

## **SCRUTINY BOARD (HEALTH AND WELL-BEING AND ADULT SOCIAL CARE)**

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Meeting to be held in on  
Wednesday, 16th May, 2012 at 10.00 am

*(A pre-meeting will take place for ALL Members of the Board at 9.30 a.m.)*

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### **MEMBERSHIP**

#### **Councillors**

R Charlwood - Moortown;  
C Fox - Adel and Wharfedale;  
S Armitage - Cross Gates and Whinmoor;  
K Bruce - Rothwell;  
J Chapman - Weetwood;  
A Hussain - Gipton and Harehills;  
J Illingworth - Kirkstall;  
L Mulherin (Chair) - Ardsley and Robin Hood;  
S Varley - Morley South;

Vacancy  
Vacancy

#### **Co-optees**

Joy Fisher Alliance of Service Users  
Sally Morgan Equality Issues  
Betty Smithson Leeds LINK  
Paul Truswell Leeds LINK

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*Please note: Certain or all items on this agenda may be recorded*

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# A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
1			<p><b>APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS</b></p> <p>To consider any appeals in accordance with Procedure Rule 25* of the Access to Information Procedure Rules (in the event of an Appeal the press and public will be excluded).</p> <p>(* In accordance with Procedure Rule 25, notice of an appeal must be received in writing by the Head of Governance Services at least 24 hours before the meeting).</p>	
2			<p><b>EXEMPT INFORMATION - POSSIBLE EXCLUSION OF THE PRESS AND THE PUBLIC</b></p> <p>1 To highlight reports or appendices which officers have identified as containing exempt information, and where officers consider that the public interest in maintaining the exemption outweighs the public interest in disclosing the information, for the reasons outlined in the report.</p> <p>2 To consider whether or not to accept the officers recommendation in respect of the above information.</p> <p>3 If so, to formally pass the following resolution:-</p> <p><b>RESOLVED –</b> That the press and public be excluded from the meeting during consideration of the following parts of the agenda designated as containing exempt information on the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the press and public were present there would be disclosure to them of exempt information, as follows:-  <b>No exempt items on this agenda.</b></p>	

3		<p><b>LATE ITEMS</b></p> <p>To identify items which have been admitted to the agenda by the Chair for consideration.</p> <p>(The special circumstances shall be specified in the minutes.)</p>	
4		<p><b>DECLARATIONS OF INTEREST</b></p> <p>To declare any personal / prejudicial interests for the purpose of Section 81 (3) of the Local Government Act 2000 and paragraphs 8 to 12 of the Members Code of Conduct.</p>	
5		<p><b>APOLOGIES FOR ABSENCE AND NOTIFICATION OF SUBSTITUTES</b></p> <p>To receive any apologies for absence and notification of substitutes.</p>	
6		<p><b>MINUTES</b></p> <p>To approve the minutes of the Scrutiny Board (Health and Wellbeing and Adult Social Care) meeting held on 18<sup>th</sup> April 2012</p> <p>(minutes attached)</p>	1 - 12
7		<p><b>REVIEW OF CHILDREN'S NEUROSURGERY - A PROPOSED FRAMEWORK FOR SERVICES AND STANDARDS SPECIFICATION IN ENGLAND</b></p> <p>To consider a report of the Head of Scrutiny and Member Development setting out the draft documentation which has been published in relation to a proposed framework and specification standards for Children's Neuroscience Networks</p> <p>(report attached)</p>	13 - 110

8		<p><b>LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST - CARE QUALITY COMMISSION COMPLIANCE UPDATE</b></p> <p>To consider a report of the Head of Scrutiny and Member Development on recent Care Quality Commission inspection reports relating to the Leeds and York Partnership NHS Foundation Trust</p> <p>(report attached)</p>	111 - 184
9		<p><b>QUALITY ACCOUNTS FOR 2012</b></p> <p>To consider a report of the Head of Scrutiny and Member Development updating the Board on the production of local healthcare providers' Quality Accounts for 2012</p> <p>(report attached)</p>	185 - 244
10		<p><b>REDUCING SMOKING IN LEEDS - DRAFT SCRUTINY BOARD REPORT</b></p> <p>To consider a report of the Head of Scrutiny and Member Development setting out the draft Inquiry report following the Board's inquiry into reducing smoking in the city</p> <p>(report attached) – draft Inquiry report to follow</p>	245 - 246
11		<p><b>TRANSFORMATION OF HEALTH AND SOCIAL CARE SERVICES IN LEEDS - DRAFT SCRUTINY BOARD REPORT</b></p> <p>To consider a report of the Head of Scrutiny and Member Development on the draft report following the Board's consideration of the transformation of Health and Social Care Services in Leeds</p> <p>(report attached) – draft report to follow</p>	247 - 248

**REDUCING HEALTH INEQUALITIES IN LEEDS -  
DRAFT SCRUTINY BOARD REPORT**249 -  
250

To consider a report of the Head of Scrutiny and Member Development setting out the draft report following the Board's consideration of issues relating to reducing health inequalities in Leeds

(report attached) – draft report to follow

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## SCRUTINY BOARD (HEALTH AND WELL-BEING AND ADULT SOCIAL CARE)

**WEDNESDAY, 18TH APRIL, 2012**

**PRESENT:** Councillor L Mulherin in the Chair

Councillors S Armitage, K Bruce,  
J Chapman, A Hussain, W Hyde,  
J Illingworth, G Kirkland and S Varley

### **CO-OPTED MEMBERS**

Joy Fisher – Alliance of Service Users

Sally Morgan – Equality Issues

### **87 Late Items**

Although there were no formal late items, the Board was in receipt of the following supplementary information, for consideration at the meeting:

- Leeds Health and Social Care Transformation Programme: Replacement Appendix 1 (Minute 92 refers);
- A Review of Compliance report by the Care Quality Commission (CQC) following an inspection at the LGI on 29<sup>th</sup> February and 1<sup>st</sup> March 2012. The report was tabled to the Board at the pre-meeting as it was being published by the CQC on the day of the meeting (Minute 96 refers);
- A briefing note prepared for the Board by The Leeds Teaching Hospitals NHS Trust relating to nursing staff levels in relation to issues raised by the CQC's inspection (Minute 96 refers);

### **88 Declarations of Interest**

The following Members declared personal/prejudicial interests for the purposes of Section 81(3) of the Local Government Act 2000 and paragraphs 8 to 12 of the Members Code of Conduct:

Councillor Mulherin declared a general personal interest as a member of Unison – but not the Health Branch.

Councillor Armitage declared personal interests as a member of Unison – Health Branch and as a patient currently receiving hospital treatment.

Joy Fisher declared a personal interest in respect of the Calculating progress in the delivery of personalised support through being a representative on this issue on the NESTA Board (Minute 97 refers).

**89 Apologies for Absence and Notification of Substitutes**

Apologies for absence were received from Councillor Fox, Councillor Charwood, Paul Truswell and Betty Smithson.

Councillor Chapman apologised that she would need to leave the meeting before it concluded.

**90 Minutes**

**RESOLVED** - That the minutes of the Scrutiny Board (Health and Wellbeing and Adult Social Care) meeting held on 21<sup>st</sup> March 2012 be approved.

**91 Scrutiny Inquiry Report: Reducing Smoking**

In view of the number of items being considered at this meeting, the Board agreed to defer consideration of the draft Scrutiny Inquiry report to the May meeting.

The Chair asked that the Principal Scrutiny Adviser e-mail the draft report to all Board Members to enable them to forward any amendments and comments on the draft report.

**92 Leeds Health and Social Care Transformation Programme: Update**

Further to minute 69 of the Scrutiny Board (Health and Wellbeing and Adult Social Care) meeting held on 29<sup>th</sup> February 2012 where the Board considered a report on the work of the Transformation Board, Members considered a further report relating to the efficiencies identified and generated through the work of the Transformation Board and supporting projects.

Information around the NHS Airedale, Bradford and Leeds' Quality Innovation Productivity and Prevention (QIPP) programme was appended to the report. A revised report providing further information had been circulated immediately prior to the meeting.

Attending for this item was Philomena Corrigan (Executive Director for Delivery and Service Transformation) – NHS Airedale, Bradford and Leeds who introduced the report, highlighting the following points:

The Transformation Programme had been running for approximately two years, and its main aims were to:

- Improve the patient experience
- Make care much more integrated
- Make it easier for patients to navigate their way through the care system
- Smooth some care pathways
- Free up resources by making savings and improving productivity



The Executive Director added that providers were required to make 4% savings per year – 2½% inflationary and 1½% deflation on the financial value of contracts. The Executive Director for Delivery and Service Transformation then responded to Members' questions and comments, which included the following key points of discussion:

- Disappointment around the lack of clear information within the report, despite the Board's request at its February meeting. The aim of the report should have been to demonstrate the savings achieved through the work of the Transformation Board and supporting programme of work and where any savings had been reinvested.
- The need for a 'more consumable' report, in terms of its clarity, use of language and acronyms. Clear advice had been given that it should be written in plain English so it could be understood by a member of the public.
- The complex and changing nature of NHS structures and associated funding.
- Top-slicing of NHS funding and whether well-run Primary Care Trusts (PCTs) were subsidising less well-managed PCTs.
- The need for PCTs to be financially balanced by the end of 2012/13 to ensure any of the Clinical Commissioning Groups (CCGs) did not inherit a deficit.
- Significant risks likely to impact on the NHS QIPP programme, including:
  1. The Local Authority's ability to continue to support people in the community;
  2. Changes to national commissioning policies and specialised commissioning;
  3. Providers unable to meet the 4% savings target
  4. The need for continued and appropriate support for CCGs over the next 12 months.

The Executive Director accepted the Board's comments about the content of the report, explained that not all savings would be measured on a 'cash releasing' basis as some savings would be around increased productivity. The Executive Director agreed to provide a further, more detailed report to a future meeting of the Board.

#### **RESOLVED -**

- (i) To note the information provided and comments made at the meeting.
- (ii) That a further, more detailed report be presented to a future meeting of the Board, reflecting the comments made by members at both the current meeting and the Board meeting held in February 2012.

### **93 NHS Leeds Performance Report - Follow Up**

Further to minute 83 of the Scrutiny Board (Health and Wellbeing and Adult Social Care) meeting held on 21<sup>st</sup> March 2012 where the Board considered the latest performance data from NHS Airedale, Bradford and Leeds,

Draft minutes to be approved at the meeting  
to be held on Wednesday, 16th May, 2012

Members considered a further report of the Head of Scrutiny and Member Development and a briefing note prepared by NHS Airedale, Bradford and Leeds providing further details on areas identified by the Scrutiny Board.

The Board noted the updates and clarifications relating to:

- City wide steering group on tobacco
- Carbon monoxide monitors for staff providing healthcare for pregnant women
- Smoking prevalence data for under 18s
- Early intervention service in psychosis
- Health visitor numbers
- A & E performance

Attending for this item were:

Philomena Corrigan (Executive Director for Delivery and Service Transformation) – NHS Airedale, Bradford and Leeds

Graham Brown (Performance Manager) – NHS Airedale, Bradford and Leeds

Brenda Fullard (Consultant in Public Health) – NHS Airedale, Bradford and Leeds

Dr Ian Cameron (Joint Director of Public Health) – NHS Airedale, Bradford and Leeds and Leeds City Council

Nichola Stephens (Senior Information Manager (Public Health, Staying Healthy and LA)) – NHS Airedale, Bradford and Leeds

The main points of discussion were:

Tobacco – the Board was informed that the information previously provided about the existence of a citywide group addressing tobacco issues had been incorrect and that there was citywide Tobacco Control Management Group. The membership included Trading Standards and aimed to help coordinate sub-regional enforcement activity around the availability of illicit tobacco. The Board was further advised that data from the JSNA was being used to target activity towards areas of the City with the highest levels of smoking-related problems.

Carbon monoxide monitors for midwives – the Joint Director of Public Health confirmed that funding for these had been approved. Members of the Board welcomed this outcome.

A discussion around the role and work of the Health Improvement Board followed, which included the following main points:

- The Health Improvement Board was a sub-group of the Health and Wellbeing Board, which had held its inaugural meeting in early March 2012, with a second meeting having taken place in April 2012.
- As part of its remit, the Health Improvement Board would focus on two of the four City Priorities of the Health and Wellbeing Board, these being Tobacco and Reducing Health Inequalities. It was envisaged

that the rest of the work programme would be determined by what emerged from the Joint Health and Wellbeing Strategy.

- The membership of the Health Improvement Board comprised representatives from the Clinical Commissioning Groups, Leeds City Council Directors, along with representatives from Public Health Leeds, local NHS Trusts, Universities and the Third Sector.

The Chair expressed concern around some of the arrangement for the Health Improvement Board (including notification of meeting dates and the availability of meeting papers in advance of meetings) and disappointment that the development of this sub-group had not been brought to the Scrutiny Board's attention formally.

It was requested that further clarity be provided on how the Health Improvement Board was taking forward its work around Tobacco and Health Inequalities, to ensure there was no duplication with the work being undertaken by the Scrutiny Board on these areas.

The Joint Director of Public Health apologised for any oversight around the Health Improvement Board and undertook to report back on the areas of concern highlighted at the meeting.

**RESOLVED** - To note the information presented and the comments now made.

#### **94 Urgent Care Update - Consultation**

Further to minute 59 of the Scrutiny Board (Health and Wellbeing and Adult Social Care) meeting held on 25<sup>th</sup> January 2012 where the Board considered NHS Airedale Bradford and Leeds' public consultation around the future provision of urgent care services in Leeds, Members considered a further report on the outcome of the engagement and consultation and the subsequent decision of the NHS Airedale Bradford and Leeds Board.

Attending for this item were:

Martin Ford (Head of Commissioning – Urgent Care Lead) – NHS Airedale, Bradford and Leeds

Philomena Corrigan (Executive Director for Delivery and Service Transformation) – NHS Airedale, Bradford and Leeds

Details of the extensive consultation process which had been carried out were outlined. The Board was informed that around 500 written responses had been received and analysis of the consultation showed that while the majority of respondents preferred Option B – configuration of provision, with potential use of current A&E sites - many did not like any of the three proposed options. Hence, having also taken into account the view of key stakeholders, the NHS Airedale, Bradford and Leeds Board had concluded that a case for changing the Urgent Primary Care Medical Out of Hours service locations had not been made. However, in terms of the current provision at Lexicon House,

it had been agreed that better signage and improved lighting would be provided.

The Board discussed the report, with the main areas of discussion being:

- Signage – While the proposed improvements to the directional signage to Lexicon House were welcomed, it was felt this must be clear that this was a doctors facility rather than a Primary Care Centre, which many people did not understand or relate to; that the sites for the signs should be selected carefully so they were not diminished by existing signage and that signs further away, along York Road should also be considered.
- An appropriate ‘mystery shopper’ approach be undertaken for the journey from the East of the City to Lexicon House to help fully understand the bus routes and road signs when approaching the site from this part of the city, in order to ensure the facility was properly signposted.
- The majority view of those who responded had not been reflected in the decision of the NHS Airedale, Bradford and Leeds Board.
- With only 31% of respondents voluntarily providing postcode data, it was recognised that this had not helped in the analysis of consultation responses. It was suggested that for future consultation exercises the response form should require people to include postcode information. Furthermore, it should be recognised that some Leeds residents had BD and WF postcodes and that these should be included in any future postcode analysis.

**RESOLVED** - To note the report and the comments now made.

## **95 Reducing Health Inequalities - Clinical Commissioning Groups Perspective**

As part of the Board’s examination of Health Inequalities, Members considered a report of the Head of Scrutiny and Member Development, which included the draft Health and Wellbeing City Priority Action Plan (4e) related to ensuring equitable access to services that prevent and reduce ill-health. The main purpose of the item was to consider the future role of the emerging Clinical Commissioning Groups (CCGs) in this regard. Appended to the report was the draft action plan for Priority Action 4e and a written submission by the three Leeds Clinical CCGs.

Attending for this item to present the report and respond to the Board’s questions and comments were:

Gordon Sinclair (Shadow Accountable Officer) – Leeds West Clinical Commissioning Group (CCG)  
Victoria Eaton (Consultant in Public Health) – NHS Airedale, Bradford and Leeds – working with Leeds West CCG  
Jason Broch (Shadow Chair) – Leeds North Clinical Commissioning Group (CCG)

Draft minutes to be approved at the meeting  
to be held on Wednesday, 16th May, 2012

Lucy Jackson (Consultant in Public Health) – NHS Airedale, Bradford and Leeds – working with Leeds North CCG  
Nichola Stephens (Senior Information Manager (Public Health, Staying Healthy & LA) – NHS Airedale, Bradford and Leeds

Apologies were received from Andy Harris (Leeds South and East Clinical Commissioning Group), with issues relating to this CCG, being covered by Jason Broch and Gordon Sinclair.

The key points of discussion were:

- the importance to all of the CCGs of reducing health inequalities and, notwithstanding the variation on matters pertinent to the local areas, the shared approach being undertaken across the City;
- Public Health to be at the core of the CCG organisations' thinking with commissioning based on need;
- data issues, the difficulties of demonstrating quick wins in this area; the possibility of using proxy indicators; the importance of using postcode data and the reliability and accuracy of the data being collected
- the method used for extracting data from GP practices;
- the Leeds-based Information Strategy and the need for this to include those Leeds residents with BD and WF postcodes;
- the need for data collection systems to be compatible. It was noted that in the Outer South the incompatibility of data systems effectively excluded 15,000 residents from the information collected, which was not acceptable, and skewed the figures. It was stressed that this anomaly, which had recurred for years, must be addressed;
- the role of the CCGs in signposting people to services, especially those where a social or economic problem, e.g. poor housing, was affecting their health; the time constraints on GPs and the use of the multi-agency referral system (MARS), with the Board being informed MARS had been considered but was felt to offer limited additional value, other than for advice on benefits, with different pathways being used for signposting to other services. Some concerns around 'data sharing' had also been raised and fed back into the evaluation process;
- how CCGs would meet the needs of those people who did not readily engage with society or were not registered with a GP;
- the use of data, above and beyond the primary care data available across the city, to help estimate the likely prevalence of particular health conditions within particular populations and/or communities,
- a method of patient engagement using a social marketing approach to help improve / encourage patient access to services.

#### **RESOLVED -**

- (i) To note the report, the information provided by the CCGs and the comments made at the meeting.
- (ii) That the information presented and discussed at meeting be used to inform the drafting of the Board's inquiry report around health inequalities.

(During consideration of this matter, Councillor Hussain left the meeting)

**96 Leeds Teaching Hospital NHS Trust - Care Quality Commission (CQC) Compliance - Update**

Further to minute 83 of the Scrutiny Board (Health and Wellbeing and Adult Social Care) meeting held on 21<sup>st</sup> March 2012, where the Board considered a report of the Care Quality Commission (CQC) that identified improvements needed at St James' University Hospital (as part of Leeds Teaching Hospitals NHS Trust (LTHT)) to consider a report of the Head of Scrutiny and Member Development providing further information around the action plan relating to nursing staff with a focus on Older People's medicine.

Appended to the report was a copy of a press release dated 29<sup>th</sup> March 2012, which followed a formal warning issued by the CQC to LTHT following an unannounced inspection at Leeds General Infirmary. During that inspection, inspectors considered that patients' needs were not always being met and attributed this to poor care and on two of the three wards inspected on this visit to insufficient staff. As supplementary information (Item 87 refers), the Board was in receipt of the CQC's Review of Compliance report outlining the actions LTHT had been asked to take at the LGI and a briefing note from LTHT on nursing staff levels.

Attending for this item to provide further information and respond to the Board's queries and comments were:

Maggie Boyle (Chief Executive) – Leeds Teaching Hospitals NHS Trust  
Karl Milner (Director of Communications and External Affairs) – Leeds Teaching Hospitals NHS Trust  
Wendy Dixon (Compliance Manager (Yorkshire and the Humber)) – Care Quality Commission

Apologies due to illness were received from Jo Coombs (Director of Quality and Nursing) NHS Airedale, Bradford and Leeds. It was also reported that Ruth Holt (Chief Nurse (LTHT)) was unable to attend the meeting due to a CQC visit taking place at the same time.

The Chief Executive of LTHT began by informing the Board that:

- she had been horrified by the findings of the CQC;
- immediate actions had been taken to address the situation, including the closure of Ward 53 and assurance work undertaken across adult inpatients wards to give surety that the findings of the CQC were not evident in other areas of the Trust;
- staff had been made aware of the outcome of the inspection and of the remedies required;
- the warning notices issued required the Trust to declare compliance by 31 March 2012. It was reported that this had been achieved and the CQC was currently on site to check that the Trust was now compliant with the required standards.

The Board was informed of the circumstances around Wards 53 and 55, which had been inspected by the CQC, these being:

- in late December 2011, due to increased patient numbers, including patients with fractured neck of femur, a decision was taken to temporarily open a third ward, which was planned to close at the end of March 2012;
- staffing levels of 30 staff (this figure was rounded up for easier understanding) per ward would have been the usual level. As only 60 staff were available, the decision was taken that rather than remove this much needed capacity, three wards would be in operation with 20 staff per ward and the additional 10 posts per ward to be filled by use of overtime and the nursing bank. In the event, it had not proved possible to always provide cover for staff shortages, especially where absences had occurred at short notice;
- the CQC visited on 29<sup>th</sup> February – 1<sup>st</sup> March 2012 and following its findings, Ward 53 was closed. As some patients were on Ward 53 awaiting discharge, through the spot purchase of 20 beds by Social Care colleagues, it was possible to discharge these patients and move others to different wards.

Details of the actions which were taken were provided and included:

- Reiterated in writing to all staff the standards of care which were expected within the Trust;
- Visited all adult inpatients, focussing on the three areas of concern highlighted by the CQC;
- Emphasised the importance of documentation being completed to ensure that the evidence existed of the care being delivered.

The Chief Executive also outlined other initiatives to address the issues raised by the CQC, which included:

- Building on the initiatives within the Managing for Success Programme, i.e. more efficient use of the bed base and better management of discharge planning
- Looking at how to achieve standardisation of care
- Reinforcing the Mission Statement
- Created new website where people can raise issues without the need to go through the lengthy complaints procedure
- Implementing monthly recruitment campaigns
- Use of electronic rostering with additional funding being directed to this to bring this facility on-line more quickly
- Every Ward Manager to be assessed to see if additional support is required
- Measures to address the quality of care being provided, including the introduction of patient feedback upon discharge and feedback from staff at the end of each shift

- Tackling attitudes and behaviours to ensure greater nurse/patient contact
- Re-examining the nursing blueprint to ensure staffing levels are properly distributed across all areas and finding a mechanism for ensuring that staff cover was provided where needed, even if it was on Wards which were less popular among nursing staff
- a review of the oversight mechanisms, with an acceptance that the issues raised by the CQC should have been picked up earlier

Reference was made to the quality of care, with the Chief Executive stating that staffing levels alone did not always account for quality of care. It was highlighted that leadership on Wards was of paramount importance and, in the cases seen by the CQC, better standards of care could have been provided.

The Board discussed the report and the information provided at the meeting, with the main discussion points being:

- the disgraceful situation as reported by the CQC; that this followed a CQC inspection at St James' where failings had been found and the need for reassurances to be given to the Board that these issues were being addressed;
- the monitoring mechanisms in place and how Senior Management would have discovered what had been taking place had the CQC not visited at this time;
- patient discharge planning; evidence given to a previous Scrutiny Board inquiry indicating this began once patients were admitted, yet several patients on Ward 53 were awaiting discharge at the time of the inspection;
- staffing levels and the statement in the supplementary information supplied to the Board by the Leeds Teaching Hospital NHS Trust that 'Staff levels were not the pivotal factor in determining how a patient was treated ....'
- the distribution of staff across the organisation with concerns raised that this was not always carried out effectively;
- concerns about the quality of care provided; the attitudes of some staff to patients; the amount of information patients were given about their care and the level of involvement with patients;
- the importance of team working on wards, including clerical and portering staff as well as the medical teams;
- the mechanisms for patient complaints; the deep-rooted view that existed, that to complain could have an impact on the care received;
- the need to have mechanisms in place to ensure that the many dedicated, hardworking members of nursing staff could raise concerns in confidence and know that their voices were heard without fear of repercussions for their jobs

The Chief Executive recognised the Board's concerns and gave her assurance that these issues would be addressed.



Wendy Dixon stated that once a Compliance Report was issued and was in the public domain, it was usual for further concerns and issues to be raised and drawn to the attention of the CQC.

In summing up the session on behalf of the Board, in deploring the situation as set out by the CQC, the Chair stated that there were many diligent and caring staff, some of whom were working in difficult situations and that the Board wanted to see that their concerns were being addressed and that that staff were being supported.

The Chair thanked the representatives from LTHT and the CQC for attending the meeting and contributing to the Board's consideration of the matters raised.

**RESOLVED -**

- (i) That the report and information presented to the meeting be noted;
- (ii) That the Scrutiny Board maintain an overview of the performance of the Trust and its future compliance with the CQC standards.

(During consideration of this matter, Councillor Chapman withdrew from the meeting)

**97 Calculating Progress in the Delivery of Personalised Support**

Further to minute 82 of the Scrutiny Board (Health and Wellbeing and Adult Social Care) meeting held on 21<sup>st</sup> March where the Board, as part of its examination of the relevant quarter 3 performance data, requested information about changes to the calculation of a key performance measure relating to the provision of social care through personal budgets, the Board considered a report of the Director of Adult Social Services.

Stuart Cameron Strickland (Head of Performance and Improvement) – Leeds City Council, Adult Social Services attended for this item.

The Board was informed that whilst this issue was important in terms of measuring performance, it did not affect any service which was being received.

In terms of the proportion of people in Leeds using social care who received self directed support, the level of 47.8% was average, with the Board being informed that Rotherham Council as the regional lead in this area was being visited by Officers within Adult Social Services to see what could be learnt from this Authority.

**RESOLVED -** That the report be noted.

(During consideration of this matter, Councillor Bruce left the meeting)

**98 Work Schedule - April 2012**

A report was submitted by the Head of Scrutiny and Member Development which detailed the Scrutiny Board's work programme for the remainder of the current municipal year. Appended to the report for Members' information was the current version of the Board's work programme and an extract from the Forward Plan of Key Decisions for the period 1<sup>st</sup> April 2012 – 31<sup>st</sup> July 2012.

**RESOLVED** – That the work programme be approved subject to the amendment for the May meeting which would now include the Draft Scrutiny Inquiry Report on Reducing Smoking.

**99 Councillor Kirkland**

The Chair gave credit to Councillor Kirkland who was stepping down from the Council in May 2012 after 45 years. On behalf of both past and present members of the Scrutiny Board, the Chair thanked him for his work, dedication and insight as a retired GP brought to a range of issues that had been considered.

**100 Date and Time of the Next Meeting**

Wednesday 16<sup>th</sup> May 2012 at 10.00am with a pre-meeting for all Board Members at 9.30am.

## Report of Head of Scrutiny and Member Development

### Report to Scrutiny Board (Health and Well-Being and Adult Social Care)

**Date: 16 May 2012**

**Subject: Review of Children's Neurosurgery - a proposed framework for services and standards specification in England**

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Are there implications for equality and diversity and cohesion and integration?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Is the decision eligible for Call-In?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

## Summary of main issues

1. In January 2012, the Scrutiny Board received an update on the progress of the national review of children's neurosurgical services in England and considered some of the potential local implications of the review outcomes.
2. At that meeting, members of the Scrutiny Board were advised that draft documentation was due to be published, setting out the a proposed framework and specification standards for Children's Neuroscience Networks (for the Neurosurgical Child). Members of the Board expressed a desire to consider the proposed framework and standards documents once available.
3. To assist the Boards consideration, the following documents are appended to this report:
  - Briefing note from North of England Specialised Commissioning Group (Yorkshire and the Humber Office) – Appendix 1
  - Children's Neuroscience Networks (for the neurosurgical child); a framework for services in England (February 2012) – Appendix 2
  - Children's Neuroscience Networks (for the neurosurgical child): specification standards (February 2012) – Appendix 3
  - Children's Neuroscience Networks (for the Neurosurgical Child) – Questionnaire – Appendix 4

**Recommendations**

4. To consider the information presented and determine any response to be the questionnaire (attached at Appendix ), to submitted as the Board's response to the public engagement work.

**Background documents**

None

**LEEDS HEALTH OVERVIEW AND SCRUTINY COMMITTEE –  
16 MAY 2012**

**SAFE AND SUSTAINABLE: PAEDIATRIC NEUROSURGERY REVIEW**

**1 Introduction and Background**

The national Safe and Sustainable Team have been working on a review of paediatric neurosurgery services in England, on behalf of the NHS Medical Director and the 10 SCGs since 2009. The review was commissioned to address three key concerns:-

- Children's neurosurgical services have developed in England but in an ad hoc way with no strategic oversight for this specialty service nationally.
- Children and their families expect a "world class service" for the challenging conditions these children have and current services are not sustainable nor able to meet future requirements and developments in the field, and may not be able to match the best outcomes when compared internationally.
- Few of the current children's neurosurgical services are able to provide access to specialists 24/7.

The first phase of the work has been to work with clinicians, other health professionals, parents and families to develop:

- a model of care
- patient pathways
- service standards

The second phase of the engagement work is to circulate the relevant documents to secure wider ownership and final sign off of the proposed way forward.

**2 Paediatric Neurosurgery**

Paediatric neurosurgery is a complex specialty and interfaces with a number of other key specialties. There are also very different pathways dependent on the nature of the neurosurgical condition.

There are around 4200 paediatric neurosurgery operations performed in England each year of which 70% are emergency.

The main sub-specialties of neurosurgical care, and therefore the different patient pathways, relate to: hydrocephalus; trauma/head injury; brain tumour and epilepsy.

There are currently 14 NHS hospitals in England recognised as providers of paediatric neurosurgery. Most of these operations are carried out by trained paediatric neurosurgeons or neurosurgeons with a paediatric interest. However, they are mostly based in general neurosurgical centres and only 5 centres in England have a dedicated paediatric neurosurgery consultant rota.

### **3 Proposed Model of Care**

The proposed model of care is that in future there will be a number of Children's Neuroscience Networks (for the neurosurgical child) (CNN) across England who meet the geographical and service criteria described in the national framework document. These networks will comprise at least two Children's Neurosurgical Centres (CNC), one of which will be responsible for the management role for the network supported by clinical leaders from the CNC and/or clinical leaders who are responsible for specific pathways or subspecialties across the network.

### **4 Process**

Two documents have been launched to support the wider consultation process plus a questionnaire:-

- Children's Neuroscience Networks (for the neurosurgical child); a framework for services in England – February 2012.
- Children's Neuroscience Networks (for the neurosurgical child): specification standards – February 2012.

These are available on the Safe and Sustainable Website ([www.specialisedservices.nhs.uk/document/steering-group-reports](http://www.specialisedservices.nhs.uk/document/steering-group-reports)).

There is an online questionnaire and individual patients, families, carers and clinicians are encouraged to use this method of response. The web link for the questionnaire is: [www.jacksonsurveys.com/nhsneuro](http://www.jacksonsurveys.com/nhsneuro)

The results will be analysed by an independent consultant and the report submitted to the next meeting of the national Steering Group. The deadline for the questionnaire submissions is 9 May 2012.

It is suggested that Trusts, other organisations or groups of clinicians respond to the following email address: [childneuro@london.nhs.uk](mailto:childneuro@london.nhs.uk) using the PDF version of the questionnaire to help frame responses around specific questionnaires.

The deadline for any other comments, views or suggestions is 5.00pm on Wednesday, 16 May 2012 and these should be sent to Stephanie Stanwick, Programme Manager for the Safe and Sustainable Children's Neurosurgical Services review by either:-

- Email: [childneuro@london.nhs.uk](mailto:childneuro@london.nhs.uk)
- Letter: NHS Specialised Services, 2<sup>nd</sup> Floor, Southside, 105 Victoria Street, London SW1E 6QT
- Telephone: 0207 932 3958

### **5 Position in Yorkshire and the Humber**

There are two providers of paediatric neurosurgery in Yorkshire and the Humber: Sheffield Children's Hospital and Leeds Teaching Hospital. There are three providers of adult neurosurgery: Sheffield Teaching Hospitals, Leeds Teaching Hospitals and Hull and East Yorkshire Hospital. At the moment neither of the two services meet the required standards and can operate as independent services with fully compliant rotas. Both Trusts have plans to recruit an additional consultant.

With regard to the development of the networks there has already been a “regional workshop” held involving North East and Yorkshire and the Humber Specialised Commissioners, and clinicians and managers from the providers in Newcastle, Leeds and Sheffield. This was held on 28 September 2011. The Sheffield provider and the Yorkshire and the Humber Specialised Commissioner also participated in a similar workshop held by the Midlands and the East “region”.

The workshops focussed on the emerging proposals from the national review work and exploring possible linkages in terms of clinical networks and patient pathways.

The proposed clinical networks for paediatric neurosurgery also need to take into account the adult neurosurgical centres. The possible network footprints currently under consideration are:-

- Leeds, Sheffield, Newcastle, Hull and Middlesbrough
- Leeds, Newcastle, Hull and Middlesbrough (Sheffield would be in Midlands Network)
- North of England solution

At this stage it is considered that a North of England solution would be too large and too unwieldy in terms of developing patient pathways and strengthening clinical links.

It is very important to ensure that the paediatric neurosciences network footprint takes account of and is coherent with the pathways for children’s cancer, paediatric trauma and paediatric critical care.

Bilateral meetings have taken place between the Yorkshire and the Humber Specialised Commissioning leads and the relevant senior managers and clinicians in Leeds and Sheffield. The meeting with Leeds took place on 3 April. The Sheffield meeting took place on 24 April.

It is recognised that Leeds and Newcastle will need to be covered by a single network. The key question is whether or not Sheffield should also be part of the same network.

The discussions with Sheffield have identified a number of advantages and disadvantages around the two options for Sheffield. There are various links with the service in Nottingham e.g. medical staff training rotations and there are also links with Leeds e.g. paediatric intensive care.

It has been agreed that the specialised commissioning leads will complete a risk assessment of both options to help determine the most appropriate way forward.

The national deadline for specialised commissioners agreeing all the “footprints” for the networks is 31 July 2012. It is envisaged that a report outlining the preferred option will be received by the North of England on 13 July 2012.

Cathy Edwards  
**Director of Specialised Commissioning**  
**Yorkshire & the Humber Office**  
**North of England SCG**

2 May 2012

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# CHILDREN'S NEUROSCIENCE NETWORKS (FOR THE NEUROSURGICAL CHILD): A FRAMEWORK FOR SERVICES IN ENGLAND

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## STEERING GROUP REPORT

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FEBRUARY 2012

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## EXECUTIVE SUMMARY

The provision of children's neurosurgical services is not only about neurosurgeons, but also about a wide ranging team of people with skills and expertise to support the individual child and their family in a caring atmosphere that creates confidence and safety for that child and their family. These services need to work together for the emergency or urgent condition but they also need to provide care and support to the child and their families for long term conditions such as hydrocephalus and spina bifida. It is because of this wide ranging diversity of professions who are involved in the care of these children, the term 'neuroscience' - rather than 'neurosurgery' - is more appropriately used in this document.

Families expect care to be as local as possible, so that they can manage as best they can the challenges of long hospital stays whilst trying to maintain some stability for the rest of the family. Families also expect to be able to access the 'best there is' for very rare conditions that may only affect a handful of children every year. This is why the NHS in England proposes that the surgical care of some of these very complex conditions, (a very small proportion of all children's neurosurgical procedures) should be concentrated in a smaller number of units than is presently the case.

There are key points from the review of current services (Steers and Stower report September 2010) that support the need for change and these issues were reinforced by parents, carers and their representatives:

- There is considerable variation in the infrastructure, resources, people and skills for these services across the country and this includes variability in access and support along the pathway for different conditions from local hospitals, emergency departments, diagnosis, imaging, the care environment, accommodation and support for families.
- A high quality, effective multi-disciplinary team (MDT) is a crucial factor for services. Paediatric MDTs for both formal meetings and the wider MDT for the whole pathway of care - from the initial concern raised by parents, through assessment, diagnosis, treatment and after care, all of this requires an enormous range of expert professional skills and these are essential for a 'world class' service.
- Rehabilitation and re-ablement services emerge as a priority for the future and it is included as a key area in the exemplar pathways and standards. However, current services are variable and patchy within the different geographical areas around the country, and this was identified as a significant area of need by wide ranging groups of clinicians and parents of clinicians and parents

Some of the clinical evidence supporting the need for change includes:

- There tends to be a longer time between the onset of symptoms and diagnosis of brain tumours than other childhood tumours<sup>1, 2</sup>
- The resection rate for some tumours is lower in the UK than international centres of excellence.<sup>3</sup>
- The 30 day, 1 year and 5 year survival rates for some brain tumours in the UK may be lower than in the US and there are potentially many reasons for this.<sup>4</sup>
- International evidence exists to suggest centres performing more ventricular shunt procedures have better outcomes than lower volume centres.<sup>5</sup>
- Shunts performed by a consultant out-of-hours fare better than those performed by a trainee<sup>6</sup>
- The 30 day shunt revision rate in the UK may be higher than international centres of excellence<sup>7</sup>
- 1 in 10 admissions for children to an intensive care unit with traumatic brain injury has a fatal outcome. Outcomes vary considerably across England and Wales for these severe cases: from between 8.1% in some units and 18.8% in others.<sup>8</sup>
- Wide variation is reported in the process of care for children with severe traumatic brain injury, with potential impacts on survival.<sup>9</sup>
- Internationally, lower mortality rates have been demonstrated for children with traumatic brain injury treated in paediatric trauma centres than for those treated in adult trauma centres.<sup>10</sup>

The NHS recommends that children should expect to be treated by a paediatric-trained neurosurgeon, with access to care, advice and support *24 hours a day, 7 days a week*. The recent NHS Clinical Advisory Group guidance for the Management of Children with Major Trauma<sup>11</sup>, sets out the expectations for children's neurosurgery in providing care and support to the child with a major head injury, that paediatric neurosurgical consultants should be available for consultation and care to the Trauma Network 24/7. This rota for advice and care should be widely available throughout the network of referring hospitals and clinicians caring for children with the other wide ranging neurosurgical conditions.

The NHS recommends that the service in the future needs all parts of the care system to work closely together in a managed network in order to make the best use of rare specialist expertise, standardising care, improving access, and reducing any distance delay effects that can result from the concentration of specialist services in large centres. These networks should be called 'Childrens Neuroscience Networks' (for the neurosurgical child) (CNNs) and together, those working in the network, can improve services and share learning. The networks must provide coherence and integration from the parent and family perspective,

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- 1 Wilne S.H. et al, 2006. The presenting features of brain tumours: a review of 200 cases. *Archives of Disease in Childhood*, 91, pp. 502-506.
  - 2 Wilne S et al, 2007. Progression from first symptoms to diagnosis in childhood brain tumours: A multicentre study. *Archives of Disease in Childhood*, 92(Suppl.1), p.A69.
  - 3 Bouffet E., 2007. Recent advances in ependymoma management. *Liverpool ISPN*.
  - 4 Paediatric Neurosurgery Evidence National Specialised Commissioning 2011
  - 5 *ibid* (4)
  - 6 Richards H, et al 2009. Who should perform shunt surgery? Data from UK Shunt Registry. *Cerebrospinal Fluid Research*, 6(Suppl 1), p.S31
  - 7 Paediatric Neurosurgery Evidence, National Specialised Commissioning 2011
  - 8 Tasker R.C., Fleming T.J., Young A.E.R., Morris K.P., Parslow R.C., 2011. Severe head injury in children: intensive care unit activity and mortality in England and Wales. *British Journal of Neurosurgery* 25, pp.68-77.
  - 9 Morris K.P. et al (2006) UK Paediatric Traumatic Brain Injury Study Group intra-cranial pressure complicating severe traumatic brain injury in children: monitoring and management. *Intensive Care Medicine*, 32, p1606-1612
  - 10 Paediatric Neurosurgery Evidence National Specialised Commissioning 2011
  - 11 Management of Children with trauma NHS Clinical Advisory Group Report <http://www.excellence.eastmidlands.nhs.uk/welcome/improving-care/emergency-urgent-care/major-trauma/nhs-clinical-advisory-group/>

from presentation, diagnosis, treatment, after care and finally ongoing support at home and at school. Whilst the best management of the condition is paramount, the impact on the child and the consequence for the family should not be forgotten and should therefore form an integral part of the therapeutic package for the family.

