amendment or approval as appropriate. It should not be regarded or published as Trust Policy until it is formally agreed at the Board meeting, which the press and public are entitled to attend.	

Improving Adult Mental Health Acute In-Patient Care

Introduction

1. This report sets out current and planned work to improve acute in-patient care. It covers a range of operational and developmental aspects of in-patient care including care pathways; standards of care; workforce development; leadership; ward environment and the Division's recovery strategy.

2. The report provides assurance, in addition to that provided through routine performance management and clinical governance processes, about the Division's actions to address unsatisfactory standards of care identified in trends in very serious incidents and two recent Coroner's verdicts. It is, however, important to note that an extensive programme of work is already in place to improve all the Division's services embodied in: the Service Development Initiative (SDI); the delivery of Service Development Improvement Plans (SDIPs), the implementation of CQUINs and the achievement of quality schedule targets as part of the Trust's contract; action to achieve key performance indicators; cost improvement plans; implementation of care pathways and implementation of SI action plans.

Bed Occupancy

3. Table 1 shows the occupancy of each acute in-patient ward from March – July 2012, with occupancy in excess of 100% highlighted in bold.

Ward	Mar	April	May	June	July	Average Mar-July
Ashby	98%	96%	98%	99%	99%	98%
Aston	92%	91%	97%	98%	97%	95%
Beaumont	94%	96%	96%	97%	98%	96%
Belvoir (PICU)	99%	99%	99%	100%	96%	99%
Bosworth	98%	**100%**	**101%**	**102%**	**103%**	**101%**
Heather (F)	82%	93%	96%	98%	99%	94%
Kirby	92%	98%	98%	98%	98%	97%
Thornton	98%	97%	98%	98%	100%	98%

Table 1: Average Occupancy per Acute In-patient Ward March – July 2012

The bed occupancy required by the PCTs is an average of 85% (note that the target in the Trust's community hospital wards is 93%), a figure once proposed by the Royal College of Psychiatrists as a desirable level. Prolonged operation at near maximum capacity creates pressure on staff and the system overall, leaving little or no capacity for emergencies.

Table 2 shows the total number of admissions, discharges and the average length of stay for the same period.

	March	April	May	June	July	Total
Admissions	116	105	128	111	113	573
Discharges	112	93	135	141	138	619
ALOS	34.2	37.4	36.6	45	45.5	198.7

Table 2: Acute Inpatient Ward Admissions, Discharges & ALOS March-July 2012

The data shows admissions steadily increased until May and returned to usual levels in June and July. However despite increased discharges, an increase in length of stay has created pressure on occupancy. Referrals to the crisis resolution team peaked in May (155) and June (142) and dropped to 117 in July, the same level as April 2012. April to July home treatments are below the cumulative target (262 against a target of 288) but the proportion of referrals to crisis resolution receiving home treatments has gone up.

The interrelationship between performances against the targets is being analysed and discussed with clinical colleagues. Consultants maintain there are very few inappropriate admissions but consider there are in the region of 15-20 patients whose successful discharge depends on suitable accommodation. This is being highlighted further through the newly introduced daily reviews and liaison with the local authorities. Consideration is also being given to appointing a discharge co-ordinator for a trial period.

Financial Position

For the period ending 31st July (M4), the draft overall position for Adult Mental Health Services was reported as an overspend of £587,179. This consisted of an overspend on pay of £478,400 (3.4%), an underspend on non pay of £178,565 (7.2%) and an under-recovery of income of £287,344 (1.3%).

Total income for the AMH division in 2012/13 is £66.4m and the main contracts are listed below:

Leicester City PCT	25.6 m
Leicestershire County and Rutland PCT	26.0m
Specialised Commissioning	3.0m
IAPT (City)	1.6m
IAPT (County)	1.8m
ECR Income	1.8m

The values of the PCT contracts (other than IAPT) are based on historical spends which are amended each year by applying growth monies and nationally determined efficiency targets. Other than IAPT services which were a national initiative from 2008, there has not been any large scale investment in adult mental health services since the early 2000s when specialist services

(Assertive Outreach, Early Intervention and Crisis Resolution) began to be introduced following the National Service Framework published in 1999.

As the Board is aware, the Trust is paid under a block contract and apportions income to each service area. However, internal tariffs for in-patient care have been established and these vary from just over £200 per bed day to £645 per bed day:

Alcohol Service (detox)	£235
Assertive Outreach	£212
Drug service	£400
General Psychiatry	£232
Psychiatric Intensive Care	£645

Two recent reports by Mental Health Strategies, the first on a Mental Health Benchmarking pilot published in May 2012 and the second a similar national report published in July 2012 showed that spending on working age adult mental health services per head of population in LLR is low when compared regionally and nationally to other PCTs (see table 3 below). The first report also showed that of the money spent in LLR expenditure on community mental health teams, in relation to inpatient services, was substantially lower than comparative areas.