In proposing managed Children's Neuroscience Networks (CNNs) are the vehicles for change and developing these services; they will need to demonstrate that they can provide: a management structure for the network, user involvement, excellence in clinical practice, supported by research training and development. It is envisaged that there will need to be a number of networks who meet the geographical and service criteria described in this document, across England. All centres and services that are currently part of delivering neurosurgical care to children will be involved. CNNs will involve at least 2 children's neurosurgical centres working closely together and in this situation one will take the a management role for the network supported by clinical leaders from the Children's Neurosurgical Centres (CNC) and/or clinical leaders who are responsible for specific pathways or subspecialties across the network. Some children's neurosurgical services, such as the very rare brain cancers and complex epilepsy surgery in younger children, will require these networks to work together over a wider geographical area.

CNNs will need to provide the infrastructure which brings all the component parts of the service together in a collaborative rather than a competitive way. Although there will be a national model for children's neurosurgical services underpinned by a framework of standards for commissioning services, the delivery of the model will lead to different configurations depending on local circumstances and therefore CNNs need to be established as a 'best fit' for local people.

This framework document builds on work undertaken with professional associations, clinicians, charities, parents and families over the past 2 years. Over the summer 2011, it has been distributed to professional associations involved who sought the feedback of their members, and their views have been incorporated into this latest version of the document and the service specification standards.

There is ongoing work with the professional associations to develop an outline assessment process for CNNs, based on the draft criteria in this document and the standards document, with a view to creating a measurable, transparent framework by which future CNNs can be judged. This should be completed by summer 2012. The Steering Group and professional associations have supported the proposal to use 'peer reviews' of CNNs with clinicians recognising that such approaches have a proven track record in contributing to improvements in clinical practice across different organisations. Prior to network implementation there will be a national review of all network and clinical leadership proposals to ensure 'best fit' with national policies and criteria; to ensure appropriate access is available across all children's neurosurgical services, and to assess the impact these proposals may have on other linked services and networks such as trauma and cancer.

Subject to legislation, the implementation of network proposals and plans will be overseen by the NHS Commissioning Board and local development priorities would be agreed within the commissioning framework developed for these services.

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# 1. INTRODUCTION

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Around 4,200 paediatric neurosurgery operations are performed in England each year, of which 70% are emergency and 30% are elective. Most emergency operations are performed on children with hydrocephalus, head injury or brain tumours. Hydrocephalus accounts for about 1,700 procedures each year and central nervous system tumours, craniofacial disorders and epilepsy each account for about 400 cases every year. The remaining caseload comprises children with spinal dysraphism and other disorders.

There are currently 14 NHS hospitals in England recognised as providers of paediatric neurosurgery. Most of these operations are carried out by trained paediatric neurosurgeons or neurosurgeons with a paediatric interest. However, they are mostly based in general neurosurgical centres and only 5 centres in England have a dedicated paediatric neurosurgery consultant rota. Others rely on joint rotas with emergency competent adult surgeons.

The NHS proposes that in the future there will be a number of Children's Neuroscience Networks (for the neurosurgical child) (CNN) across England who meet the geographical and service criteria described in this document. These will comprise at least two Children's Neurosurgical Centres (CNC), one of which will be responsible for the management role for the network supported by clinical leaders from the CNC and/or clinical leaders who are responsible for specific pathways or subspecialties across the network. This document explains the proposed network model of care.

## 2. BACKGROUND

Safe and Sustainable (within the National Specialised Commissioning Team), has been working on a review of paediatric neurosurgical services in England on behalf of the NHS Medical Director and the ten Specialised Commissioning Groups since 2009. The review was commissioned to address three key concerns:

- Children's neurosurgical services have developed in England but in an ad hoc way with no strategic oversight for this specialty service nationally.
- Children and their families expect a 'world class service' for the challenging conditions these children have and current services are not sustainable nor able to meet future requirements and developments in the field, and may not be able to match the best outcomes when compared internationally.
- Few of the current children's neurosurgical services are able to provide access to specialists 24/7.

The provision of children's neurosurgical services is not just about neurosurgeons, but about a wide ranging team of people with skills and expertise to support the individual child and their family in a caring atmosphere that creates confidence and safety for that child and their parents.

Part of the challenge for these services is their complexity; they need to work closely with the different services that come together to care for a child with a Traumatic Brain Injury (TBI) on the one hand, whilst also meeting the requirements for the different services that come together to care for a different child with a brain tumour. They also need to provide care and support to the child and their families for 'life time' conditions such as hydrocephalus and spina bifida, and the challenges for emergencies, urgent and elective care - 24/7. Families expect care to be as local as possible, so that they can manage as best they can the challenges of long hospital stays whilst trying to maintain some stability for the rest of the family. Families also expect to be able to access the 'best there is' for very rare conditions that may only affect a handful of children every year

Throughout the review, the aim has been to combine clinical evidence of best practice, expert advice from clinical leaders in the field, with national policies and guidelines on standards in the key areas such as children's cancer. This has been brought together with the insights of parents of children who have experienced brain or spinal cancer, brain trauma and conditions such as epilepsy, hydrocephalus and spina bifida, as well as the views of clinicians in the fields of neuroscience, paediatric medicine and rehabilitation in order to provide a framework and strategy for developing these services in England for the future.

The review has been developed and managed through a Steering Group comprising the relevant professional associations and lay people, a Standards Writing Group - who have produced and tested draft service standards, and a Models of Care Group who have further tested and developed care pathways and best practice for some conditions. Committee memberships and minutes from all these meetings can be found on the specialised services - safe and sustainable children's neurosurgery section of the website.<sup>12</sup>

<sup>12</sup> [http://www.specialisedservices.nhs.uk/safe\\_sustainable/childrens-neurosurgical-services](http://www.specialisedservices.nhs.uk/safe_sustainable/childrens-neurosurgical-services)

### 3. LINKS TO NATIONAL POLICY

The NHS White Paper *Equity and Excellence - Liberating the NHS* (2010)<sup>13</sup> explained that all NHS services must be focused on outcomes and the quality standards that deliver them. The focus to reduce mortality and morbidity, increase safety, and improve patient experience and outcomes for all is the basis of the NHS Outcomes Framework 2011/12<sup>14</sup> which is developed to provide that national level accountability for the outcomes that the NHS delivers; to provide a national level overview of how well the NHS is performing, wherever possible in an international context; and to act as a catalyst for driving quality improvement and outcome measurement.

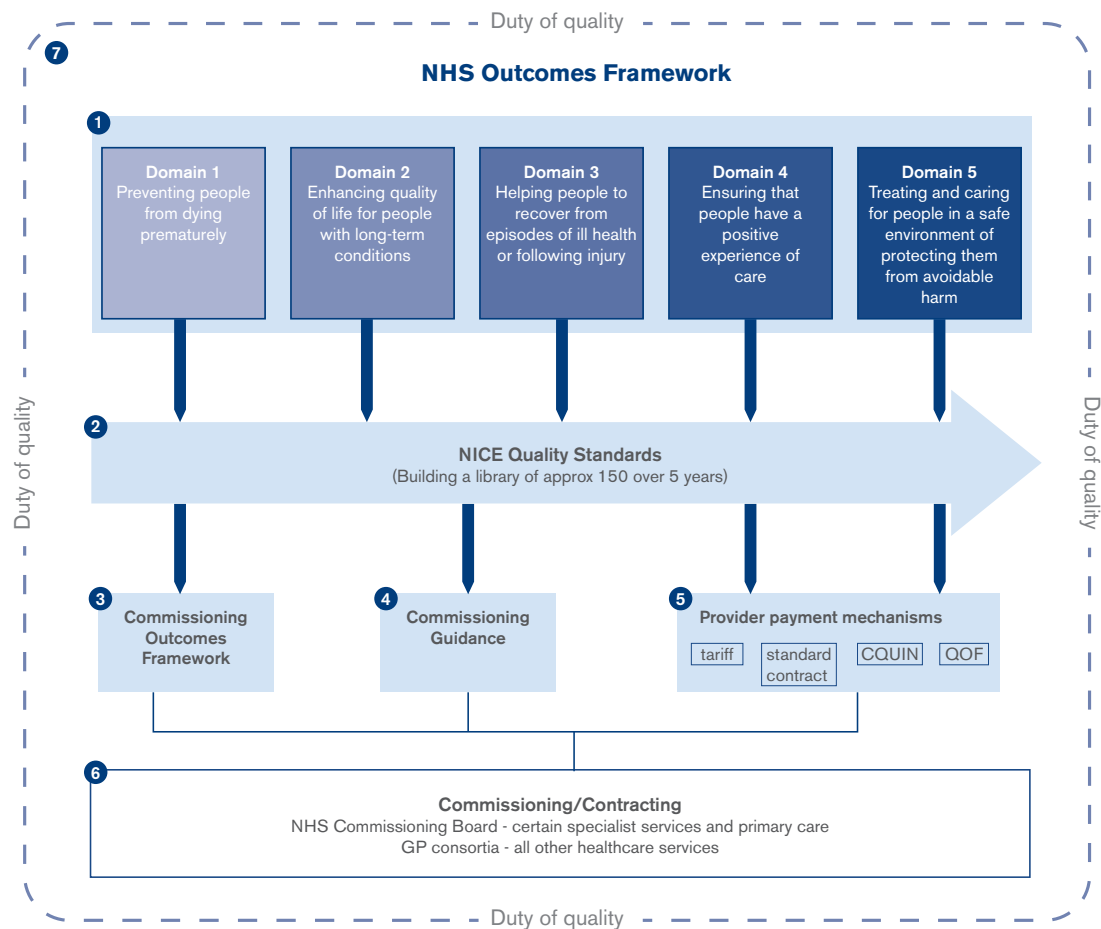


Figure 1.

The 'duty of quality' is set out in figure 1: The NHS Commissioning Board will commission the National Institute for Health and Clinical Excellence (NICE) to develop Quality Standards (2) which will set out the evidence-based characteristics of a high quality service for a particular clinical pathway or condition. These standards will, where appropriate, look across several or all five domains of the NHS Outcomes Framework. Drawing on these Quality Standards, the NHS Commissioning Board will translate the national outcomes into outcomes and indicators that are meaningful at a local level in the Commissioning Outcomes Framework (3).

<sup>13</sup> The NHS White Paper *Equity and Excellence - Liberating the NHS* 2010  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_117353](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353)

<sup>14</sup> NHS Outcomes Framework 2011/12  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_122944](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122944)



In this way this document 'Children's Neurosurgical Services in England - A Framework for the Future' and the associated standards document for children's neurosurgery services, sits across all domains of the outcomes framework and will provide best practice for commissioning these services.

Considerable progress has also been made nationally in describing and developing networks for paediatricians and specialist paediatricians, neonatologists and neurologists. All these (trauma, cancer, paediatrics, neurology), provide essential elements to build on for the future.

The document on the future of children's health services produced by the Royal College of Paediatrics and Child Health<sup>15</sup> identifies the challenges for specialist paediatric services describing the widespread support amongst paediatricians for greater cooperation between teams and organisations working in a geographical area. This includes sharing clinical protocols, working in managed networks and rotating staff between services.

Defining the specialties that need 24/7 hands-on consultant delivery and developing better on-call consultation. All these services are also essential components for children's neurosurgical services as in many instances local paediatric services, specialist paediatric services and or paediatric neurologists are essential at the early presentation of the condition, and involved in supporting the longer term conditions, preventing or minimising complications and supporting after care.

There are other imperatives that have considerable impact on children's neurosurgery services. The recent NHS Clinical Advisory Group guidance for the Management of Children with Major Trauma<sup>16</sup> builds on the earlier NHS report on regional networks for major trauma<sup>17</sup> and sets out the expectations for children's neurosurgery in providing care and support to the child with a major head injury. Most importantly that paediatric neurosurgery consultants should be available for consultation and care to the Trauma Network 24/7 and should be involved in creating a management plan for children with severe head injury together with a consultant in paediatric intensive care within one hour of CT imaging.

All the specialist centres and units contributing to the network of care for children with brain tumours have an obligation nationally to comply with the NICE Children and Young People with Cancer Improving Outcomes Guidance (CYPIOG).<sup>18</sup> This is essential for units delivering any aspect of treatment/care (diagnostics, surgery, chemotherapy, radiotherapy, supportive care) to children with these conditions and is subject to cancer Peer Review against the children cancer measures arising from the IOG. Progress against these measures are published annually as part of the National Cancer Peer Review Programme.<sup>19</sup>

15 Modelling the Future, A consultation Document on the future of children's health services - Royal College of Paediatrics and Child Health September 2007

16 Management of Children with trauma NHS Clinical Advisory Group Report 2011 <http://www.excellence.eastmidlands.nhs.uk/welcome/improving-care/emergency-urgent-care/major-trauma/nhs-clinical-advisory-group/>

17 Regional Networks for Major Trauma NHS Clinical Advisory Group Report September 2010 <http://www.excellence.eastmidlands.nhs.uk/welcome/improving-care/emergency-urgent-care/major-trauma/nhs-clinical-advisory-group>

18 National Institute for Health and Clinical Excellence 2005 Improving Outcomes in Children and Young People with Cancer

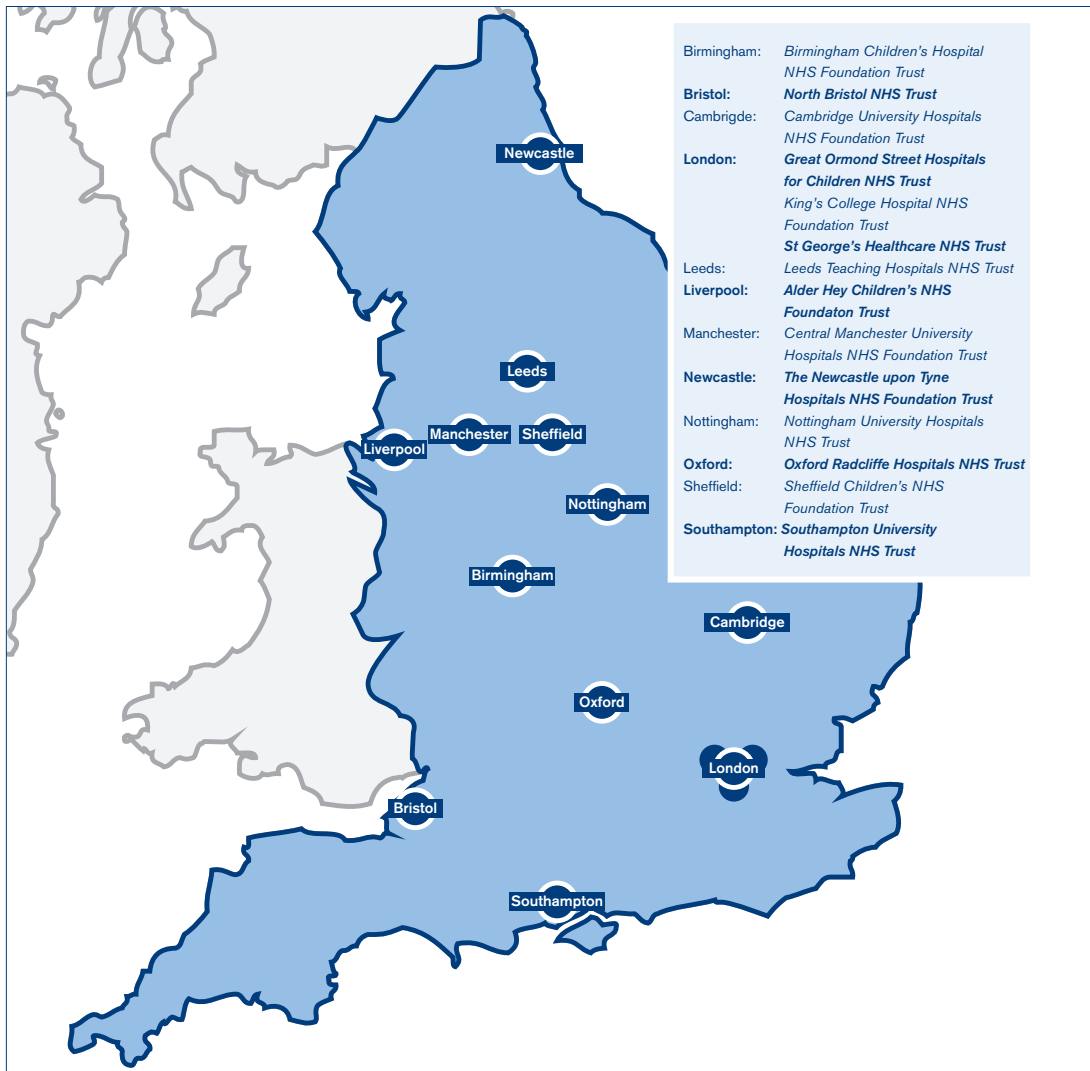
19 An overview of the findings from the 2009/2010 National Cancer Peer Review Programme for Children's Cancer Services in England National Cancer Action Team Report 2009/2010



## 3. THE CASE FOR CHANGE

### 3.1 The current service

There are 14 Children's Neurosurgery Centres (CNC) in England:

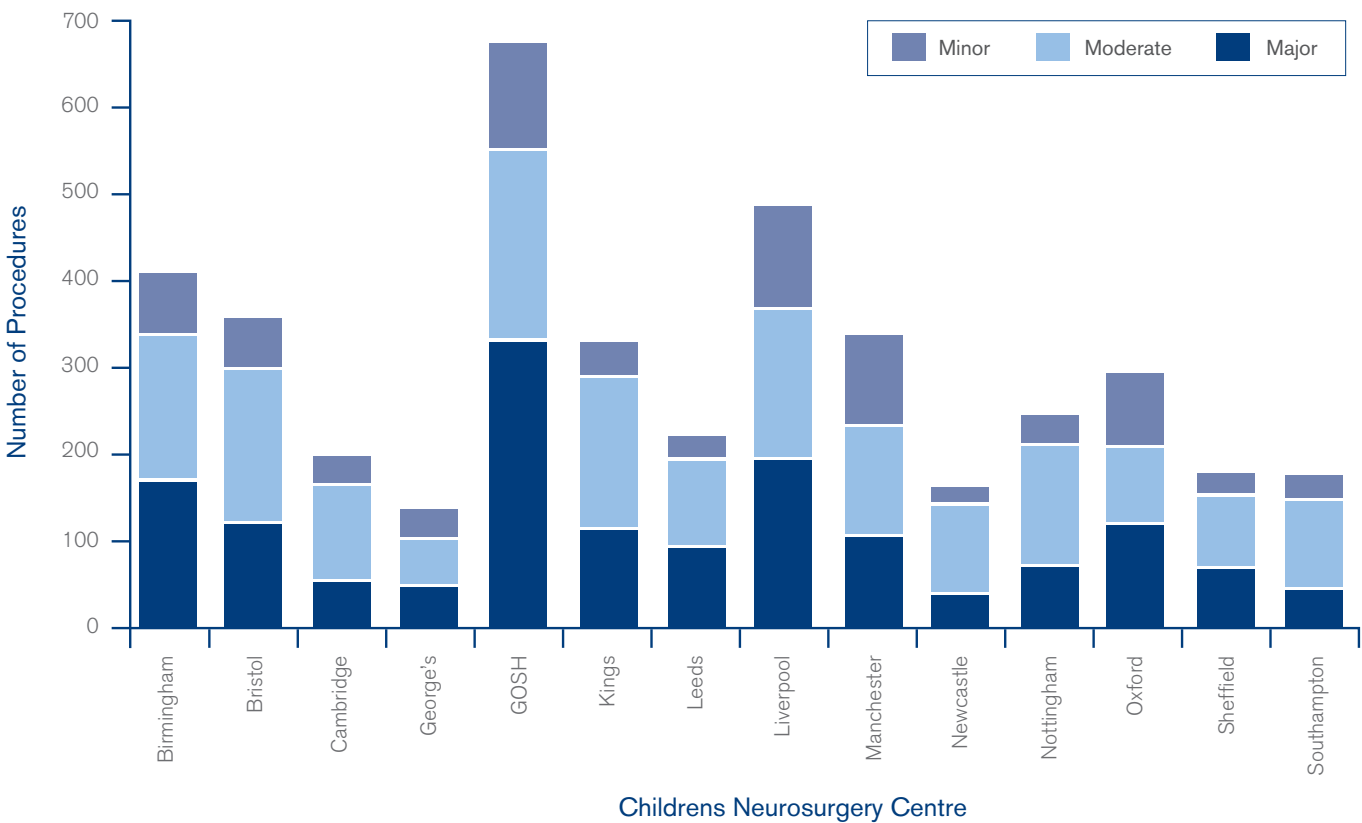


In 2010, each of the 14 paediatric neurosurgical centres submitted detailed information about the service they provide and this was followed by centre visits by Mr James Steers, retired neurosurgeon and past president of the Society of British Neurological Surgeons, and Sharon Stower, senior children's nurse representing the Royal College of Nursing. The purpose of these visits was to clarify the information provided by the centres, understand policies, procedures and ways of working, gather evidence of good practice relating to patient/family centred care including support services, environment and facilities, and identifying the range of paediatric expertise linked to the service and the networks of care. This information is available in a separate report.<sup>20</sup>

20 Safe and Sustainable Paediatric Neurosurgery -Report of the Unit Visits Mr. James Steers and Ms Sharon Stower  
September 2010

The following table shows the activity undertaken by each of the children’s neurosurgery centres, this is based on the audit undertaken by British Paediatric Neurosurgical Group<sup>21</sup>, it uses data from 2008-09 and is annualised. There are (approximately) 4,200 neurosurgical procedures performed each year in England. The activity is grouped into categories for ‘Major’ (for example craniotomies, spinal fixations and cranioplasty); ‘Moderate’ (for example burr hole surgery and shunts; and ‘Minor’ (for example shunt removal and intra cranial pressure monitoring).

- Units performing more than 300 cases each year are: Great Ormond Street, Liverpool, Birmingham, Bristol, Manchester and Kings College Hospital.
- Units performing between 200-300 cases each year are: Oxford, Nottingham, Leeds and Cambridge; and
- Units performing under 200 cases each year are: Sheffield, Southampton, Newcastle and St George’s.



21 BPNG audit 2010

However, in summary the following conclusions are made in the Steers and Stower report:

- There is considerable variation in the infrastructure for these services across the country and this includes variability in access and support along the pathway for different conditions from local hospitals, emergency departments, diagnosis, imaging, the care environment, accommodation and support for families, training for staff, rehabilitation and after care. Some variation in the infrastructure (people, skills, buildings, linked services) is inevitable, but children and their families should expect a 'child friendly' environment with room for the families to be at the bedside, room for play and a room for privacy when difficult discussions concerning their child need to take place.
- To improve children's neurosurgical services for the future, 24/7 advice and care from a paediatric neurosurgeon needs to be available across a network. Five units provide a 24/7 paediatric neurosurgical on call rota; three units where cover for paediatric neurosurgery relies on adult neurosurgeons who have an 'official' written rota for the available paediatric neurosurgeon. Seven units have no identifiable rota for paediatric neurosurgery relying on the on call adult neurosurgeon to find/contact an available paediatric neurosurgeon when necessary. This means that clinicians from outside hospitals are disadvantaged if an urgent discussion about a child or young person is required.
- Paediatric neurosurgery throughout the UK has not been planned systematically and has developed incrementally. The visits highlighted the different ways in which units are resourced both in terms of structure and personnel. There are key elements which must be the foundations for a world class service for the future:
  - The development of an academic paediatric neurosurgical structure;
  - Opportunities for continuing professional development (CPD) in all units;
  - Consistent approaches to Specialist Registrar (SpR) training which provide sufficient experience;
  - Formally recognised training in paediatric neurosurgery in the UK.
- A high quality, effective multi-disciplinary team (MDT) is a crucial factor for services and parents reinforced this. Paediatric MDTs for both formal meetings and the wider MDT for the whole pathway of care - from the initial concern raised by parents, through assessment, diagnosis, treatment and after care, all of this requires an enormous range of expert professional skills and these are essential for a 'world class' service.

*'Whilst there is not yet consensus on the future shape of paediatric neurosurgical services in England, it is clear that there is broad agreement on the need to seize the opportunity that the Safe and Sustainable review provides for addressing long-standing areas of concern and debate'*

REPORT OF MR JAMES STEERS AND SHARON STOWER, 2010

### 3.2 Clinical evidence for change

This review has generated widespread and variable comments from different clinicians.

Many clinicians agree that a strategic framework for the service is necessary in order to:

- *improve* the care and safety provided for children,
- *improve* the experience those children and their families have from the point of the initial concern, diagnosis, through to aftercare (including rehabilitation) and support at home.
- *improve* the outcomes of care through the robust collection of nationally agreed information.

Clinicians also support the fact that services need to be 'world class' and that services can improve on what is offered to children and families now. They have spent considerable time reviewing evidence and developing standards which will be the foundation of improvements in service quality. It is fundamental that any change is managed carefully so as to avoid destabilising care, harnessing improvement approaches which introduce systematic and incremental change, whilst transforming parent and family experiences along the whole pathway and system of care.

A number of reviews have examined the relationship between hospital and/or physician volume and outcomes, demonstrating an association between high volume and better outcomes for a range of procedures and conditions, but this evidence is more marked for more high-risk procedures including surgery for pancreatic and oesophageal cancer, abdominal aortic aneurysms and paediatric cardiac surgery<sup>22</sup>. The Department of Health (DH) document *Commissioning Safe and Sustainable Specialised Paediatric Services*<sup>23</sup> states that centres providing specialised paediatric services must have a sufficient volume of specialised care to ensure that they can provide sustainable and comprehensive support services.

The clinical evidence has been summarised in a separate document.<sup>24</sup> It has been shared with clinical members of the various working groups, the challenge has been in the interpretation of the published data taking account of the very different contexts of children's neurosurgical services in this country or internationally.

From the evidence the following conclusions can be drawn:

- There tends to be a longer time between the onset of symptoms and diagnosis of brain tumours than other childhood tumours.<sup>25, 26</sup>
- That the resection rate for some tumours is lower in the UK than international centres of excellence.<sup>27</sup>
- That the 30 day, 1 year and 5 year survival rates for some brain tumours in the UK may be lower than in the US and there are potentially many reasons for this<sup>28</sup>
- International evidence exists to suggest centres performing more ventricular shunt procedures have better outcomes than lower volume centres.<sup>29</sup>

22 Halm E.A., Lee C., Chassin M.R., Is Volume Related to Outcome in Health Care? A Systematic Review and Methodological Critique of the Literature. *Annals of Internal Medicine* 2002; 137: 511-520.

23 Department of Health, *Commissioning Safe and Sustainable Specialised Paediatric Services: A framework of Critical Inter-Dependencies*, August 2008

24 Paediatric Neurosurgery Evidence National Specialised Commissioning 2011

25 Wilne S.H. et al, 2006. The presenting features of brain tumours: a review of 200 cases. *Archives of Disease in Childhood*, 91, pp. 502-506.

26 Wilne S et al, 2007. Progression from first symptoms to diagnosis in childhood brain tumours: A multicentre study. *Archives of Disease in Childhood*, 92(Suppl.1), p.A69.

27 Bouffet E, 2007. Recent advances in ependymoma management. Liverpool ISPN.

28 Paediatric Neurosurgery Evidence National Specialised Commissioning 2011

29 Ibid (28)

- That shunts performed by a consultant out-of-hours fare better than those performed by a trainee<sup>30</sup>
- That the 30 day shunt revision rate in the UK may be higher than international centres of excellence<sup>31</sup>
- 1 in 10 admissions for children to an intensive care unit with traumatic brain injury has a fatal outcome. Outcomes across England and Wales varies considerably for these severe cases: from between 8.1% in some units and 18.8% in others.<sup>32</sup>
- Wide variation is reported in the process of care for children with severe traumatic brain injury, with potential impacts on survival.<sup>33</sup>
- Internationally, lower mortality rates have been demonstrated for children with traumatic brain injury treated in paediatric trauma centres than for those treated in adult trauma centres<sup>34</sup>

### 3.3 The experience of parents and carers

Understanding more about the experience that parents, carers and their representatives have had of services has been undertaken in two main ways. Firstly, parents were interviewed on an individual basis or in small focus groups at each centre as part of the centre visits. This information was thematically analysed and reported by Robert Hughes, Chairman of the Charity, Anna's Hope, and Steering Group member, in July 2010. Secondly, using the exemplar pathways developed by the Models of Care Group, these themes were tested with parents in a series of six regional workshops that took place in November 2010, engaging participants with the review, its progress, and the developing pathways and drawing upon their experience and insight to help design safe and sustainable neurosurgical services for children for the future.

This important work is available in two separate reports<sup>35, 36</sup> and some key points are reflected below:

- Specialist treatment, knowledgeable support and advice are highly valued by parents. The support and advice needs to be accessible by phone 7 days a week for parents and 24/7 for professionals working in local health services.
- The importance of local care, where possible.
- Providing fast access – this is about providing information to by-pass local gatekeepers when necessary because parents are trusted, their child's records are 'red-flagged' or they have their own electronic copy of records, and scans.
- Being known and trusted is a vital two-way part of the relationship between a family and an excellent service provider.

30 Richards H, et al 2009. Who should perform shunt surgery? Data from UK Shunt Registry. Cerebrospinal Fluid Research, 6(Suppl 1), p.S31.

31 Paediatric Neurosurgery Evidence National Specialised Commissioning 2011

32 Tasker R.C., Fleming T.J., Young A.E.R., Morris K.P., Parslow R.C., 2011. Severe head injury in children: intensive care unit activity and mortality in England and Wales. British Journal of Neurosurgery 25, pp.68-77

33 Morris K.P. et al (2006) UK Paediatric Traumatic Brain Injury Study Group, Intracranial pressure complicating severe traumatic brain injury in children: monitoring and management. Intensive Care Medicine, 32, pp.1606- 1612

34 Paediatric Neurosurgery Evidence National Specialised Commissioning 2011

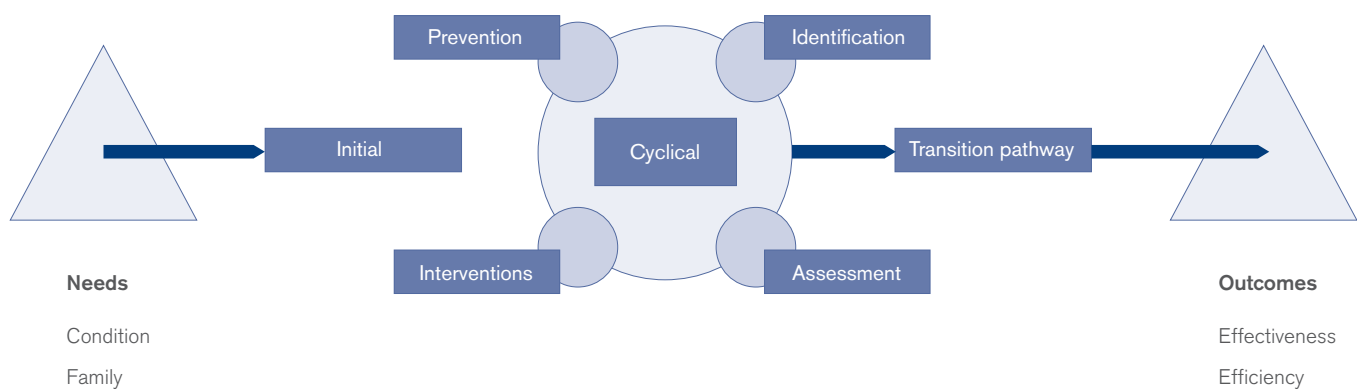
35 Emerging themes on the pathway design based on patients' and parents' experiences  
[http://www.specialisedservices.nhs.uk/library/31/15\\_July\\_2010\\_Parent\\_and\\_patient\\_experiences\\_paper\\_1.pdf](http://www.specialisedservices.nhs.uk/library/31/15_July_2010_Parent_and_patient_experiences_paper_1.pdf)

36 Report from Regional Charity/parent Workshops November 2010  
[http://www.specialisedservices.nhs.uk/library/31/Regional\\_ParentCharity\\_Workshops\\_\\_November\\_2010.pdf](http://www.specialisedservices.nhs.uk/library/31/Regional_ParentCharity_Workshops__November_2010.pdf)

- There are several crucial transition stages in most family's experiences:
  - From noting symptoms to finding a diagnosis,
  - Diagnosis to treatment options and perhaps surgery,
  - Managing frequent and/or long periods of treatment in hospital,
  - Transition into care at home.

These can be complex and parents need information, participation and a key worker to help them negotiate and co-ordinate these complex changes.

- Essentially parents were reflecting the challenges posed by three stages along the pathway of care (Figure 2)<sup>37</sup>; from presentation through to initial diagnosis and treatment; living with the on-going condition and the repeat cycles necessitating further identification, assessment and treatments preventing other complications; and the transition either back to normality, through to adult services or sadly death.



**Figure 2:** Diagrammatic representation of a pathway illustrating three stages, an initial pathway, a cyclical pathway and a transition pathway.

<sup>37</sup> Child Health Services in Europe, Wolff I ed. (anticipated publication date 2011), Chapter: Integrated care, informatics and improvement for children's services, Lenton S, European Public Health Observatory

## 4. DEVELOPING STANDARDS

The more detailed work on developing standards and pathways has been entirely reliant on clinicians from wide ranging professional bodies. They have led the work at every level in particular:

- Lead clinician(s) chaired the Standards Group and led the development of the standards.
- They led the fact finding visits to every centre.
- They contributed to the development of sub-specialty papers identifying best practice for the Models of Care, published evidence and the development of pathway principles for epilepsy, hydrocephalus, trauma, tumours and spinal dysraphism.
- They presented key evidence and findings to the Models of Care group's consideration.
- Lead clinicians supported the regional workshops for charities, parents and carers.
- They drafted the key areas of care documents for each specialty and commented frequently on their iterations and development.

The standards are broken down into key areas relating to the following:

- |          |                                   |
|----------|-----------------------------------|
| <b>A</b> | The network approach              |
| <b>B</b> | Making choices                    |
| <b>C</b> | The patient and family experience |
| <b>D</b> | Access to services                |
| <b>E</b> | Age appropriate care              |
| <b>F</b> | Prenatal Screening                |
| <b>G</b> | Excellent Care                    |

The standards are prioritised by importance for implementation in the networks and include best practice principles for the pathways of care for epilepsy surgery, hydrocephalus, brain tumours, brain trauma and spinal dysraphisms.

This work was discussed further in November 2010 in a workshop for over 200 clinicians including specialist nurses, anaesthetists, ambulance staff, neurosurgeons, paediatric neurologists, paediatric intensive care unit (PICU) staff, therapists, theatre staff, radiologists and oncologists. One of the aims of the workshop was to seek input and contributions to the development of this work on brain trauma, brain tumours, epilepsy and hydrocephalus and explore other aspects of service development and provision such as networks for paediatric neurosciences, education and training, research and development, audit and outcome measures. All comments from the workshops were reviewed by the Models of Care Group and comments have been taken into account in the subsequent work.

Throughout the review rehabilitation and re-ablement services emerge as a priority for the future and it is included as a key area in the exemplar pathways and standards. However, current services are variable and patchy within the different geographical areas around the country. This was identified as a significant area of need by wide ranging groups of clinicians during the site visits. Rehabilitation and re-ablement should be an integral part of the planning process for the managed care of the injured child, and for children with other neurosurgical conditions. Social, behavioural, mental health and educational needs of the child must be explicitly addressed in designing services for children as well as the needs of families especially where the child has ongoing complex healthcare needs or requires palliative care.

As part of developing the work for the Standards Group and Models of Care the National Specialised Commissioning Team commissioned a review of acquired brain injury in children including rehabilitation models and systems of care<sup>38</sup>. Rehabilitation services described in the literature mostly appear successful and have been designed around five key principles:

- a systematic approach for delivering the service
- a philosophy of enhanced participation in line with WHO concepts of disability
- high levels of communication, coordination and clarity of roles within the team
- a focus on the needs of families and the future educational potential of children
- formal evaluation of the service and a desire to improve the quality of care

This includes: comprehensive multidisciplinary assessment; a holistic goal setting approach with individually designed programmes focussing on context specific physical, cognitive, and behavioural function; strong links to outside agencies, particularly in the education and social care sectors, especially where there are safeguarding concerns. Important components specific to the rehabilitation of children include programmes that focus on memory and behavioural problems (including long lasting and severe problems that may need inpatient care), education liaison and outreach services, and programmes that target support for families.

This approach provides a rehabilitation framework for the future and should form part of the network of services for children's neurosurgery and it needs to be a discrete focus for multiagency commissioners of these services in the future.

38 Acquired Brain Injury in Children: A rapid review of post-acute rehabilitation models and systems of care, a literature review to inform policy for commissioning rehabilitation services following traumatic brain injury and neurosurgical procedures in childhood September 2010 Bazian



## 5. THE MODEL OF CARE - A FRAMEWORK FOR THE FUTURE

The quality of the paediatric neurosurgery service is dependent on a common purpose, values and practice shared between the various multi-disciplinary teams providing care. This purpose is to improve the care and safety for children, to improve the experience that children and their families have of services, and improve the outcome of care. It relies on wide ranging skills and expertise within these different teams.

The model of care for the services is described in the following sections and builds services around the journeys that children and families take through the various services involved, and common journeys are grouped together in pathways that share common components. Each component is delivered by a competent team and these teams work within a managed network striving for continuous improvements in the quality, safety, experience and outcomes of the service they provide. It relies on wide ranging skills and expertise within these different teams.

In developing the model of care, five exemplar pathways were used to describe the various elements of the services that would need to come together initially and these are: oncology, trauma, hydrocephalus, epilepsy and spinal dysraphism (spinal neural tube defects). The services covered are found not just in the specialist centre providing neurosurgery but in paediatric departments, Principal Treatment Centres for children's cancer, neurological centres, behavioural and psychological services, emergency departments, paediatric intensive care units, and diagnostic and imaging departments in a number of different hospitals and trusts across a regional area.

The service in the future needs all the component parts of the care system to work closely together in a managed network in order to make the best use of rare specialist expertise, standardising care, improving access, and reducing any distance delay effects that can result from the concentration of specialist services in large centres. The teams in these networks can actively work together to improve services and share learning. A network is described as a virtual organisation which drives continuous quality improvement; they need to provide coherence and integration from the parent and family perspective, from presentation, diagnosis, treatment, after care and support at home and at school.

The focus on rehabilitation services (as described in the previous section), from both a multidisciplinary perspective in specialised units, the community and schools, reinforces (amongst other things) the need for a systematic approach to delivering rehabilitation services within the network, high levels of communication, continuity, co-ordination and clarity of roles within the team, a focus on the needs of all family members and the future educational potential of children.

In proposing that managed networks are the vehicle for developing the services in the future, providing the mechanisms which brings all parts of the service together in a collaborative rather than a competitive way; it is clear that though there will be a national model for children's neurosurgical services, the delivery of the model will lead to different configurations depending on local circumstances and therefore networks around specialist centres need to be established as a 'best fit' for local people.

## 6. THE EXEMPLAR PATHWAYS AND AREAS OF CARE

Following the clinical workshop in November 2010 where the focus of the discussion was on pathways for brain tumour, brain trauma, hydrocephalus, epilepsy, an additional pathway for spinal dysraphism (spinal neural tube defects) has been developed with a total of 5 exemplar pathways to shape the model of care. Standards have been developed for each describing the key principles and best practice in care in the following domains:

- access,
- the principles of care,
- diagnosis and assessment,
- the MDT and the management plan,
- Interventions and Procedures,
- rehabilitation ongoing care and support

These standards are in Appendix A of the Children's Neurosurgery Specification Standards document.

Proposed quality measures are being developed for each pathway in order to support the improvements in service provision. It is important that services in the future can demonstrate continuous improvement in the care and safety provided for children; the experience that children and their families have and the outcomes of care through the robust collection of nationally agreed information. Some measures can be used to demonstrate improvement in the processes of care along the pathways within the networks and would feature as part of a network audit/improvement plan. Other measures are based on the systematic collection of agreed information on morbidity for example and can demonstrate comparative information about children's neurosurgery centres and networks in a way similar to that used by the national cancer programme.

The proposed elements of the service for children's neurosurgery are described in the following sections and are a commitment to the future. It will take a number of years to be realised and progress will be incremental.

## 7. THE MODEL OF CARE, UNDERPINNING PRINCIPLES

### 7.1 The network of care

The Children's Neuroscience Network (for the neurosurgical child) (CNN) will have clearly identified clinical leaders responsible for developing and agreeing the pathways of care with their local services. The core aim for these networks is that care and treatment should be provided as close as possible to the child's home, while ensuring the best possible outcome for the child. They will be required to develop formal pathways for paediatric neurosurgical sub-specialties (as described in the Standards document, Appendix A) identifying key processes appropriate to the local network, covering routine, urgent and emergency care, including the critical transition points along the pathway of care. Diagrammatic representations of the condition specific pathways are set out within this section and show the complex relationships between the different organisations. It is imperative that there are clear routes into the Children's Neurosurgical Centre's for all emergencies which are clearly understood by all.

The CNN's clinical leaders will be responsible for developing plans for improving skills across the network and demonstrating improved care outcomes in line with national requirements.

The network of care includes:

<b>Obstetricians, Perinatologists and Neonatologists</b>	Involved in investigation, diagnosis and counselling during pregnancy, planning and management of delivery and care of the newborn baby.
<b>GPs</b>	Plays a key role in the early recognition of the condition, appropriate referral, support and follow up.
<b>Paediatricians and Specialist Paediatricians in Child Health services in local DGHs</b>	Are often the first point of contact in hospital following the initial presentation of the child's condition. They are likely to initiate further investigations and seek the advice and support from the Paediatric Neurosurgeons and Radiologists in the Children's Neurosurgery Centre. They also play a key role in after care and support.
<b>Children's Neurological Centre/ Services</b>	May also be the point of specialist advice following the initial presentation or involved in support of specialist paediatrics to agree a diagnosis. They may also seek the support of clinical and behavioural psychologists.
<b>Children's Neurosurgery Centre (CNC)</b>	Has 24/7 advice and support provided by Paediatric Neurosurgeons (PNs) who can discuss diagnosis and treatment plans with clinicians in the network. They will undertake the neurosurgical procedure and agree the management plan for follow up and after care.
<b>Principal Treatment Centres for Children's Cancer (PTC)</b>	The Paediatric Oncologist (who has received appropriate training in the management of brain tumours), and the multidisciplinary team will be involved in agreeing the management plan for children with brain cancer, together with the PNs. They will be integral to the monitoring and review of the treatment plan and the child's after care and support.

<b>Trauma Unit</b>	When a child has been involved in an accident, this unit, which is part of the Major Trauma Network, may be responsible for stabilising the child's condition, undertaking urgent scans and discussing treatment plans with the MTC.
<b>Major Trauma Centres (MTC) and/or Children's MTC</b>	These are the Major Trauma Centres (MTC) in the Trauma Network. In some places they will be combined caring for adults and children, and in others they will be dedicated children's services. There will be a trained trauma team present 24/7. They will assess, investigate, stabilise and prioritise the treatments required and agree the immediate and ongoing management of head injuries with the PNS.
<b>Adult Neurosurgical Centre (ANC)</b>	These centres have an important role to play in the delivery of care for children with neurosurgical conditions: they will admit and treat children with life-threatening emergency conditions in discussion with the PNS. After life-saving surgery, the child will be transferred to the lead Children's Neurosurgery Centre. They will also play a key role in the transition to adult services.
<b>Rehabilitation Services</b>	The comprehensive multidisciplinary assessment starts in the CNC, and includes a holistic goal setting approach with individually designed programmes focussing on specific physical, cognitive, and behavioural function. This may include services provided in a rehabilitation centre and service provided in the community based around the child's home and school.

**A Paediatric Neurosurgeon** is defined within the proposed standards document (G1) and is a consultant neurosurgeon who has undertaken a one-year GMC recognised Fellowship in a recognised paediatric neurosurgical centre as recommended in *Safe Paediatric Neurosurgery* (2001)<sup>39</sup>. If accepted, this standard will be applied to all new appointments, and it is recognised that some existing consultants with substantial paediatric practice may not have undertaken formal fellowships. A substantial proportion of the consultant's job plan (minimum of 50% or 5 PAs) should be allocated to paediatric neurosurgery and it is recommended that this should translate into being involved in approximately 80 operative cases per year. It is accepted that this individual operative workload may vary within a CNC team according to particular paediatric or adult sub-specialist interests. There should be evidence of regular Continuing Professional Development (CPD) in paediatric neurosurgery.

It should be noted that all qualified neurosurgeons are competent to undertake life saving care for children in an emergency situation.

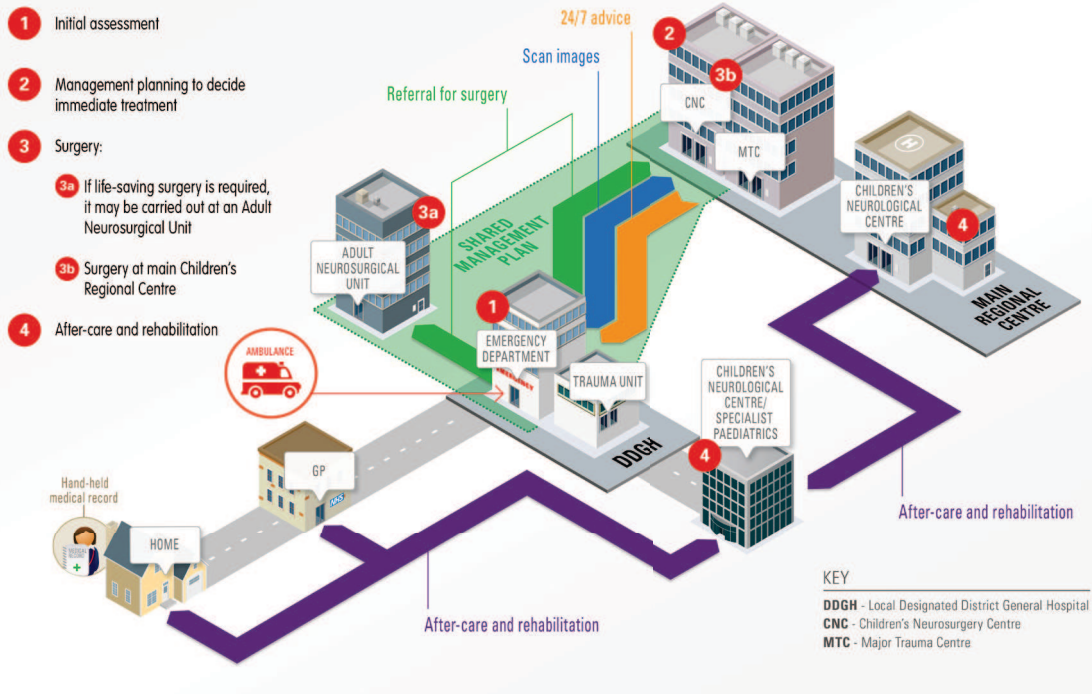
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39 Safe Paediatric Neurosurgery 2001 – A Report from the Society of British Neurological Surgeons (2001)

		Trauma	Hydrocephalus	Spinal neural tube defects	Tumours	Epilepsy
<b>Obstetricians Perinatologists Neonatologists</b>	<ul style="list-style-type: none"> <li>Antenatal investigation and diagnosis.</li> <li>Counselling and planning.</li> <li>Management of delivery and stabilisation and care of newborn.</li> </ul>		✓	✓		
<b>GPs</b>	<ul style="list-style-type: none"> <li>Early presentation of the condition.</li> <li>Longer term condition's.</li> <li>Cycles of care supporting after care.</li> </ul>	✓	✓	✓	✓	✓
<b>Paediatricians and Specialist Paediatricians in Child Health services in local DGHs</b>	<ul style="list-style-type: none"> <li>First point of contact.</li> <li>Initiate further investigations.</li> <li>Advice and support from PNs in CNC after care and support.</li> </ul>	✓	✓	✓	✓	✓
<b>Children's Neurological Centre/Services</b>	<ul style="list-style-type: none"> <li>Point of specialist advice.</li> <li>Support of specialist paediatrics to agree a diagnosis .</li> <li>After care and support.</li> </ul>	✓	✓	✓	✓	✓
<b>Children's Neurosurgery Centre (CNC)</b>	<ul style="list-style-type: none"> <li>24/7 PNs advice and support.</li> <li>Discuss diagnosis and treatment plans with clinicians in the network.</li> <li>Agree the management plan follow up and after care.</li> </ul>	✓	✓	✓	✓	✓
<b>Principal Treatment Centres for Children's Cancer (PTC)</b>	<ul style="list-style-type: none"> <li>Multidisciplinary team agree management plan with the monitor &amp; review treatment plan with PNs after care and support.</li> </ul>		✓		✓	
<b>Trauma Unit</b>	<ul style="list-style-type: none"> <li>Stabilise child's condition, urgent scans, discuss treatment plans with the MTC.</li> </ul>	✓				
<b>Major Trauma Centres (MTC) and/or Children's MTC</b>	<ul style="list-style-type: none"> <li>Trained trauma team present 24/7 assess, investigate, stabilise prioritise agree management of head injuries with PNs.</li> </ul>	✓				
<b>Adult Neurosurgical Centre (ANC)</b>	<ul style="list-style-type: none"> <li>Treat children with life-threatening emergency conditions.</li> <li>Key role in the transition to adult services.</li> </ul>	✓	✓	✓		
<b>Rehabilitation Services</b>	<ul style="list-style-type: none"> <li>Individual programmes focussed on physical, cognitive, and behavioural functions.</li> <li>A rehabilitation service in CNC and around the child's home and school.</li> </ul>	✓	✓	✓	✓	✓

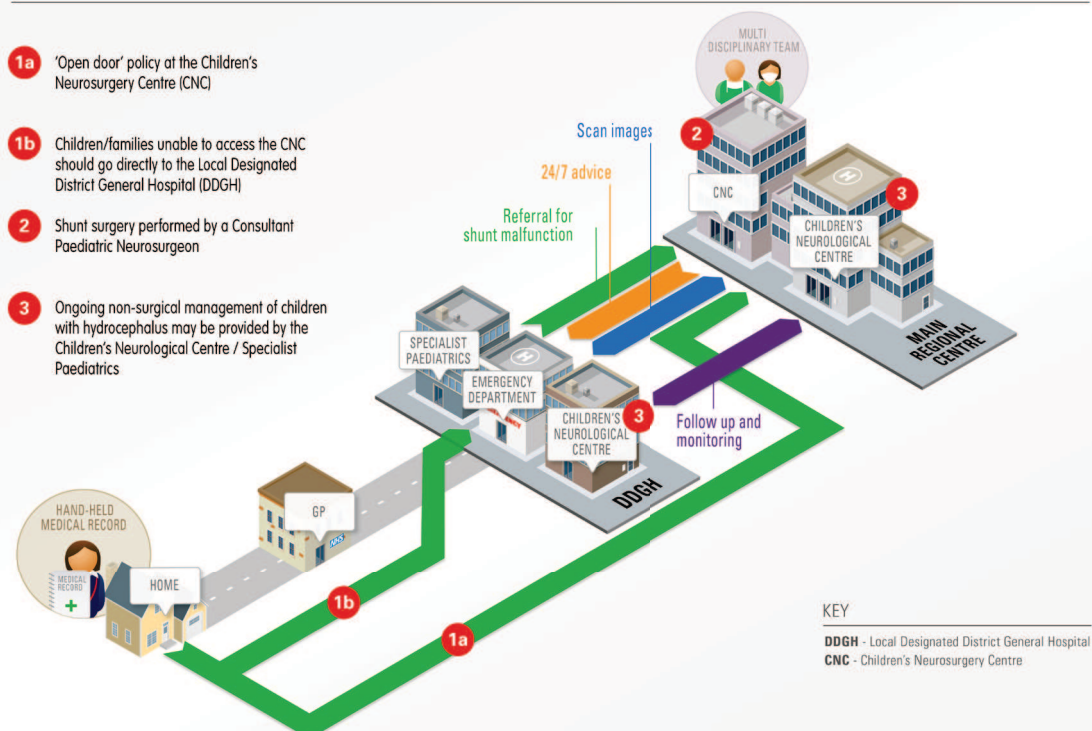
## LOCAL NEUROSURGICAL NETWORK: Brain Trauma

Safe and Sustainable  
Children's Neurosurgical Services



## LOCAL NEUROSURGICAL NETWORK: Hydrocephalus

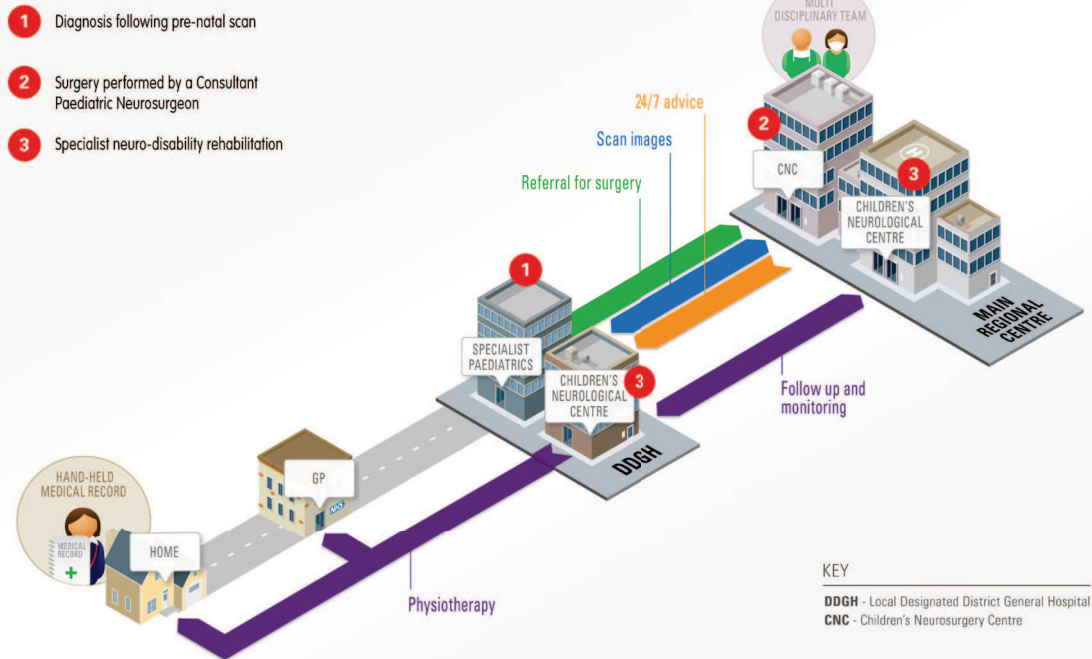
Safe and Sustainable  
Children's Neurosurgical Services





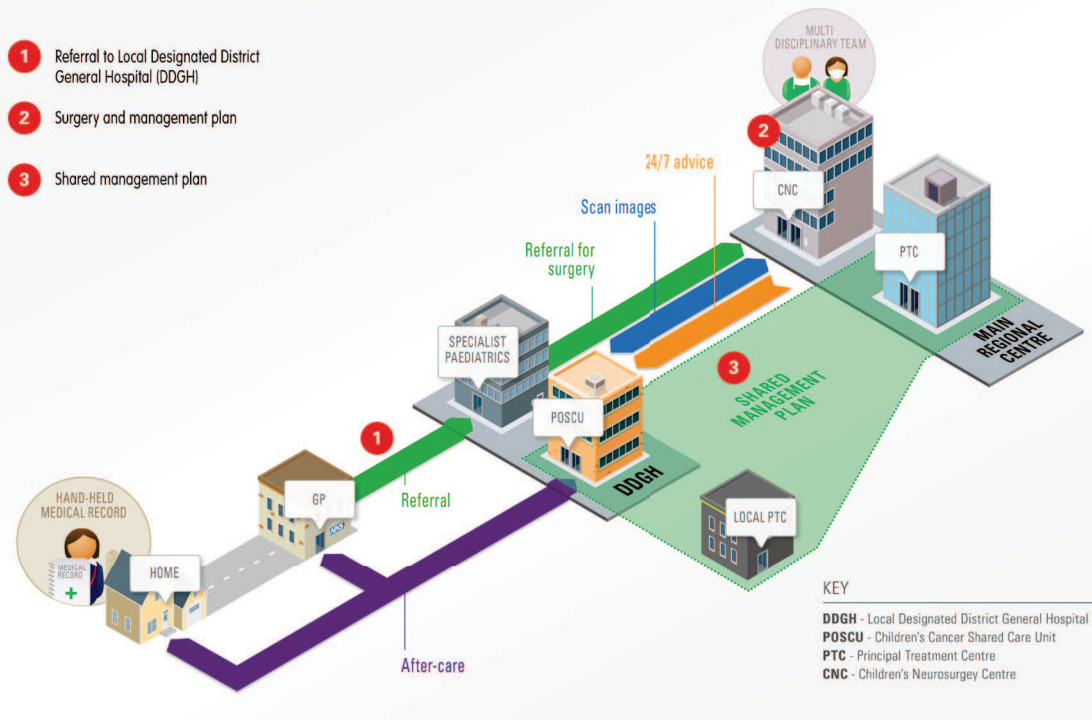
## LOCAL NEUROSURGICAL NETWORK: Spinal Neural Tube Defects

Safe and Sustainable  
Children's Neurosurgical Services



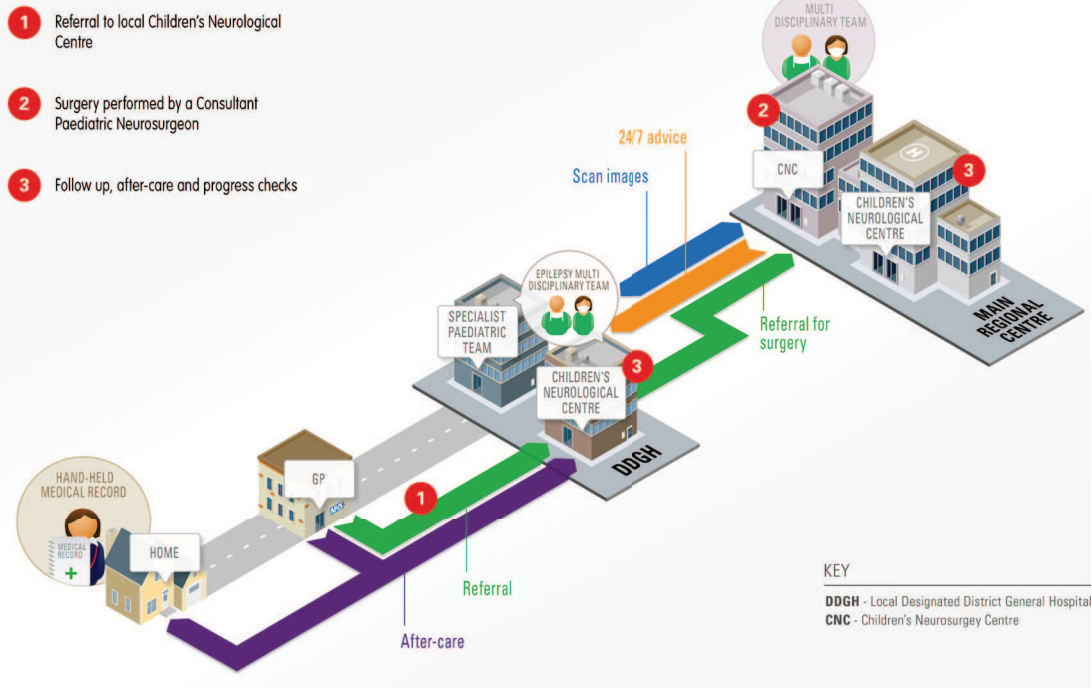
## LOCAL NEUROSURGICAL NETWORK: Brain Tumour

Safe and Sustainable  
Children's Neurosurgical Services



## LOCAL NEUROSURGICAL NETWORK: Epilepsy

Safe and Sustainable  
Children's Neurosurgical Services





## 7.2 Children's Neuroscience Network (for the neurosurgical child)

### - The Network Management Role

There are 14 centres currently across the country as described in section 3.1 It is envisaged that there will need to be a number of networks across England each covering a defined population and who meet the service criteria described in this document. CNNs need to involve at least 2 Children's Neurosurgical Centres working closely together so that they can develop shared clinical guidelines and protocols; benefit from shared audit, research, training and development. One of the Children's Neurosurgical Centres (CNC) will take a management role for the network supported by clinical leaders from the network who are responsible for specific pathways or subspecialties across the network.

Children's Neuroscience Networks need to have:

- a) clear governance structures supported by agreements with participating organisations*
- b) an identifiable management team and support for the network provided by an NHS trust with a Children's Neurosurgical Centre;*
- c) clinical leaders with defined roles, responsibilities and accountabilities either for the network overall or for clinical pathways or subspecialties across the network;*
- d) active user involvement;*
- e) robust clinical governance arrangements;*
- f) processes to achieve excellence, including assessment and review against standards, shared policies and guidelines, audit;*
- g) research, training and development, including supported continuing professional development processes and a programme of shared learning across the organisations.*

## 7.3 Network criteria

Each Network should be in a position to offer their population a world class service for virtually the whole range of paediatric neurosurgical conditions – although there will remain a need for some rarer conditions to still be managed in fewer national centre(s). In order to achieve the range of provision over time, these services might need to be concentrated in one hospital within the network taking account of the skills and experience of the local children's neurosurgical multidisciplinary teams. This needs to be agreed locally within the networks and with service commissioners, taking account of the particular neurosurgical skills and the need to maintain expertise for specialist conditions and avoid occasional practice.

These are the overarching principles of care for services across the network:

- 24/7 advice and support will be provided by Consultant Paediatric Neurosurgeons (PNS) to the relevant regional networks providing care for trauma (Major Trauma Centres and Trauma Units), cancer and other clinical neurosurgical services as required. This information about rotas will be shared widely with services within the network.
- Local referral pathways for urgent review and assessment, diagnosis and treatment need to be developed for each network for each condition, developed by the Clinical Leads in the Children's Neuroscience Network in conjunction with the wider clinicians involved in the care of children and disseminated widely to referring clinicians. However even though there are different specific clinical issues for the different conditions, and complex relationships within the network for these conditions, it is imperative that there are clear routes into the CNC's for all emergencies which are clearly understood by all.
- Networks need to clearly appraise the balance of consultant paediatric neurosurgical skills available to them. They will need to assess the type of procedures being undertaken by the network for the ranges of surgical subspecialties provided and collectively agree how that develops and changes over time to ensure the best service available for their children and families.
- Networks will need to develop plans for training and continuing professional development (of both medical and non-medical staff) which will be agreed by the network and supported by the different organisations.
- The network for care will be underpinned by good communication, co-ordination and clarity of role. These are essential for both clinicians and parents to understand the networks and the relationships for different elements of their child's care. This information should be provided to families.
- Neurosurgical networks should provide agreed hand held records with key information about the child's care. This may include scans and other information where relevant so that parents can provide this in situations, for example family holidays or when problems arise.
- In an emergency and 24/7, a management plan will be agreed with the referring hospital within an hour; and there would be access to emergency procedures undertaken by Consultant Paediatric Neurosurgeons as required according to the needs of the child.
- The management plan is a fundamental part of every child's care and needs to be agreed with the family and shared with them on an ongoing basis as the needs of the child changes. This should include the appropriate prevention of secondary complications for long term conditions such as shunt management and potential behaviour problems associated with brain injury.
- All designated services within the various networks must have an image exchange portal for transfer and remote viewing of scans for specialist advice and support.

- There are good working relations between the Children's Neuroscience Network (CNN) and 'adult' neurosurgery. This is important not only for access to relevant clinical expertise (from the adult to the children's service and vice versa), but also to underpin neuroscience research, and to support the transition to adult services whenever that is appropriate for the child.
- Some rarer and more complex procedures, such as those for some rare brain cancers and complex epilepsy surgery in young children may not be undertaken in every network and therefore will require networks to collaborate across a wider geographical area.

## 7.4 The Designated Local DGH

These are the overarching principles of care for services for the Designated DGH:

- These services would play a key role in the network and provide a specialist role as first point of access for most conditions. They would have access to 24/7 advice and support from the consultant Paediatric Neurosurgeons (PNS) based in the Children's Neurosurgery Centres (CNC) and from the Children's Neurological Service and network. The nature of the services required for these more specialised DGHs will mean that there will not be one in every local DGH.
- These services would be the local Trauma Unit and part of the paediatric trauma network and would be able to provide appropriate scanning to support initial diagnosis and referral following discussion with Major Trauma Centres (MTCs).
- The lead clinician(s) would play a key communication and coordination role in the networks for cancer, trauma and neurology. They would support the Children's Neurological Centre and CNC and provide appropriate after care and support.

## 7.5 Children's Neurological Centres and Networks

Children's Neurological networks are already a fundamental part of the services for children with wide ranging different neurological conditions that don't require neurosurgical input. These networks link to local specialist paediatric services with many specialist children's neurologists providing outpatient clinics locally for children and their families. The proposals in this document strengthen and build on this approach.

These are the overarching principles of care for the Children's Neurological Centres:

- The Children's Neurological Centre will have a specialist role in the network providing diagnosis, expert advice and treatment of a range of conditions. Within any particular neuroscience network there will be Children's Neurological Centres co-located with the CNC and others will not be co-located but will continue to play a key role in providing specialist neurological care. Over time these services will also be co-located with some specialist designated DGHs.
- The Children's Neurological Centre will play a leadership role in the provision of specialised paediatric neurology services across the network, with 24 hour availability of a Consultant Paediatric Neurologist.

- The Children's Neurological Centre would be expected to manage children with most acute neurological disorders not requiring intensive care. Paediatric Neurology input for most would be provided by a combination of 24 hour on-call telephone advices from the linked CNC with a greatly enhanced day-time out-reach service.
- In-patient acute neurological care provided by paediatric neurologists would only be undertaken at the CNCs and some other larger specialist centres.
- The Children's Neurological Centre with be a focus for the multi professional team required to support rehabilitation and would ensure the care is age and needs appropriate managing the transition to adult services when that is most appropriate for the individual and their family.
- The Paediatric Specialist in Neuro-disability with specialist therapists would provide a key role in these services and networks.
- Behavioural and clinical psychological services are important part of the services available to the network both for the specialist interventions at the CNC /Children's Neurological Centre and the more local support for the family.

## 7.6 Principal Treatment Centres for Children's Cancer

The services that need to come together for the care of the child with brain cancer are many, requiring close co-ordination between the different elements. These include: the Principal Treatment Centres (PTCs) and the Shared Care Units (POSCUS) which may be involved in giving chemotherapy more locally to the child's home. All the specialist centres and units contributing to the network of care for children with brain tumours should comply with the National Institute for Health and Clinical Excellence (NICE) Children's and Young People with Cancer Improving Outcomes Guidance (CYPIOG).<sup>40</sup> This is essential for units delivering any aspect of treatment/care (diagnostics, surgery, chemotherapy, radiotherapy, supportive care) to children with these conditions and will be subject to cancer Peer Review against the children cancer measures arising from the IOG.

These are the overarching principles of care for Principal Treatment Centres for children's brain cancer:

- The Children's Neurosurgery Centres (CNC) must be co-located with Principal Treatment Centres (PTC) for childhood cancer. In line with the Service Inter-Dependency Framework<sup>41</sup> co-location is essential to provide a full specialised service; otherwise a very close clinical network would be essential.
- Not every Principal Treatment Centres (PTC) would provide care for children with brain cancer. At diagnosis children would be admitted directly from their local hospital to the CNC with its associated PTC for diagnosis and surgery. If there is a more local PTC they would not be admitted there first as this may result in unacceptable delays in care. Once the condition is stable following surgery, children may be transferred from the specialist CNC to a more local PTC for chemotherapy and other treatment.

40 National Institute for Health and Clinical Excellence 2005 Improving Outcomes in Children and Young People with Cancer

41 Department of Health, Commissioning Safe and Sustainable Specialised Paediatric Services: A framework of Critical Inter-Dependencies, August 2008

- The specialist MDT at the PTC co-located with the CNC would be responsible for the diagnosis, decision making, treatment plan and review for the individual child as well as co-ordinating the provision of the care provided within the network, either with the more local PTC (if there is one) and Shared Care Unit
- For some very rare cancers a regional specialist MDT may be established which operates across a number of networks to agree the decision making, treatment plan co-ordinating monitoring and reviewing the provision of the care.
- The local PTC working with their Children's Neurological Centre would be responsible for the rehabilitation plan for children within their local area.

## 7.7 Adult Neurosurgery

These are the overarching principles of care for the adult neurosurgery services working closely with children's services. Adult Neurosurgical Centres have an important role to play in the delivery of care for children with neurosurgical conditions:

- The Adult Neurosurgical Centre will admit and treat children with life-threatening emergency conditions where the timing of surgery will improve the chances of a good outcome. The decision to proceed is achieved in discussion with the Children's Neurosurgery Centre (CNC)
- Usually after life-saving surgery the child will be subsequently transferred to the CNC, there may be some circumstances where it is in the child's best interests to stay at the adult neurosurgical centre for some elements of their continuing care.
- All neurosurgeons on the emergency rota should maintain competence in emergency surgery for babies and children requiring such care. Support for the continuous professional development for these surgeons should be provided by the CNC.
- There must be close working relationships between the Adult Neurosurgery Centre and the CNC. Some PNS will also work with adults and this will be formalised in the consultant's job plans. A named Adult Neurosurgeon will be the link with the CNS and vice versa.
- There will clear transition plans for young people moving into adult services with a named neurosurgeon for key conditions.

## 7.8 Children's Neurosurgery Centre (CNC)

The pathways and services described for in all the diagrams of the services show the key role that Children's Neurosurgery Centres (CNCs) play in the networks for these services.

These are the overarching principles of care for services across the network:

- 24/7 care would be provided by Consultant Paediatric Neurosurgeons. A definition of a Consultant Paediatric Neurosurgeon is someone who spends 50% of time (equivalent to 5 programmed activities) in paediatric neurosurgery. This should translate into being involved in approximately 80 operative cases per year, it is accepted that this individual operative workload may vary within a CNC team according to particular paediatric or adult sub-specialist interests.
- 24/7 advice and support would be provided by Consultant Paediatric Neurosurgeons to the relevant regional networks for trauma, cancer and other clinical neurosurgical conditions as required. In an emergency a management plan would be agreed with the referring hospital within an hour and there would be access to emergency procedures as required according to the needs of the child.
- All new admissions should be seen by a Consultant Paediatric Neurosurgeon within 24 hours of admission and all children requiring neurosurgical input (including ward, HDU and PICU) should be reviewed daily by a Paediatric Neurosurgeon.
- The Children's Neurosurgery Centres (CNC) may have a minimum of 4 such surgeons some of whom may spend 100% of their time in caring for children; others may have a mixed adult and children's practice.
- Trauma and shunt procedures would be core to every Paediatric Neurosurgeon.
- The CNC would provide most surgery but some very specialist tumours or epilepsy surgery for example will take place in a more limited number of more specialised centres.
- The CNC will be co-located with the Children's Neurological Centre supporting the network for children's neurological services.
- The key worker role would be provided by the CNC in order to provide help and support to parents during active treatment for the particular pathway. This support may pass to the PTC or Children's Neurosurgical Centre as appropriate during different phases of the child's care.
- Specialist consultant neuroradiologists are integral to the MDT at the CNC and will be required to support the network advisory role. This needs to be properly resourced within the job plan together with the leadership and professional development roles.
- The CNC would be responsible for providing agreed outcome data for key procedures and responsible for the contribution of the network to national audit. National comparative outcome data analysis will occur on a regular basis as part of the national commissioning process.

## 7.9 Specialist Neuro-rehabilitation Services

These are the overarching principles of care for these services:

- Rehabilitation and re-ablement services should be an integral part of the planning process for the managed care of the injured child, and for children with other neurosurgical conditions.
- There must be a systematic approach to delivering rehabilitation services with high levels of communication, co-ordination and clarity of roles within and between teams, focusing on the needs of families and the future social and educational potential of children.
- The comprehensive multidisciplinary assessment starts in the CNC, and includes a holistic goal setting approach with individually designed programmes focussing on specific physical, cognitive, and behavioural functions.
- There should be a lead consultant in rehabilitation who provides leadership in developing the child's management and rehabilitation plan who also provides advice and support for the care required through the network of services.
- A key worker must be identified within the network providing an important role in supporting children and families and a care package must be identified prior to discharge from the CNC which identifies ongoing care rehabilitation and support in the community around the child's home and school. This might include clinical care at home, information and training for the family, the needs for supporting education, and strategies for learning and concentration.
- Early contact/referrals should be made with local paediatricians, multidisciplinary teams, and GPs so that they can be involved in planning the long-term care.



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## 8. CONCLUSIONS

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Doing nothing is not a viable option. This document reminds us that children's neurosurgical services are very complex with areas of care linked to complicated networks such as cancer and trauma. These services need to provide care and support to the child and their families for 'long term conditions' such as hydrocephalus and spina bifida, and the challenges for emergencies, urgent and elective care - 24/7. In the 21st century parents expect that their child can be treated by a paediatric-trained neurosurgeon, with access to care and support 24 hours a day, 7 days a week.

The proposals to establish managed Children's Neuroscience Networks allows these services to continue to evolve within a national framework of standards and approaches. As they do so they will become better at demonstrating improvements in the services' care and safety, the experience children and their families have of the whole pathway of care and improvements in the outcomes of care through the robust collection of national information. They will also clearly appraise the balance of consultant paediatric neurosurgical skills available to them, assessing the type of procedures being undertaken by the network for the ranges of surgical subspecialties provided and collectively agree how that develops and changes over time to ensure the best service is available for their children and their families.

Children's Neuroscience Networks provide the opportunity to develop these services in a cost effective way, sharing knowledge and learning. This is not the 'easy' option for managing change; it is the most comprehensive approach providing improvement challenges from referral to treatment and aftercare, whether this takes place locally or in more specialist regional services. If we want a world class, safe and sustainable service that we can rely on to provide the very best standards of care for these children for the future, this year on year improvement should be systematic, comprehensive and transparent, providing coherence and integration from the parent and family perspective.



ACKNOWLEDGEMENTS

The review has been led by a Steering Group with representatives from the following:

- Lay representation
- British Paediatric Neurosurgical Group
- Society of British Neurological Surgeons
- British Paediatric Neurology Association
- Children’s Cancer and Leukaemia Group
- Paediatric Intensive Care Society
- Royal College of Paediatrics and Child Health
- Royal College of Anaesthetists
- Neuroanaesthesia Society of Great Britain & Ireland
- Association of Paediatric Anaesthetists
- Royal College of Nursing
- NHS commissioners
- NHS in Scotland and Wales
- NHS public health doctors
- NHS Strategic Health Authorities
- Department of Health

## Comments

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# CHILDREN'S NEUROSCIENCE NETWORKS (FOR THE NEUROSURGICAL CHILD) SPECIFICATION STANDARDS

## FEBRUARY 2012

# INTRODUCTION

The National Specialised Services Safe and Sustainable Team have been working on a national review of paediatric neurosurgical services in England on behalf of the NHS Medical Director and the ten Specialised Commissioning Groups since 2009. Throughout the review, the aim has been to combine clinical evidence of best practice, expert advice from clinical leaders in the field, with national policies and guidelines on standards in key areas. This has been brought together with the insights of parents of children who have experienced brain or spinal cancer, brain trauma and conditions such as epilepsy, hydrocephalus and spina bifida, and the views of clinicians in the fields of neuroscience, paediatric medicine and rehabilitation in order to provide a framework and strategy for developing these services in England for the future.

These standards support the model of care for these services and have been developed by the Standards Writing Group reporting to the Steering Group for Paediatric Neurosurgery Services. The first version of these standards was distributed widely for comment in November 2009 and those comments have been taken into account in this document, but they have also been changed to reflect the work on the service framework and the work on the exemplar pathways for brain tumour, brain trauma, epilepsy, hydrocephalus and spinal neural tube defects which now appear in Appendix A. The Steering Group has endorsed the proposal to establish regional children's neuroscience networks (for the neurosurgical child) to manage change in a proactive way. These standards will support this approach.