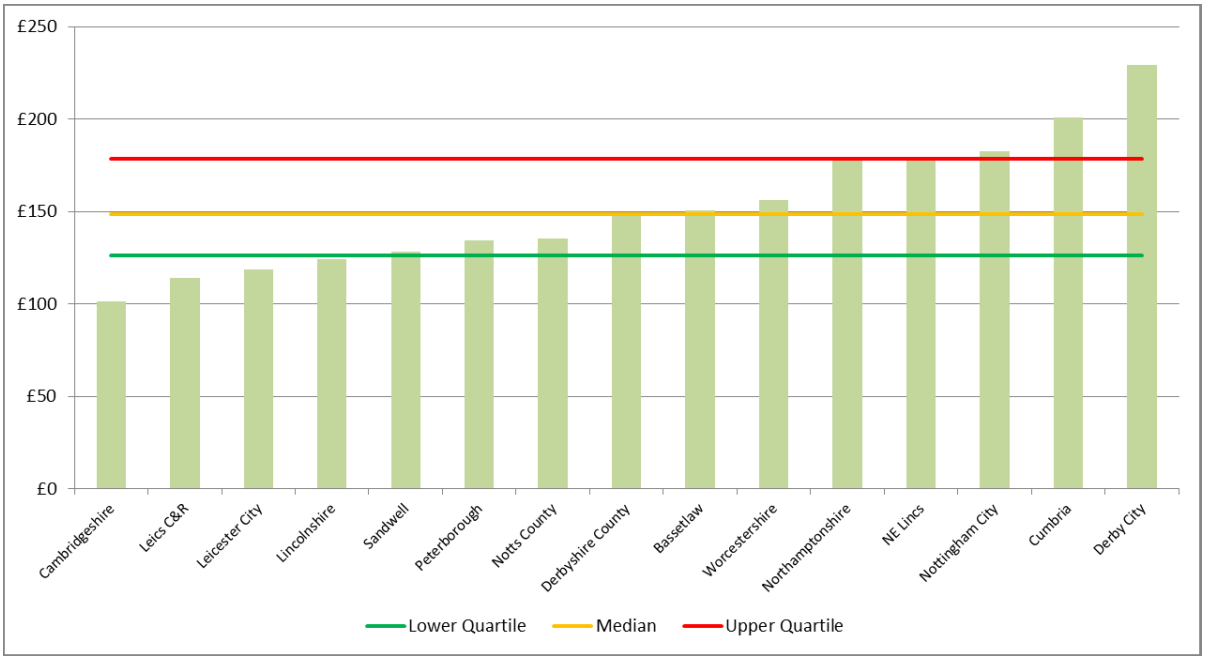

Table 3: Total spend on working age adult mental health services per head of weighted population (aged 18-64) 2010/11

Acute Care Pathway

4. The Division's overall programme of work to improve in patient care started in November 2011 when the new management team was largely in place. In November 2011, the Trust Board considered a paper entitled "Proposed Acute Care Pathway for Adult Mental Health Services and Associated Service Changes." In essence this paper brought together a range of existing initiatives and proposed service changes to improve in-patient care.

5. The Division engaged stakeholders, service users and staff about the proposals through a subsequent discussion document during December 2011 and January 2012. On the basis of responses received and CCG input, the Division is implementing a number of major service changes which feature in CIPs, SDIPs and most importantly the Division's Service Development Initiative as part of the Trust's Integrated Business Plan. The headline changes are:

    - Single point of access – from September 2012
    - Re-designed crisis resolution and home treatment service (CRHT) – from September 2012
    - Co-location of CRHT at the Bradgate Unit – completed by November 2012
    - New acute care pathway – from January 2013
    - Recovery college – from January 2013

6. This package of service changes are fully supported by the CCGs and attracted approximately £1m of transformational monies. These SDI changes are being executed and monitored within the Division but are also subject to programme management in the Trust overall and by commissioners.

Care Pathways

7. The introduction of Payment by Results (PbR) into mental health services primarily affects adult mental health services. Developing and introducing 17 new care pathways constitutes a major change to clinical and operational practice which is demanding of staff time and capacity. The new pathways, developed within the Division, are based on best practice and clarify the Division's service offer i.e. what patients can expect and timescales for delivering care.

8. Implementing PbR is a Trust-wide programme managed by a Programme Board with a supporting Project Team, Project Manager and associated action plans and monitoring arrangements.

Standards of Care

9. Standards of care are determined by many factors such as, staffing levels, staff competency and attitude, leadership, risk management, environment, care planning, service standards etc. The list is almost endless, but in essence the real standards of care are fundamentally what staff actually do or

don't do and how they do it at the very time they deliver care. All the determining factors of standards of care come together at that moment when a member of staff alone, through their judgement and actions, is the final determinant of the standard of care.

10. Standards of care in the Division's in-patient facilities have been highlighted recently through a small but significant number of very serious incidents involving patient deaths and the narrative verdicts of the Coroner in respect of two suicides. The key questions are whether any deaths were preventable, and if so, whether they were preventable at the point(s) care was delivered? Depending on the answer to both questions, investigations consider whether the staff delivering care discharged their personal and professional responsibilities properly, as well as the impact of any wider determinants of standards of care. The expectation of the senior management team is that staff are held to account through routine line management and when investigation evidence justifies, through the Trust's performance and conduct procedure.

11. Recent action and work already underway in the Division to improve standards of care is considerable. The wider determinants of standards of care have been considered afresh in response to the Coroner's verdicts and trends in serious incidents. This was initiated by the Director of Nursing and has led to a number of immediate actions by the Division's access management team:

    - A review of care plans and observation charts
    - Every ward handover from 21st – 28th June included a reminder to staff about personal accountability
    - Ward paperwork review

12. Further specific work is underway in respect of:

    Handover - A standard operating procedure for the wards at the Bradgate Unit is under development, and it will provide consistent standards for handover, identification of the nurse in charge and a head count of all patients on the ward at shift changeover. The handover records kept at ward level will also be standardised so that adherence to these standards can be monitored.

    Observation - A revised observation policy has been ratified by the Trust Policy Group, and the new policy addresses lessons learned from recent serious incidents. Lead Nurses will be training all matrons on the new policy in September 2012, and matrons will then be asked to cascade this training to all ward staff in October.

    Professional Practice – Funding has been obtained to deliver a professional practice workshop to all Bradgate Unit staff in the next few weeks (start date to be agreed). The full day workshops will cover professional issues such as accountability and delegation, fitness to practise, raising concerns and boundaries.