The following priorities have been used for each of these standards:

MANDATORY	Must be in place within the network at the establishment of the networks	These will be reviewed at 6 months to assess the effectiveness of implementation
MANDATORY ORANGE	Plans will be in place to achieve these standards within a time critical period - usually 6 months from the establishment of the network	These will be reviewed at the end of the first year to assess progress
YELLOW	Plans will be in place to achieve these in the second year of the network	These will be reviewed at the end of the second year
GREEN	These are important generic standards which are part of NHS 'Core' standards	

# THE NETWORK APPROACH

A1	<p>The Children's Neuroscience Network - for the neurosurgical child, will have a formal and dedicated management group, with a lead consultant, nurse and administrator, for the management and coordination of the service, responsible for the continuous improvement of standards within the network as set out in this section. This group will be based at a Children's Neurosurgical Centre (CNC) having the management responsibilities for the network, and supported by relevant inter-trust agreements.</p>
A2	<p>All centres will provide clear leadership and participation in their children's neuroscience networks, with a formally nominated Clinical Lead and Lead Nurse in order to manage and develop further referral, care and treatment pathways, policies, procedures, performance monitoring and audit, relevant professional training and development in referring hospitals and primary care. The Clinical Leads may have a pathway/condition responsibility in which case all would need to be involved in the management of the network.</p> <p>The Children's Neuroscience Network will hold regular multi-disciplinary meetings across the network and local services for developing these issues.</p>
A3	<p>All regional Children's Neuroscience Network's will be co-ordinated and reviewed nationally by NHS Specialised Services; this will include comparative outcomes and measures as set out in this document, job plans and CPD activity of all consultant paediatric neurosurgeons. The number of annual surgical procedures per centre, the range of surgical procedures and the planning population required to achieve this will be reviewed regularly within each regional network to minimise occasional practice and maintain the skills of all paediatric neurosurgeons, in line with standard G1.</p>
A4	<p>The Children's Neuroscience Network of services will be responsible for the pathways of care that reflect the principle that as much care and treatment should be provided as close as possible to the child's home, while ensuring the best possible outcome for the child.</p> <p>The clinical leaders for the network will develop and coordinate the formal pathways for paediatric neurosurgical sub-specialities (as detailed in Appendix A), including trauma, hydrocephalus, tumours, epilepsy and dysraphism. They will identify key processes appropriate to the local network that cover the critical transition points along the pathway of care.</p> <p>There must be coordinated Safeguarding arrangements throughout the network.</p>
A5	<p>All centres must provide comprehensive care which is linked to local services, other tertiary centres, nationally designated specialist services and demonstrate compliance with requirements for networks for major trauma and children's cancer.</p>
A6	<p>Protocols must be developed for the delivery of emergency life-saving treatment that may be necessary at referring hospitals in accordance with the <i>Joint Statement from the Society of British Neurological Surgeons (SBNS)</i> and the <i>Royal College of Anaesthetists (RCoA) Regarding the Provision of Emergency Paediatric Neurosurgical Services (Appendix C)</i>.</p> <p>Emergency and urgent care pathways must be developed by each network and widely disseminated to referring clinicians and units.</p>

A7	<p>The pathway for children requiring life-saving surgery within the network area will be the formal responsibility of the Children's Neurosurgery Centre with the network management responsibility for the pathway. This must be clearly elaborated within the network. The on call paediatric neurosurgeon (PNS) for the network will be responsible for developing the management plan in conjunction with the referring hospital and will provide on-going definitive care and/or transfer when there is insufficient capacity in the children's neurosurgery centre. There will be a single point of contact responsible for co-ordinating care.</p>
A8	<p>Adult Neurosurgical Centres have an important role to play in the delivery of care for children with neurosurgical conditions:</p> <ul style="list-style-type: none"><li>• The adult neurosurgical centre will admit and treat children with life-threatening emergency conditions where early surgical intervention will improve the chances of a good outcome. The decision making to proceed will be achieved in collaboration with the on-call PNS. Usually after life-saving surgery the child will be subsequently transferred to the relevant CNC. However, there may be some circumstances following agreement where it is in the child's best interests to stay at the adult neurosurgical centre for continuing care. Where this is necessary the environment must meet the minimum standards outline in the RCN (2011) Health care service standards in caring for neonates, children and young People, London: RCN.</li><li>• The adult neurosurgical centre must maintain availability of key equipment for emergency surgery on neonates and children agreed by the relevant CNC</li><li>• This equipment must be checked by the CNC on an annual basis</li><li>• There should be a named surgeon for paediatric neurosurgery liaison in the adult centre who is the link to the CNC</li><li>• The annual audit of clinical outcomes (G9 standard) must include all cases operated on throughout the network [not just those at the main centre providing the child's care]</li></ul>
A9	<p>There will be specific guidelines within each network for the transfer of children requiring neurosurgery which will include a clear description of roles and responsibilities for the paediatric neurosurgeon leading the care of the child and the PICU retrieval service.</p>
A10	<p>The Children's Neuroscience Network will develop a training plan for their networks which will build on best practice including awareness of symptoms requiring investigation, escalation and the mechanisms for this.</p> <p>In particular this should include "Pathways to diagnosis" project, and the Diagnosis of Brain Tumours in Children, a Guideline for Health Professionals; neurological assessment in accordance with NICE guidelines: Head Injury: triage, assessment, investigation and early management of head injury in infants, children and adults. 2007.</p> <p>There should be written policy and guidelines for neurological observations for all wards in the network which reflect these.</p>
A11	<p>There should be evidence of good communication covering the different levels of interactions between clinicians, and between clinicians and parents / carers and between clinicians and children / young people. Protocols for communication will be developed and agreed with local referring paediatricians, paediatric neurologists, children's neurosurgical specialist nurses, clinical psychologists and patient groups.</p>

A12	Children transferring between services will be accompanied by high quality information, including a health records summary (with the responsible clinician's name) and an on-going management plan agreed and shared with carers.
A13	All referring hospitals (specialist DGHs, Children's Neurological Centres, Principal Treatment Centres, Trauma Units, Major Trauma Centres, and Adult Neurosurgical Centres) within the network must have imaging facilities and links which allow for immediate transfer of images to the Children's Neurosurgery Centre.
A14	Each Network will identify a named lead consultant in neuro-rehabilitation, who will provide rehabilitation services where required and act as the source of expert advice for network local paediatricians and GPs to facilitate the local delivery of services where possible.

B. MAKING CHOICES

B1	Information must be made available to children and their families in different formats. It must include information about the condition and the range of treatments appropriate to their needs at various points of the pathway. It should be clear, comprehensive, understandable, culturally sensitive, evidence based and include important procedures such as anaesthesia and radiology for example.
B2	Parents/carers must be kept fully informed about their child's care (including care plan and progress) and be partners in decision making about their child's care.  The family must be helped to understand the child's condition, the effect it may have on their child's health and future life and the treatment that they will receive. They must be encouraged to actively participate at every stage in their child's care.
B3	Patients, parents and carers whose first language is not English must be provided with appropriate interpreting and translation services.
B4	Where surgery is planned, the child and their parents or carers must have the opportunity to visit the centre and to meet the clinicians who will be responsible for their care, including an opportunity to discuss the planned operation with a consultant paediatric neurosurgeon or children's neurosurgical specialist nurse.  Consent for planned procedures should normally be sought by the Consultant in advance of the admission and the status of consent re-checked before the operation, reflecting that the process of consent is continuous.
B5	Parents, carers and all health professionals involved in the child's care must be given details of who and how to contact if they have any questions or concerns, including information on the main signs and symptoms of possible complications or deterioration and what steps they should take. They must have immediate 24-hour access to a member of the clinical team for advice, information and support.
B6	Parents and carers must be fully supported in obtaining further opinions when requested (both within the centre and from neurosurgeons outside the centre).



C. THE PATIENT AND FAMILY EXPERIENCE

C1	There must be dedicated clinical facilities that are designed around the needs of children (diagnostic, ward, theatre, staffing, support).
C2	Each child must have named individuals (consultant and children’s neurosurgical specialist nurse) responsible for coordinating their care, and who acts as a liaison between the clinical team and the child throughout their care.
C3	Parents and carers must be provided with accessible information about the service and the hospital, including information about amenities in the local area, travelling, parking and public transport.
C4	Children, their parents and carers should be encouraged to provide feedback on the quality of care and their experience of the service, and they should be encouraged to participate in national Patient Reported Outcome/Experience Measures (PROMS) and patient experience measures and surveys. Centres must make this feedback openly available, and they must demonstrate how they take this feedback into account when planning and delivering their services.
C5	Centres must support patient and family support groups and networks.  The children’s neurosurgical specialist nurse should provide children and their families/carers with information about how to get in touch with patient groups.  Additional information should be available for families on support groups and other parents who are willing to share their experiences.
C6	Centres must provide facilities that are easy and convenient for parents and carers to use.  Facilities and support include: sufficient accommodation for the family to stay at the hospital and for parents to stay with their child in the ward 24 hours per day when appropriate, access to refreshments, and to be able to play and interact with their child (and their other children). There must be a quiet room available on the ward or centre completely separate from general family facilities. Access to care should not be inhibited by problems of parking facilities or cost.
C7	There should be access to culturally appropriate support services including faith support, social workers, interpreters, clinical psychologists benefits advice and bereavement counsellors. These should be made available at the specialist centre and links to facilitate this at a local level should also be developed.

C8	There must be facilities that allow the mothers of new-born babies who are admitted as emergencies to stay with their baby. This should include access to maternity staff to support bonding, breast feeding and the emotional health of the mother and baby.
C9	Children should have access to general resources including toys, books, magazines, computers and other age-appropriate activity coordinated by play specialist teams.
C10	Staff in the multidisciplinary team should receive training in communication with children, young people and parents, which shall include training in conveying difficult information in a sympathetic way.
C11	Parents, carers and support groups will be regularly updated with appropriate information on issues of clinical governance and the results of local and national audits.
C12	Children's Neurosurgery Centres will develop and implement a hand held patient record which contains relevant neuro-images. This should include a clear concise summary of information that supports rapid assessment and treatment in local or more distant services, and include an anaesthetic summary where this is relevant to the emergency care of the child.
C13	There must be formal arrangements for addressing complaints and other comments made by children, parents and carers.

D. ACCESS TO SERVICES

D1	<p>All children must have access to consultant paediatric neurosurgical advice and care within a network on a 24 hour, 7 days per week basis, with a formal designated rota which is widely shared and understood within the network of referring hospitals and any other regional networks and services (such as trauma).</p> <p>A management plan for the acutely ill child must be agreed within an hour.</p> <p>All new admissions must be assessed by a consultant paediatric neurosurgeon within 24 hours of admission and all children requiring neurosurgical input (including ward, HDU and PICU) must be reviewed daily by a paediatric neurosurgeon. In occasional situations such as where emergency life-saving treatment precludes the child's transfer to a Children's Neurosurgery Centre within 24 hours these reviews will be undertaken by an adult neurosurgeon in discussion with the nearest on-call paediatric neurosurgeon.</p>
D2	<p>Relevant middle grade paediatric cover must be available on-site.</p> <p>Middle grade neurosurgical cover must be available within 30 minutes.</p> <p>A paediatric resuscitation team must be available on site 24/7.</p>
D3	<p>Each centre will be co-located with a paediatric intensive care unit and there must be access to a defined neurosurgical high dependency care area. (This is red/mandatory relationship within the Department of Health (DH) framework of critical inter-dependencies 2008<sup>1</sup>).</p>
D4	<p>Each centre will have paediatric anaesthesia co-located with paediatric neurosurgery. (This is red/mandatory relationship within the DH framework of critical inter-dependencies 2008).</p> <p>Paediatric anaesthetists must demonstrate that they have continuing experience in paediatric neuroanaesthesia.</p>
D5	<p>Each centre will be co-located with 24/7 paediatric neurology services (This is a red/mandatory relationship within the DH framework of critical inter-dependencies 2008) and must include appropriate early rehabilitation services.</p>
D6	<p>Centres must be able to provide specialist services in accordance with the Framework of Critical Inter-Dependencies.<sup>2</sup></p>

1 Department of Health, Commissioning Safe and Sustainable Specialised Paediatric Services: A framework of Critical Inter-Dependencies, August 2008

2 Ibid

D7	<p>Centres must have access to a full range of diagnostic equipment, run by sufficient numbers of radiographers and neuro radiologists with dedicated children's sessions in their job plans:</p> <ul style="list-style-type: none"><li>• Computed Tomography (CT) Scanner, including CT angiography – this must be available at all times (24/7 access) and with quick access to the CT scanner from the neurosurgery theatre/s and from the Paediatric Intensive Care Unit (PICU) such that a scan must be completed and reported within 60 minutes of a request, where clinically indicated.</li><li>• Magnetic Resonance Imaging (MRI) scanner – available at all times (24/7 access).</li><li>• Functional Magnetic Resonance Imaging - available from Monday to Friday within normal working hours (5 day access).</li></ul> <p>It would be highly desirable for the centre to have access to a High gradient 3T neuro-optimised scanner with functional Magnetic Resonance Imaging – with capacity to undertake spectroscopy.</p> <p>All out-patient neuro-imaging (including GA MRI scans) must be completed according to National neuro-radiological standards, or within current NHS wait-time targets.</p> <p>The preferred model is for all services and resources to be dedicated for children's services, with close proximity to wards and theatres. Where children are being treated within an adult setting all staff must be trained in the care of children, in accordance with the Royal College of Nursing (RCN) Health care service standards in caring for neonates, children and young People, (2011) and the investigations carried out using specifically designed policies and procedures for paediatric patients.</p> <p>Centres must have access to a full range of diagnostic procedures and have the anaesthesia sessions to support this if required:</p>
D8	<ul style="list-style-type: none"><li>• 24/7 access to intra-cranial monitoring is mandatory and access to CSF infusion studies desirable</li><li>• Biplane angiography &amp; interventional neuroradiology – available 5 days a week from 9 am to 5 pm (7 day access desirable)</li><li>• EEG Electroencephalography – available as a minimum from Monday to Friday from 9 am to 5 pm. (7 day access preferred)</li><li>• EMG Electromyography – available from Monday to Friday from 9 am to 5 pm (5 day access)</li><li>• EEG Videotelemetry – available from Monday to Friday from 9 am to 5 pm (5 day access )(7 day access for an epilepsy centre)</li><li>• EEG ambulatory – available from Monday to Friday from 9 am to 5 pm (5 day access) (7 day access for an epilepsy centre)</li><li>• NCS Nerve Conduction Studies – available from Monday to Friday from 9 am to 5 pm (5 day access)</li></ul> <p>Neuropathology reporting service - available from Monday to Friday from 9 am to 5 pm (5 day access) and available for frozen section and smears</p>

D9	<p>Centres must have access to a full range of intraoperative techniques:</p> <ul style="list-style-type: none"><li>• Spinal cord monitoring (SSEPs and MEPS) - 5 day access</li><li>• EEG/cortical monitoring - 5 day access</li><li>• Evoked potentials - 5 day access</li><li>• Intraoperative image guidance system 24/7 access</li><li>• Neuro-endoscopy - 24/7 access</li><li>• Imaging ultrasound - 24/7 access</li><li>• Ultrasonic aspirator - 24/7 access</li></ul> <p>And it would be desirable for centres to have access to:</p> <ul style="list-style-type: none"><li>• Single Photon Emission Computed Tomography (SPECT) and Positron Emission Tomography (PET)</li><li>• Advanced radiotherapy techniques (e.g. IMRT) (5 day access)</li><li>• Intraoperative MRI, CT and advanced intraoperative ultrasound (5 day access), depending on support from any emerging cost-effectiveness data (these new technologies currently lack sufficient evidence to advocate routine usage).</li></ul>
D10	<p>All children requiring neurosurgical investigation, treatment and care must receive that care from staff trained in looking after children and trained specifically in neurosciences according to the requirements for their profession/discipline.</p> <p>Children must be admitted to a dedicated neurosurgical ward or a neuroscience ward which is staffed by nurses trained in the care of children with acute neurological problems.</p> <p>The senior nurse in charge of the ward out of hours will be required to provide telephone advice to parents in the region. This is in accordance with the Royal College of Nursing (RCN) Health care service standards in caring for neonates, children and young People, (2011) and RCN Defining safe staffing levels for children and young people's services (2003).</p> <p>When required, there must be daily delivery of the management plan for children's rehabilitation.</p>
D11	<p>Centres must ensure that they plan sufficient capacity (resources and bed capacity) to accommodate expected and unpredictable peaks in demand. Neurosurgical patients must not be "lodged" on wards staffed by nurses who are not trained in the care of paediatric neuroscience patients; support and advice from staff with the relevant expertise must be available at all times.</p>

D12	<p>Children requiring high dependency level care (HDC) must be looked after within a high dependency unit or within a paediatric intensive care unit (PICU) – providing that the HDU capacity is protected and not disadvantaged by surges in PICU requirements. All hospitals admitting children for neurosurgical care must be able to deliver HDC.</p> <p>Children requiring HDC must be looked after by nurses who have received formal training in HDC, and with a nurse to patient ratio of 1:2 (or 1:1 if the patient is looked after in a single occupancy cubicle) in line with the RCN documents in D10.</p> <p>Children requiring HDC must be reviewed by both paediatric neurosurgical and medical teams (general paediatrics, paediatric neurology, and PICU or paediatric anaesthesia), with consultant-led ward rounds at least twice a day. There must be access to on-site middle grade paediatric cover, and if required an anaesthetic / PICU registrar, at all times.</p> <p>Episodes of HDC must be documented on a daily basis using the Paediatric Critical Care Minimum Dataset (PCCMDS). Data must be submitted by Trusts to the Secondary User Service (SUS).</p>
D13	<p>All paediatric neurosurgery (for a planned operation or for an emergency procedure) must be carried out in a dedicated theatre specifically equipped and staffed for paediatric neurological surgery. Ideally, this would occur in a paediatric theatre suite.</p> <p>When undertaken in an adult theatre suite the facilities (including the recovery area) must be in keeping with those found in paediatric settings and must include care provided by appropriately trained staff. However, the theatre staff (scrub nurse and “runner”) for emergency and elective cases must be neurosurgically trained and be involved in neurosurgical operations on a daily/frequent basis.</p> <p>Centres must ensure that they have sufficient theatre capacity for children requiring unplanned operations (these emergency operations can be up to 70% of the workload).</p>
D14	<p>Centres must provide sufficient theatre capacity and related resources to ensure a low cancellation rate for planned operations. The cancellation rate must be no more than 0.5% over a 6 month period and there must be immediate access to a theatre for life-threatening cases.</p>
D15	<p>Theatres will be equipped with the specialist equipment required for paediatric neurosurgery.</p> <p>This includes a specialist table and headrest, an image-guidance system, ultrasonic aspirator, imaging ultrasound, EEG, spinal cord monitoring, and at least one theatre must be equipped with C-arm X-ray imaging.</p>
D16	<p>Paediatric anaesthetic cover in the CNC must be provided according to standards set out in Appendix B.</p>
D17	<p>Paediatric Intensive Care Units must comply with the PICS (Paediatric Intensive Care Society) Standards and the RCN (2011) Health care service standards in caring for neonates, children and young people.</p>

D18	<p>Paediatric Intensive Care Units must have sufficient capacity (beds, staff, equipment, transport) to meet the needs of their catchment population and to accept all emergency paediatric neurosurgical referrals in their catchment area.</p>
D19	<p>Centres must have sufficient capacity (beds, staff, equipment, transport) for the expected number of children requiring high dependency care.</p> <p>There must be sufficient high dependency capacity to ensure acceptance of all emergency paediatric referrals and a cancellation rate of no higher than 0.5% over 6 months for planned operations.</p>
D20	<p>Centres must ensure that the job plans of the paediatric neurosurgeons have a balance of emergency paediatric and elective direct clinical care, as well as time for supporting professional activities.</p>
D21	<p>Centres must have access to consultant paediatric neuro-oncology opinion 7 days a week. A paediatric neuro-oncologist is defined as a paediatric oncologist who is on the GMC specialist Register for Paediatrics (Paediatric Oncology).</p> <p>The preferred model would be for principal treatment centres for children's cancer dealing with brain tumours, to be co-located with paediatric neurosurgery.</p> <p>This is an Amber 3* relationship according to the Department of Health framework of critical inter-dependencies<sup>3</sup> which is essential to provide a full specialised service.</p> <p>There must be discussion between the oncologist and surgeon of the management plan for all tumour cases on presentation.</p>
D22	<p>Centres providing specialist care will have a nurse specialist/s covering each of the relevant areas:</p> <ul style="list-style-type: none"><li>• Hydrocephalus</li><li>• Paediatric neuro-oncology</li><li>• Epilepsy</li><li>• Children's traumatic brain injury</li><li>• Spinal dysraphism</li></ul>

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3 Department of Health, *Commissioning Safe and Sustainable Specialised Paediatric Services: A framework of Critical Inter-Dependencies*, August 2008



D23	<p>Nursing care must be provided by a dedicated team of nursing staff trained in the care of children and in paediatric neurosurgery in line with RCN (2003) Defining safe staffing levels for children and young people's services, London: RCN.</p> <p>Staff within the High Dependency Unit (HDU) and PICU must have specialist training in the care and management of patients with high dependency/PICU needs, as well as the neurological care of children.</p> <p>High dependency care will be staffed by competent nursing staff at a ratio of 1 nurse to 2 children, unless physical layout (e.g. cubicles) requires consideration of 1:1 nursing.</p>
D24	<p>Centres will ensure that, as a minimum, the on-site multi-disciplinary team includes the following specialist staff members with specialised training in managing patients within paediatric neurosurgery and paediatric neuro-rehabilitation:</p> <ul style="list-style-type: none"><li>• Data collection manager</li><li>• Neuropsychology</li><li>• Neuroradiology</li><li>• Dietician</li><li>• Play specialists</li><li>• Physiotherapists</li><li>• Occupational therapist</li><li>• Speech and language therapist</li><li>• Paediatric pharmacist – access to advice at all times</li><li>• Hospital school teacher – access to service</li></ul> <p>Some of these specialist staff may be members of teams working across paediatric neurology and neurosurgery.</p> <p>The MDT must also have access to an orthotist, neuro psychology, Child and Adolescent Mental Health Services at the relevant stages in the child's care.</p>



D25	<p>There must be access to other specialist opinions with specialist training in paediatrics:</p> <ul style="list-style-type: none"><li>• Neuropsychology and child psychiatry (CAMH) opinion based on clinical needs</li><li>• Immediate access to Neuropathology diagnosis for frozen section or smear</li><li>• Easy access to Neuropathology opinion for case discussion and multi-disciplinary team meetings</li></ul> <p>The attendance of a Neuropathologist at multi-disciplinary team meetings</p> <p>Each Centre will have access to dedicated neuro-rehabilitation facilities either on site or as part of the care pathway; they will be responsible for managing the early rehabilitation plan.</p> <p>The Centre will provide early involvement of rehabilitation and neuropsychology teams in assessing a child's and family's needs in a care package and in providing support in reintegration to the community and to education.</p> <p>All children must have equal access to any neuro and physical rehabilitation services they require, regardless of where they receive their acute care.</p> <p>The Centre will have ongoing involvement and responsibility in following up and monitoring this process and assessing longer term outcomes and quality of life in survivors. They will link closely with the Network lead consultant in neuro-rehabilitation and lead therapist who will provide rehabilitation services where required and act as the source of expert advice for network local paediatricians and GPs to facilitate the local delivery of services where possible.</p> <p>The Centre will ensure that multidisciplinary follow up is provided with continuing access to the service via care co-ordinators, clinic systems and/or key worker both at the Children's Neurosurgery Centre and in some cases at an involved shared care centre more locally and this will be agreed with carers. Early and regular contact must be made with local paediatricians and GPs so that they can be involved in the planning of care at the earliest stage.</p> <p>Transition arrangements will be in place for age appropriate continued follow up.</p>
D27	<p>There must be an appropriate mechanism for arranging safe retrieval and transfer of patients in accordance with the Joint Statement from the Society of British Neurological Surgeons (SBNS) and the Royal College of Anaesthetists (RCoA) Regarding the Provision of Emergency Paediatric Neurosurgical Services (Appendix C) and the designation standards for Paediatric Intensive Care services.</p> <p><i>Transfer and retrieval arrangements must include the ability to receive patients by helicopter.</i></p>
D28	<p>All delays to transfers/retrievals (as defined by PIC Standards for the Care of Critically Ill Children 2010) must be monitored and reported to NHS Specialised Services as part of contract monitoring and performance.</p>

## E. AGE APPROPRIATE CARE

E1	<p>Planning the transition from children's to adult services should start at 14 years of age. There should not be a fixed age for transition from children's to adult services which will vary according to the needs of the child and their family.</p> <p>Centres will be responsible for developing a transition plan that will include the close involvement of the adult neurosurgeon; full discussion with the child/adolescent and their parents/carers about the clinical issues, their views, opinions and feelings. Ideally this will occur through joint paediatric/'adult' neurosurgical out-patient clinics.</p> <p>During the period of transition continuity of care with the paediatric neurosurgical team will be maintained, including the delivery of non-emergency care in the adult setting.</p> <p>This should also be in accordance with RCN (2004) Adolescent transition care. Guidance for nursing staff, London: RCN (2011) Health care service standards in caring for neonates, children and young People, London.</p>
E2	<p>For safety reasons the immediate peri-operative care of adolescent patients will be delivered in either the adult or paediatric neurosurgical setting – whichever is the most appropriate for each particular patient.</p>
E3	<p>Paediatric neurosurgeons should have sufficient flexibility in their job plans to provide advice and surgical care to adults with relevant neurosurgical conditions, such as congenital spinal dysraphism and complex hydrocephalus.</p>
E4	<p>The patient's management plan must be reviewed at each consultation to make sure that it continues to be relevant to their particular stage of development.</p>
E5	<p>Young people should have the opportunity to be seen by the consultant for part of the consultation without a parent being present.</p>

F. PRENATAL SCREENING

F1	Centres will agree and establish protocols with maternity and neonatal units in their catchment area for the care and treatment of pregnant women whose foetus has been diagnosed with a CNS condition. Any protocols must comply with the NHS 18+-20+weeks Fetal Anomaly Standards and Guidance 2010.
F2	The protocols must ensure that pregnant women are referred to the relevant specialist as early as possible when appropriate, and that accurate diagnosis is made promptly with the aid of a foetal MRI scan where appropriate and in line with the NHS FASP guidelines.
F3	Parents who have been told that their expected child has a CNS anomaly must have access to non-directive counselling and support to help them interpret the diagnosis and possible outcomes. Parents must also be given contact details for relevant local and national support groups at this point.
F4	A consultant paediatric neurosurgeon must be available for antenatal counselling related to congenital central nervous system anomalies as soon as possible.
F5	At diagnosis, a plan must be agreed between the centre, the maternity unit, the neonatal team and the parents about arrangements for the delivery of the baby, minimising the possibility of separation of mother and child after delivery.
F6	There should be a facility to deliver the baby close to the centre if necessary (for example, at a linked obstetric unit). If the plan is for the delivery of the baby at the local maternity unit, this should include arrangements for the transfer of the baby to the neurosurgical centre if required. A neonatal team must be available at delivery and to care for the baby whilst awaiting transfer by a neonatal transfer team.
F7	If need for Neonatal Intensive Care is anticipated, delivery should be planned at a Unit where this can be provided. This unit should have links with a local Children's Neurosurgical Centre.

G. EXCELLENT CARE

G1	<p><i>Children must be treated by a paediatric-trained neurosurgeon. A Paediatric Neurosurgeon is defined as a consultant neurosurgeon who has undertaken a one-year GMC recognised Fellowship in a recognised paediatric neurosurgical centre as recommended in Safe Paediatric Neurosurgery (2001)<sup>4</sup>. This standard will be applied to all new appointments, and it is recognised that some existing consultants with substantial paediatric practice may not have undertaken formal fellowships.</i></p> <p><i>A substantial proportion of the consultant's job plan (minimum of 50%), or 5 PAs, must be allocated to paediatric neurosurgery and there must be evidence of regular Continuing Professional Development (CPD) in paediatric neurosurgery. It is recommended that this should translate into being involved in approximately 80 operative cases per year on children, although it is accepted that this individual operative workload may vary within a CNC team according to particular paediatric or adult sub-specialist interests.</i></p> <p><i>In addition, paediatric neurosurgery consultants undertaking epilepsy and craniofacial surgery must have undertaken a period of attachment to a recognised epilepsy surgery centre or craniofacial surgery centre (as appropriate) either in the United Kingdom or abroad.</i></p> <p><i>It should be noted that all qualified neurosurgeons are competent to undertake life saving care for children in an emergency situation.</i></p>
G2	<p>There will be dedicated time allocated within each consultant paediatric neurosurgeon's job plan for training of junior staff, update education of adult neurosurgeons within the network and mentoring of new consultant paediatric neurosurgeons.</p>
G3	<p>There are some rare conditions in children which require the input of adult-trained neurosurgeons with specialist expertise. In these cases the adult-trained neurosurgeons would not need any specific training in paediatric neurosurgery. However the care of these children must be co-ordinated jointly with a paediatric neurosurgeon in order to ensure that the other paediatric aspects of the case are appropriate for the child's needs.</p>
G4	<p>Centres will assist in maintaining core competences in all adult neurosurgical services to continue safe provision of immediate treatment and stabilisation of children with life threatening intracranial conditions (e.g. insertion of a drain for acute hydrocephalus).</p>
G5	<p>Centres will develop and maintain a training programme and training register for all members of the multi-disciplinary team (MDT). This training would include the care of children, life support and infection control. All members of the multi-disciplinary team will take part in continuing education and CPD.</p>
G6	<p>Centres will have a nominated consultant with responsibility for trainee medical education in coordination with the regional Training Programme Director.</p>

4 Safe Paediatric Neurosurgery 2001- A Report from the Society of British Neurological Surgeons (2001)

G7	<p>The training programme must also include the competences to recognise child maltreatment and to take effective action as appropriate to their role and responsibilities as described in the Intercollegiate Document September 2010: Safeguarding of Children and Young People In Roles and Competences For Health Care Staff.</p>
G8	<p>Children must be anaesthetised by paediatric anaesthetists with Royal College of Anaesthetists approved training in paediatric anaesthesia (in line with Appendix B).</p>
G9	<p>Within each centre, there must be a lead radiologist with a special interest in paediatric neuro-radiology who is responsible for arranging cover of the relevant MDTs, prioritising imaging protocols (in accordance with national guidelines and studies), and standardising imaging protocols across the network. Such a post must allow provision for appropriate CPD. Providing additional specialist imaging advice and support to the network must also be recognised within the job plan of the relevant staff.</p> <p>Centres must ensure there is access to GA imaging in a timely fashion and relevant training for staff.</p>
G10	<p>All clinical teams will operate within a robust and documented clinical governance framework that includes morbidity and mortality reviews, clinical incident reporting and review, clinical audit and improvement measures.</p>
G11	<p>All Centres must undertake an annual audit of clinical outcomes, using appropriate benchmark comparators, and must produce a report for the clinical network and the commissioner. The annual audit of clinical outcomes must include all cases operated on throughout the network not just those at each centre.</p> <p>This annual audit will cover all key subspecialty areas including CSF Disorders, neuro-oncology, craniofacial surgery, traumatic brain injury, epilepsy surgery, dysraphism and miscellaneous categories. The proposed performance and outcome measures for each subspecialty are set out below.</p> <p>Results will be monitored and compared against national outcome statistics in particular 30 day mortality figures, and 30 day readmission rates for all Paediatric Neurosurgical cases. Action plans will be developed and improvements made.</p>

<b>G12</b>	<p>Centres treating children with Cerebral-spinal fluid (CSF) disorders will monitor performance and outcomes using the following measures:</p> <ul style="list-style-type: none"> <li>• Primary shunt infection rates in children under 16yrs</li> <li>• Primary shunt one year failure rates</li> <li>• Shunt revision rate for any reason including infection within 30 days post operation</li> <li>• Open access to ward for parents of children with hydrocephalus</li> <li>• Rate of success of ETV at 1 year</li> </ul> <p>All units undertaking treatment of children with hydrocephalus must be involved in national audit</p>
<b>G13</b>	<p>Centres treating children for tumours of the central nervous system will monitor performance and outcomes using the following measures:</p> <ul style="list-style-type: none"> <li>• Contribution of data to national audit (morbidity, mortality and pre- &amp; post-resection radiology)</li> <li>• 30 day intervention-related mortality rate, with all deaths formally externally peer-reviewed</li> <li>• Five-year survival rate for all children with brain tumours</li> <li>• Five-year independently mobile, tracheostomy-free survival rate for children with brain tumours</li> <li>• Children registered with CCLG - more than 95 per cent compliance</li> <li>• Fresh tissue taken for storage and cytogenetics of more than 90 per cent compliance</li> </ul>
<b>G14</b>	<p>Centres treating children with craniofacial conditions will monitor performance and outcomes using the following measures:</p> <ul style="list-style-type: none"> <li>• Compliance with relevant NHS Specialised Services craniofacial standards and data collection</li> <li>• Mortality from craniofacial surgery (non-syndromic) less than 1 per cent</li> </ul>
<b>G15</b>	<p>Centres treating children with traumatic brain injury will monitor performance and outcomes using the following measures:</p> <ul style="list-style-type: none"> <li>• All units undertaking treatment of children with traumatic brain injury must be involved in national audit and formal mandatory reporting to a national database</li> <li>• Mortality rate for severe head injury (30 day and 1 year mortality)</li> <li>• All children with severe traumatic brain injury (Glasgow Coma Score less than 9) must be managed in PICU co-located with paediatric neurosurgery services.</li> <li>• Children with severe traumatic brain injury requiring prolonged ventilation <i>must be managed</i> using Intra Cranial Pressure (ICP) monitoring and their surgical management led by paediatric neurosurgeons.</li> <li>• Formal mandatory reporting to a national database of: <ul style="list-style-type: none"> <li>- Transfer times: time to reach first hospital, time to reach tertiary neurosurgical centre, mode of transfer (referring hosp vs. retrieval), time to surgical procedure</li> <li>- Survival in specific diagnostic groups e.g. non accidental injury (NAI), SDH, EDH, diffuse head injury - along with confirmed post-resuscitation Glasgow Coma Score (GCS)</li> <li>- Length of stay in relation to severity</li> </ul> </li> </ul>



G16	<p>Centres treating children with epilepsy will monitor performance and outcomes using the following measures:</p> <ul style="list-style-type: none"><li>• Mortality (peri-surgical and late) with cause</li><li>• Peri-operative surgical morbidity (within 30 days)</li><li>• Late surgical morbidity</li><li>• Seizure outcome 1 and 5 years (related to procedure and pathology)</li><li>• Neurological outcome (Better/no change/worse /expected/unexpected)</li><li>• Neurodevelopment/cognitive/neurobehavioral outcome at 2 and 5 years (better/no change/deterioration)</li><li>• Re-operation rate</li><li>• Quality of life</li><li>• Patient satisfaction</li></ul>
G17	<p>Centres treating children with spinal dysraphism will monitor performance and outcome using the following measures:</p> <ul style="list-style-type: none"><li>• 30 day re-operation rate for post-operative CSF leakage</li><li>• Continence and mobility status at 1 and 5 years post-op</li></ul>
G18	<p>Centres must contribute to existing/new national databases, registries and audits, with defined minimum data sets, including:</p> <ul style="list-style-type: none"><li>• Registration of patients to the Children’s Cancer and Leukaemia Group</li><li>• Shunt registry</li><li>• Paediatric Intensive Care Audit Network data</li><li>• British Paediatric Neurosurgical Group ( BPNG) basic numbers audit and morbidity / mortality audit</li></ul> <p>Systems will be in place to allow the managed introduction of new treatments and techniques into the centre. Centres will follow mandatory NICE guidance and work within the constraints set within relevant NICE Interventional Procedures Guidance<sup>5</sup>.</p> <p>Centres will collaborate nationally at a clinical, audit, research and administrative level, and will take part in formal inter-unit and inter-network peer review.</p> <p>For research activity there must be a focus on contributing to a few high-quality multi-centre research projects, rather than single centre case series. Paediatric Neurosurgeons with proven academic experience will be expected to initiate and coordinate these multi-centre studies and must peer-review new research-proposals from other Centres.</p>
G19	
G20	

5 A summary of how NICE develops interventional procedures guidance is available at [www.nice.org.uk/guidance](http://www.nice.org.uk/guidance)

# APPENDIX A

## HYDROCEPHALUS: AREAS OF CARE, PRINCIPLES AND BEST PRACTICE



### Context

Until relatively recently, paediatric hydrocephalus was treated by both neurosurgeons and paediatric general surgeons. Today it is generally accepted that all hydrocephalus management must be co-ordinated by the paediatric neurosurgical team. The mainstay of treatment of hydrocephalus remains insertion of a ventriculo-peritoneal shunt but unfortunately studies show that in children approximately 30% of shunts will require revision within a year of insertion (this figure being higher for neonatal patients). After the first year, the risk of shunt malfunction is approximately 5% per year. Likewise, from the literature, the infection rate after primary shunt insertion is 5% to 10%. Unfortunately, each year a number of children die as a result of hydrocephalus. These are often preventable deaths and usually result from a delay in diagnosis. Endoscopic Third Ventriculostomy (ETV) is an alternative treatment option in some patients with obstructive hydrocephalus. The use of ETV has increased dramatically since the 1980's and while the failure rate for ETV (in carefully selected patients) is still of the order of 30%, it is felt that the long term malfunction rate of a functioning ETV is significantly lower than that seen with shunts. Use of ETV in patients who have previously been shunted is receiving increasing interest in the paediatric neurosurgical community and it is likely that a significant percentage of patients who present with shunt blockage are potential candidates for ETV.

Examination of data from HES shows a significant drop off in the number of shunts performed on the weekend. Furthermore funnel plots from the UK Shunt Registry show that children having their shunt revised on a Sunday have a significantly higher risk of subsequent failure of the shunt than shunts inserted/revised on any other day of the week. From the Shunt Registry data, it seems likely that there is a difference in treatment received by children on a weekend compared to the rest of the week. A more robust (case controlled) study undertaken by the UK Shunt Registry compared the outcome of shunts performed by a trainee as opposed to those undertaken by a consultant. This study showed a significant benefit for patients treated by a consultant rather than a trainee out of hours.

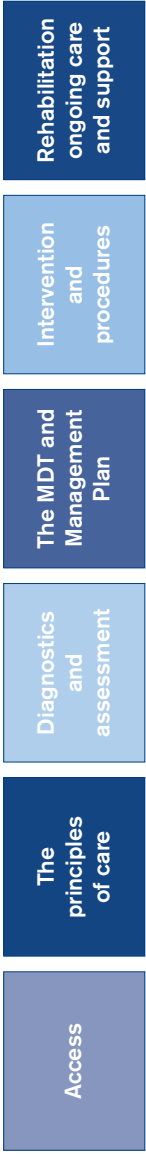


Access	
<b>A1</b>	Local pathways for hydrocephalus care must be developed in each Children's Neuroscience Network (CNN) supported by the Children's Neurosurgery Centre (CNC) and there needs to be a clear referral pathway for urgent and emergency care.
<b>A2</b>	An 'open door' policy needs to be available in every CNC with all contacts (direct and telephone) recorded and audited. In Networks where this is not feasible then robust alternative arrangements which avoid unnecessary delays in referring from designated District General Hospital (DGH) must be demonstrated.
<b>A3</b>	Children/families unable to access the 'open door' policy at the CNC, with a suspected shunt blockage must go directly to designated DGHs local to them in the first instance. These hospitals must be part of a network of care where consultant paediatric neurosurgical advice and care is available 24/7.
<b>Principles of care</b>	
<b>P1</b>	Shunt surgery must be a consultant delivered service and whenever possible this must be performed or directly supervised by a Consultant Paediatric Neurosurgeon (PNS) at a CNC.
<b>P2</b>	Where life-saving surgical management is deemed necessary locally then surgery must be performed or directly supervised by an emergency competent Neurosurgeon available following discussion with the PNS at the CNC.
<b>P3</b>	Consultant Paediatric Neurosurgeons will undertake 'peripheral' out-patient (OP) clinics which, when appropriate, will allow patients to be reviewed and have surveillance imaging closer to home.
<b>P4</b>	All units undertaking treatment of paediatric patients with hydrocephalus must be involved in national audit.
<b>Diagnosis and assessment</b>	
<b>D1</b>	Each CNN must have designated DGHs who can respond urgently to scanning and imaging requests from clinicians. Such DGHs must notify the CNC when a child with a shunt is admitted acutely in order for the investigation and management to be co-ordinated. Notification of a possible shunt malfunction must occur at the point of triage in A&E or admission to the ward if a direct GP referral has been made.
<b>D2</b>	The designated DGH must have an image exchange portal for transfer and remote viewing of scans so that specialist advice can be given urgently.

<b>D3</b>	There must be an agreed transfer plan for each child depending on their clinical condition – and this needs to be agreed in consultation with the Consultant Paediatric Neurosurgeon, the local Paediatrician and Anaesthetist and the PICU Consultant. This should be done through conference call facilities managed through PICUs who can arrange calls between various lead clinicians managing the child's care.
<b>D4</b>	Children's Neurosurgery Centres (CNC) must have CT, MRI (with or without GA) and ultrasound available for children 24/7 in an appropriate timeframe dictated by clinical need.
<b>The Multi-Disciplinary Team (MDT) and Management Plan</b>	
<b>M1</b>	The management plan for children with a suspected blocked shunt needs to be agreed with the Consultant Paediatric Neurosurgeon providing advice and support 24/7 at the CNC; the local Paediatrician and local Ophthalmologist in some instances.
<b>M2</b>	The Management Plan needs to be agreed with the family and shared with them on an ongoing basis as the needs of the child changes.
<b>M3</b>	Where hydrocephalus is caused by tumour then the ongoing management plan will be agreed in consultation with the neuro-oncology MDT and care managed by the Principal Treatment Centre (PTC).
<b>M4</b>	Adult Neurosurgical Centres have an important role to play in the delivery of care for children with neurosurgical conditions associated with hydrocephalus. Transition to adult hydrocephalus services at the relevant point in the young person's care must be to a named neurosurgeon in the adult service. Ideally, this transfer to adult services must be undertaken at a transition out-patient clinic attended by both a paediatric and "adult" neurosurgeon. There should be an agreed policy around shunt technology that spans the period of transition.
<b>Interventions and Procedures</b>	
<b>I&amp;P 1</b>	The child should arrive in the neurosurgical centre within 4 hours of initial referral. Children in coma or with a deteriorating conscious level should be transferred within 1 hour. In the latter situation the Consultant Paediatric Neurosurgeon may suggest that the child has emergency surgery in an adult neurosurgical centre if this is closer. The Consultant Paediatric Neurosurgeon might also suggest that Cerebral Spinal Fluid (CSF) be aspirated under aseptic conditions from the shunt reservoir in order to 'buy time'.
<b>I&amp;P 2</b>	The child with a suspected blocked shunt must be accepted by the closest Children's Neurosurgery Centre regardless of whether there is a PICU or ward bed available at the time of referral.

<b>I&amp;P 3</b>	If clinically indicated, direct transfer from DGH to the operating theatre within the Children's Neurosurgery Centre must be arranged for a child with a suspected blocked shunt.
<b>I&amp;P 4</b>	Any child with a suspected shunt problem must be reviewed by a member of the neurosurgical team and be discussed with the consultant neurosurgeon within 1 hour of arrival in the neurosurgical centre.
<b>I&amp;P 5</b>	Any child with a suspected shunt problem must be seen and assessed by a Consultant Paediatric Neurosurgeon within 24 hours of hospital admission.
<b>Rehabilitation, ongoing care and support</b>	
<b>R1</b>	A full time nurse specialist(s) in paediatric hydrocephalus providing advice and support must be available in hours to help co-ordinate the care of children with hydrocephalus in their network.
<b>R2</b>	The ongoing non-surgical management of children with hydrocephalus may be provided by the Children's Neurological Centre or by a designated service more locally within the CNN.
<b>R3</b>	There will be agreement within the CNN where ongoing reviews, including eye checks, may best be managed, and this will be agreed with the carers.
<b>R4</b>	Baseline scans must be made available to parents/carers so that comparisons can be made when potential problems arise, particularly for those going on holiday.

# BRAIN TRAUMA: AREAS OF CARE, PRINCIPLES AND BEST PRACTICE



## Context

Traumatic Brain Injury (TBI) is the most common cause of morbidity, mortality and disability in children over 1 year of age. In the UK there are over 500 cases of severe TBI admitted to Paediatric Intensive Care (PIC) each year. For those that reach hospital, mortality varies with the severity and injury type. Average mortality rates in children after severe TBI admitted to PICU are between 9 and 10%. Severity of TBI is most commonly related to a post-resuscitation Glasgow Coma Score (GCS) at presentation. Severe TBI is defined as a GCS of less than 9 and a moderate TBI as a GCS of 9-12. The need for urgent neurosurgical decompression is rare in children. However, there is an equivalent urgency to access intracranial pressure monitoring, as more children than adults suffer diffuse brain injuries with associated cerebral oedema. The key elements for the care of these children include: high quality trauma resuscitation; neuro-imaging; emergency decision making; surgical skills relating to trauma and 24/7 expert children's neurosurgical advice with the ability to transfer these children safely to the nearest Children's Neurosurgery Centre (CNC). There are currently no formalised or nationally agreed clinical guidelines in the UK for the use of ICP monitoring, surgical management including de-compressive craniectomy, hyperventilation, osmotic diuretics or the use of barbiturates in children with TBI.

Access	
<b>A1</b>	Local trauma pathways need to be developed for each Trauma Network. There are two options, children either follow the same pre-hospital pathway as adults and are managed in the combined Major Trauma Centre (MTC) or the destination is a dedicated Children's MTC.
<b>A2</b>	The seriously injured child needs to be transferred to the Combined MTC or Children's MTC directly (if the transfer time is less than 45 minutes); but if transfer times are more than 45 minutes, it may be necessary for treatment to be initiated in an Adult or Combined MTC or Trauma Unit. Paediatric Neurosurgeons must be available 24/7 for consultation and care to the Trauma Network and must be involved in all decisions to operate for TBI in children.
<b>Principles of care</b>	
<b>P1</b>	Good communication, coordination and clarity of team roles are essential for clinicians and parents understanding of networks and the relationships between different elements of their child's care. This information must be clearly provided to families.
<b>P2</b>	All units undertaking treatment of children with moderate or severe head injury must be involved in relevant national audit. They must be able to provide emergency management of children with spinal cord injuries.
<b>Diagnosis and assessment</b>	
<b>D1</b>	Each Trauma Network must have designated DGHs/Trauma Units who can respond urgently to scanning and imaging requests for children with major trauma.
<b>D2</b>	These services must have Consultant Radiology Support available 24/7 for neuroradiological imaging and an ability to provide paediatric anaesthesia to a standard specified by the Royal College of Anaesthetists.
<b>D3</b>	The designated DGH must have an image exchange portal for transfer and remote viewing of scans so that consultant paediatric neurosurgical and paediatric intensivist advice can be given urgently.
<b>D4</b>	Children's Neurosurgery Centres (CNC) must have CT, MRI, ultrasound and general radiology available for children 24/7.
<b>D5</b>	CNCs will develop a training plan for their CNNs which will build on best practice including awareness of symptoms requiring investigation, escalation and the mechanisms for this. In particular this must include, neurological assessment in accordance with NICE guidelines: head injury: triage, assessment, investigation and early management of head injury in infants, children and adults.

The Multi-Disciplinary Team (MDT) and Management Plan	
<b>M1</b>	A management plan must be created for children with severe brain injury by the paediatric neurosurgeon and consultant in paediatric intensive care within an hour of CT imaging. This must address surgical treatment, Intra-Cranial Pressure (ICP) monitoring and paediatric intensive care.
<b>M2</b>	Ongoing care of children with severe head injury (GCS≤8) must be managed in the CNC and transfer should occur after life-saving critical interventions.
<b>M3</b>	<p>There will be a lead consultant/neurologist in children's neuro-disability responsible for the rehabilitation management plan. They will provide specialised rehabilitation services and act as a source of expertise and advice to the network.</p> <p>The MDT for neuro-rehabilitation must be included at relevant discussions for developing the plan; Paediatric Intensivist, Paediatric Neurosurgeon, Paediatric Neurologist, Neuroradiologist with expertise in paediatric neuroradiology, Paediatric Neuropsychologist, Children's Neurosurgical Specialist Nurse, Therapy; Paediatric Physiotherapist, Paediatric Occupational Therapist, Paediatric Speech and Language Therapist, Play Specialist, Dietician, and access to orthotics, pharmacy, educational and social work support</p> <p>There must be access to multidisciplinary neuro-rehabilitation provided by specialist paediatric neuro-rehabilitation staff as soon as the child is medically stable.</p> <p>Each relevant member of the MDT must complete an appropriate assessment to determine the child/family's needs.</p>
<b>M4</b>	The rehabilitation management plan will be discussed and agreed at the MDT with the relevant Paediatric Neurosurgeon in attendance.
<b>M5</b>	The Management Plan needs to be agreed with the family and shared with them on an ongoing basis as the needs of the child changes.

Interventions and Procedures	
<b>I&amp;P 1</b>	<p>The receiving hospital, whether a Children's MTC, Combined MTC or designated Trauma Unit, depending on the condition of the child, must be able to achieve:</p> <ul style="list-style-type: none"><li>• Intubation within 10 mins</li><li>• CT scan report and management plan within 1 hour of CT scan, after discussion with Paediatric Neurosurgeon and PIC consultant. This must include scan reporting and image transfer.</li></ul>
<b>I&amp;P 2</b>	<p>The Children's Neurosurgery Centre/CMTC will take responsibility for the child and accept for surgery. If there is no PIC capacity then they will accept for surgery and take responsibility for post operative PIC placement. Transfer should achieve surgery at the CMTC within 3 hours of injury.</p>
<b>I&amp;P 3</b>	<p>Where the child has a GCS of between 9-13 and a normal CT scan, a management plan must be agreed between local clinicians and the Paediatric Neurosurgeon. Formal review of this plan must occur at no more than 6 hours after injury.</p>
<b>I&amp;P 4</b>	<p>The child should arrive at the CMTC within 3 hours from the time of the injury and must be transferred with the referring hospital anaesthetist. PIC retrieval should only be considered in exceptional circumstances.</p>
<b>I&amp;P 5</b>	<p>Where a child is being cared for in an Adult/Combined MTC, and the condition is acutely deteriorating then immediate surgery should be undertaken by an Adult Neurosurgeon in discussion with the CNC/Children's MTC on-call Paediatric Neurosurgeon, and then once stable transfer to the CNC should be achieved as soon as possible.</p>



Rehabilitation, ongoing care and support	
<b>R1</b>	Each CNN must identify a named lead consultant/neurologist in children's neuro-disability who will provide specialised rehabilitation services and act as a source of expertise and advice to the network, co-ordinating early rehabilitation, developing the management plan and discharge plan for discussion and agreement at the MDT.
<b>R2</b>	A key worker/children's neurosurgical specialist nurse must be identified within the CNN providing an important role in supporting children and families; they will also provide information advice and reassurance.
<b>R3</b>	<p>A care package must be identified prior to discharge from the CNC which identifies ongoing care rehabilitation and support in the community; this might include clinical care at home, information and training for the family, the needs for supporting education, and strategies for learning and concentration.</p> <p>Early contact/referrals must be made with local paediatricians, multidisciplinary teams, and GPs and childrens community nursing team so that they can be involved in planning the long-term care.</p>
<b>R4</b>	The local Children's Neurological Centre will provide a key network role for specialist rehabilitation and support. At particular points in a child's treatment specialised emotional and psychological support might be required and needs to be provided by the CNN.
<b>R5</b>	Early contact must be made with local paediatricians, multidisciplinary teams, GPs and children's community nursing team so that they can be involved in planning the long-term care.
<b>R6</b>	The Children's Neurological Centre will be responsible for monitoring and reviewing the rehabilitation plan and planning delivery of key service locally to where the child lives.
<b>R7</b>	There will be agreement within the CNN where ongoing reviews may best be managed, and this will be agreed with the carers.
<b>R8</b>	There should be a CNN-wide school re-integration policy for children following Traumatic Brain Injury.



# BRAIN TUMOURS: AREAS OF CARE, PRINCIPLES AND BEST PRACTICE



## Context

There are approximately 500 cases of new Central Nervous System (CNS) tumours in children and adolescents each year in the UK. The majority (75%) present as emergencies via Paediatric A&E or as urgent referrals from general paediatrics to paediatric neurology, and limited imaging will have been done at the point of presentation. The degree of urgency is dependent on: conscious level (altered by hydrocephalus and tumour size), pace of disease (altering focal neurology) to this point, and the degree of hydrocephalus. The time between the onset of the first symptom and the diagnosis of childhood brain tumour is considerably longer than other childhood cancers. The varied symptoms, relative rarity of CNS tumours and difficulties in prioritising access to brain scanning combine to explain this delay. Neurosurgical services will provide specific components of highly specialist diagnostic, disease management and follow up services. These will be part of commissioned CNNs comprising identified providers of different components of care required by children and their families. Children's Neurosurgery Centres (CNCs) will be required to work closely with other providers to deliver coordinated multidisciplinary, multi-modality treatment and holistic family-centred care. This will include primary care, paediatric oncology Principal Treatment Centres (PTC), paediatric oncology shared care units (POSCUs) and children's community services or palliative care services to deliver care from first presentation, throughout treatment and beyond to long term survival or palliative and end of life care.

The broad Children and Young People's (CYP) cancer pathway and requirements of commissioned services is detailed in the NICE CYPIOG (2005) which must be fully implemented and to which this work aligns. Therefore re-stating all the components of paediatric oncology care outlined in CYPIOG is unnecessary and beyond the scope of this project. This document concentrates on those aspects that have been identified as specifically and additionally pertinent to neurosurgery and the role played in the MDT. All the specialist centres and units contributing to the network of care for children with brain tumours must comply with the NICE Children's and Young People with Cancer Improving Outcomes Guidance (CYPIOG). This is essential for units delivering any aspect of treatment/care (diagnostics, surgery, chemotherapy, radiotherapy, supportive care) to children with these conditions and will be subject to cancer Peer Review against the children's cancer measures arising from the IOG.

Access	
A1	<p><i>Awareness</i></p> <p>Networks must demonstrate that they are supporting the national campaign to raise awareness of symptoms requiring investigation and the mechanisms for this.</p> <p>(‘Pathways to diagnosis’ project <a href="http://www.rcpch.ac.uk/Research/cc/Guidelines-frontpage/Guideline-Appraisals-by-Organisation/Pathways-to-Diagnosis">http://www.rcpch.ac.uk/Research/cc/Guidelines-frontpage/Guideline-Appraisals-by-Organisation/Pathways-to-Diagnosis</a> ; and in particular Diagnosis of Brain Tumours in Children, a Guideline for Health Professionals.)</p>
A2	<p><i>Pathways to diagnosis</i></p> <p>Each CNN supported by the CNC must provide clear information for referring clinicians about appropriate local routes and urgency of investigation for children with symptoms and signs suggestive of CNS tumour.</p> <p>The CNN will have access to advice on management from the paediatric neurosurgical team at the CNC 24/7.</p>
Principles of care	
P1	<p><i>Communication</i></p> <p>CNNs which include incorporating the CNC, the PTC and referring hospital, must provide information about the network based approaches to care, emphasising clarity of roles and communication between different centres within the network, between individual team members within centres, and with parents.</p> <p>There will be an identified key worker for each patient to coordinate care and ensure good communication.</p>
P2	<p><i>Continual Audit, Research and Service Development</i></p> <p>All CNCs must be involved in national audits of activity and outcomes from surgery and following adjuvant treatments.</p> <p>Tumour banking and involvement in available relevant clinical trials or observational studies should be encouraged for all patients with central notification of reasons for failure to enrol patients into such studies.</p> <p>Developing techniques such as intrathecal therapies and targeted biological therapies will be delivered in centres with specific expertise and research support.</p>

Diagnosics and Assessment	
D1	<p><i>Neuroradiology</i></p> <p><i>All referring hospitals within the CNN must have imaging facilities and links which allow for immediate transfer of images to the CNC.</i></p> <p><i>Definitive tumour imaging will be conducted pre and post operatively at CNC, with appropriate anaesthetic support, according to nationally agreed protocols and will be reported by radiologists with expertise in children's CNS tumours.</i></p> <p><i>These paediatric radiologists will attend all the MDTs.</i></p>
D2	<p><i>Neuropathology</i></p> <p><i>CNCs will have rapid reliable access to intra-operative smear reports.</i></p> <p><i>Reporting will be undertaken by neuropathologists with expertise in Children's CNS tumours with peer review and central standardisation of reporting.</i></p> <p><i>These neuropathologists or their cover will attend all the MDTs.</i></p> <p><i>There must be facilities for tumour banking, release and transfer to other centres.</i></p>
D3	<p><i>Endocrinology</i></p> <p><i>CNCs must have sufficient endocrinology expertise available for the initial MDT assessment and ongoing management for midline tumours and good access to advice for the peri-operative management of these children.</i></p>

The Multi-Disciplinary Team (MDT) and Management Plan	
M1	<p><i>MDT Working</i></p> <p><i>There must be the facility for urgent MDT discussion between core members at any time; all cases at some stage must be discussed at formal MDT meetings with all core members attending, in line with cancer peer review requirements. Selected difficult or unusual cases will be discussed at a supra-regional level across a network of centres.</i></p>
M2	<p><i>Where possible with planned surgery a pre-surgical evaluation should be undertaken by members of the MDT to establish current level of function regarding communication, cognition and mobility.</i></p>
M3	<p><i>Adult Neurosurgical Centres have an important role to play in the delivery of care for children with neurosurgical conditions: Transition to adult neuro-oncology services at the relevant period in the young person's care should be to a core neurosurgical member of the CNS tumours MDT.</i></p>

Interventions and Procedures	
<b>I&amp;P1</b>	<p><i>Surgery</i></p> <p><i>Emergency life-saving surgery, such as for associated hydrocephalus, must be provided without delay by an appropriately skilled neurosurgeon.</i></p> <p><i>Definitive surgery must be conducted by a Consultant Paediatric Neurosurgeon experienced in paediatric CNS tumours, a member of the MDT, and when necessary supported by another surgeon with specialist skills for lesions in certain anatomical sites.</i></p>
<b>I&amp;P2</b>	<p><i>Complex Cases</i></p> <p><i>For certain rare tumour types where neurosurgery is required, more specialist advice may be sought and this surgery may then take place at a supra-regional level centres. This might also be required where second or subsequent surgery is being considered. In these cases centres will collaborate closely involving carers in all discussion. They may be managed following discussions at a supra-regional level and if necessary in centres with established expertise in managing that particular problem.</i></p>
<b>I&amp;P3</b>	<p><i>Radiotherapy</i></p> <p><i>Appropriately sited and resourced services with all of the facilities, personnel and anaesthetic support will deliver paediatric radiotherapy and this must meet the IOG.</i></p> <p><i>MDT mechanisms must ensure selected children are managed appropriately with specialist treatments such as stereotactic radiosurgery or proton beam therapy where this is beneficial for them.</i></p>

Rehabilitation, ongoing care and support	
<b>R1</b>	<p><i>End of Life Pathways</i></p> <p>Within each CNN there must be available pathways for the transition into supportive end of life services for the child and their family in appropriate cases.</p>
<b>R2</b>	<p>A post surgical evaluation must be undertaken by relevant members of the MDT to evaluate any change in presentation and guide rehabilitation and care package decision making.</p>
<b>R3</b>	<p><i>Care Package and Follow-up</i></p> <p>As soon as the child is medically stable, the CNC working with the PTC will provide early involvement of rehabilitation and neuropsychology teams in assessing a child's and family's needs in a care package. They will also identify the child's and families ongoing needs and provide support in reintegrating to the community, local services and education.</p> <p>The CNC will have ongoing involvement and responsibility for following up and monitoring this process and assessing longer term outcomes and quality of life in survivors, adhering to specifically identified cancer measures.</p> <p>The CNC will ensure that multidisciplinary follow up is provided with continuing access to the service via clinic systems / key worker both at the CNC and in some cases at an involved shared care centre more locally and this will be agreed with carers.</p> <p>Transition arrangements will be in place for age appropriate continued follow up.</p>
<b>R4</b>	<p>CNNs must provide agreed hand held records about the child's care for the carers. This may include scans where relevant so that parents can provide key information if they are going away or when potential problems arise.</p>
<b>R5</b>	<p>There should be a network wide school re-integration policy for children with CNS tumours.</p>

# EPILEPSY SURGERY:

## AREAS OF CARE, PRINCIPLES AND BEST PRACTICE



### Context

Epilepsy surgery is increasingly recognised as beneficial in selected children. There is also evidence that children should be considered earlier rather than later in view of the consequence of ongoing seizures on brain development, and greater ability for brain reorganisation in the young, as well as the likely long term psycho-social consequences of ongoing seizures. There is no evidence to suggest that surgery is deleterious in appropriately selected candidates and therefore no benefit to waiting once drug resistance has been demonstrated. Indeed emerging evidence suggests there are significant advantages with early surgery (in children under 5). There is scant data available addressing the number of children who might benefit from surgery. A recent study from Connecticut, USA followed children newly diagnosed with epilepsy for 10 years (10). From this it estimated that in the USA 127/1,000,000 children present with drug resistant epilepsy per year and that 52/1,000,000 children should undergo a pre-surgical evaluation and 27/1,000,000 a resective surgical procedure. This suggests that in the UK 780 children should be evaluated per year and 405 should have a resective surgical procedure. During 2008, 392 children were evaluated and 106 underwent resective surgery. Twelve had required invasive EEG monitoring. In addition to resective surgery, 105 vagal nerve stimulators were implanted. The number of resective procedures performed was one quarter the numbers of procedures estimates predict ‘should’ have been performed. Only 4 centres performed more than 10 resective procedures during the year and only 4 centres undertook more than 4 resective procedures in children under 5 years of age.

Access	
<b>A1</b>	Local review and epilepsy surgery referral pathways need to be developed for each CNN supported by the CNC designated as an epilepsy surgery centre and disseminated widely to referring clinicians.
<b>A2</b>	All children with a recent onset suspected seizure must be seen by a paediatrician with training and expertise in epilepsies (within 2 weeks) and they will have a regular structured review managed by the local services. Local pathways must be in place which reflect this.
<b>A3</b>	Children must be referred to the Paediatric Neurologist at the Children's Neurological Centre in their local network: in line with NICE guidelines below;  <i>Children's referral for more specialist care (NICE Clinical Guideline)</i>  Where there is: <ul style="list-style-type: none"> <li>• behavioural or developmental regression,</li> <li>• unidentifiable epilepsy syndrome,</li> <li>• when they are under 2 yrs of age,</li> <li>• seizures are not controlled within 2 yrs,</li> <li>• 2 anti-epileptic drugs have been unsuccessful,</li> <li>• there are unacceptable medication side effects,</li> <li>• a unilateral structural lesion,</li> <li>• psychiatric co-morbidity,</li> <li>• diagnostic doubt.</li> </ul>
<b>A4</b>	Parents and children must have high quality information about their child's condition and the choices available to them, this must include options for second opinions and the choice of centre to be referred to.
<b>A5</b>	The referral must be made to the epilepsy team at the Children' Neurological Centre where there will be an initial outpatient review and an admission for further investigation.



Principles of care	
P1	Good communication, coordination and clarity of team roles are essential for both clinicians and parents to understand the networks and the relationships for different elements of their child's care. This information must be provided to families so they can better understand this.
P2	CNCs must demonstrate that arrangements are in place that allow parents, carers and children to actively participate in decision making at every stage in their child's care.
P3	All units undertaking treatment of paediatric patients with epilepsy must be involved in national audit.
Diagnosis and assessment	
D1	The data required pre-surgery evaluation is set out below and this will be discussed by the epilepsy MDT as part of the epilepsy surgery pathway;  <i>The pre-surgical evaluation:</i>  Interictal sleep EEG recording, Video EEG recording of seizures, MRI with specified protocol including serial scans, access to Functional imaging, age appropriate neuropsychology assessment including neuropsychiatry.
D2	The designated DGH and centres within the CNN must have an image exchange portal for transfer and remote viewing of scans so that specialist advice can be given when required.

The Multi-Disciplinary Team (MDT) and Management Plan	
<b>M1</b>	This is a complex process requiring a number of specialist staff with different essential expertise as set out below;
	<p><i>The Multidisciplinary Team required:</i></p> <p>Paediatric Epileptologist,  Neurosurgeon with expertise in paediatric epilepsy,  Neurophysiologist with an expertise in Paediatric Neurophysiology,  Neuroradiologist with expertise in paediatric Neuroradiology,  Paediatric Neuropsychology,  Paediatric Neuropsychiatrist, dedicated children's epilepsy specialist nurse,  Therapy: Paediatric OT, SLT, Physiotherapy, Paediatric Neuroanaesthetist, Neuropathologist and Paediatric Ophthalmologist.</p>
<b>M2</b>	The pre-surgical evaluation will be undertaken and discussed and reviewed by the epilepsy MDT.
<b>M3</b>	The Management Plan needs to be agreed with the family and shared with them on an ongoing basis as the needs of the child changes.
<b>Interventions and Procedures</b>	
<b>I&amp;P1</b>	All epilepsy surgery will take place in designated centres. Where surgery is to be undertaken at a Children's Neurosurgery Centre not co-located with the Children's Neurology Centre undertaking the review then this must discussed fully with the MDT including the Paediatric Epileptologists and paediatric neurosurgeon, so that repeat investigations may be avoided.
<b>I&amp;P2</b>	Definitive surgery must be undertaken by a Consultant Paediatric Neurosurgeon experienced in epilepsy surgery.
<b>Rehabilitation, ongoing care and support</b>	
<b>R1</b>	<p>Post-operative evaluation must be undertaken by relevant members of the MDT (minimum of speech and language therapist, occupational therapist and physiotherapist) to identify any change in presentation and rehabilitation which needs to guide discharge planning.</p> <p>In discussion with the parents post operative after-care and rehabilitation (where required) could be undertaken at a Centre closer to the family; this could be on a shared care basis with the CNC.</p>

<b>R2</b>	<p>A care package must be identified prior to discharge which identifies ongoing care rehabilitation and support in the community; this might include clinical care at home, information and training for the family, the needs for supporting education, and strategies for learning and concentration.</p>
<b>R3</b>	<p>The Children's Neurosurgery / Neurological Centre will have a children's epilepsy specialist nurse who will demonstrate appropriate knowledge and skills in this area and provide information, support and advice for the parents and their children about the condition, the surgery and the services and support available to them in their local network.</p>
<b>R4</b>	<p>CNNs will have clear information and protocols in place for shared care arrangements with designated DGHs with a paediatrician with training and expertise in the epilepsies.</p>
<b>R5</b>	<p>Centres will have access to specialist advice and support within the CNN for cognition and behaviour management for children and their carers where this is needed for particular children.</p>
<b>R6</b>	<p>There should be a CNN-wide school re-integration policy for children following epilepsy surgery.</p>

# SPINAL NEURAL TUBE DEFECTS: AREAS OF CARE, PRINCIPLES AND BEST PRACTICE



## Context

Neural Tube Defects (NTDs) comprise a group of developmental disorders of the brain and spinal cord that have their embryological origin in the initial stages of central nervous system formation early in the first trimester of pregnancy. These are broadly divided into the open NTDs that may affect the brain encephaloceles, meningoencephaloceles) or the spine (myelomeningocele, meningocele, spina bifida aperta) and the closed NTDs (spinal lipomas, split spinal cord anomalies, dermal sinus tracks etc).

Urgent surgery within 48 hours of birth is usually required for newborns with open NTDs to prevent the onset of meningitis, whereas the surgery for closed NTDs (often called spinal cord ‘de-tethering’) is planned on an elective basis and can be complex and time-consuming.

The incidence of open NTDs has declined over recent decades due most likely to a combination of antenatal diagnosis, improved general nutrition and the wider use of folic acid supplementation. The change in incidence has however not been seen in the closed NTDs. For open NTDs improvements in antenatal and initial post natal care have led to reduced mortality from these conditions. Furthermore advances in the multidisciplinary management of these conditions means that functional outcomes have improved significantly for both open and closed NTDs.

There were 246 operations for open dysraphism performed in the UK children’s neurosurgical centres, based on the average of 2008/2009 BPNG audit data. 70% of babies with NTD also have hydrocephalus.

Until relatively recently, NTDs were treated by both neurosurgeons and paediatric general surgeons. Today it is generally accepted that surgical treatment of spinal dysraphism must be conducted by paediatric neurosurgeons and ongoing management be co-ordinated through a multidisciplinary team consisting of paediatrician, urologist, orthopaedist and physiotherapist as a minimum.

Access	
<b>A1</b>	Local pathways for assessment and diagnosis need to be developed for each CNN supported by the Children's Neurosurgery Centre (CNC) and disseminated widely to referring clinicians. This must include pathways for referral by paediatricians for urgent referrals and transfers for open dysraphism, and dysraphism associated with hydrocephalus and also for the referral of closed dysraphism for further evaluation and surgical treatment where necessary.
<b>A2</b>	Each CNN for children with NTDs must have designated DGHs who can respond urgently to scanning and imaging requests from clinicians. This unit must be part of a network with a Children's Neurosurgery Centre where consultant paediatric neurosurgical advice is available 24/7.
<b>A3</b>	Children/families need to have clear information about how and where to access services should problems arise whether this involves contacting a children's neurosurgical specialist nurse, going to designated DGHs, or the Children's Neurological Centre more local to them.
Principles of care	
<b>P1</b>	Good communication, coordination and clarity of team roles are essential for both clinicians and parents to understand the networks and the relationships for different elements of their child's care. This information must be provided to families so they can better understand this.
<b>P2</b>	All units undertaking treatment of NTDs must be involved in national audit.
Diagnosis and assessment	
<b>D1</b>	Each network will have appropriately trained staff who can perform and report on spinal ultrasounds in the neonatal period and until approximately 3 months of age.
<b>D2</b>	The designated DGH must have an image exchange portal for transfer and remote viewing of scans so that specialist advice from the CNC can be given urgently.

The Multi-Disciplinary Team (MDT) and Management Plan	
<b>M1</b>	The immediate management plan for the child needs to be agreed between the referring clinician and the Consultant Paediatric Neurosurgeon (PNS) at the Children's Neurosurgery Centre.
<b>M2</b>	The pre-surgical evaluation will be undertaken and discussed and reviewed by the epilepsy MDT.
<b>M3</b>	The management plan needs to be agreed with the family and shared with them on an ongoing basis as the needs of the child changes.
<b>M4</b>	The neurosurgical and urology teams must work closely together in the management of these children. Agreed guidelines must be in place to assess and monitor the upper and lower renal tracts of these patients and mechanisms in place to respond in a timely manner to changes in bladder or renal function.
<b>M5</b>	A Specialist Physiotherapy assessment is essential to provide a record of muscle function before treatment and in the course of follow up. The role of the physiotherapist should also include coordination of care between physiotherapy services and the specialised centre and locally.
<b>M6</b>	The Specialist MDT at the CNC should follow up the child at regular intervals after initial surgery and agree shared care arrangements within the network, including monitoring for urological and motor deterioration as well as hydrocephalus or Chiari complications in the case of open defects.
Interventions and Procedures	
<b>I&amp;P1</b>	<p>Ideally surgical repair for open dysraphism should be undertaken within 48 hours of birth because of the risk of infection, chronic CSF leakage and for reasons of cosmesis and ease of care.</p> <p>Complex closed dysraphic conditions (e.g. lipomyelomeningocele) should be treated in specialist centres.</p>
<b>I&amp;P2</b>	<p>Babies with open dysraphism will require urgent transfer.</p> <p>There must be an agreed transfer plan for each child depending on their clinical condition and this needs to be agreed in consultation with the Consultant Paediatric Neurosurgeon, the local paediatrician and anaesthetist and the PICU consultant where appropriate.</p>
<b>I&amp;P3</b>	Definitive surgery must be undertaken by a Consultant Paediatric Neurosurgeon experienced in spinal dysraphism.

Rehabilitation, ongoing care and support	
R1	The children’s neurosurgical specialist nurse within the network provides an important role in supporting children and their families; they will also provide information advice and reassurance. Providing information about any ongoing involvement advice and support of therapy staff.
R2	A care package must be identified prior to discharge following surgery which identifies ongoing care rehabilitation and support this will include clinical care at home, information and training for the family, the needs for supporting education, and strategies for learning and support as necessary for the needs of the child.
R3	The local Children’s Neurological Centre will provide a key network role for specialist neuro-disability rehabilitation and support.
R4	Neurodevelopmental paediatricians, specialist paediatric physiotherapists and other therapies must also be provided more locally within the CNN to monitor the child’s development and ongoing functional capabilities, supporting the family in providing a management plan for movement and development in the home.

# APPENDIX B

## Anaesthetic Competency Requirements

All neonates, infants and children requiring elective or emergency neurosurgery, should receive the highest standard of anaesthetic and peri-operative care, delivered (or supervised by) Consultant Anaesthetists demonstrating training, continuing clinical experience and professional development in this specialised area of practice. Every child should have care delivered by an anaesthetist or anaesthetists who possess the relevant competencies as demanded by the patient's age, disease and co-morbidities.

In Children's Neurosurgical Centres, the necessary competencies will be held by a Consultant Anaesthetist with a regular commitment to elective paediatric neuroanaesthesia and who have trained to the equivalent level identified in the CCT in Anaesthesia. Consultant anaesthetists who provide emergency neuroanaesthesia in these centres should possess the necessary competencies required to provide high quality and safe anaesthesia for such surgery. New appointees to consultant posts with a significant or whole time interest in paediatric neuroanaesthesia should have successfully completed 'Advanced Level' training in paediatric anaesthesia as defined in the CCT in Anaesthesia (August 2010), or equivalent, and an additional six months training in adult and paediatric neuroanaesthesia in a recognised neurosurgical centre. It is recognised that this training will need to be individually tailored after discussion with the RCoA Training Department and local School of Anaesthesia. For highly specialised or complex procedures, joint working of two Consultant Anaesthetists bringing together their individual expertise may be in the best interests of the patient.

In adult neurosurgical services admitting less complex elective and emergency paediatric cases, relevant anaesthetic competencies may be provided by neuroanaesthetists who can demonstrate that they undertake regular paediatric anaesthetic practice and CPD in paediatric anaesthesia, resuscitation and perioperative care. Emergency cases may require the combined efforts of an adult neuroanaesthetist working with a paediatric anaesthetist to ensure that the required competencies are assembled for any particular patient.

The RCoA will define the competencies required for revalidation in conjunction with the relevant Specialist Societies.

*It should be noted that all qualified anaesthetists are competent to undertake life saving care for children in an emergency situation.*



# APPENDIX C

Joint Statement from the Society of British Neurological Surgeons (SBNS) and the Royal College of Anaesthetists (RCoA) Regarding the Provision of Emergency Paediatric Neurosurgical Services

(2010, Extract from main document, <http://www.rcoa.ac.uk/docs/paed-nsurgery-statement.pdf>)

**1.** Hospitals accepting acute paediatric admissions should be co-located with Emergency Departments, Anaesthesia and ICU services and should have on-site CT scanners. It should also be possible to perform a CT scan on a child within one hour of admission. Ambulance services should be briefed on which hospitals are suitable for such emergency paediatric admissions.

**2.** All children with urgent or emergency neurosurgical conditions should be discussed with the closest service providing paediatric neurosurgical care except those children admitted to hospitals with on-site “adult” neurosurgical services. In these cases, discussion should initially be with the resident team.

**3.** In a true emergency situation involving a child requiring urgent neurosurgery for a deteriorating condition admitted to an ‘adult-only’ neurosurgical service, the most appropriate surgeon, anaesthetist and intensivist available would be expected to provide life-saving care including emergency resuscitation and surgery. This should be undertaken following full consultation with clinicians at the paediatric neurosurgical centre and be supported by senior hospital management. This action would be fully supported by both the RCoA and SBNS.

**4.** Transfers of children for emergency neurosurgery should normally be undertaken by the referring hospital. Children deteriorating from acute neurosurgical conditions will be transferred directly by the referring hospital following primary resuscitation / CT scanning in consultation with the lead centre consultant paediatric neurosurgeon and PIC on call consultant. This transfer should be undertaken by the most appropriate and senior team possible. Very rarely, the use of retrieval teams may be appropriate (very early referral, short distances, complex associated injuries); such a decision will only be made by the Paediatric Neurosurgeon in consultation with local clinicians and the PIC/Retrieval Consultant. In patients with no indication for immediate neurosurgery, the balance of risks between retrieval and local team transfer should be agreed between the paediatric neurosurgical the PIC/Retrieval teams and local clinicians.

**5.** Referring Hospitals should have policies and protocols in place for such situations. These should detail the personnel who should be called upon to secure the airway, stabilise and transfer the child, together with the necessary equipment (2). Ambulance services should be informed in advance of the need for systems to expedite these transfers promptly.

# APPENDIX D - SERVICE INTER-DEPENDENCIES FRAMEWORK

## Department of Health, Commissioning safe and Sustainable Specialised Paediatric Services: A framework of Critical Inter-Dependencies, August 2008

This is a summary of some of the key elements from the full document. The framework of Critical Inter-dependencies was produced in order to provide a clear clinically agreed statement of relationships for specialised paediatric services. Children often need access to a number of different specialised paediatric services at any one time and these needs to be considered together. In developing the standards for safe and sustainable paediatric neurosurgery, this inter-dependencies framework remains the standard for describing these relationships.

### Co-location in this context is defined as either:

- Location on the same hospital site; or
- Location in other neighbouring hospitals if specialist opinion and intervention were available within the same parameters as if services were on the same site. These would be reinforced through formal links such as consultant job plans and consultant on call rotas.

**Relationships coding:** The relationships between services are colour coded as follows:

RED	Absolute dependency requiring co-location	AMBER 3	Co-location is desirable but may not be practical in all configurations: <ul style="list-style-type: none"><li>• An integrated clinical service</li><li>• Visit by consultant paediatric specialist or transfer of care</li><li>• Timescale available within 4 hours</li></ul>
AMBER 1	Relationships under some circumstances requiring varying levels of access and contact between specialists, but not necessarily co-location: <ul style="list-style-type: none"><li>• Planned intervention</li><li>• Timescale - as required</li></ul>	AMBER 3*	Co-location is essential to provide a full specialised services, but a decision not to co-locate made be made to ensure optimum access to service centres. If an Amber 3* relationship is not co-located, the full medical specialty would not be able to provide a full specialised service and a very close clinical network with the relevant surgical specialty would be essential.
AMBER 2	<ul style="list-style-type: none"><li>• Visit by consultant or transfer of care</li><li>• Timescale - next working day</li></ul>	GREEN	Indirect no relationship

*An integrated clinical service would be demonstrated by reference to consultant job plans and on-call arrangements, agreed clinical guidelines and pathways of care. Transfer of care would be direct to the optimum site of treatment, requiring an effective transfer support system to and from the specialist service.*

Specialised Paediatric Service		A BMT	B Clinical haemo	C Immun	D Met Med	E Onc	F Burns	G Infect Dis	H Resp Med	I Cardio	J Card Surg	K Neuro	L Neuro Surg	M Major Trauma	N Spec Ortho & Spinal	O Neph	P Uro	Q Endo	R Gastro	S ENT Airway	T Neonato	U Spec Paed Surg	V Paed Crit Care	W Spec Paed Anaesth
1	Blood and Marrow Transplant					3		2	3	1		1				3			2			3		1
2	Clinical Haematology (Non-malignant)			1						1													2	1
3	Immunological Disorder	2	1					3	2							1			3			1	1	1
4	Metabolic Medicine		2						1	2		2				1								1
5	Oncology (inc Haemato-oncology)	1						1	3	1	1	3	3*	1	1	3	2	1	2	1				
6	Burns											1		3		1								
7	Infectious Diseases			2					1	1		1							1				2	1
8	Respiratory Medicine			1				2		3		1						1	3	3		3*	3	1
9	Cardiology								1		3*	1										1		1
10	Cardiothoracic Surgery		1						2			2				1				2	1	3		
11	Neurology		1	1	2			1	2	1			3*		1	1		1	1	2		1		1
12	Neurosurgery					3								3*	2	1	1	2		2	1	2		
13	Major Trauma (inc Maxfax and Plastics)		1							2	2	1			1	1	2							
14	Spec Ortho and Spinal Surgery					1			2	1		2	1				1					1	3*	
15	Nephrology		2	2	1	1		1	2	3		2			2		3*	2	2	2	3			
16	Urology					2										3*						3		1
17	Endocrinology												1										1	1
18	Gastroenterology			2	1			2														3	1	1
19	ENT (Airway)								3	2	2	1		1								2		
20	Neonatology									2												3		1
21	Specialised Paediatric Surgery		3			1			3	1	1	2	3	1	3		3	3	3	1	3			
22	Paediatric Critical Care		3	1	2			1	3	3		2	3	2		2	1		1					
23	Specialised Paediatric Anaesthesia		1						1	1								1		1	1	1		

The common core of any specialist paediatric centre or network is Paediatric Critical Care; Specialist Paediatric Anaesthesia; ENT (Airway) and specialised Paediatric Surgery.