Unit Coordination – New guidelines for unit coordination have been developed and implemented by the Clinical Services Manager. However, they will be reviewed in line with the service changes mentioned in paragraph 4 above and as part of the staffing review (see paragraph14).

13. The new acute care pathway includes standards at every stage – admission, assessment, treatment and discharge – covering elements of care such as the timeliness of process, legal basis for admission, assessment, risk assessment, care planning, named nurse, kindness and optimistic approach to recovery, patient rights and information. When implemented the pathway will be a means of assuring standards are maintained.

14. Managing risk is a major part of the Division's activity particularly in the case of vulnerable people who abscond or do not return from leave on time. The Division, supported by good liaison at board level, has improved working relationships with the Leicestershire Police Service in the last nine months. Improved mutual understanding of our respective roles, responsibilities and functions is at the heart of the improvement but to capitalize on this progress the Division has organised a joint seminar between acute ward staff and senior police officers on 11th September 2012. It is anticipated that the seminar will generate actions to improve our joint management and response to 'missing' patients.

Workforce

15. The acute wards have been operating at 5:5:3 for some time in accordance with the 2011 rule 43 action plan. Ward staffing is subject to annual review in August 2012, led by the Head of Access. The review will assess the impact of the 5:5:3 rota and review the ward and deputy matron roles with the overall aim of determining the right frontline staffing establishment (nursing, medical and trained but not qualified staff) and effective ward management and nurse leadership. The review will be completed by October 2012 and any proposed changes included in a planned CIP management of change process due to start that month.

16. The e-rostering system implemented over the last few months uses in-built rules to optimise shift allocation and reduce inefficiency. When used properly the system will help ensure a smooth availability of staffing resources across the rota period and minimise the use of bank staff. The Division's senior management team discussed progress in using e-rostering at its meeting on 8th August and resolved to review operational fidelity to the system as it is not yet being used to maximum efficiency. The Head of HR is compiling a report to help identify robust steps to fully implement e-rostering in the Division by October 2012.

17. The Division is monitored against several workforce KPIs via the monthly performance review meetings and it is acknowledged further progress is required to achieve these targets. Analysis of each acute ward's performance in respect of mandatory training, appraisals, sickness and employee relations compared to the Division overall and acute wards overall is now available.

This shows a much improved position regarding mandatory training across the board but some distinct variation between wards in targets for training specific to role, sickness and appraisal. Each ward has plans to release staff to complete their training updates though this is more difficult during the summer holiday period. The demands on staff time for mandatory and other training (e.g. PbR/clustering) are significant and the staffing review will clarify the training time which must be built into the rota to ensure the training targets are met.

Clinical Leadership

18. The ward matrons (band 7s) were appointed two years ago to provide greater nurse leadership and ward management and they have since received management development. Until 13th August they reported to the Service Manager for Acute Care (band 8b) but the Division has just strengthened nurse leadership and management by introducing the post of Inpatient Lead (band 8a) specifically to focus on improving standards on the wards. The post is also a general nursing role to strengthen knowledge and leadership regarding the physical health needs of patients. This post was developed in consultation with the ward matrons as part of a CIP service re-design.

19. As mentioned in paragraph 14, the staffing review will consider the ward and deputy ward matron roles, not necessarily to move away from that model but to examine the job content of those roles so their capacity to manage, lead and maintain standards of care is maximised. From September, bed management will be undertaken by the new SPA which will have a positive impact on ward management capacity.

20. Consultants and doctors are a major source of clinical leadership and each ward has named consultants. The new daily ward reviews introduced in July 2012 (a CQUIN) not only speed up discharge but are also designed to ensure daily routine medical input into the care of patients and enhance clinical leadership of the staff team. However, there may be further steps available to make sure all wards have consistent medical leadership through every ward having dedicated medical staffing responsible for patients on that ward only. At present the locality ward model means some consultants often have patients (outliers) on several wards waiting for a bed on their locality ward, which increases intra-ward patient moves and works against a consistent dedicated medical presence on some wards. Co-ordinating those moves and preparing for multiple consultant input impacts on ward matron and deputy ward matron capacity and moves are not welcomed by patients.

21. The discussion document on the acute care pathway sought views on ward configuration but feedback was inconclusive. The Division has undertaken to make fresh proposals on ward configuration and these will be drawn up as part of the staff review, take account of clinical leadership issues and feature in the next management of change process planned for October.

Ward Environment

22. The centre of excellence project (CoE) is a major investment by the Trust to radically improve ward environments and not just in adult mental health. By March 2013, the CoE project will have delivered on the Bradgate site, a re-furbished ward; two new wards; a bespoke eating disorders facility and a re-furbished ward for older people. This work is to current DoH standards providing single ensuite rooms and a modern, fit for purpose environment. However, two recent serious incidents have occurred on the newest ward and not the challenging older ward environments, some of which are on the Division's risk register because they are hard to manage.

23. In the light of recent experience the Division, in consultation with the Trust health and safety lead, has resolved to review and improve access/egress systems on every ward; to examine possible greater use of CCTV to monitor blind spots; and to improve recreational areas. This work will be led by the Division's security lead and in consultation with the health and safety lead and EFM colleagues. In addition the CoE board and project team will seek assurance that current construction is at all times in accordance with DoH specifications.

Recovery Strategy

24. The Division has a draft recovery strategy, which will be considered by the senior management team on 22nd August. The strategy is designed to embed the recovery approach in delivering care and in particular establish a recovery college operating at the Bradgate site and other suitable locations in the community. Several Trusts now have colleges which offer a range of courses and resources for service users, families, friends, carers and staff. The colleges aim to support people to become experts in their own self-care and for families, friends, carers and staff to better understand mental health conditions and support people in their recovery journey. Research shows that such facilities and opportunities are a major contribution to the standard of care offered.

25. The college will enhance significantly the activities, learning and development opportunities currently available to in-patients and be provided in partnership with local voluntary organisations and further education providers. A project manager has been appointed who will take up their duties by November with a deadline to start the college in January 2013.

Conclusion

26. The overall programme of change to improve acute in-patient care in the Division is vast whilst also managing high demand for beds and the financial challenges to achieve CIP targets. All the actions and work described above feature in various action plans and are subject to various monitoring and scrutiny within the access management team, the Division, the Trust, by commissioners and not least through personal objectives and routine line management. Significant progress is being made to implement change and it is pleasing to note that the net promoter feedback about the Division's acute care is overwhelmingly positive. This report is intended to provide assurance

that Divisional actions to improve acute care are on-going and that the implications of the trends in very serious incidents and the recent Coroner's court verdicts have been immediately factored into the Division's work programme.

Paul Miller
Divisional Director
Adult Mental Health and Learning Disability

24th August 2012

APPENDIX V2

CORPORATE LEVEL ACTION PLAN-PATIENT SAFETY ASSURANCE					
RELATED STRATEGIC OBJECTIVES **We will continuously improve quality, with services shaped from user experience, audit and research.** **We will build our reputation as a successful, inclusive organisation, working in partnership to improve health and wellbeing**					
AREA	**Key actions**	**Timescale**	**Exec Lead**	**Expected Outcome**	**Assurance**
Independent review	External review to of inpatient suicides to be undertaken by Professor Louis Appleby This will involve an assessment of suicide risk assessment policies and procedures, alongside a review of all suicides since 2010 supported by a Board development session and the report will be completed for October 2012.	October 31st 2012	Medical Director & Chief Nurse	Report identifies key learning points for implementation	Trust Board
Independent perspective on SI process	Independent author commissioned to write the SI investigation report into two incidents.	September 30th 2012	Director of Quality & Innovation /Chief Nurse	SI reports completed - external perspective to identify any key changes	Quality Assurance Committee
Serious Incident management Process	Review SI management processes and framework for investigations	November 30th 2012	Medical Director & Chief Nurse	SI process changes informed by independent review and author findings	Quality Assurance Committee
Clinical Risk Round table discussion	Additional round table clinical exercise with external leaders arranged to work through the issues so far, explore best practice and discuss lessons learnt.	August 21st 2012	Medical Director & Chief Nurse	Key learning points shared and fed into Intensive Support Programme	Trust Board

Clinical Records	Electronic record plan implementation to agreed timescales. Provider contract to be awarded in September 2012 with implementation of the preferred system to start in October 1st 2012	Commenced in 2011,	Managing Director Finance & Performance Information	EPR programme implemented	Finance & Performance Committee
Clinical leadership	Commission 6 months Intensive Support Programme(ISP) for AMH wards	Commence September 1st 2012	Medical Director & Chief Nurse	Support plan instigated	Quality Assurance Committee
	Organisational commitment to ensuring the maintenance of professional standards through academy support and resources following needs identification through ISP.	Commence October 1st 2012	Director Of HR & OD	Training plan instigated	Workforce & Organisational Development Committee
	In line with the Trust's HR Strategy, review compliance of HR processes in relation to performance and conduct and ensure they meet organisational needs. Following review, develop revised approaches to performance management and recruitment	September 30th 2012	Director Of HR & OD	Revised framework for recruitment and performance review implemented (and demonstrates change)	Workforce & Organisational Development Committee
Communication and Reputation	In your shoes – Patient experience programme delivery across AMH services.	Commence October 1st 2012	Director of Quality & Innovation /Chief Nurse	User involvement established and informs change	Quality Assurance Committee
	Proactive relationship management and communication with media, stakeholders, and commissioners.	Immediate	Communications Lead	Established practice	Executive Team
	Awareness raising on mental health and suicide (anti stigma campaign)	September 15th 2012	Communication Lead	Implementation plan and campaign delivered	Executive Team

Appendix B

CQC Warning Notices: IMMEDIATE ACTIONS v.10 August 30/8/13

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

ACTIONS REQUIRED			
[note - Other linked inspections : *CQC additional July visit: Assessment and Admission* *MHA visit (19th July) – Report expected within 6 weeks ie during response period for CQC reports and warning notices*]			
1. Managing the process with the CQC **Director with lead responsibility :** **Adrian Childs – Chief Nurse**	**Who**	**By When**	**Progress/Assurance**
Assess CQC warning letters and actions required (Immediate 30 days)	Chief Nurse	Completed 31/7/13	Escalation response – 48 hour meetings in place three times per week from with a COBRA style approach
'Clarity ' Response to be sent at 10 day period	Chief Nurse	Complete 12/8/13	CQC deadline 16/8/13 Response has been sent to Warning Notices and Factual Report Action plan for the compliance notices underway
Share response with the CCGs electronically before 15/8/13	Chief Nurse	Complete 14/8/13	

Trust Board and CQC Report / Response	Acting Chief Executive	29/8/13	Response to be prepared and shared with Board at 29/8/13 meeting / development session. Paper presented to Trust Board in public session 29/08/13 including immediate action plan, warning notices and full CQC report.
Assess CQC full and final report and those actions required in the medium term to address all findings*	Chief Operating Officer	Outline medium term plan (draft)	SMT discussion took place 19/8/13 Outline plan being refined. For Trust Board discussion on 29/8/13
Chair and Acting Chief Executive to meet CQC Compliance Manager and Regional Director	Chair and Acting Chief Executive	Complete	Meeting held 14/8/13
Arrange a visit to Coventry to look at their CQC relationship and approach to care plans / records	Chief Nurse	Complete	Visit undertaken 14/8/13