Major Trauma (including Maxillofacial and plastic surgery) requires co-location with the common core above plus Neurology and Neurosurgery.

Specialised Paediatric Service		A BMT	B Clinical haemo	C Immun	D Met Med	E Onc	F Burns	G Infect Dis	H Resp Med	I Cardio	J Card Surg	K Neuro	L Neuro Surg	M Major Trauma	N Spec Ortho & Spinal	O Neph	P Uro	Q Endo	R Gastro	S ENT Airway	T Neonato	U Spec Paed Surg	V Paed Crit Care	W Spec Paed Anaesth
1	Blood and Marrow Transplant																							
2	Clinical Haematology (Non-malignant)																							
3	Immunological Disorder																							
4	Metabolic Medicine																							
5	Oncology (inc Haemato-oncology)																							
6	Burns																							
7	Infectious Diseases																							
8	Respiratory Medicine																							
9	Cardiology																							
10	Cardiothoracic Surgery																							
11	Neurology																							
12	Neurosurgery																							
13	Major Trauma (inc Maxfax and Plastics)																							
14	Spec Ortho and Spinal Surgery																							
15	Nephrology																							
16	Urology																							
17	Endocrinology																							
18	Gastroenterology																							
19	ENT (Airway)																							
20	Neonatology																							
21	Specialised Paediatric Surgery																							
22	Paediatric Critical Care																							
23	Specialised Paediatric Anaesthesia																							

## Comments

If you have any comments, views or suggestions on this document please contact Safe and Sustainable:

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Write to: Stephanie Stanwick,  
Safe and Sustainable,  
National Specialised Commissioning Team,  
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#### Children's Neuroscience Networks (for the Neurosurgical Child) - Questionnaire

##### Introduction

Feedback from parents, contributions from Professional Associations and emerging clinical evidence has helped to define the needs and challenges for Children's Neurological Services into the future. This is what we found:

- There tends to be a longer time between the onset of symptoms and diagnosis of brain tumours than other childhood tumours.
- The resection rate for some tumours is lower in the UK than international centres of excellence. (This relates to the clear surgical removal of tumour cells.)
- The 30 day, 1 year and 5 year survival rates for some brain tumours in the UK may be lower than in the US and there are potentially many reasons for this.
- International evidence exists to suggest services performing more ventricular shunt procedures have better outcomes than services performing fewer procedures.
- Shunts performed by a consultant 'out-of-hours' fare better than those performed by a trainee.
- The 30 day shunt revision rate (those that need to be re-done within 30 days) in the UK may be higher than recognised international centres of excellence.
- 1 in 10 admissions for children to an intensive care unit with traumatic brain injury has a fatal outcome. Outcomes vary considerably across England and Wales for these severe cases.
- Wide variation is reported in the detailed *processes* of care for children with severe traumatic brain injury, with potential impacts on survival.

Meeting these needs and challenges will collectively make this service 'world class'.

The NHS is proposing Children's Neuroscience Networks (for the Neurosurgical Child) will provide stronger coordination of care for patients and their families and achieve 24/7 paediatric neurosurgical care. It is envisaged that there will need to be a number of networks across England. All centres and services that are currently delivering neurological care to children will continue to provide services and be active participants in the network. At least two Children's Neurosurgical Centres will work closely together so they can develop shared clinical guidelines and protocols and benefit from shared audit, research, training and development.

More information about the proposals can be found within two Steering Group documents:

- 1) Children's Neuroscience Networks (for the Neurosurgical Child): A Framework for services in England – February 2012
- 2) Children's Neuroscience Networks (for the Neurosurgical Child): Specification Standards – February 2012

These documents can be found on the Safe and Sustainable website using the following link:

[www.specialisedservices.nhs.uk/document/steering-group-reports](http://www.specialisedservices.nhs.uk/document/steering-group-reports)

The current documents have been developed following detailed ongoing discussions and feedback from a wide range of Professional Associations. However it is important that the views of different organisations are sought including NHS Trusts, clinicians local authorities, families and carers. All comments received and the results of this questionnaire will be discussed by the Steering Group with the aim of finalising the documents by early summer. We do recommend you read the documents before completing the questionnaire.

### **The proposed model of care**

**Obstetricians, Perinatologists and Neonatologists** who will be involved in investigation, diagnosis and counselling during pregnancy, the planning and management of delivery and the care of the new-born baby.

**GPs** play a key role in the early recognition of the condition, appropriate referral, support and follow up

**Paediatricians and Specialist Paediatricians in Child Health in services in local DGHs** are often the first point of contact in hospital following the initial presentation of the child's condition. They are likely to initiate further investigations and seek the advice and support from the Paediatric Neurosurgeons and Radiologists in the Children's Neurosurgery Centre. They also play a key role in after care and support.

**Children's Neurological Centre/Services.** This Centre or Service may also be the point of specialist advice following the initial presentation or involved in support of specialist paediatrics to agree a diagnosis. They also play a key role in after care and support.

**Children's Neurosurgery Centre (CNC).** The CNC has 24/7 advice and support provided by Paediatric Neurosurgeons (PNs) who can discuss diagnosis and treatment plans with clinicians in the network. They will undertake the neurosurgical procedure and agree the management plan for follow up and after care. They may also seek the support of clinical and behavioural psychologists.

**Principal Treatment Centres for Children's Cancer (PTC).** The Paediatric Oncologist (who has received appropriate training in the management of brain tumours) and the multidisciplinary team will be involved in agreeing the management plan for children with brain cancer, together with the PNs. They will be integral to the monitoring and review of the treatment plan and the child's after care and support.

**Trauma Unit.** When a child has been involved in an accident, this unit, which is part of the Major Trauma Network, may be responsible for stabilising the child's condition, undertaking urgent scans, discussing treatment plans with the Major Trauma Centre (MTC)

**Major Trauma Centres (MTC) and/or Children's MTC.** These are the Major Trauma Centres (MTC) in the Trauma Network. In some places they will be combined caring for adults and children, and in others they will be dedicated children's services. There will be a trained trauma team present 24/7. They will assess, investigate, stabilise and prioritise the treatments required and agree the immediate and ongoing management of head injuries with the PNs.

**Adult Neurosurgical Centre (ANC).** These centres have an important role to play in the delivery of care for children with neurosurgical conditions: they will admit and treat children with life-threatening emergency conditions in discussion with the PNs. After life-saving surgery, the child will be transferred to the lead Children's Neurosurgery Centre. They will also play a key role in the transition to adult services.



**Rehabilitation.** The comprehensive multidisciplinary assessment starts in the CNC, and includes a holistic goal setting approach with individually designed programmes focussing on specific, physical, cognitive, and behavioural function. This may include services provided in a rehabilitation centre and service provided in the community based around the child's home and school.

1. Does the proposal make adequately clear the separate and distinct roles for:
 

• specialist district general hospitals	Yes/No/Don't know
• specialist paediatricians	Yes/No/Don't know
• children's neurological services	Yes/No/Don't know
• children's cancer and oncology services	Yes/No/Don't know
  
2. What is not clear?
  - specialist district general hospitals
  
  - specialist paediatricians
  
  - children's neurological services
  
  - children's cancer and oncology services

**A Paediatric Neurosurgeon** is defined within the proposed standards document (G1) and is a consultant neurosurgeon who has undertaken a one-year GMC recognised Fellowship in a recognised paediatric neurosurgical centre as recommended in *Safe Paediatric Neurosurgery* (2001). If accepted, this standard will be applied to all new appointments, and it is recognised that some existing consultants with substantial paediatric practice may not have undertaken formal fellowships. A substantial proportion of the consultant's job plan (minimum of 50% or 5 PAs) should be allocated to paediatric neurosurgery and there should be evidence of regular Continuing Professional Development (CPD) in paediatric neurosurgery.

It is recommended that this should translate into being involved in approximately 80 operative cases per year on children, *although it is accepted that this individual operative workload may vary within a Children's Neurosurgery Centre (CNC) team according to particular paediatric or adult sub-specialist interests.*

3. Do you agree with the proposed definition of a paediatric neurosurgeon?

Yes/No/Don't know

4. Do you want to comment on the definition?

## **24/7 Specialist cover**

5. Do you support the proposal that a rota of named consultant paediatric neurosurgeons must be available for advice, care and support to each network of referring hospitals on a 24/7 basis?

Yes/No/Don't know

6. Do you support the proposal that each network of referring hospitals and the named consultant paediatric neurosurgeon must be able to transmit and receive real time brain scans/imaging on a 24/7 basis?

Yes/No/Don't know

7. Do you think that the network proposals will improve access to services for parents in an emergency?

Yes/No/Don't know

8. Do you think that the proposals will improve access to services for parents to obtain earlier diagnosis and treatment for their children?

Yes/No/Don't know

### **Patient-held records**

9. Do you think that parents should be provided with summary records and scans of the child's condition?

Yes/No/Don't know

10 Please rank your preferred methods for doing this? (put your most preferred method first and so on)

- ☐ Paper files
- ☐ A computer memory stick
- ☐ A data file on your mobile phone
- ☐ A secure computer link

### **Care Quality Assurance**

It is proposed to develop an outline assessment process for Children's Neuroscience Networks (CNNs), based on the draft criteria within the Steering Group documents, with a view to creating a measurable, transparent framework by which future CNNs can be judged. This should be completed by summer 2012.

This will be assessed and 'peer reviewed' by clinicians of CNNs recognising that such approaches have a proven track record in contributing to improvements in clinical practice across different organisations.

11. Do you agree that networks should each provide data on the outcomes of their treatment and care within a national framework and definitions, so that comparisons can be made?

Yes/No/Don't know

12. Do you agree with the proposal for networks to use self-assessment followed by peer review, as the main way of ensuring treatment and care quality standards?

Yes/No/Don't know

13. What, if any, are your concerns with this approach to ensuring high standards of treatment and care?

14. Should referral policies and pathways for key conditions be the same for all networks nationally or should there be freedom to design these locally? Please indicate which you believe to be the correct balance.

Referral policies and pathways should....

- be identical for all networks nationally
- be mostly the same with only minor variation locally where necessary
- be based upon national approaches but adjusted to local circumstances
- be determined mostly by the local network, with reference to others' nationally
- be determined by the circumstances in each local network

### **Arrangements between Networks**

**Trauma Unit** When a child has been involved in an accident, this unit, which is part of the Major Trauma Network, may be responsible for stabilising the child's condition, undertaking urgent scans and discussing treatment plans with the MTC.

**Major Trauma Centres (MTC) and/or Children's MTC.** These are the Major Trauma Centres (MTC) in the Trauma Network. In some places they will be combined, caring for adults and children, and in others they will be dedicated children's services. There will be a trained trauma team present 24/7. They will assess, investigate, stabilise and prioritise the treatments required and agree the immediate and on-going management of head injuries with the Paediatric Neurosurgeons (PNs).

15. Should Children's Neuroscience Networks (for the Neurosurgical Child) provide real time advice and support by a consultant paediatric neurosurgeon to the major trauma networks for children in your location?

Yes/No/Don't know

16. What local difficulties are you aware of, in achieving this?

### **Arrangements within Networks**

Children's Neuroscience Networks need to have:

- clear governance structures supported by agreements with participating organisations;
- an identifiable management team and support for the network provided by an NHS Trust with a Children's Neurosurgical Centre;
- clinical leaders with defined roles, responsibilities and accountabilities either for the network overall or for clinical pathways or subspecialties across the network;
- active user involvement;
- robust clinical governance arrangements;
- processes to achieve excellence, including assessment and review against standards, shared policies and guidelines, audit;

- research, training and development, including supported continuing professional development processes and a programme of shared learning across the organisations.

17. In a network where there is more than one Children's Neurosurgery Centre, is it important to have clearly identified leaders?

Yes/No/Don't know

18. Would it be beneficial to have identified leaders for each pathway such as for children with tumours or with hydrocephalus?

Yes/No/Don't know

19. Why do you think this?

### **Commitment and implementation**

There will be a national review of all network and clinical leadership proposals to ensure 'best fit' with national policies and criteria; to ensure appropriate access is available across all children's neurosurgical services, and to assess the impact these proposals may have on other linked services and networks such as trauma and cancer.

Subject to legislation, the implementation of network proposals and plans will be overseen by the NHS Commissioning Board and local development priorities will be agreed within the commissioning framework developed for these services.

20. Do you believe that a managed network which coordinates all health services will improve the quality of care provided to patients in your region?

- Significantly improve care
- Somewhat improve care
- No effect either way
- Some risk to quality of care
- Significant risk to quality of care

21. Do you agree the proposed implementation process for establishing networks?

Yes/No/Don't know

22. How long will it be before the network is fully implemented in your region?

- 2 years
- 3 years
- 4 years
- Longer than 4 years
- Don't know

## Report of Head of Scrutiny and Member Development

### Report to Scrutiny Board (Health and Well-Being and Adult Social Care)

**Date: 16 May 2012**

**Subject: Leeds and York Partnership NHS Foundation Trust – Care Quality Commission compliance update**

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Are there implications for equality and diversity and cohesion and integration?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Is the decision eligible for Call-In?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

### Summary of main issues

- At its meeting held on 18 March 2012, the Scrutiny Board (Health and Wellbeing and Adult Social Care) considered a Care Quality Commission (CQC) compliance report relating St. James' University Hospitals (part of Leeds Teaching Hospitals NHS Trust (LTHT)) and the associated response.
- At that meeting it was highlighted that Leeds and York Partnership NHS Foundation Trust (LYPFT) was also in receipt of recent CQC inspection reports. It was agreed to consider those reports and associated response at the meeting in May 2012.
- This following information is appended to this report.
  - CQC review of compliance report (December 2011) – the Newsam Centre (Ward 3)
  - CQC review of compliance report (April 2012) – St Mary's Hospital
  - CQC review of compliance report (October 2011) – St Mary's Hospital
  - Associated responses from LYPFT
- Representatives from LYPFT and the CQC have been invited to the meeting to discuss the matters in more detail.

### Recommendations

- To consider the information presented and determine any additional scrutiny activity that may be required.

## **Background documents** <sup>1</sup>

None used

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<sup>1</sup> The background documents listed in this section are available for inspection on request for a period of four years following the date of the relevant meeting. Accordingly this list does not include documents containing exempt or confidential information, or any published works. Requests to inspect any background documents should be submitted to the report author.

# Review of compliance

**Leeds Partnership NHS Foundation Trust**

**The Newsam Centre (Ward 3)**

<b>Region:</b>	Yorkshire & Humberside
<b>Location address:</b>	Ward 3 The Newsam Centre Seacroft Hospital York Road Leeds LS14 6WB
<b>Type of service:</b>	Hospital services for patients with mental health needs, learning disabilities and problems with substance misuse.
<b>Date the review was completed:</b>	December 2011
<b>Overview of the service:</b>	The Service is a low secure forensic in patient ward for patients with a mental disorder and learning disability who may have been involved with the criminal justice system. Five of the beds offer a service to patients with forensic mental health needs and learning disabilities.  On the days of our inspection there were 17

	<p>patients on the ward. Four of the patients had a mild learning disability. Therefore we concentrated our inspection on these four patients.</p> <p>All of the patients were detained under the Mental Health Act 2007, Part 2 Civil Sections and Part 3. Patients have been involved in criminal proceedings, some of whom will be subject to Ministry of Justice restrictions.</p> <p>The regulated activities, which the service is registered to provide are:</p> <ul style="list-style-type: none"> <li>• Assessment or medical treatment for persons detained under the Mental Health Act 1983</li> <li>• Treatment of disease, disorder or injury</li> <li>• Diagnostic and Screening</li> </ul>
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## Summary of our findings for the essential standards of quality and safety

### What we found overall

**We found that The Newsam Centre (Ward 3) was not meeting one or more essential standards. Improvements are needed.**

The summary below describes why we carried out the review, what we found and any action required.

### Why we carried out this review

This review is part of a targeted inspection programme to services that care for people with learning disabilities to assess how well they experience effective, safe and appropriate care treatment and support that meets their needs and protects their rights; and whether they are protected from abuse.

### How we carried out this review

The inspection teams are led by Care Quality Commission (CQC) inspectors who are joined by two 'experts by experience', these are people who have experience of using services (either first hand or as a family carer) who can provide that perspective and a professional advisor.

We reviewed all the information we hold about this provider, then carried out a visit on 5 and 6 December 2011. We observed how people (patients) were being cared for, spoke with the patients and staff, checked the provider's records and looked at patients' care records.

As part of our inspection, telephone discussions were also held with relatives and other professionals who we were not able to meet during our visit. Their comments are included within this report.

To help us to understand the patients' experiences, people have we used our Short Observational Framework for Inspection (SOFI) tool. The SOFI tool allows us to spend time watching what is going on in a service and helps us to record how people spend their time, the type of support they get and whether they have positive experiences. We did not use this tool on this occasion, as all of the patients were able to communicate their views to us verbally.

## What people told us

We spoke with four patients when we visited, Ward 3, Newsam Centre.

Some patients were satisfied with the care, treatment and support they received at the hospital. They said they had care plans and were able to attend review meetings with advocates to support them. They told us:

“I have a care plan and health care plans.”

“I have a care plan and I reckon staff are following it.”

“I have meetings with the doctors and nurses and I’ve got an advocate.”

Patients told us they attended daily community meetings with staff where their daily activities and leave could be organised. Patients said they had access to meaningful activities and said:

“I do art, poetry and ten pin bowling.”

“I have some friends here and I like playing the DS (*computer game*)”.

These patients told us they had developed good relationships with staff, had many meaningful activities to do and felt they were making progress.

Other patients told us they did not get on with or feel adequately supported by some staff. They told us they had been bullied by another patient and did not always feel safe.

“I might have a care plan, but not sure. I don’t know what’s in it.” In addition, “Sometimes I don’t get support from staff; I’m left to do my own thing.” They went on to say, “I don’t like it here, I preferred where I was before.”

A patient said, “When I first moved here I was bullied by other patients, this went on for six months, I was called names, they would ‘bang’ (*speak disrespectfully about*) my family”.

Some patients complained they did not like the food available on the unit. One patient said, “I eat take-away food or go to my mums.” Another patient told us, “Food is not very tasty.” Patients said staff would only allow them to order take away meals on Friday and Saturday nights.

Patients told us about restrictions placed on them by staff, which included smoking. This was limited to one cigarette per hour. One patient told us, “We have cigarettes on the hour. When it is meal times, we have cigarettes at quarter past the hour. If you are a slow eater and have not finished by quarter past then you have a choice of whether you have your meal or a cigarette.”

## **What we found about the standards we reviewed and how well, The Newsam Centre (Ward 3) was meeting them**

### **Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights**

Patients' needs were assessed; care plans and risk assessments were in place. There was little evidence that patients and their relatives were meaningfully involved in the care planning process and care was not planned using person centred approaches. Some patients' choices and independence were restricted without proper safeguards in place to demonstrate whether such restrictions were the 'least restrictive' options or person centred. This meant that patients did not always experience effective and appropriate care and support that met their individual needs and protected their dignity and human rights.

- Overall, we found that, The Newsam Centre (Ward 3) was not meeting this essential standard. Improvements are needed.

### **Outcome 7: People should be protected from abuse and staff should respect their human rights**

Safeguarding procedures were not followed in a robust way. Allegations of abuse were not treated with an 'appropriate urgency' and there was no clear recorded audit trail of the actions taken by staff to safeguard patients. This meant patients were not adequately protected from abuse or the risk of abuse, as the safeguarding procedures were not implemented effectively.

- Overall, we found that, The Newsam Centre (Ward 3) was not meeting this essential standard. Improvements are needed.

## **Action we have asked the service to take**

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

We have ensured that two safeguarding referrals were made to the relevant safeguarding teams to make sure any necessary actions can be taken to protect patients from abuse. The two safeguarding concerns were raised by the individual patients during the inspection. One was a new concern regarding an external provider and the second was the re-emergence of a previous concern, which the ward had already taken some actions to address.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. Any regulatory decision that CQC takes is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

**What we found**  
for each essential standard of quality  
and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

**Compliant** means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*.

## Outcome 4: Care and welfare of people who use services

### What the outcome says

This is what people who use services should expect.

People who use services:

- Experience effective, safe and appropriate care, treatment and support that meet their needs and protects their rights.

### What we found

#### Our judgement

**There were moderate concerns with  
Outcome 4: Care and welfare of people who use services**

#### Our findings

##### What people who use the service experienced and told us

We spoke with four patients to gain their views about the care, treatment and support they received on Ward 3, The Newsam Centre.

A patient told us “I have a care plan and health care plans.” Another patient said they had two advocacy workers and they keep themselves busy by taking part in a range of activities. They went on to tell us, “I enjoy attending the gym.”

Other comments included:

“I have a care plan and I reckon staff, are following it.”

“I do art, poetry and ten pin bowling.”

“I have some friends here and I like playing the DS (*computer game*).”

“I have meetings with the doctors and nurses and I’ve got an advocate.”

“My family come and visit me.”

“Staff, explain the risks involved in the choices I make.”

Overall, these patients told us they were satisfied about the care, treatment and support they received from the service.

Other patients told us, “I might have a care plan, but not sure. I don’t know what’s in it.” In addition, “Sometimes I don’t get support from staff; I’m left to do my own thing.” And, “I have an advocate, who I see every two weeks.” They went on to say,

"I don't like it here, I preferred where I was before."

One patient told us, "We have cigarettes on the hour. When it is meal times, we have cigarettes at quarter past the hour. If you are a slow eater and have not finished by quarter past then you have a choice of whether you have your meal or a cigarette." We observed that patients were only allowed out of the ward in to the court yard area once an hour, on the hour for a cigarette. One patient told us they thought the smoking restriction was in place because staff had made the decision to only allow patients to smoke once an hour, they did not think it was fair and did not understand why it was in place. This indicated 'restrictions' were placed on patients (see *Other evidence*, Delivering care, section below).

Other concerns raised by patients related to a lack of privacy during phone calls, from the patients' phone. One patient said, "Patients' ask you questions about what you have been talking about on the phone, there's no privacy." We saw the phone was located on a communal corridor and this did not offer patients adequate privacy. The staff told us patients could use the phone in the clinic room for privacy.

In addition, two of the four patients told us they did not like the food on the ward. One patient said, "I eat take-away food or go to my mums." Another patient told us, "Food is not very tasty." A third patient said, "Meal times are set, you can't choose."

We spoke with two relatives to gather their views about the care, treatment and support offered to patients. These were their comments:

One relative told us, "*(patient's name)* has a care plan and I think he has a Health Action Plan (HAP) and an annual health check." The relative said they were invited to review meetings. They said they felt invites to the meetings were, "Rather tokenistic." And said, "I am not really listened to. All along whether I or *(patient's name)* have been involved or not the doctors and staff have had the ultimate say in the decision making."

The second relative told us they had very little contact with the staff on the ward. They commented, "We were not informed when *(patient's name)* was moved here." They said, "Staff did not contact me or their dad. We only found out when *(patient's name)* phoned to tell us." They said they were not happy about the lack of consultation and involvement with the staff. We passed on these concerns to the Clinical Team Manager (CTM) to address, at the time of the visit, as we were unsure of whether the patient had consented to their relative's involvement.

During our inspection, we observed some staff interactions with patients, which were friendly and empowering. However, we also observed staff interactions with patients, which were not respectful and did not protect patient dignity. For example we observed a patient being told by staff, "Do not to swear in front of a lady." (Meaning the inspector). In this case, a patient was having a conversation with a member of staff. They were generally chatting, the patient was not presenting as agitated, angry or shouting. They were having a general conversation and in the context of the conversation the patient swore, this was not out of context, extremely explicit or observed to be offensive to other staff or patients in the vicinity. The member of staff talking with the patient did not stop the conversation to address this or advise him of any concern in relation to this behaviour. However, another

member of staff then walked across to the patient and said, "Don't swear in front of a lady." (Pointing to the inspector). When the member of staff intervened in this way, the patient then became angry because of the way the member of staff had intervened, the patient told the staff, he was just having a chat.

Another poor interaction observed was when several patients were approached by a member of staff and were told, "Don't use this as an excuse to have a cigarette." (During a fire evacuation from the building, as a result of a fire bell sounding). When we raised concerns about this interaction the Clinical Team Manager (CTM) told us, which member of staff it would be and they were correct. This indicated to us, they were aware of this member of staff's approaches / attitude prior to our visit. Both the CTM and Service Manager agreed this approach to engaging patients was not appropriate and they advised us, they would take action to address this with the member of staff.

Overall, from our observations we found there was limited social interaction between patients and some staff. The general atmosphere on the ward was quiet.

### **Other evidence**

#### Assessing people's needs

The Clinical Team Manager (CTM) told us about the referral and admissions procedures for the service. We were supplied with a copy of these. They gave staff clear instructions to follow when assessing and admitting a patient to the service.

We looked at the assessment records of four patients. These were detailed and clearly showed the patients' assessed needs. Records showed that patients had been detained prior to being admitted and we saw legal documents, which confirmed this. We were told nurses managed admissions. They then collated information from the Multi-Disciplinary Team (MDT). A primary nurse and care coordinator was then allocated and a health care assistant (HCA) is allocated to be a link worker to all patients.

We saw that on admission patients' individual needs were considered, for example, bedroom allocation was dependent on the patient's needs, including physical disability, vulnerability and other individual diversity issues.

Patients had discharge plans, which staff began to develop on the patient's admission.

#### Care planning

We looked at four patient's care plans. The care plans checked were based on the patient's needs assessments made prior to and on admission to the unit. These were detailed. Those care plans checked, were regularly reviewed on a monthly basis. They were devised in written formats, were written in a technical and clinical way and were therefore not person centred in approach. There was little evidence they had been devised in conjunction with patients and the patients had not signed the care plans to show their agreement about what was recorded in their care plans. Overall, the care plans checked, did not indicate a person centred approach to



planning patient care.

None of the patients we spoke with had a copy of their care plan. Staff said all the care plans were kept in the staff office, to protect patient confidentiality. The CTM said if patients wanted a copy of their plan, they would be made available.

When we asked whether any person centred care plans were planned with patients, staff said patients had discharge plans called, 'My future plan'. They said these had been devised using person centred principles. One patient told us they had been involved in devising their 'My future plan'. We checked three of these plans, one was comprehensive, it detailed the patient's views and wishes and used pictures and easy read formats to meet the patient's communication needs. However, the two other plans lacked written evidence of any patient involvement and were incomplete. We were told after the inspection that the reason the plans were incomplete was, "The two incomplete plans were as a result of them still being in the process of completion with the service users." This did not demonstrate that person centred approaches to care planning were yet embedded within the service.

There was evidence that Care Programme Approach (CPA) reviews, were carried out regularly. Staff told us, they had a pre-CPA meeting checklist and we saw evidence these were completed; this included asking if the patient would like an advocate present at their meeting to speak up for them. We saw evidence in one patient's records of a CPA self-assessment report. This had been completed by the patient prior to their CPA review. This practice involved the patient and protected their rights.

A risk assessment and review system was in place. The risk assessments checked had been regularly reviewed. Staff told us, risks were explained to patients and one patient told us that risks relating to the medication they had been prescribed had been explained to them. This supported the patient to understand the effects and side effects of the medication.

Whilst there was written evidence (in some cases) to show that staff had explained patients' rights to them whilst detained under the Mental Health Act, there was little written evidence to confirm that patients had received this information. For example, in two patient's records we saw that although staff had recorded, they had 'Read the patient their rights under the Mental Health Act 1983', neither of these had been signed by the patient and only one was signed by a member of staff.

From speaking with patients and some of their relatives, we found that overall patients were not involved in making important decisions about their individual care and the records we checked in relation to patient care confirmed this. Overall, we found that patients did not receive person centred care.

#### Meeting people's health needs

Patients did not have health action plans. We saw care plans relating to health needs and this demonstrated how patient's needs were being met. Staff told us patients had physical health checks on admission; this was evidenced within care records checked. Staff said patients also had annual health checks, patients confirmed to us their health needs were recognised and they were offered

appropriate treatment to meet their health needs.

Staff told us that a psychologist and two psychotherapists carry out work sessions with patients to provide support with their mental health needs.

We saw evidence that a patient had requested to read their health records with a solicitor present and the ward staff had arranged for this to happen. This protected the patient's rights.

#### Delivering care

Staff confirmed that smoking restrictions were in place on the ward. We found these 'smoking restrictions', were rigid with little attention given to patients' rights and choices. When we asked the senior staff about this restriction, we were told this was not in place for any specific reason other than monitoring patients. The CTM advised us, that if any of the patients wanted to leave the ward to smoke they could, as they all had 'Section 17 leave granted' (this is where patients can have the opportunity to leave the ward for a specified amount or time under certain conditions). The next day we were advised that the reason the restriction was in place was because the fence in the court yard posed an 'absconding risk' as it was too low to meet the low secure unit standards for security.

We acknowledged that some restrictions placed on patients in the unit may be as a result of the nature of their detention under the Mental Health Act. There are situations where it would be appropriate to place restrictions on patients in order to keep them and other people safe. However, we looked to see whether restrictions, which were placed on patients met the following criteria:

- The restrictions were based on specialist need and risk assessments, or recorded evidence the restriction was required by their treatment programme;
- Whether patients had agreed or been informed about the restrictions during the assessment process;
- Whether the restrictions were proportionate and in line with Human Rights legislation.

We asked for, but were told there was no recorded evidence to demonstrate that before restrictions were placed on patients, that these factors had been considered in relation to individual patients smoking, ordering take away meals and access to the external courtyard area. Therefore, we could not be satisfied that the restrictions were 'person centred' and / or were the, 'least restrictive options' available to the staff team / service. This did not protect patients' rights.

We found the restrictions were placed on all patients on the ward. This was a 'blanket approach' and compromised patients' rights and dignity.

The manager explained that patients were encouraged to limit or stop smoking and there are smoking cessation groups for patients.

We saw an activities board on the ward corridor, with all the weekly activities on display. The activities board included photos and pictures to support patients'

communication needs. Each patient had a weekly activity programme. There was an art room, a laundry (where patients did their own washing and ironing) and a kitchen to enable patients to develop cookery skills. Walking and exercise groups also formed part of the weekly activities programme. An Occupational Therapist (OT) works on the ward five days a week, to support patients' activities. These meaningful activities supported patients and met their social, physical and mental health needs.

Staff explained that mealtimes were flexible. However, this was not supported by some patient comments. Food was provided by an external catering firm. Staff said 'taster sessions', were being held, so that patients favourite foods could be included on the menu. The CTM told us there were plans for a 'special festivals and events menu' to celebrate occasions. This recognised patients' diversity. After the inspection the trust told us, "Whilst there is some flexibility within mealtimes, hot meals have to be served within a strict time frame in order to adhere to food hygiene laws. Snacks and fruit are also available throughout the day. There are also facilities available for service users to self cater as part of their recovery plan and this is actively encouraged."

Staff told us, 'healthy eating', was encouraged and there was information available to patients about this. Staff told us that patients could only have takeaway meals on two set nights per week. The CTM told us, this decision had been made by the staff team to ensure patients were not constantly ordering take away food, as this was not consistent with 'healthy eating'. However, given the fact that several patients had told us the food was poor and given that this was a rehabilitation ward prior to patients moving onto more independent living, the philosophy came across as 'staff know what is best for you'. Because of this patients' level of independence was 'restricted' and their right to make choices was not protected.

Patients had access to independent advocacy agencies, (a local Leeds Learning Disability and Mental Health advocacy service). This included Independent Mental Capacity Advocate (IMCA) and Independent Mental Health Advocate (IMHA) who attend fortnightly MDT reviews, which the patient and their relatives were also invited to attend.

Staff told us morning meetings were held daily with patients in order to organise activities and individuals, 'Section 17 leave', from the ward. The patients we spoke with confirmed this. This enabled patients to have some involvement in organising how they spent their time.

Patients told us, and we saw records of, minutes from patient involvement meetings. The records showed patient representatives from each ward had the opportunity to be involved in a patient involvement group that takes place fortnightly for the in-patient services provided at The Newsam Centre. This demonstrated patients had some opportunities to be involved in decision making within the service. We saw minutes of the meetings and discussed with the occupational therapist whether they were made available in other accessible formats for patients who may not read. They advised this was not done at present, but could be looked into.

We saw visitor records, which showed that family, friends and professionals visited people at the service at different times and at weekends. The visitors we spoke with

felt they could visit during the stated times and said they saw patients in the visitors' rooms, just outside the ward. This enabled patients to have privacy and to maintain important relationships.

### Managing behaviour that challenges

Overall, we found there were care plans in place, which indicated how to minimise risks relating to patients who may present behaviour that challenges. There was recorded evidence, in incident records, that staff regularly used de-escalation techniques. There were clear guidelines for staff to follow if physical interventions were used including the importance of monitoring patients both during and after the incident.

### **Judgement**

Patients' needs were assessed; care plans and risk assessments were in place. There was little evidence that patients and their relatives were meaningfully involved in the care planning process and care was not planned using person centred approaches. Some patients' choices and independence were restricted without proper safeguards in place to demonstrate whether such restrictions were the 'least restrictive' options or person centred. This meant that patients did not always experience effective and appropriate care and support that met their individual needs and protected their dignity and human rights.

## Outcome 7: Safeguarding people who use services from abuse

### What the outcome says

This is what people who use services should expect.

People who use services:

- Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

### What we found

#### Our judgement

There were major concerns with  
**Outcome 7: Safeguarding people who use services from abuse**

#### Our findings

##### What people who use the service experienced and told us

We spoke with four patients to gain their views about the care, treatment and support they received on Ward 3, at the Newsam Centre. One patient was very happy with the support they received at the unit and it was clear staff had formed good relationships with the individual. He told us, "I love it here; it's a lot better than where I was before." And "Staff are good." They went on to tell us they would feel able to discuss any concerns with staff and staff had recently talked to them about 'bullying' and how to report any concerns they may have.

A second patient told us, "Sometimes, I get confused, but I know I want to stay here."

A relative told us, they had always been involved in their son's care. Overall, the relative believed the patient was generally happy at the Newsam Centre and the relative was happy with their care.

A third patient told us, "When I first moved here I was bullied by other patients, this went on for six months, I was called names, they would 'bang' (*speak disrespectfully about*) my family". He said he had told the staff about these concerns. This patient went on to tell us, "There are 'anti-bullying' posters on the ward, been there for two weeks and no one has explained them to people who can't

read”.

The patient went on to tell us they did not have a good relationship with some staff, “Some of the staff are nasty to me, they put fingers up to me. These are male members of staff.” They did not name any individual staff. This concern was fed back to the CTM to address with the patient directly.

A fourth patient told us, “Staff pretend to be polite when there are visitors”. They told us, another member of staff, “Was very intrusive in personal space, when we complain to the doctor, (Name) gets upset and walks past the patient who has complained and has a cigarette.” They went on to tell us, “There are only a handful of staff that are nice and respectful.” “(Name) is really good with me.”

We fed back these patient’s concerns about staff, back to the CTM, the service manager and consultant psychiatrist on the first day of the inspection. We asked them to follow up these concerns with the patients. The service manager agreed to follow this up and take appropriate action.

One patient made an allegation to us about how they were treated by staff in another facility (outside the trust) before they moved to Ward 3 at the Newsam Centre. This allegation was made on the day of the inspection and was not previously known to staff. We asked the CTM to follow this up with the patient. The provider told us a safeguarding referral was made on 5 December 2011 and they were allocating this to a trust safeguarding adult enquiry co-ordinator (SAEC). We followed this up with the local safeguarding team responsible and we were advised the trust had made a safeguarding referral to this safeguarding team on 13 December 2011.

Another patient told us they were currently being bullied by a patient on the unit, they said, they were ‘being asked for money’. When we spoke with the patient’s relative, they said the patient had complained to them about being bullied for money by another patient. The relative told us this was the reason the patient had absconded from the ward (three months prior to our visit). We passed this information on to the CTM, the service manager and the associate director and asked them to follow this up with the patient and relative to ensure the patient was adequately safeguarded. The trust notified us on 9 December that a safeguarding referral was made on 6 December 2011, to the trust’s Safeguarding Lead. We followed this up by sending a referral to the Leeds safeguarding adults team in order to safeguard the patient.

## **Other evidence**

### Preventing abuse

Senior managers provided us with a copy of the trust’s and the Leeds multi agency adult safeguarding procedures. They confirmed that the trust works within the multi-agency procedures. We looked at the trust’s procedures and found it was due for review on 1 December 2011. A senior manager said the policy was currently under review. Staff told us the safeguarding policy and procedures were stored electronically on the trust’s intranet, which was available in the ward office and was available to all staff.



We spoke with three members of staff who told us they knew about and had access to the trust's safeguarding policy and procedures. All three staff told us they would report all allegations of abuse to their line managers or to the trust's safeguarding co-ordinators (SAEC) or the Safeguarding Lead (SL). Three staff interviewed, all confirmed they had completed safeguarding training and also had access to electronic training sessions on this subject.

We also spoke with the Lead Occupational Therapist, who is one of the Adult Safeguarding Co-ordinators within the Forensic Service. She had completed the Leeds multi agency adult protection and investigation training and was clinically involved with all four patients.

Members of staff we spoke with were aware of whistle-blowing procedures. They were able to explain to us what they would do if they needed to use these to raise concerns. We were given a copy of the trust's whistle-blowing policy, this indicated that systems were in place to advise staff how to address and report any concerns they may have.

#### Responding to allegations of abuse

During the inspection, we asked the CTM and other senior managers for information about the number of safeguarding referrals made from the ward over the last year. We were told initially there were three, then were given a record indicating there had been two referrals and when we asked whether the referrals led to strategy meetings or to investigations and case conferences, managers were unclear and we received conflicting information. They told us this was because they had no central records to check to identify the number of incidents referred to safeguarding. This did not enable us to verify whether safeguarding procedures had been effectively followed; this could place patients at risk. This demonstrated the systems in place were not adequately robust to ensure patients were effectively safeguarded.

We spoke to the trust's SL who confirmed that the records relating to advice they had given staff, following safeguarding enquiries were not always recorded by the SL or SAEC. They would expect it to be recorded at the local level, by staff. In the case of this ward, the advice from the SL had not been recorded in a way that the information could be easily accessed and checked. This demonstrated the system was not effective to ensure a clear, accountable and accessible safeguarding audit trail was maintained by the trust.

The trust's safeguarding procedures checked did not indicate a clear timescale within which an 'alert' or a 'referral' should be made to the trust SAEC or Safeguarding Lead. The Leeds multi agency procedure states, "Every reported incident of abuse of a vulnerable adult must be treated with appropriate urgency". These procedures stated this should be done, "within the same working day". We saw evidence that safeguarding referrals were not being managed with, an 'appropriate urgency', to protect patients from abuse or the risk of abuse.

In mid August 2011, several patients told staff in a community meeting they were being, 'bullied', by other patients on the ward. This took the form of, 'name calling' and 'threats made to beat up a patient', asking patients for their snacks, selling

goods to patients for one price and then demanding further payments for the goods, with threats of violence if they did not agree. We asked what action had been taken to address the patient's allegations.