2. Patient Safety – Care Planning and Discharge arrangements Director with lead responsibility: Adrian Childs – Chief Nurse	Who	By When	Progress/Assurance
2wtes Programme managers to be in place on a full time basis throughout August to review all care plans across Bradgate to: • Triage wards and start with those in need of most help (Thornton, Heather, and Beaumont) • Achieve consistent content and presentation of care plans • Ensure actions are taken on individual care plan basis. • Include discharge planning matters associated with care plans • Ensure all aspects of discharge planning are clearly recorded including • Estimated date of discharge and documented patient/carer/relative involvement in discharge planning • Assurance that tasks in support of discharge are completed on time s to support smooth discharge arrangements • Include physical care planning needs • Include recommendations regarding MHA aspects • Confirmation of a trajectory, with weekly reporting against it • Ensure learning is transferred across all wards on ' what good looks like for sustainability of position	2x wte reporting to chief nurse, plus administrative support , plus other senior nursing support from Enabling services	30/8/13	Materials have been created to undertake a comprehensive review /audit by the review team (covering assessment of need/care planning/ discharge planning/ patient involvement). All inpatient records have been audited. Feedback has been provided to each Ward Matron and the responsible Named Nurse. Within 2 weeks, assess one ward in full per day and feed back to matrons and named nurses the actions needed to address quality of care planning / discharge planning. New documentation files ordered and to be introduced during September 2013. Week 3 to be used for re-auditing the position. Re-audit undertaken, data to be made available 30/08/13. Improvements can be seen in most areas. Concern still exists within Thornton Ward and Bosworth Ward and resource has been focused on these two wards. Extra people have been co-opted to assist the original 2wtes programme. Currently on plan for delivering the audit/review outputs.

2. Patient Safety – Care Planning and Discharge arrangements Director with lead responsibility: Adrian Childs – Chief Nurse	Who	By When	Progress/Assurance
			New discharge care plan document has been created and there is a plan to roll this out. Secondments being arranged to create 2 lead clinical quality assurance roles (nursing) for Bradgate Unit. Secondment for 6 months with back fill for their core roles. Expressions of interest requested for both posts, interviews planned 06/09/13.
Feasibility, resources and timescale for roll out to all other inpatient areas to be finalised.(Agnes Unit to be next priority) NOTE – see link to section on ' impact on other areas within the trust ')	Chief Nurse and Chief Operating Officer	Incorporated into the medium term plan	Discussion with all Divisional and Clinical directors to SMT on 5/8/13; weekly update to include progress on other areas across the Trust. Expecting feedback by 16/8/13 from Clinical Governance Groups.
Extraordinary board meeting proposed to receive assurance on progress and delivery of CQC Response / Action Plan	Chair & Board Secretary	Trust Board meeting / development session 29/8	Minutes from Board Meeting / Development Session. Paper presented to the public Board meeting 29/08/13 including immediate action plan, warning notices and full CQC report.

2. Patient Safety – Care Planning and Discharge arrangements Director with lead responsibility: Adrian Childs – Chief Nurse	Who	By When	Progress/Assurance
Records Management – Commence a review of records tracking and records movement across the Trust - to include outlining staff responsibilities, staff communications and an amnesty on misplaced records	Trust Information Governance Lead and Chief Operating Officer	To be continued until the end of August	Implemented 6/8/13 Update given 19/8/13 at SMT
Review the whole CQC report for other clinical matters that should be added to the patient safety, clinical leadership and culture sections of the table.	Chief Nurse & Medical Director	Complete	Edits made to this action plan in prior versions, and items for medium term action plan also captured. Full action plan regarding compliance notices to be sent to CQC on 4/09/13.

3. Staff Support – clinical leadership and culture Directors with lead responsibility: Adrian Childs – Chief Nurse Satheesh Kumar – Clinical Director	Who	By When	Assurance
Exec Team presence/attendance at Bradgate every day	Exec Team	Started 30/7/13	In place (Chief Nurse, Medical Director and COO)
Regular ward leaders meeting, including consultants, with the 2 programme managers and 2 lead consultants (Adrian Vann & Mo Abbas)	Medical Director and Chief Nurse - support from Chief Operating Officer and divisional management team	Green	Now holding 3 meetings per week on site with clinical teams on the wards, with the same COBRA approach
Reiteration of expectations /responsibilities "on a page" for clinical staff with regard to care planning/discharge and clinical safety.	Deputy Chief Nurse Deputy Medical Director	Green	Plan on a page developed and issued
Acting Chief Executive meeting with AMH Consultants at Bradgate Unit	Acting Chief Executive	Green	Acting Chief Executive held constructive meeting with AMH Consultants on 9/8/13. Medical Director to lead on taking forward the key issues raised which focused on what is preventing good quality care from their perspective.
Cultural awareness/assessment programme in AMH (part of Appleby action plan and supported by the CCGs)– includes survey and focus groups , linked to LiA	Divisional Director AMH	Commenced 5/8/13	Initial focus groups held and questionnaire for all AMH staff under development for distribution in September. Progress report to SMT 19/8/13
Prioritisation of some wards from AMH for the LiA pioneer teams to start in early September – nominations to be confirmed by 17/8/13 Identification of other priority teams (Agnes Unit / Oakham House)	CEO and the Chief Nurse	Specific Wards and Crisis Team selected	Sponsor group for LiA Buddying up AMH wards; and include Crisis Team for LiA approach