Information made available to us by managers during the inspection was confused, contradictory and incomplete. We spoke with the service manager, consultant psychiatrist and associate director about our concerns that safeguarding procedures were not being followed robustly and that this could place patients at risk. We also advised that we had been given conflicting information about whether safeguarding referrals had been made, by whom and their status. Due to this we asked for a report to be sent in to us within 48 hours to clarify what action the staff had taken in the case of the patients alleging bullying in the ward meeting.

The report was sent in by the trust on 9 December 2011. It confirmed that no safeguarding 'alert' or 'referral' was made to the safeguarding lead at the trust or to the local area safeguarding team on the same day. It was sent in over three weeks after the initial concerns were raised. This did not demonstrate an 'appropriate level of urgency', to address patient's allegations of abuse and this may have placed patients at risk of abuse. It also indicated that managers were not robust in following the trusts or the local area safeguarding procedures.

The report explained the reason that the safeguarding referral was not sent immediately. It stated, "This was a general ward safeguarding referral due to a number of issues of inappropriate behaviour being displayed". The trust went on to tell us a ward action plan was in place. They said, "The trust's safeguarding lead has not deemed it necessary to progress this to a case conference and to this end this is not an open case. The trust's safeguarding lead (SL) was sufficiently assured that it was appropriate for this to be managed by the clinical team". The trust told us in their report to us that after the safeguarding referral was made on 15 September 2011 to the SL; that a decision not to proceed with the case was made by the SL. However, there was no recorded reason for this decision making available on the ward when we visited.

The trust's safeguarding procedure stated that, "a decision about how to respond to the concerns will be made following consultation with all relevant individuals and after consideration of the legal and ethical parameters,... This will be made by the SAEC following consultation with all relevant parties... There may be some cases where it is felt appropriate to refer to the Local Authority, this decision will be made after multidisciplinary consultation and after taking advice from Leeds Safeguarding Adults unit". We were not provided with recorded evidence to demonstrate that this process had been followed.

We were told that Leeds safeguarding adults team had not been involved in the case as the seriousness of the allegation was deemed to be 'Level 1 – safeguarding', (Lowest level) and this was to be dealt with via the clinical team on the ward. There was no recorded information about how, why and when this decision had been made.

We were concerned that patient's allegations were not being recognised as 'allegations of abuse', staff were not responding with an 'appropriate level of urgency', records were not being kept in relation to when allegations were made



and the rationale for decision making. This meant that safeguarding procedures were not being effectively implemented and any actions staff had taken were not being appropriately recorded. This did not ensure that patients were adequately protected from abuse or the risk of abuse.

### Using restraint

Staff told us they had received training in order to safely use physical interventions (restraint) as a last resort. We found staff mainly used de-escalation techniques and incident records showed staff very rarely used restraint or physical interventions with patients. We saw evidence in incident records that when patients had presented 'challenging behaviour', they were supported by staff who used de-escalation techniques and these were effective in supporting patients. Staff told us, the ward does not have a seclusion room but there is the facility available within another unit. We were told that seclusion had not been used at the service for over two years. We saw evidence that incident records had been audited by the trust's risk management team. Staff said they would use the information to identify any trends or near misses to ensure patient safety. This ensured that patients safety was being monitored.

### **Judgement**

Safeguarding procedures were not followed in a robust way. Allegations of abuse were not treated with an 'appropriate urgency' and there was no clear recorded audit trail of the actions taken by staff to safeguard patients. This meant patients were not adequately protected from abuse or the risk of abuse, as the safeguarding procedures were not implemented effectively.

## Action

we have asked the provider to take

### Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
<p>Assessment or medical treatment for persons detained under the Mental Health Act 1983.</p> <p>Treatment of disease, disorder or injury.</p>	<b>Regulation 9</b>	<b>Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights</b>
	<p><b>How the regulation is not being met:</b></p> <p>Patients' needs were assessed; care plans and risk assessments were in place. There was little evidence that patients and their relatives were meaningfully involved in the care planning process and care was not planned using person centred approaches. Some patients' choices and independence were restricted without proper safeguards in place to demonstrate whether such restrictions were the 'least restrictive' options or person centred. This meant that patients did not always experience effective and appropriate care and support that met their individual needs and protected their dignity and human rights.</p>	
<p>Assessment or medical treatment for persons detained under the Mental Health Act 1983.</p> <p>Treatment of disease, disorder or injury.</p>	<b>Regulation 11</b>	<b>Outcome 7: People should be protected from abuse and staff should respect their human rights</b>
	<p><b>How the regulation is not being met:</b></p> <p>Safeguarding procedures were not followed in a robust way. Allegations of abuse were not treated with an 'appropriate urgency' and there was no clear recorded audit trail of the actions taken by staff to</p>	

	safeguard patients. This meant, patients were not adequately protected from abuse or the risk of abuse, as the safeguarding procedures were not implemented effectively.
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The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

# What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

**Improvement actions:** These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

**Compliance actions:** These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

**Enforcement action:** These are actions we take using the criminal and/or civil procedures in the Health and Adult Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

## Information for the reader

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## CARE QUALITY COMMISSION REVIEW OF COMPLIANCE

### Ward 3 Newsam Centre

#### 1. INTRODUCTION

As part of the targeted inspection programme to services that care for people with learning disabilities the Care Quality Commission (CQC) carried out a visit to Ward 3 Newsam Centre on the 5<sup>th</sup> and 6<sup>th</sup> December 2011.

The review focused on the following two outcomes:

- Outcome 4 – Care and welfare of people who use services
- Outcome 7 – Safeguarding people who use services from abuse

In undertaking the review the CQC observed how people were being supported and cared for, talked with people using the service, talked with relatives or representatives, talked with members of staff and looked at records of people using the service.

#### 2. FINDINGS FROM THE REVIEW

The final draft report has now been received from the CQC. On receipt of the first draft the Trust raised some concerns with the CQC around the proportionality of the report, the language used and the context of some of the findings within a low secure service. A meeting took place with the CQC on the 8<sup>th</sup> February to discuss in detail the issues raised by the Trust. The report has been amended to reflect some of the issues raised and to include positive practice that was identified at the inspection. The outcome of the inspection, however, remains the same. The Trust still has continued concerns with the proportionality of the outcomes within the revised report due to the number of positive findings by the inspection. The Trust also has concerns as to the understanding by the CQC of a low secure setting and the necessary balance required between appropriate restrictions to manage risk and safety.

The table below shows a summary of the CQC findings. A moderate concern was identified with Outcome 4, meaning that people who use the service are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this. A major concern was identified with Outcome 7, meaning that people who use the service are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Outcome	CQC Judgement
Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights	Overall the CQC had moderate concerns and found that improvements were needed for this essential standard. The Trust therefore received a compliance action.
Outcome 7: People should be protected from abuse and staff should respect their human rights	Overall the CQC had major concerns and found that improvements were needed for this essential standard. The Trust therefore received a compliance action.

### **3. DETAILED FINDINGS FROM THE REVIEW**

#### **Outcome 4: Care and Welfare of people who use Services**

Overall, the CQC had moderate concerns with Ward 3, Newsam Centre, and found that improvements were needed for this essential standard. The Trust therefore received a compliance action.

The CQC spoke with 4 people using the service who told the CQC that they were satisfied with the care, treatment and support they received. Positive comments included 'I have a care plan and health care plans', 'I have meetings with the doctors and nurses and I've got an advocate' and 'staff explain the risks involved in the choices I make'.

Concerns were raised by patients relating to a lack of privacy during phone calls as the phone was located on a communal corridor. Staff informed the CQC that patients could use the phone in the clinic room for privacy.

The CQC spoke with 2 relatives to gather their views about the care, treatment and support offered to patients. One relative told the CQC that "(patient's name) has a care plan and I think he has a Health Action Plan and an annual health check". The relative said they were invited to review meetings but felt that they were not really listened to and that doctors and staff have had the ultimate say in the decision making. The second relative told the CQC they had very little contact with the staff on the ward and were unhappy about the lack of consultation and involvement with staff. However, the service user had specifically stated during the early stages of his admission that he did not want staff to discuss his care with specific members of his family. At a later date he agreed that the clinical team could contact named relatives, but his relationship with them is such that the team would always ask him first, and this permission was sometimes withdrawn.

During the inspection the CQC observed some staff interactions with patients which were friendly and empowering. However, the CQC also reported that they observed some interactions which they didn't find to be respectful and which didn't protect patient dignity and that in some cases there was limited social interaction between patients and some staff.

#### **Assessing people's needs**

Staff explained the referral and admissions procedure and provided the CQC with copies which were found to give clear instructions when assessing and admitting a patient to the service. Patients were found to have discharge plans, which staff began to develop on their admission.

The CQC examined the assessment records of 4 patients which were found to be detailed and clearly showed the patients' assessed needs. Records showed that patients had been detained prior to being admitted, with evidence supporting this.

Overall the CQC found evidence that on admission patients individual needs were considered, for example, bedroom allocation was dependent on the patient's needs, including physical disability, vulnerability and other individual diversity issues.



## **Care Planning**

Four patients care plans were looked at in detail by the CQC. The care plans checked were based on the patients needs assessments made prior to and on admission to the unit. These care plans were found to be detailed and were regularly reviewed on a monthly basis. However, the CQC found the care plans to be written in a clinical and technical way, with little evidence to suggest that these had been devised in conjunction with patients. The care plans checked had not been signed by patients to show their agreement about what was recorded in their care plans. The CQC's view was that the care plans checked did not demonstrate a person-centred approach to planning patient care.

All care plans were found to be kept locked in a staff office in order to protect patient confidentiality. Neither of the 4 patients whose care plans were checked had their own copy. However, staff reported that if people requested their care plan then a copy would be made available to them.

The CQC asked staff whether any person centred care plans were planned with patients. Staff informed the CQC that patients had discharge plans in place called 'My future plan' and that these had been devised using person centred principles. Three of the plans were looked at in detail with one of them being found to be comprehensive, detailing the patient's views and wishes and using pictures and easy read formats to meet the patients' communication needs. The other two plans were found to lack written evidence of any patient involvement, however these plans were still in the process of completion with the patients.

There was evidence that CPA reviews were carried out regularly with pre-CPA checklists being completed. Evidence was found in one patient's record of a CPA self-assessment report which had been completed by the patient prior to their CPA review. This practice involved the patient and protected their rights.

The CQC found that a risk assessment and review system was in place and there was evidence that the risk assessments checked had been regularly reviewed. Staff informed the CQC that risks were explained to patients and one patient told the CQC that risks relating to the medication they had been prescribed had been explained. This supported the patient to understand the effects and side effects of the medication.

Written evidence was found to show that staff had explained patients' rights to them whilst detained under the Mental Health Act. However, there was little written evidence to confirm that patients had received this information. In two patients' records it was recorded that patients rights had been explained to them, however these hadn't been signed by the patients.

Overall, from speaking with patients and some of their relatives, the CQC's view was that patients were not involved in making important decisions about their individual care and that patients did not receive person centred care.

## **Meeting People's Health Needs**

The CQC found that patients did not have health action plans, however care plans relating to health need were in place which demonstrated how patient's needs were being met. Staff informed the CQC that patients had physical health checks on

admission as well as annual health checks. This was evidenced within care records and patients confirmed to the CQC that their health needs were recognised and they were offered appropriate treatment to meet these.

The CQC found evidence that a patient had requested to read their health records with a solicitor present and the ward staff had arranged for this to happen. This protected the patient's rights.

## **Delivering Care**

The CQC found that the "smoking restrictions" in place on the ward were rigid with little attention given to patients' rights and choice. The Clinical Team Manager advised the CQC that if any of the patients wanted to leave the ward to smoke they could as they all have Section 17 leave granted. The CQC acknowledged that some restrictions placed on patients in the unit may be as a result of the nature of their detention under the Mental Health Act and that there are situations where it will be appropriate to place restrictions on people in order to keep them and others safe. However there was no recorded evidence to demonstrate that before restrictions were placed on patients' specialist need and risk assessments had been taken into account and that patients had agreed or been informed about the restrictions. The CQC viewed this as the Trust taking a 'blanket approach' to restrictions, particularly with regard to smoking, access to the external courtyard area and the ordering of take away meals and therefore could not be satisfied that the restrictions were person centred or the least restrictive options.

Patients were found to have individualised weekly activity programmes which included walking and exercise groups. An Occupational Therapist works on the ward 5 days a week to support patient's activities. The CQC reported that these meaningful activities supported patients and met their social, physical and mental health needs.

With regard to meals on the ward staff informed the CQC that "taster sessions" were being held so that patients favourite food could be included on the menu and there were plans for a "special festivals and event menu" to celebrate occasions. The CQC felt that this recognised patients' diversity.

Healthy eating was encouraged on the ward with information available to patients. Staff informed the CQC that patients could only have takeaway meals on 2 set nights per week to ensure patients were not constantly ordering take away food as this was not consistent with healthy eating. The CQC felt that given Ward 3 was a rehabilitation ward, prior to moving onto more independent living, that this decision restricted patients' level of independence and that their rights to make choices were not protected.

There was evidence that patients had access to independent advocacy agencies which included Independent Mental Capacity Advocate and Independent Mental Health Advocate who attend fortnightly MDT reviews, which the patient and their relatives were also invited to attend. Patients confirmed that meetings were also held daily with them in order to organise activities and Section 17 leave from the ward. This enabled patients to have some involvement in organising how they spent their time.

Evidence was found of patient involvement meetings with patient representatives from each ward having the opportunity to be involved in a patient involvement group. The CQC felt that this demonstrated patients' had some opportunities to be involved in decision making within the service. The CQC asked whether the minutes of the meetings could be made available in accessible formats for patients who may not read, which the ward agreed to look into.

From observations and from visitor records, the CQC found that patients' family, friends and professionals visited at different times of the day and at weekends. The visitors the CQC spoke to felt they could visit during the stated times and said they saw patients in the visitors rooms just outside of the ward. This enabled patients to have privacy and to maintain important relationships.

### **Managing Behaviour that Challenges:**

The CQC found that overall there were care plans in place which indicated how to minimise risks relating to patients who may present behaviour that challenges. There was recorded evidence in incident records that staff regularly used de-escalation techniques and there were clear guidelines for staff to follow if physical interventions were used including the importance of monitoring patients both during and after the incident.

For this outcome the judgement by the CQC was that patients' needs were assessed with care plans and risk assessments in place. However, there was little evidence that patients and their relatives were meaningfully involved in the care planning process and care was not planned using person centred approaches. Some patients' choices and independence were restricted without proper safeguards in place to demonstrate whether such restrictions were the "least restrictive" options or person centred. The CQC's view was that this meant that patients did not always experience effective and appropriate care and support that met their individual needs and protected their dignity and human rights.

### **Outcome 7: Safeguarding People who use Services from Abuse:**

Overall, the CQC had major concerns with Ward 3, Newsam Centre and found that improvements were needed for this essential standard. The Trust therefore received a compliance action.

The CQC spoke with 4 people using the service who told the CQC that they were satisfied with the care, treatment and support they received. Positive comments included 'I love it here' and 'staff are good'. They informed the CQC that they would feel able to discuss any concerns with staff and that staff had recently talked to them about bullying and how to report any concerns they may have.

The CQC spoke with a relative who informed them that they had always been involved in their son's care, that their son was generally happy at the Newsam Centre and that they were happy with the care provided.

A patient told the CQC that when they first moved to the ward they were bullied by other patients and that he had raised concerns with staff. He went on to tell the CQC that he did not have a good relationship with some staff but did not name any individual staff. This concern was fed back to the Clinical Team Manager to address with the patient directly.

One patient made an allegation to the CQC about how they were treated by staff in another facility outside of the Trust. This allegation was made on the day of the inspection and was not previously known to staff. A safeguarding referral was made on the 5<sup>th</sup> December by the ward to the Trust Adult Safeguarding Lead. The CQC followed this up with the local safeguarding team responsible and were advised a safeguarding referral was made to this team on the 13<sup>th</sup> December.

Another patient informed the CQC that they were currently being bullied by another patient on the unit and when the CQC spoke to a relative of the person she identified that this was the reason the patient had absconded from the ward previously. The CQC requested that the ward follow this up with the patient and relative to ensure the patient was adequately safeguarded and a safeguarding referral was made on the 6<sup>th</sup> December.

### **Preventing Abuse**

The CQC were provided with a copy of the Trust's and the Leeds multi agency adult safeguarding procedures. The Trust policy was due for review on the 1<sup>st</sup> December 2011 and the CQC were informed that this was currently under review. Three members of staff were spoken to who all knew about and had access to the Trust's policies and procedures relating to safeguarding. Each staff member confirmed they would report all allegations of abuse to their line manager or to the Trust's safeguarding co-ordinators or the Safeguarding Lead. All 3 staff confirmed they had completed safeguarding training and also had access to electronic training sessions on this subject. The Lead Occupational Therapist spoke to the CQC who is one of the Adult Safeguarding Co-ordinators within the Forensic service. She confirmed she had completed the Leeds multi-agency adult protection and investigation training and was clinically involved with all 4 patients on the ward.

Members of staff spoken to were aware of whistle blowing procedures and were able to explain to the CQC what they would do if they needed to raise concerns. The CQC were given a copy of this policy which indicated that systems were in place to advise staff how to address and report any concerns they may have.

### **Responding to Allegations of Abuse**

Staff informed the CQC that there were 3 safeguarding referrals made from the ward over the last year. However, when the CQC checked records it was evident that there had been 2 referrals and when questioned whether the referrals led to strategy meetings or to investigations and case conferences, managers were unclear and the CQC received conflicting information. The CQC were unable to verify whether safeguarding procedures had been effectively followed and did not feel that the systems in place were adequately robust to ensure patients were effectively safeguarded.

The Trust's Safeguarding Lead confirmed that advice given to staff, following safeguarding enquiries was not always recorded by the safeguarding lead or co-ordinators and that it is expected to be recorded at a local level by staff. However, the CQC found evidence that advice from the safeguarding lead had not been recorded in a way that could be easily accessed and checked. The CQC felt that this demonstrated the system was not effective to ensure a clear, accountable and accessible safeguarding audit trail was maintained by the Trust.

The Trust's safeguarding procedure was not found to indicate a clear timescale within which an "alert" or a "referral" should be made to the Trust safeguarding co-ordinators or safeguarding lead. The Leeds multi-agency procedure specified that safeguarding alerts or referrals should be made within the same working day. The CQC saw evidence that safeguarding referrals were not being managed with appropriate urgency to protect patients from abuse or the risk of abuse.

In mid August 2011, several patients told staff in a community meeting they were being "bullied" by other patients on the ward. When the CQC asked managers what action had been taken, information made available to the CQC has been reported to be confusing,

contradictory and incomplete. The CQC raised concerns with the ward that safeguarding procedures were not being followed robustly and requested a report be sent to them within 48 hours to clarify what action had been taken by staff in response to this allegation. The report received by the CQC confirmed that no safeguarding “alert” or “referral” was made to the safeguarding lead or to the local area safeguarding team on the same day. It was sent in over 3 weeks after the initial concerns were raised. The CQC felt that this did not demonstrate an appropriate level of urgency to address patient’s allegations of abuse and this may have placed patients at risk of abuse. It also indicated to the CQC that managers were not robust in following the Trusts or the local safeguarding procedures.

This report also explained the reason why the safeguarding referral was not sent immediately. It stated, “This was a general ward safeguarding referral due to a number of issues of inappropriate behaviour being displayed”. The Trust went on to inform the CQC that a ward action plan was in place and that the Trust Safeguarding Adults Lead had not deemed it necessary to progress this to a case conference. The Trust’s Safeguarding Lead was sufficiently assured that it was appropriate for this to be managed by the clinical team. However, the CQC could find no evidence of a recorded reason for this decision making available on the ward when they visited. The CQC could also not find any evidence that the process, highlighted within the Trust’s safeguarding procedure, had been followed.

The CQC had concerns that patient’s allegations were not being recognised as allegations of abuse, staff were not responding with an “appropriate level of urgency”, and records were not being kept in relation to when allegations were made and the rationale for decision making. This meant that safeguarding procedures were not being effectively implemented and any actions staff had taken were not being appropriately recorded. According to the CQC this did not ensure that patients were adequately protected from abuse or the risk of abuse.

### **Using Restraint**

Staff spoken to confirmed that they had received training in order to safely use physical interventions (restraint) as a last resort. Staff were found to use de-escalation techniques mainly, with incident records showing staff very rarely used restraint or physical intervention with patients. The CQC saw evidence in incident records that when patients had presented “challenging behaviour”, they were supported by staff who used de-escalation techniques and these were effective in supporting patients. There was evidence of incident records being audited and staff informed the CQC that they would use the information to identify any trends or near misses to ensure patient safety. The CQC were satisfied that this ensured that patients safety was being monitored.

For this outcome the judgement by the CQC was that safeguarding procedures were not followed in a robust way. Allegations of abuse were not treated with an appropriate urgency and there was no clear recorded audit trail of the actions taken by staff to safeguard patients. This meant that patients were not adequately protected from abuse or the risk of abuse, as the safeguarding procedures were not implemented effectively.

## **4. IMPACT ON PERFORMANCE AND ACTION PLANNING**

The Trust still has continued concerns with the proportionality of the outcomes within the revised draft report due to the number of positive findings by the inspection. The Trust

also has concerns as to the understanding by the CQC of a low secure setting and the necessary balance required between appropriate restrictions to manage risk and safety.

Based on the findings from the final draft report our Monitor Governance Risk Rating will remain at an 'amber-red'.

In early January 2012 a review was undertaken into safeguarding incidents and critical Incidents across learning Disability services, specifically with regard to the following:

- A review of trends, themes and frequency of serious untoward incidents (SUIs) within the directorate
- A review of trends, themes and frequency of safeguarding referrals within the directorate, as well as actions from serious case reviews
- A reflection upon the Care Quality Commission (CQC) recommendations and findings as a consequence of their recent visits to 3 Woodland square and Ward 3 Newsam Centre.

There was not found to be any commonalities or trends as a result of the review and there were found to be robust action plans in place which were being actively implemented.

Further work is being undertaken within the Trust in relation to safeguarding to ensure that all systems and processes are robust as follows:

- A full and detailed internal review of safeguarding processes is currently underway within the Trust
- A mechanism is being developed to ensure all safeguarding enquiries are recorded
- A specific safeguarding section has been included within patients' records to ensure that all safeguarding concerns are documented.

An action plan has also been developed, which is set out in Appendix A to address the actions required and has been submitted to the CQC.

The CQC will revisit the service to ensure that all actions have been completed. To ensure that our compliance actions are removed as quickly as possible all actions are due to be completed by the end of April 2012. Work is on track to achieve this timescale.

Regulation 9, Outcome 4: Care and welfare of people who use the service	Action required	Lead individual	Target Date	Progress & Evidence
<i>There was little evidence that patients and their relatives were meaningfully involved in the care planning process and care was not planned using person centred approaches. Some patients' choices and independence were restricted and this limited patients' involvement in making decisions</i>	<b>To ensure all service users planning of care is approached in a person centred way.</b> <ul style="list-style-type: none"> <li>Care plans will be completed in collaboration with service users, and when appropriate, their relatives</li> </ul>	Clinical Team Manager	February 2012	<b>Completed.</b> Copy of the signed care plan will be found in each service users care records and documented reason why the service user has not signed if refused.  Audit to be completed by the Adult Lead Nurse in April 2012.
<i>about their daily routines. This meant that patients did not always experience effective and appropriate care and support that met their individual needs and protected their dignity and human rights.</i>	- All Learning Disability service users will have a Health Action Plan (HAP). All other service users will have an Annual Health Check.	Lead Nurses for Adult & Learning Disability Services	January 2012	<b>Completed.</b> HAP documentation will be found in Learning Disability service user care records. Annual Health Checks are monitored via the service quarterly as a Key Performance Indicator.
	- All service users will be given the opportunity to sign and have a copy of their own treatment plan.	Clinical Team Manager	February 2012	<b>Completed.</b> Audit to be completed by the Adult Lead Nurse in April 2012.
	- All service users will receive information in a format that meets their needs. A selection of materials will be made available to service users.	Lead Nurses for Adult & Learning Disability Services	March 2012	<b>Completed.</b> Information Boards have been developed. These include photos and information in different formats. The ward welcome pack/information booklet includes photos and easy to read text.
	- All ward staff will receive training in engaging with service users who have communication difficulties.	Lead Nurses for Adult & Learning Disability Services	April 2012	A list of staff who attended the training will be maintained.
	- The "20 Service User Defined Standards" for CPA will be met.	Modern Matron	January 2012	<b>Completed.</b> Reported through Key Performance Indicators quarterly reports.

Regulation 9, Outcome 4: Care and welfare of people who use the service	Action required	Lead individual	Target Date	Progress & Evidence
	- A welcome pack/information booklet will be made available for all service users which will include information about the care Service users can expect on the ward, including how they can expect to be treated as an individual and will include information on CPAs, ward rounds and other helpful information. This will be provided in a variety of formats.	Modern Matron	March 2012	<b>Completed.</b> Visibility and accessibility of the welcome pack/information booklet is available in service user bedrooms, and sent to service users prior to admission.
	- Carers will receive information about what they can expect from the ward team and how they can get involved. A Carers Leaflet will be developed	Modern Matron & Trust Carer's Lead	April 2012	<b>Completed.</b> Carer's information resources are available. A carer's board containing relevant information has been installed in the entrance lobby. Each ward has a carers lead. The Trust's Carers Manager is working with the service to improve carer engagement.
	- Specific work will be undertaken to identify the most appropriate mechanisms for engaging and supporting carers. Specific options will be identified and implemented.	Carers Lead & Modern Matron	March 2012	A number of different mechanisms will be available eg written information and displays, carers service referral numbers will be monitored.
	- Ensure that all staff are completing appropriate documentation when informing service users of their rights under the Mental Health Act 2007.	Lead Nurse Adult Services	January 2012	<b>Completed.</b> Service user care notes. Adult Lead Nurse will complete an audit in April 2012 and will feature in the Annual Documentation audit.
	- All service users will receive their rights in a format that they are able to understand.	Lead Nurse Adult & Learning Disability Services	January 2012	<b>Completed.</b> Mental Health Act information booklets are now made available on the ward.
	- There will be a review of the Multi Disciplinary Team (MDT) process to ensure that the service user and their carer are at the centre of the planning of their care.  An MDT review form will be developed and implemented which will be completed by the	Modern Matron & Lead Consultant Psychiatrist	April 2012	<b>Completed.</b> Process completed and communicated to staff. Away day on 14 March focussed on MDT working. Work stream projects will be progressed. Ward 3 is engaging in a pilot project regarding the



Regulation 9, Outcome 4: Care and welfare of people who use the service	Action required	Lead individual	Target Date	Progress & Evidence
	primary worker prior to the review meeting. This will be done in partnership with the service user to identify progress, any risks or concerns.			MDT process.  Productive Mental Health Wards process module will evidence MDT new ways of working.  There will be evidence of standardised documentation in the service user's care records.
	- The ward, in partnership with service users, should ensure that healthy diet options are available and promoted on the ward and that there is an agreement with service users regarding how and when access to take-away meals will be facilitated.	Dining Experience CQUIN Lead	February 2012	<b>Completed.</b> New menus are now in use. Information boards about nutrition and healthy eating are installed in the dining area. Evidence is contained in the service user feedback forms, Your Views meetings and the service user involvement leads. This is a CQUIN for the service and quarterly reports are produced. Staff discuss with service users regarding access to take-aways.
Regulation 11, Outcome 7: People should be protected from abuse and staff should respect their human rights	Action required	Lead individual	Target Date	Progress & Evidence
<i>Safeguarding procedures were not followed in a robust way. Allegations of abuse were not treated with an "appropriate urgency" and there was no clear recorded audit trail of the actions taken by staff to safeguard patients. This meant, patients were not adequately protected from abuse or the risk of abuse, as the safeguarding procedures were not implemented effectively.</i>	<b>To ensure that the Leeds Adult Safeguarding Procedure is implemented to and adhered to.</b>			
	- A specific training package will be developed and implemented which will support staff skill development to empower service users in their being involved in their care planning and how to support a service user who has raised a concern.	Lead Nurse Adult & Learning Disability Services	April 2012	Production of a training package and training attendance records. Service User feedback.
	- To include in the ward welcome pack/information pack, information for	Modern Matron	March 2012	<b>Completed.</b> The welcome/information pack is now

Regulation 9, Outcome 4: Care and welfare of people who use the service	Action required	Lead individual	Target Date	Progress & Evidence
	service users on how to raise concerns and how they can be expected to be treated by staff.			available on the ward
	- A central Adult Safeguarding referral email inbox is established that is accessible by designated members of the safeguarding team.	Trust Safeguarding Lead	February 2012	<b>Completed.</b> A central safeguarding adult mailbox has been developed.
	- The safeguarding team will develop a mechanism by which they can record all enquiries and provide an auditable trail. They will also maintain a central log of concerns raised.	Trust Safeguarding Lead	March 2012	Evidence of the log will be available.
	- All safeguarding concerns will be documented in the service user's records with an indication of what further actions are required. All risk assessment and treatment plans should be updated to reflect these concerns and actions taken. Where there are specific safeguarding concerns an individual safeguarding care plan will be developed.	Clinical Team Manager	February 2012	<b>Completed.</b> There is a specific safeguarding section in the service user's care records. Staff are aware of how to record enquiries and referrals in this section of the notes.

# Review of compliance

## Leeds Partnership NHS Foundation Trust St Mary's Hospital (3 Woodlands Square)

<b>Region:</b>	Yorkshire & Humberside
<b>Location address:</b>	St Mary's Hospital Greenhill Road, Armley, LS12 3QE
<b>Type of service:</b>	Hospital services for patients with mental health needs, learning disabilities and problems with substance misuse.
<b>Date the review was completed:</b>	October 2011
<b>Overview of the service:</b>	<p>We inspected 3 Woodland Square, at St Mary's Hospital. This service provides a continuing treatment in-patient service for people with a learning disability who require longer-term treatment in a hospital setting. The unit provides care for people, who have complex needs. The service can accommodate up to eight patients and at the time of our inspection, seven patients were in residence.</p> <p>The regulated activities, which the service is registered to provide are:</p>

	Assessment or medical treatment for persons detained under the Mental Health Act 1983. Treatment of disease, disorder or injury. Diagnostic and Screening.
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# Summary of our findings for the essential standards of quality and safety

## What we found overall

**We found that St. Mary's Hospital was not meeting one or more essential standards. Improvements are needed.**

The summary below describes why we carried out the review, what we found and any action required.

## Why we carried out this review

This review is part of a targeted inspection programme to services that care for people with learning disabilities to assess how well they experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights; and whether they are protected from abuse.

## How we carried out this review

The inspection teams are led by Care Quality Commission inspectors joined by two 'experts by experience' – people who have experience of using services (either first hand or as a carer) and who can provide that perspective and a professional advisor

We reviewed all the information we hold about this provider, then carried out a visit on 25 and 26 October 2011. We observed how people were being supported and cared for, talked with people who use services, talked with their relatives or representatives, talked with staff, checked the provider's records and looked at records of people who use services.

To help us to understand the experiences people have we can use our Short Observational Framework for Inspection (SOFI) tool. The SOFI tool allows us to spend time watching what is going on in a service and helps us to record how people spend their time, the type of support they get and whether they have positive experiences. This tool was not used on this occasion, as it was not appropriate to meet the patients' needs.

## What people told us

There were seven patients in 3 Woodlands Square at St Mary's Hospital when we visited. Five of the seven patients were detained under the Mental Health Act. Two patients were voluntary patients. We met and introduced ourselves to six of the patients using the service. One patient was on leave on the first day of our inspection and was discharged from the service on the second day of our inspection. We spoke with five patients to get their views of the service.

Overall, patients and their relatives told us they were satisfied with the care and treatment at the unit. Patients we spoke with said, “I like all the staff”. “I like living here”. One relative told us, “Smashing care”. Patients’ told us they enjoyed the activities on offer from the service and were able to still attend their usual daytime activities whilst staying at the unit. This was positive as it enabled people to have consistency in the support they received.

## **What we found about the standards we reviewed and how well St. Mary’s Hospital was meeting them.**

### **Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights**

Patients’ needs were assessed; some patient care plans and risk assessments were comprehensive and implemented effectively to ensure the delivery of care met patients’ identified needs. Other care plans and risk assessments were not comprehensive, regularly reviewed and care delivery was not always implemented effectively. This placed patients’ at risk of receiving inappropriate or unsafe care, treatment and support. Patients were not routinely involved in devising their care plans, the care plans were not devised using person centred principles and they were not in accessible formats to meet individual’s communication needs. We found that some decisions to restrict patients’ liberty had been undertaken without consultation with them and in adherence with the Mental Capacity Act 2005. This did not protect their rights.

- Overall, we found that St Mary’s Hospital (3 Woodlands Square) was not meeting this essential standard. Improvements are needed.

### **Outcome 7: People should be protected from abuse and staff should respect their human rights**

There were clear policies and procedures in place for staff to follow to safeguard patients from abuse or the risk of abuse. Overall, there was evidence these procedures were implemented effectively. However, the actions taken to address one patient’s allegations against staff, had not been effectively implemented or managed. This meant the patient’s welfare was not fully protected and could leave them vulnerable to the risk of abuse. Incidents of challenging behaviour, where restraints had been used by staff were not always fully recorded or reported via the correct procedures and there was a lack of evidence of review and learning from these the incidents. This could place patients’ at risk of receiving inappropriate care, treatment and support.

- Overall, we found that St Mary’s Hospital (3 Woodlands Square) was not meeting this essential standard. Improvements are needed.

## **Action we have asked the service to take**

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

We have ensured that a safeguarding referral from the hospital managers to the local area, Leeds Safeguarding team had been received and was being assessed.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. Any regulatory decision that CQC takes is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

## **Other information**

Please see previous review reports for more information.

**What we found**  
for each essential standard of quality  
and safety we reviewed



The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

**Compliant** means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*.

## Outcome 4: Care and welfare of people who use services

### What the outcome says

This is what people who use services should expect.

People who use services:

- Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

### What we found

#### Our judgement

**There were Moderate concerns with  
Outcome 4: Care and welfare of people who use services**

#### Our findings

##### What people who use the service experienced and told us

We spoke with five patients. Their comments about the care, treatment and support at the unit included:

“I like the staff”. “I like living here”. “I have a care plan but I have not got a copy”.

“I like to go shopping for food and I like cooking”.

“I can attend my review meetings with the staff”.

We spoke with two parents and overall, they were very positive about the support, care and treatment their relatives received. They told us, “We can attend weekly meetings and have attended some”. Another relative told us, “We are always invited to review meetings”. This was positive and demonstrated people’s relatives were actively invited to attend patients’ meetings.

A relative told us, “We keep a very close eye on (*patient’s name*). “They are ready for discharge in November (2011)”. “They are going to live in a supported living unit, and we are very pleased”. They said, “We have not seen (*patient’s name*) care plan yet. Another relative said, “I have a copy of their care plan”. They told us they thought it was comprehensive and covered health needs well. However, they said staff had not asked their views or discussed the care plans with them.

There seemed to be a disparity between the relatives’ perception of being invited to attend meetings but not having seen and or contributed towards the development of

patients care plans.

From our observations, we found that most staff engaged well with patients, staff had informal but professional relationships with people and positive regard for each patient.

## **Other evidence**

### Assessing people's needs

The nurses told us about the referral and admissions policies for the service. We were shown a copy of the procedures and we examined this whilst at the service. The procedures were satisfactory and gave staff clear instructions to follow when assessing and admitting a person to the service.

We looked at the '72 hour assessment', records for two patients', to see if their needs were identified. The two we looked at were comprehensive and identified a wide range of needs.

Discharge 'pathways planning' was in place. This included comprehensive details of people's history and current needs that would aid a smooth transition when they left the service. The service manager told us and showed us admission and discharge records, which showed the average length of stay was 43 days for most patients. Three patients (excluded from the average stay figures) had been living in the service for between three and fourteen years. This was because historically this service was for patients' with longer-term placement needs. The staff told us they had not found suitable alternative accommodation for two of the three patients. We asked the service manager about this and were told, two patients had recently been referred to local commissioners to find suitable alternative placements. The staff said a third patient was due to move out in November 2011 and we saw recorded evidence of this.

### Care planning

We looked at two patient's care plans in detail. We did this to identify what the patient's needs were, how they were to be met and if there was evidence, they had been met. The care plans we looked at were based on the '72 hour assessments'. We asked a nurse how often patient's care plans should be reviewed. We were told this should be, 'as often as required'. They said they had told nurses to review the care plans when they were on night shifts. However, this would mean that patients' and their relatives would not be involved in the process and this would not meet patient's needs.

Overall, there was evidence that patients needs, values and diversity were taken into account when devising care plans. For example a range of specific health, social and cultural needs were identified.

There was evidence the care plans checked had been evaluated and reviewed. In one case, we found the care plan was comprehensive, covered a whole range of needs and there was evidence the care plan guidance was implemented in practice by staff delivering care. These care plans had been regularly, reviewed and evaluated. However, the dates of the reviews of the other patient's care plans were

spasmodic; For example, the records indicated the plans had been reviewed three times in 33 months. This did not provide evidence the patients' needs were regularly reviewed, to identify whether the care and support they received was effective. We saw evidence in this patients' care plan of recordings, which were vague, for example, one care plan stated, "Use common sense in judgements". This was too vague to clearly indicate the approach to be taken by staff. We found evidence in patients' 'daily general notes' that the care plan had not been consistently followed by staff in the delivery of care to this patient. This placed the patient at risk of receiving inappropriate or unsafe care, treatment and support. This did not protect their rights. (See outcome 7)

Neither of the care plans checked were devised in accessible formats. They were written in a technical way, for the staff to follow as opposed to being 'person centred'. The care plans checked did not take in to account the patient's individual communication needs and this meant that the care plans were inaccessible to them, as they did not read. There was evidence that two care plans had been signed by patients' and staff told us they would speak to patients' to inform them of the content of the plans before they were asked to sign them.

A risk assessment and review system was in place. A nurse told us told us, "Risks are always explained to patients in their multi-disciplinary team (MDT) meetings". Risk assessments checked had been devised in an electronic form, there was evidence most were accurate and had been regularly reviewed. We saw evidence that one risk assessment had not included some risks identified in the patient's daily notes and the nurse addressed this, on the day of the inspection.

Overall, we found evidence on the patients care records that some important records were not accurate, up to date, fully completed or adequately detailed. Examples of this included; a risk assessment, which did not contain details of risks identified in a patient's daily notes, a care plan which, had not been regularly reviewed and had not been reviewed after a serious incident had occurred. These examples of poor record keeping at the unit could place patients at risk of receiving inappropriate care, treatment and support.

All the care plans were kept locked in a staff office to protect patient confidentiality. Neither of the patient's whose care plans we checked, had their own copy. Staff said if people requested their care plan, it would be made available.

There was evidence in some of the care plans checked that staff had sought the views and involvement of some carers or relatives in developing plans.

We spoke to the lead nurse about the how they implemented the Mental Capacity Act, 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) within the service. They told us that staff were trained in MCA and DoLS, and where applicable, they only use DoLS when it is in the best interests of the patient and in accordance with the Mental Capacity Act 2005.

We asked for evidence of whether two voluntary patients were able to leave the ward of their own volition. We were told by a nurse the patients were not able to go out alone, but needed staff support to ensure their safety. We asked whether mental capacity assessments had been undertaken or best interest meetings had

been held and were told this had not happened in either case. This did not protect the patients' rights.