3. Staff Support – clinical leadership and culture Directors with lead responsibility: Adrian Childs – Chief Nurse Satheesh Kumar – Clinical Director	Who	By When	Assurance
Review links with MHA visit	Medical Director	Complete	Paper to QAC refers

4. Staff Support – stress management and recruitment Director with lead responsibility: Alan Duffell – Director Of Human Resource and OD	Who	By When	Assurance
Additional targeted support from HR including stress management:- • Support to be provided on an individual basis to clinical leads in AMH	Chief Nurse & Medical Director.	In place and on-going	Specific targeted support in place. Provision of feedback on this work to SMT on 19/8/13
Undertake a whistle-blowing thematic review:- • Alan Duffell to review other recent whistleblowing incidents raised internally / externally to check whether or not we have captured all relevant themes. • Register needed with feeds from various routes.	Director of HR & OD	Report completed - further work planned	Report on findings to SMT on 19/8/13 Further analysis and discussion planned on 2/9/13
Improvement to recruitment processes for AMH wards.	Director of HR & OD	Commenced 12/8/13.	Rolling recruitment programme for AMH being implemented – 2 band 2s allocated to support additional recruitment in HR. Further improvements required - also identified within LiA action plan

5. Communications & Reputation Management Director with lead responsibility: Cheryl Davenport – Director of Business Development			
5.1: Patient, Carers & Service Users	**Who**	**By When**	**Progress/Assurance**
Contact patient and carer groups with information and reassurance (NB Awareness that patients and relatives may group together to raise joint concerns).	Chief Nurse	w/c 5/8/13	A meeting has been organised with service users at Network for Change on 13/09/13 in response to group concern.
"Changing your experience for the better" – review recent comprehensive results from service user focus groups within AMH	Chief Nurse	21/8/13	A meeting has been organised for 17/09/13 inviting voluntary and community sector organisations to provide them with information regarding the CQC findings, Trust actions and to hear from them about any concerns they may have. Patient experience team and AMH Divisional Director have undertaken a thematic review of these findings undertaken to support development of the medium term action plan.

Undertake a thematic review of recent external feedback, complaints and enquires from patients and public concerning Bradgate Unit:- • Sam Wood to be asked to review recent complaints and customer service enquires concerning Bradgate, including comments on Twitter and Facebook and NHS Choices messaging about the Trust in the last 2 months.	Chief Nurse	By 19/8/13	Patient Experience Team Progressing – further assurance needed on progress and outputs.
5.2: Media	**Who**	**By When**	**Progress/Assurance**
Leicester Mercury meeting with Editor	Acting CEO and Chair	Meeting booked	Comms rep to attend also.
Identifying immediate spokespeople and additional media training for these people as required.	Director of Business Development and Chief Operating Officer	Complete	A planned media training programme for senior leaders starts 11/09/13 and a list of people to be trained is already available. Clinical Directors and any Execs (who have not yet received training) to attend Individual coaching can be arranged ahead of this for key spokes people who may be needed before this starts.

5.3: External Stakeholders	Who	By When	Progress/Assurance
Forwarding draft CQC report to lead commissioner	Chief Operating Officer	8/8/13	Completed
Meeting with Local Health Watch	Chief Nurse	Meetings booked	Meetings will include LPT Chair Letter also received from LHW to Acting CEO.
Commissioner awareness, involvement and support for the immediate and medium term actions – set up an extraordinary exec team meeting with commissioners	Director of Finance	Complete	Commissioner meeting 15/8/13.
MP Briefings	Acting CEO	Complete	Regular appointments already in place, all MPs being offered a telephone call updating them on the position
TDA relationship management and assurance on grip of situation from the Board. Immediate initial meeting with TDA to brief on CQC and FT.	Acting CEO and Exec team	In place	Constructive meeting held with TDA on 13/8/13 Actions incorporated into Immediate and Medium Term Action Plan where applicable. Further meeting with TDA on 2/9/13.

5.4: Local Authorities, Scrutiny Committees and Health and Wellbeing Boards	Who	By When	Progress/Assurance
Briefing sessions offered to overview and scrutiny committees x3	Director of Business Development	2/8/13	All scrutiny officers contacted: • Leics CC - Medical Director and Chief Operating Officer to attend on 12/9/13 at 4pm • Leicester City Acting CEO and Director of Business Development to attend on 3/9/13 at 5.30pm • Rutland CC Director of Business Development and Chief Nurse to attend on 26/9/13 at 7pm The Chair of the Leics County and Rutland Adult Safeguarding Board is being invited to the Leics CC scrutiny meeting on September 12, we will suggest same approach for City.
Generic Report produced for Scrutiny Committees that can be adapted over time/to address specific council queries.	Director of Business Development	21/8/13	Report completed and submitted for Leicester City deadline for papers (21/8)
Briefing sessions to be offered to safeguarding adults boards locally x 2	Director of Business Development	Complete	Incorporated into scrutiny plans above
Briefing sessions to be offered to the chairs of the 3 local health and wellbeing boards	Director of Business Development	6/8/13	Acting CEO office contacted all 3 chairs to offer individual briefings as needed. Acting CEO briefing meeting held with Ernie White on 21/8/13.

5.6: Other External Stakeholder Management and Bulletins including FT Implications	Who	By When	Progress/Assurance
FT messaging/handling/comms cascade (Handling plan includes FT programme board agreement to internal and external comms plan on 20/8, specific actions to address the impact on QGF external review (Tenon), Ernst and Young HDD, Mock board to board arrangements with Deloitte)	Acting CEO and Director of Business Development	Comms plan agreed and being enacted	FT messages and handling plan ready for mobilisation post 13/8/13 and in line with Trust Board meeting papers publication on 23/8/13 and Trust board meeting on meeting 29/8/13 Letter sent by Acting CEO to TDA post our meeting with them on 13/8/13 to confirm our intention to withdraw from FT Monitor application. Acting CEO phone call with Monitor on 23/8/13. Acting CEO letter to Monitor planned post Board meeting on 29/8/13.
Guidance for FT Applicants to be reviewed to ensure all aspects have been covered	Judy McCarthy	Complete	
Briefing arrangements for lead governor/governor communications	Board secretary	Meeting for Acting CEO, Chairman and Lead Governor booked on 29/8/13	Acting CEO office booking a meeting with staff governors Chairman/Lead Governor considering extraordinary governors meeting. Lead governor receiving all stakeholder briefings and regular updates from the Chairman
Weekly stakeholder update to core comms stakeholder list	Director of Business Development and Head of Comms	31/7/13 (first) 8/8/13 (second) 12/8 & 13/ 8 (third)	To review regularity at 3 and 6 weeks Acting CEO announcement and announcement about the appointment of the new CEO

5.7: Internal Communications	Who	By When	Progress/Assurance
Statement on the receipt of the full CQC report Statement on increasing independence of SI investigations Statement to clarify suicide numbers – for Chair and CEO	Director of Business Development Chief Nurse	7/8/13 6/8/13	Complete – combined and issued via staff briefing and stakeholder briefing on 7/8/13 Issued to CEO and Chair on 6/8/13. Further detail and refinements made to data analysis by Chief Nurse by 20/8
Comms forward planner showing reputational issues and mitigation plans Comms forward events planner and channel of good news stories	Director of Business Development and Head of Comms Director of Business Development and Head of Comms	2/8/13 2/8/13	Complete - shared at SMT on 5/8/13 Updated for ET on 12/8/13 – updated weekly Complete - product coming to ET on 12/8/13 and updated b-weekly
Cascade of CQC report through AMH	Chief Operating Officer and Divisional Director	8/8/13	Cascaded. Medical Director confirmed all appropriate clinical staff have received it personally.
Ongoing staff communication to reinforce board support and report our progress	Acting CEO & Chair through comms	31/7/13 and 8/8/13 12/8 & 13/8	Special editions of team brief on CQC Report. Acting CEO announcement & CEO appointment announcement
Organisational sign up to the Speak Out Safely campaign Communicate the purpose of this campaign to staff/stakeholders	Acting CEO Comms team	1/8/13 2/8/13	Complete Complete - via Staff Enewsletter and stakeholder briefings

Issue CQC report to other Divisional Directors and discussion/action on: • thematic review of CQC report by other divisions • additional divisional comms/leadership on patient safety and record keeping • identification of other areas of CQC risk (Oakham House/Agnes Unit) where record keeping/case note improvements and other interventions are needed	Director of Business Development/Chief Operating Officer	Thematic review and risk assessment completed	Discussed with Divisional Directors who are progressing actions accordingly. COO follow up via fortnightly Ops team and monthly EPRs Initial Thematic review complete and reported to SMT on 19/8/13

5.7: Internal Communications	**Who**	**By When**	**Progress/Assurance**
Comms leadership and additional resource to manage the escalation period.	Director of Business Development	Complete	Additional comms resource sourced and in place
CEO appointment messaging/handling	Chair and Director of Business Development	Complete	Staff E-newsletter carrying holding statement on 8/8, announcement made on 12/8 & 13/8
Weekly briefing for Board to be shared with Matrons across all divisions	Chief Nurse	In place.	

5.9: Other Communications actions including AGM Handling Plan	Who	By When	Assurance
Small suite of initial public facing products on the Trust, patient safety and other activities/profile.	Medical Director, Chief Operating Officer and head of comms	By end of August	Initial topics agreed w/c 12/8/13. Initial products by 30/8/13, then rolling programme.
Handling plan for AGM on 7/09/13 (includes further publicity on AGM)	Board Secretary, Acting CEO and Chair	Handling plan complete	Handling plan developed. On ET agenda for 12/8/13 for discussion. Meeting to finalise arrangements 15/8/13. Adjustments made to tone and programme in light of recent events. Handling plan to be reviewed again 48 hours ahead of the event.
Development of strategy for handling potential media coverage surrounding AGM and publicity related to CQC Report:- • Engagement of crisis media support • Development of FAQs	Director of Business Development	Complete	Comms plan for CQC report publication finalised 22/8/13 including AGM aspects – additional comms resources and comms products in place.
Co-ordination ref publication of CQC Report and associated comms including handling for Trust Board and Risk Summit on 29/8/13.	Chief Nurse and Director of Business Development	Co-ordination in place with the CQC Comms plan enacted	LPT Comms plan developed and enacted 27-– 30 August in relation to the publication of the CQC report Comms handling plan developed and enacted for the Trust Board meeting. Coverage by BBC East Mids Today, Leicester Mercury and BBC Radio Leicester. Co-ordination of comms following the Risk Summit being led by Area Team. LPT fully engaged in this process and will issue a further staff and stakeholder briefing w/c 2/9/13.

6. Impact of CQC Report findings for other divisions Director with lead responsibility: Paul Miller – Chief Operating Officer	Who	By When	Assurance
Thematic reviews being undertaken by LD, CHS and FYPS:- • Review of current records audit results and follow up review of case notes in other MH inpatient areas • Assessment of potential risks at Oakham House and Agnes Unit, and Evington Centre	Chief Operating Officers and Divisional Directors	Updates being provided from 12/8/13	Standing agenda item at fortnightly ops team meetings and monthly EPRs Divisional progress reports to SMT 19/8/13, 2/9/13 and ongoing Improvement plan to SMT 19/8/13
Carry out a thematic review of incidents reported from across LPT (over the previous 6 weeks) including in hours and on-call / out of hours	Chief Nurse	This is being incorporated into the medium term plan	A thematic review of incidents will be presented at QAC under matters arising from the high July incidents noted under IQPR narrative
7. Operational and Environmental Matters **Director with lead responsibility:** **Paul Miller – Chief Operating Officer**	**Who**	**By When**	**Assurance**
Improve environment of Bradgate Unit as identified by CQC report. – seclusion rooms, interview facilities, patient telephones	Chief Operating Officer	By 28/8/13 On track	COO inspected relevant wards 9.8.13. Improvement plan to improve seclusion rooms, interview facilities and patient telephones using Watermead Ward as standard by 2/9/13. Progress report on costing and programme 12/8/13 . Any seclusion room not seen as fit for purpose not used until further notice.
Improvement to the entrance area to create a more welcoming environment. COO to gain assurance from Interserve that they will deal with this as a priority.	Chief Operating Officer	By 28/8/13 On track	List of actions to improve environment agreed with Interserve

APPENDIX C

Summary of NHS England Risk Summit for Leicestershire Partnership NHS Trust

Background

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

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

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

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

Action

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

Outcomes

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

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

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HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 12 SEPTEMBER 2013

REPORT OF THE CARE QUALITY COMMISSION

BRADGATE MENTAL HEALTH UNIT

Purpose of the report

1. The purpose of this report is to outline the inspections of the Bradgate Mental Health Unit undertaken by the Care Quality Commission on 4 and 17 July 2013, its subsequent findings and actions taken at the time and since the report has been published to drive compliance and improved outcomes for patients using this service.

Background

2. The Bradgate Mental Health Unit was registered as a location under the provider Leicestershire Partnership NHS Trust (the Trust) in April 2010. It was inspected in Spring 2011 and was found to be non-compliant across a number of outcome areas. This was mirrored at the Evington Centre, another location under this registration. Due to the number and apparent systemic nature of the non-compliance, staff at CQC debated the issuing of a warning notice. However as a result of discussions it was decided to issue a number of compliance actions. On discussion with the Trust it became clear that they would be compliant in the Autumn of 2011. On re-inspection this was found to be the case. The Trust continued to be monitored by local compliance and mental health act teams.

3. In October 2012 the team found non-compliance with supporting staff, clinical governance and record keeping. Compliance actions were set. The CQC went back in to the Trust in February to monitor compliance with these compliance actions. Whilst the Trust had not embedded actions taken following the inspection in October they had taken action and staff and patients reported positive impacts of these actions taken. The governance system was reviewed and found to have been strengthened by recent developments. The CQC inspectors remained concerned about the sustainability of the actions taken by the Trust; hence an inspection for July was scheduled.

4. At the end of November the Trust held a teleconference with CQC in respect of the recently acquired Appleby Report. At this teleconference the Trust outlined its action plans and actions it had already taken in light of early feedback from Sir Louis Appleby. CQC met with the Trust in January to monitor progress with the action plan, which was well underway. In May 2013 the Trust held round table discussions to ensure that all stakeholders were aware of actions taken and review the current state of the Trust. This was seen as positive.

Recent inspection

5. The inspection team undertook an inspection on 4 July 2013. The team reviewed care plans and discharge arrangements which had been a concern previously at the Trust. The identified safeguarding, supporting workers and governance

processes as potential areas of non-compliance given the current information held by the CQC. Inspectors found significant concerns in respect of staff understanding and managing risks. This had been a feature of the Appleby report. A large team visited the unit on 17 July in order that inspectors could visit each ward and review five sets of records to ensure that judgements made were proportional and representative.

6. At this visit the team spoke with patients whose records we had reviewed and with staff on the wards. It was clear that almost all records had the same three care plans in place but other risks were not always identified by staff and reduced through appropriate care planning. This meant that patients who have physical disorders did not have physical health needs risk assessed and care planned for. This included a diabetic, a disability and dependency on drugs or alcohol. It also meant that two people who could not speak English did not have alternate ways of communicating with staff at all times. When staff were challenged about these breaches in compliance, staff failed to see the relevance of these issues. As a result of this non-compliance two warning notices were served in respect of breaches in Regulation 9 (care and Welfare) and Regulation 24 (co-operation with others)

7. Current situation.

8. We met with other key stakeholders at the Quality Surveillance Group on 19 August 2013. We discussed the concerns of the CQC and others. We discussed the impact of having a new management team, including Chief Executive, Director of Nursing, Medical Director and Operating Officer. At this meeting it was agreed that key stakeholders would work together to continue to monitor and ensure that safety of people using the unit.

9. On 29 August the Trust held an extraordinary board meeting which discussed two items: the CQC report and the withdrawal of the Trust from the Foundation Trust process. This was attended by CQC and other stakeholders as well as the general public. In the afternoon stakeholders and the Trust gathered for a risk summit. The outcome of this meeting was that the commissioners and the Trust would review the impact of increasing capacity at the Trust on the community services. Late on 30 August the CCG issued a statement that they were confident in the level of staff available at the unit. A further meeting was due to take place on 2 September in order to review the way in which stakeholders will support the trust.

10. CQC monitored compliance with the warning notices and will update the Committee with its findings. However where the CQC serves warning notices providers are required to be complaint by the date set by CQC. If compliance is not achieved there are a number of other courses CQC can take to enforce compliance. It can issue a simple caution or fixed penalty notice and fine the Trust, impose a condition on their registration or cancel their registration. CQC always has an opportunity to undertake a special investigation approved by the Secretary of State.

Officer to contact

Rosemary Palmer
Senior Committee Officer
Tel 0116 305 6098
Email rosemary.palmer@leics.gov.uk

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