#### Meeting people's health needs

We found evidence of nursing care plan's that demonstrated people's health needs had been identified and evidence in nursing notes they were being met. For example, patients had regular health and medication reviews and there was evidence that appointments with other health professionals, for example speech therapy and GP appointments had taken place. This meant people's health needs were identified and records guided staff in how they should be met, but there was no evidence of patients' involvement.

Health Action Plans (HAP's) ensure patient's health needs are identified and assessed and include the individuals views of how their health needs should be met and managed. The nurses told us that some, but not all patients had a HAP. One Health Action Plan (HAP), we saw had been completed by a nursing assistant. The HAP seen was devised using an accessible (pictorial) format. However, it was not fully completed. Large sections of the plan were left blank. The date on the plan was March 2011 and no review dates were recorded. There was no evidence that a medical professional had signed the HAP and there was no evidence that the patient had been involved in the process or had a copy. This did not ensure that patients and or their relatives had been involved in identifying their health needs or that their views had been considered.

#### Delivering care

We saw that patients' had individualised weekly activity plans. Patients' told us and we found recorded evidence of examples of meaningful activities being provided for them. For example, daily walks for a patient to get regular exercise and this also had benefits for their mental health needs. A patient was supported by staff to visit local shops, to buy their own food and then prepare and eat their own meals, as they were being supported to eat a healthy diet. There was evidence that patients had a good mix of social activities for example trips out to go bowling, to the cinema, visits to café's and days out to local parks etc. Staff told us and we saw evidence that people's 'usual day services', were supported and we saw staff from a local care provider, come in to the service to support a patient to meet their social needs. This was positive as it demonstrated patients were offered continuity of care between the hospital care and their permanent care provision.

From our observations and from visitor records we saw that patients' family, friends and professionals visit patients at different times of the day and at weekends. The visitors we spoke to felt they were free to visit when they wanted to and were made welcome when they came.

The team manager told us an independent advocate from Leeds Advocacy service was invited to attend each; multi disciplinary team (MDT) meeting and staff said they attended most weeks. This was positive and ensured patients had an independent person in the meeting to speak up on their behalf.

#### Managing behaviour that challenges

Plans of how to manage the risks posed by patients', 'challenging behaviour' were present in all the records checked. Some of the care plans did this well. For

example, some plans checked had been devised with the support of a psychologist and included very detailed information of how staff should support the patient to prevent challenging incidents. The plan also indicated how to safely manage an incident if it placed patients' or staff at risk of harm.

**Judgement**

Patients' needs were assessed; some patient care plans and risk assessments were comprehensive and implemented effectively to ensure the delivery of care met patients' identified needs. Other care plans and risk assessments were not comprehensive, regularly reviewed and care delivery was not always implemented effectively. This placed patients' at risk of receiving inappropriate or unsafe care, treatment and support. Patients were not routinely involved in devising their care plans. The care plans were not devised using person centred principles and they were not in accessible formats to meet individual's communication needs. We found that some decisions to restrict patients' liberty had been undertaken without consultation with them and in adherence with the Mental Capacity Act 2005. These practices did not protect patient's rights.

## Outcome 7: Safeguarding people who use services from abuse

### What the outcome says

This is what people who use services should expect.

People who use services:

- Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

### What we found

#### Our judgement

**There were moderate concerns with  
with outcome 7: Safeguarding people who use services from abuse**

#### Our findings

##### What people who use the service experienced and told us

Overall, patients spoken with told us they were satisfied with the care, treatment and support they received from staff.

We spoke with two patients about safeguarding one patient told us, “I’m not sure who to tell if I was being hurt”, and then said, “Staff”. There was evidence that this patient had spoken to staff about their peer’s behaviour on occasions. We found the staff had listened to their concerns and taken action to address the patient’s concerns.

One patient we spoke with told us sometimes staff used restraint or physical interventions with patients. They told us, “They do (use restraint), but not on me because I am good”. They went on to say, “Staff do not hurt people when they do it” (restrain patients), “they do it by holding them”.

A patient told us, “Staff keep my money in the safe; I ask when I want it”.

We spoke with two relatives who told us they were satisfied with the care, treatment and support their relatives received at the unit. Both parents thought their relative was safe at the unit.



One relative told us, “(Patient’s name) is very well cared for”. They said, “I have a good impression of the care and the attitude (of staff) here”.

### **Other evidence**

#### **Preventing Abuse**

The lead nurse provided a copy of the local adult safeguarding policy and procedures that are used by the service (both the trusts and Leeds Safeguarding Partnership Board procedures). We were told these were stored on the intranet and all staff had access to these at all times. The staff we spoke to confirmed this. We spoke to three members of staff who were all aware of the trusts safeguarding procedures. However, there seemed to be some confusion from two staff about how these fitted with the Leeds local area safeguarding procedures, and at what point to refer incidents to the local area safeguarding team.

Training records showed that the majority of the staff team had up to date safeguarding training. The lead nurse told us, and the ward staff confirmed they had recently completed in-house adult safeguarding training. This training was not recorded in the training records checked. Two nurses told us they did not have up to date safeguarding adults training. This will need to be addressed to ensure patients’ are adequately safeguarded.

Members of staff we spoke to were aware of whistle-blowing procedures. They were able to explain to us what they would do if they needed to use these to raise concerns. A self-assessment form was completed by the trust following our visit. In this, the trust confirmed an up to date whistle-blowing policy and system are in place.

#### **Responding to allegations of abuse**

The nurses on the ward told us that systems were in place to both prevent and identify abuse.

Staff were able to tell us the correct procedures to follow if they suspected abuse or if abuse had been disclosed to them. They all told us they would report incidents to their line manager or seek advice from the trusts, Safeguarding Adults’ Enquiry Co-ordinator (SAEC). The lead nurse told us there were, 15 staff who acted as SAEC’s at the trust for staff to call for advice and support.

Over the last year three safeguarding alerts, had been made from this unit, to the local area adult safeguarding team. This demonstrated that the staff had followed correct procedures in these cases.

However, we also found evidence that the safeguarding adults’ procedures had not always implemented effectively. For example, one patient within the service had made an allegation against staff in September 2011. This was recorded on an incident record form. On checking the patient’s care plans we found the patient had previously made allegations against staff and others when unwell. The staff had devised a care plan to support the patient when they made allegations in this context. This was positive and demonstrated the staff had identified the patients vulnerability at these times. When we checked this patients’ care plan we found that the staff had not adequately followed the guidance in the care plan. Nursing staff had recorded the patient’s allegation on an incident form and the line manager had



signed this, but not until several weeks after the incident had occurred. The staff told us this allegation was recognised as a, 'known behaviour', from this patient. This was dealt with as a 'behavioural incident'. There were entries in the daily nursing notes to record the patient's allegation against staff, but there was no recorded evidence to indicate that other aspects of the care plan had been followed. For example, the allegation was not reported to a line manager in a timely way. Staff did not seek advice from a SAEC or report the incident as an 'alert' or 'referral' to the local area safeguarding team, as was the guidance in the care plan. This meant that the patients' welfare was not effectively protected. This could leave them at risk of abuse. We reported this to the lead nurse and a safeguarding referral was made to the local area safeguarding team on the same day. We checked with the local area safeguarding team to ensure this had been received and they confirmed it had. This incident is currently being managed through the safeguarding procedures. The lead nurse and service manager also began an internal investigation in to how this occurred. They will send their findings to us.

### Using restraint

Restraint was used within the service. Managers told us and staff we spoke with confirmed they used, 'Prevention and Management of Violence and Aggression' (PMVA) techniques to restrain patients, as a last resort. Staff said restraint takes place only as a last resort, and the preferred option was to use de-escalation techniques to prevent challenging behaviours from escalating. We saw evidence of this from our observations and from daily nursing records and incident records. Training records given to us before the end of the inspection showed staff received training to use PMVA techniques. We found staff were knowledgeable about using these physical intervention techniques and they confirmed to us that their training was up to date.

We looked at patient incident records to see if they accurately cross checked with daily records. The majority of the records did. However, the records on incident forms often lacked detail; for example, the level of restraint was not always indicated. Vague terms such as, "*patient* was redirected" was recorded but this did not tell us how. We found evidence that one incident form had not been completed for an incident where physical restraint had been used. We asked for an incident report record of a restraint used with a patient, (which was recorded in daily nursing notes), but staff could not locate this. There was no evidence that the patient's care plans had been reviewed after this incident or that staff were debriefed to learn from what happened. These practices could place patients at risk of receiving inappropriate care, treatment and support from staff.

Overall, we found a number of incident records checked did not contain adequately detailed information of the incident. We brought our concerns to the attention of the service manager to address. The examples of the quality of the record keeping at the unit could place patients at risk of receiving inappropriate care, treatment and support.

### **Judgement**

There were policies and procedures in place for staff to follow to safeguard patients from abuse or the risk of abuse. Overall, there was evidence these procedures were

implemented effectively. However, the actions taken to address one patient's allegations against staff had not been effectively implemented or managed. This meant the patient's welfare was not fully protected and could leave them vulnerable to the risk of abuse. Incidents of challenging behaviour, where restraints had been used by staff were not always fully recorded or reported via the correct procedures and there was a lack of evidence of review and learning from these the incidents. This could place patients' at risk of receiving inappropriate care, treatment and support.

## Action we have asked the provider to take

### Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Assessment or medical treatment of patients detained under the Mental Health Act 1983.  Treatment of disease, disorder or injury.	Regulation 9	Outcome 4: Patients should get safe and appropriate care that meets their needs and supports their rights
	<b>How the regulation is not being met:</b> Patients' needs were assessed; some patient care plans and risk assessments were comprehensive and implemented effectively to ensure the delivery of care met patients' identified needs. Other care plans and risk assessments were not comprehensive, regularly reviewed and care delivery was not always implemented effectively. This placed patients' at risk of receiving inappropriate or unsafe care, treatment and support. Patients were not routinely involved in devising their care plans, the care plans were not devised using person centred principles and they were not in accessible formats to meet individual's communication needs. We found that some decisions to restrict patients' liberty had been undertaken without consultation with them and in adherence with the Mental Capacity Act 2005. This did not protect their rights.	
Assessment or medical treatment of patients detained under the Mental	Regulation 11	Outcome 7 Safeguarding people who use services from abuse

<p>Health Act 1983.</p> <p>Treatment of disease, disorder or injury.</p>	<p><b>How the regulation is not being met:</b></p> <p>There were clear policies and procedures in place for staff to follow to safeguard patients from abuse or the risk of abuse. However, the processes and actions taken to address one patient's allegations against staff had not been adequately implemented or managed. This meant that this patients' welfare was not fully protected and could leave them at risk of abuse. Incidents of challenging behaviour, where restraints had been used by staff were not always fully recorded or reported via the correct procedures. There was a lack of evidence of review and learning from some of these the incidents.</p>
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The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

# What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

**Improvement actions:** These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

**Compliance actions:** These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

**Enforcement action:** These are actions we take using the criminal and/or civil procedures in the Health and Adult Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

## Information for the reader

<b>Document purpose</b>	Review of compliance report
<b>Author</b>	Care Quality Commission
<b>Audience</b>	The general public
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# Review of compliance

## Leeds and York Partnership NHS Foundation Trust St Mary's Hospital

<b>Region:</b>	Yorkshire & Humberside
<b>Location address:</b>	Greenhill Road Armley Leeds West Yorkshire LS12 3QE
<b>Type of service:</b>	Hospital services for people with mental health needs, learning disabilities and problems with substance misuse
<b>Date of Publication:</b>	April 2012
<b>Overview of the service:</b>	We inspected 3 Woodland Square, at St Mary's Hospital. This service provides a continuing treatment in-patient service for people with a learning disability who require longer-term treatment in a hospital setting. The unit provides care for people, who have complex needs. The service can accommodate up to

	eight patients and at the time of our inspection, seven patients were in residence.
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# Summary of our findings for the essential standards of quality and safety

## Our current overall judgement

**St Mary's Hospital was meeting all the essential standards of quality and safety.**

The summary below describes why we carried out this review, what we found and any action required.

### Why we carried out this review

We carried out this review to check whether St Mary's Hospital had made improvements in relation to:

Outcome 04 - Care and welfare of people who use services

Outcome 07 - Safeguarding people who use services from abuse

### How we carried out this review

We reviewed all the information we hold about this provider and carried out a visit on 6 March 2012.

### What people told us

We carried out a visit to 3 Woodlands Square at St Mary's Hospital on 6 March 2012 to follow up compliance actions made following the previous review of compliance at 3 Woodlands Square in October 2011.

Because we needed specific information from the management to demonstrate their compliance with the essential standards, we did not need to speak directly with patients from the wards.

### What we found about the standards we reviewed and how well St Mary's Hospital was meeting them

#### **Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights**

The necessary improvements have been made and will continue so that patients who use the service experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

#### **Outcome 07: People should be protected from abuse and staff should respect their human rights**

Patients are protected from abuse, or the risk of abuse and their human rights are respected and upheld.

## **Other information**

Please see previous reports for more information about previous reviews.

**What we found  
for each essential standard of quality  
and safety we reviewed**

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

**Compliant** means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

## Outcome 04: Care and welfare of people who use services

### What the outcome says

This is what people who use services should expect.

People who use services:

\* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

### What we found

#### Our judgement

The provider is compliant with Outcome 04: Care and welfare of people who use services

#### Our findings

##### What people who use the service experienced and told us

Because we needed specific information from the management to demonstrate their compliance with the essential standards, we did not need to speak directly with patients from the ward.

##### Other evidence

At our previous visit to the service in October 2011, we found that patient's care and risks associated with this were not properly recorded, provided insufficient detail and were not regularly reviewed. We also found that patients had little involvement in how their care was provided and delivered, and restrictions had been made to their liberty so their rights were compromised. Because this meant essential standards were not being met, we issued a compliance action requiring the care provider to take actions to achieve compliance.

During this visit on 6 March 2012, we found that a number of improvements had been made since we last visited the service. Patient's care records are now detailed, patient centred and regularly reviewed. Patients have involvement in their care and are involved in decision making about potential restrictions to their liberty.

We looked at three patients' care records. These were all well organised and information was easy to access. Care records were informative, easy to follow and provided up to date information about the patient's care. They are also available in different formats depending on the needs of the individual. For example, some information in the care records is in picture format for those patients with

communication difficulties. Regular care plan reviews are undertaken so that staff are aware about any changes to the patient's care.

Information within the care records is now much more patient centred. We saw that each patient has an 'Individual Pen Picture' document within their care records. Where practicably possible the patient had completed these themselves. The document provides information about the patient's past and current history. It also explains such things as the patient's hobbies and interests and their likes and dislikes. This kind of approach encourages staff to see the patient as an individual with their own personalised needs so that care and support can be provided in a patient centred way.

Each week the patient has a meeting with their key worker/named nurse to plan their activity programme for the forthcoming week. One patient's care records stated that the patient likes to visit church every week and enjoys visiting their family. When we looked in this patient's records we found evidence to show that staff support the patient to be able to do these things.

Staff use the Functional Analysis of Care Environment (FACE) assessment tool to identify any risks to the patient or others from their behaviour. This information is well detailed and includes warning signs which may indicate the patient is becoming unwell, trigger factors for behaviours and actions to be taken in the event of any relapse. This enables staff to identify concerns promptly so that the appropriate care and treatment can be put in place to prevent further relapse.

Behaviour management plans involve the patient, their relatives and other agencies such as the police where appropriate. The current behaviour management plans are very informative but contain a lot of detail. New documentation is in the process of being introduced and the psychologist who is involved in the development of the management plans showed us an example of the new documentation. This provides more specific information and is easier for people to read and understand than the existing documentation.

We saw in one patient's behaviour management plan that the patient had explained to staff the actions they wanted them to take if their behaviour caused problems to themselves or others. This helps in making sure any deterioration in the patient's mental health is identified quickly so that appropriate actions can be taken in accordance with the patient's wishes to reduce any distress to the patient or others.

Care plans are regularly reviewed and multi-disciplinary meetings are held weekly with the patient to discuss how their care and treatment is progressing. Staff explained that some patients choose not to attend this weekly meeting. A form titled 'What do I want from my meeting' has been developed so that patients who do not want to attend their meeting can still offer their views about their progress and wishes and this is recorded. This information is then passed onto members of the multi-disciplinary team by either a member of staff or independent advocate acting on behalf of the patient. This again shows a commitment to empowering patients to be involved in decision making about the care they receive.

Each patient has a detailed Health Action Plan (HAP). These ensure that all patient's health needs are identified and assessed, and incorporate the views of the patients about how they would like these needs to be met. These are regularly reviewed and are



available in different formats to help patients with communication difficulties. Patients have a yearly health check and any issues from this are included within their HAP. HAP documentation includes input and views from medical professionals involved in the patient's care and treatment.

In addition to the HAP each patient also has a hospital passport document. This is a booklet containing information about the patient if they need to go into hospital. This includes such things as how the patient wishes medical interventions to be done, their preferred ways of communication and various likes and dislikes. This enables hospital staff to have a better understanding of the patient's needs and helps in reducing anxieties for the patient.

We looked at the care records of one patient who was informal (voluntary patient) and so could leave the ward of their own volition. We saw in the patient's records there was a care plan to guide staff about how to maintain the patient's rights as an informal patient. The patient had also been given a booklet called 'Your rights and responsibilities as an informal patient', which is available in different formats. Because of their mental health problems, the patient sometimes had difficulties in making their own decisions. Mental Capacity Assessments had been carried out to determine in what kind of situations the patient would be able to or not make this decision.

We saw in the informal patient's care plan that the patient had 1:1 support from staff when going out. Staff explained this is because of the patient's physical health and evidence showed that the patient was in agreement with this action being taken in order to maintain their safety. Where potential restrictions are placed on a patient, a meeting is arranged so that all the relevant people can make a decision about the actions that need to be taken in the patient's best interests.

Staff told us that when informal patients are admitted to 3 Woodlands Square, a risk assessment is carried out to determine whether the patient is able and safe enough to have access to the keypad code so they can leave the building if they wish to do so.

All staff have received external training about care records and patient centred care. Monthly care plan audits are also undertaken by senior staff. Where there are identified shortfalls, this is addressed with individual staff within their regular supervision sessions and this is clearly recorded.

### **Our judgement**

The necessary improvements have been made and will continue so that patients who use the service experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

## Outcome 07: Safeguarding people who use services from abuse

### What the outcome says

This is what people who use services should expect.

People who use services:

\* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

### What we found

#### Our judgement

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

#### Our findings

##### What people who use the service experienced and told us

Because we needed specific information from the management to demonstrate their compliance with the essential standards, we did not need to speak directly with patients from the ward.

##### Other evidence

At our previous visit to the service in October 2011, we found actions taken to address one patient's allegations had not been effectively implemented and managed to fully protect the patient from potential harm. We also had concerns incidents where restraint had been used were not recorded or reported via the correct procedures so putting patients at risk of receiving inappropriate care, treatment and support. Because this meant essential standards were not being met, we issued a compliance action requiring the care provider to take actions to achieve compliance.

During this visit on 6 March 2012, we found that improvements had been made since we last visited the service. Proper action has now been taken in response to address previous allegations made by a patient, as identified at our last visit. Incidents of restraint are properly recorded so there is less risk to patients from receiving inappropriate care, treatment and support and de-briefing sessions are now held with staff so they can learn from serious incidents to prevent it reoccurring.

We found there are more robust safeguarding protocol and procedures in place to protect patients from abuse. Where possible or actual risk is identified, the safeguarding alert is now immediately sent to the Safeguarding Adults' Enquiry Co-ordinator (SAEC),

the Trust's Safeguarding Lead and the local authority's safeguarding team so that necessary actions can be put into place to protect people. The Clinical Care Manager told us staff also contact the local safeguarding team by telephone to notify them about alerts and to seek any advice if this is needed.

We looked at the incident records. They describe what type of incident has occurred, the immediate action taken and whether a safeguarding alert has been made to the relevant people and agencies. The incident forms are reviewed on a daily basis by either the Clinical Care Manager or a senior nurse to look at what actions need to be taken following an incident to prevent risk of re-occurrence. Where incidents involved either abuse or potential abuse, safeguarding referrals had been made to the local authority.

When we looked in patient's care records we saw that each patient has a safeguarding care plan. One patient had suffered verbal abuse from another patient and this had been recorded in the patient's notes. A safeguarding strategy meeting was arranged to discuss ways of managing this situation so that the victim of the verbal abuse was protected from further abuse. Other patients made allegations about the staff team, and their care plans clearly detailed that safeguarding referrals are to be made when these allegations are made.

In another patient's care records we saw there had been three incidents between two patients. Because of concerns about this, senior staff had arranged for this information to be sent onto the local safeguarding authority who are closely monitoring the situation.

When patients need restraining this is now fully recorded on an incident form and within the patient's care records. These provide detail about the types of restraint used and staff actions following this. Patient's care plans are very clearly set out explaining the different stages of managing the individual's behaviours with restraint used as only a last measure if all other actions have been unsuccessful.

Following serious incidents, the psychologist holds group debriefing sessions with the staff team to offer support to them and to look at what has been learned from the incident to prevent a possible repeat of it happening again.

### **Our judgement**

Patients are protected from abuse, or the risk of abuse and their human rights are respected and upheld.

# What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

**Improvement actions:** These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

**Compliance actions:** These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

**Enforcement action:** These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

## Information for the reader

<b>Document purpose</b>	Review of compliance report
<b>Author</b>	Care Quality Commission
<b>Audience</b>	The general public
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## Report of Head of Scrutiny and Member Development

### Report to Scrutiny Board (Health and Well-Being and Adult Social Care)

**Date: 16 May 2012**

**Subject: Quality Accounts for 2012**

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Are there implications for equality and diversity and cohesion and integration?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Is the decision eligible for Call-In?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

### Summary of main issues

1. The purpose of this report is to update the Board on the production of local healthcare providers' Quality Accounts for 2012 and to provide the Board the opportunity to comment of Leeds and York Partnership NHS Foundation Trust's draft Quality Account.

### Background

2. Quality Accounts were mandated by the Department of Health in 2010 for all providers of NHS care. Quality Accounts are annual public reports about the quality of services provided, and must be published by the end of June each year.
3. Quality Accounts should provide a summary of quality performance for the previous year and enable patients and the public to understand:
  - What the organisation is doing well
  - What improvements in service quality are required
  - What the priorities for improvement are for the forthcoming year
  - How the provider has involved service users, staff and others with an interest in the organisation in determining the priorities for improvement.
4. The publication process requires that providers seek comment on the account from commissioners, Local Involvement Networks (LINKs) and Overview and Scrutiny Committees (OSCs). Any statement provided by commissioners, LINKs or OSCs may be up to 1000 words in length and must be included as part of the published Quality

Account. Commissioners, LINKs and OSCs must have 30 calendar days to provide any comment, however it is important to note that there is no obligation for OSCs or LINKs to provide a response or comment.

5. The NHS funded Health Care providers based in Leeds that are required to produce a Quality Account for 2012 include:
  - Leeds Teaching Hospitals NHS Trust
  - Leeds and York Partnerships NHS Foundation Trust
  - Leeds Community Healthcare NHS Trust
6. There are other local healthcare providers required to produce Quality Accounts for 2012, however in previous years, the Council's Scrutiny Board (Health) felt it only necessary to comment on the Quality Accounts produced by the larger local healthcare providers – detailed above. However, it should also be noted that Yorkshire Ambulance Service NHS Trust must produce a Quality Account for 2012 (as in previous years).
7. The timescales for commenting on the various Quality Accounts are set out below:
  - Leeds and York Partnerships NHS Foundation Trust – 7 May 2012 (draft received 18 April 2012)
  - Yorkshire Ambulance Service NHS Trust – 11 May 2012 (updated draft received 17 April 2012)
  - Leeds Community Healthcare NHS Trust – 24 May 2012 (draft received 18 April 2012)
  - Leeds Teaching Hospitals NHS Trust – 25 May 2012 (draft received 25 April 2012)
8. Members will be aware that the Scrutiny Board has had contact with a number of the local healthcare providers over a range of issues during 2011/12.
9. Appended to this report is the draft Quality Account (2012) produced by LYPFT. The Scrutiny Board is invited to identify any comments it may wish to include with the Quality Account (2012).

### **Recommendations**

10. To note the content of this report.
11. To consider the attached draft Quality Account (2012) produced by Leeds and York Partnerships NHS Foundation Trust and agree any comments for inclusion in the final version.
12. Consider and agree the most appropriate way forward for providing comments on any other draft Quality Account 2012 produced by a local healthcare provider.

### **Background documents <sup>1</sup>**

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<sup>1</sup> The background documents listed in this section are available for inspection on request for a period of four years following the date of the relevant meeting. Accordingly this list does not include documents containing exempt or confidential information, or any published works. Requests to inspect any background documents should be submitted to the report author.



- Yorkshire Ambulance Service NHS Trust – draft Quality Account 2012
- Leeds Community Healthcare NHS Trust – draft Quality Account 2012
- Leeds Teaching Hospitals NHS Trust – draft Quality Account 2012

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# **Leeds and York Partnership NHS Foundation Trust**

## **Quality Accounts 2011-12**

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## 1.1 Chief Executive's Statement

There has been a lot of change in the NHS during 2011-12. This has been driven by a Government who, as elected representatives, desire change in how the NHS, with social care, both commissions and provides services. Specialist mental health and learning disability services have not been immune from this and, during the year covered by this Quality Accounts, working with our Governors, we became a new organisation.

The 1<sup>st</sup> of February 2012 saw the end of the Leeds Partnerships NHS Foundation Trust (LPFT) and the emergence of the *“Leeds and York Partnership NHS Foundation Trust”*. This marked the successful conclusion of LPFT's tender process to become the provider of local mental health and learning disability services across York, Selby, Tadcaster and Easingwold, along with being a provider of some services across the whole of North Yorkshire. Also, as a result of this change we have extended the range and scope of some of our tertiary services, such as Forensic Psychiatry.

This is not a crude “take-over” of these services by LPFT. The title of the transfer project is *“Better Together”*. This is important as it is my intention that we will respectfully listen to each other, including paying careful attention to the experience of service users and carers, to adopt and spread what works well for people and change what needs to be improved. There is no doubt in my mind that if this is done well that, together, the totality of the services provided will be better than the sum of their parts.

On the commissioner side of things there have also been changes. Examples include NHS Leeds being linked, or “clustered”, with NHS Bradford and Airedale. With regard to the development of Clinical Commissioning Groups (CCG), the Leeds North CCG will lead on mental health commissioning on behalf of the Leeds CCGs, whilst the Vale of York CCG will lead on mental health and learning disability services across York and North Yorkshire. Health and Wellbeing Boards have been established in both York and Leeds each with their own way of working.

There is a risk that the leadership of any organisation ends up being distracted by such deep-reaching and rapid changes. In this context, during the year in question, it has been vital for our Trust to hold fast to our purpose which is described in our strategy. This places health and wellbeing at the heart of what we do. Put simply this is,

*“Improving health, improving lives”.*

Linked to this is our ambition statement,

*“Working in partnerships we aspire to provide excellent mental health and learning disability care that supports people to achieve their goals for improving health and improving lives”.*

This broader intent is fully reflected in the Department of Health's Mental Health Strategy, *“No Health Without Mental Health”* (the Department of Health, 02 February 2011).

All of us have aspirations for what life holds for us and we continue to pay great attention to enabling people who use our services to achieve to the fullest extent possible the good things they wish for themselves. The aspirations of service users often encompass social care; the need for connectedness to family, friends and the wider community; also meaningful participation in a wider society either at work or in the vocational sphere. Treatment and active intervention by professionals is sometimes needed and the way this is provided is vitally important as it often provides a springboard for a person's broader aims to be achieved.

Our strategy summarises this as:

- § *People achieve their agreed goals for improving health and improving lives*
- § *People experience safe care*
- § *People have a positive experience of their care and support*

In this context it is our responsibility for providing safe and effective care whilst knowing that these are no more than a means by which we help people achieve their broader aspirations of living life to the full.

The term “quality” has a number of different dimensions. The most obvious are our obligations on our Trust arising from the law and/or our regulators. Another aspect are those quality initiatives which emerge from what we learn about ourselves through, for example, the outcome of inspections, or understanding the lived experience of service users and carers who are being supported by us. We also continue to use information drawn from data, such as our reports to the National Patient Safety Agency. The monthly “Performance Report” to our Board of Directors reports if we have experienced a “never event”, as defined by the Department of Health in service provision, as well as reporting on a number of things that our Board has decided that it wishes to know about with regard to the quality of service provision. We call these “trigger to Board” events. If we think that something has gone wrong we routinely check this out using a “root cause analysis” and respond to what we learn. One important area of focus for us over the coming months will be to get a better understanding of what we mean when using the word “outcomes” with regard to the work that we do.

All of our improvements must also at the same time increase productivity whilst reducing cost. This is in the context of the NHS saving £20 billion over the next few years. We will do this by, among other things, continuing to redesign how we deliver clinical services. This involves moving away from age related or speciality clinical directorates towards organisational structures designed around care pathways. We will remove artificial barriers to services based on age, as well as eliminating waste by removing duplication and reducing variation which we know adversely impacts on the provision of high quality, safe, and effective services. Our work on this to date forms part of this report.

With our Governors, we are also continuing to positively face up to the issues faced by people with mental health problems and learning disabilities through media work, actively campaigning against discrimination, by taking our positive, yet challenging, message onto the streets of our cities and towns. To make progress we are also engaging other key interest groups such as leaders in our business community.

In summary, we are here to:

- § *Provide excellent quality, evidence-based, safe care that promotes recovery and inclusion*
- § *Involve people in planning their care and in improving services*
- § *Work with partner organisations to improve health and lives*
- § *Value and develop our workforce and those supporting us*
- § *Improve our services through learning, research and innovation*
- § *Provide efficient and sustainable services*
- § *Govern our Trust effectively and meet our regulatory requirements*

This is not an easy thing to do. We are not a complacent organisation and our lived experience shows us that there are always ways in which we can improve. Key to this is

continuing to put quality at the heart of everything we do. How will we do this? We do not use much in the way of technology, we are a “people organisation”. In this context we will demonstrate our commitment to quality and to the people who use our services, their families and their carers, and to each other, by behaving according to the NHS values:

- § *Respect and dignity*
- § *Commitment to quality of care*
- § *Compassion*
- § *Improving lives*
- § *Working together*
- § *Everyone counts*

This Quality Account illustrates only some of the key points on our journey of being the best we can be.

In concluding I also want to take a moment to thank all of the staff of Leeds and York Partnership NHS Foundation Trust for their professionalism and the deep commitment they show to their work 24 hours a day, 7 days a week. We only do what we do through the work of our people and everybody working in our Trust, either directly or indirectly, contributes to creating a better future for service users and carers.

I am happy to state that to the best of my knowledge the information included in our Quality Accounts is accurate.

Chris Butler  
Chief Executive  
Leeds and York Partnership NHS Foundation Trust  
April 2012

## 2.1 Our Trust Strategy and Trust Values

### Our Trust Strategy

Our Quality Accounts are fully aligned with our five-year strategy, which sets out our plans for 2010 to 2015. The strategy is designed around the three key elements of quality: effective outcomes, safe care, and positive service user and carer experience.

Our strategy has at its heart the people who use our services, their families and carers. Development of our strategy was led by our Trust governors, with the support of people who use our services, carers, staff, our main commissioners and partner organisations.

To ensure that our strategy is accessible to the public, we have developed both a summary version and an easy read version, which is designed to be accessible to people with a learning disability.

A summary of our strategy is shown below:

<b>Summary:</b> improving health, improving lives						
<b>Purpose</b>	improving health, improving lives					
<b>Values</b>	Respect & dignity	Commitment to quality of care	Working together	Improving lives	Compassion	Everyone counts
<b>Ambition</b>	Working in partnerships, we aspire to provide excellent mental health and learning disability care that supports people to achieve their goals for improving health and improving lives.					
<b>End Goals</b>	1	People achieve their agreed goals for improving health and improving lives	2	People experience safe care	3	People have a positive experience of their care and support
<b>Means goal 1</b>	We provide excellent quality, evidence-based, safe care that promotes recovery and inclusion.					
<b>Means goal 2</b>	We involve people in planning their care and in improving services.					
<b>Means goal 3</b>	We work with partner organisations to improve health and lives.					
<b>Means goal 4</b>	We value and develop our workforce and those supporting us.					
<b>Means goal 5</b>	We improve our services through learning, research and innovation.					
<b>Means goal 6</b>	We provide efficient and sustainable services.					
<b>Means goal 7</b>	We govern our Trust effectively and meet our regulatory requirements					

Our three 'end goals' are the quality priorities that we are here to achieve. For each end goal we have set ourselves some measures of success, some outcomes that we want to achieve by 2015 and some milestones to track our progress. In setting standards and milestones we have benchmarked ourselves against best performing NHS Trusts wherever possible.



Our end goals are underpinned by seven means goals, or organisational goals, which state what we must do to achieve our ambitions and end goals. Directorate and team business plans go on to describe detailed local implementation plans.

The Trust's Governance Framework has been designed to support strategy delivery and we have a dedicated group in place to oversee the delivery of each means goal. There are clear lines of accountability for each of our goals, with the overall delivery of strategy reporting to the Means Goal 7 Standing Group. Regular progress reports on our performance against each of the measures are presented to our Board of Directors and Council of Governors, and published on our website.

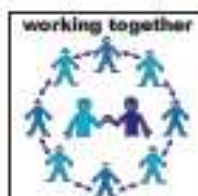
Our Trust strategy was launched at our first Annual Members' Day, in September 2010. During 2012 we will undertake a full strategy refresh; and will consult with a broad range of stakeholders to ensure that our strategy remains relevant, particularly in light of the new North Yorkshire and York (NY&Y) services that have transferred to our Trust this year. Since these services have transferred we are now a provider of several new services, notably Child and Adolescent Mental Health Services (CAMHS) and primary care mental health services, including Improving Access to Psychological Therapies (IAPT). We must also respond to the needs of the new geographical area that we cover: we now provide mental health and learning disability services across York, Selby, Tadcaster and Easingwold; as well as providing certain specialist services across the whole of North Yorkshire. We will consult with new colleagues and partners to ensure that our refreshed strategy properly reflects assessed need in these localities.

### **Implementation of our Trust Values**

Our Trust welcomed the publication of NHS Values, as set out in the NHS Constitution, and these are central to our strategy. As well as setting out *what* we aim to achieve, we have described *how* we will behave whilst doing so. In consultation with governors, service users, carers and staff, we have tailored the values to describe what they each mean, and some of the behaviours that might be expected if we are in fact meeting them.

Our Charter of Values is shown on page 6.

During the coming year we will work with new colleagues in NY&Y to share our values work, as part of the broader cultural integration work programme.



# Charter of Values

**How we go about our work, everyday, is influenced by our values – the beliefs that we hold dear and that guide how we behave.**

We commit to living our values every day and we will show this commitment to our values in the way we behave.

## Trust Values

### 1 Respect & dignity

*"We value and respect every person as an individual. We challenge the stigma surrounding mental ill health and learning disabilities. We value diversity, take what others have to say seriously, and are honest about what we can and can't do."*

### 2 Commitment to quality of care

*"We focus on quality and strive to get the basics right. We welcome feedback, learn from our experiences and build on our successes."*

### 3 Working together

*"We work together across organisational boundaries to put people first in everything we do."*

### 4 Improving lives

*"We strive to improve health and lives through providing mental health and learning disability care. We support and empower people to take the journey of recovery in every aspect of their lives."*

### 5 Compassion

*"We take time to respond to everyone's experiences. We deliver care with empathy and kindness for people we serve and work alongside."*

### 6 Everyone counts

*"We work for the benefit of the whole community and make sure nobody is excluded or left behind. We recognise that we all have a part to play in making ourselves and our communities healthier."*



Frank Griffiths  
Chairman



Chris Butler  
Chief Executive

## **2.2 Overview of Organisational Effectiveness Initiatives**

The following achievements and initiatives are examples of the Trust's continuing dedication to increasing and improving quality.

### **Integrated Organisation**

On 1 February 2012, Leeds Partnerships NHS Foundation Trust merged with mental health and learning disability services in York, Selby and Tadcaster, as well as providing some county wide services across North Yorkshire. Our integrated organisation became Leeds & York Partnership NHS Foundation Trust. As an integrated organisation we are now bringing together shared knowledge, skills and experience to deliver the highest quality mental health and learning disability services to the people of Leeds, York, Selby, Tadcaster, Easingwold and parts of North Yorkshire.

### **Transformation project**

Improving the quality of care provided to service users is a major part of our transformation project. The project will deliver redesigned clinical services which are non age bounded and which are based around integrated care pathways. We have involved service users in the mapping of existing services and held "voice of the customer" workshops to inform the analysis and design phases of the work. Service users have told us how to make our services simpler, better and more efficient. Practical examples include the suggestion that "if there was one assessment (with information used by all parts of the service) this would be easier". Individual service users wanted services "to focus on my recovery and wellbeing". We aim to increase the amount of time available for staff to spend with service users because service users tell us "they find one to one time with clinical staff valuable". We will do this by making paperwork easier to complete and improving the technology available to clinical staff.

### **Clinical Team of the Year Award**

Our Yorkshire Centre for Eating Disorders (YCED) has been nationally recognised for its work treating people who have eating disorders by winning a Beat (formerly Eating Disorders Association UK) award. YCED was nominated for the award by a service user, reflecting its history of strong partnership with patients and carers, as well as good clinical outcomes. As an early implementer of new quality standards for eating disorder services as well as a keen focus on innovative research and new treatments, YCED has grown to become one of the largest services of this kind in the UK.

### **Star Wards – The Full Monty Award**

Ward 2, Bootham Park, successfully qualified for the Full Monty Award in March 2012. The award is given to wards who have implemented all 75 Star wards ideas. Star Wards provides practical ideas for improving the daily experience and treatment outcomes of acute mental health in-patients. The award also recognises outstanding effort and achievement among Star Wards Members.

## **Nursing Strategy**

Our Nursing Team has continued to work within a defined three-year strategy which came to its conclusion in 2011. Significant areas of development through the three year strategy included work on Essence of Care, Medications Management, the establishment of education and training development and progress in preceptorship development. Following a period of review, new objectives have been established for 2012 in line with the Chief Nursing Officer's '*Energise for Excellence: Call for Action*'. A robust performance framework has been used effectively over the last 12 months allowing a range of locally developed indicators to be measured and monitored. This framework will continue to be a key focus in 2012.

## **Nursing Conference**

Over 100 delegates attended the third Annual Conference with the theme of Nursing Leadership: Today and Tomorrow. Key note speakers and workshops actively considered the impact of the nursing profession on quality, safety, education and health care policy. We were awarded Royal College of Nursing accreditation for this conference.

## **Productive Mental Health Ward**

All our inpatient areas are actively involved with "*The Productive Mental Health Ward: Releasing Time to Care*" and teams are changing the way they work in order to further improve the effectiveness, safety and reliability of our services. Adopting the Productive Mental Health Ward has enabled the Trust to compare the performance of its mental health facilities with that of others, learn from the best and make positive improvements for both staff, service users and carers.

## **AIMS (Accreditation for Acute Inpatient Mental Health Services)**

Significant work has continued throughout 2011 to develop The Mount (Older People's Service) as a centre of excellence. The Mental Health wards have utilised the AIMS process to develop a wide range of best practice standards and it was confirmed in October 2011 that the wards were successful in being awarded this nationally recognised accreditation.

Our Oakrise Acute Treatment and Assessment Unit also achieved AIMS accreditation for in-patient Mental Health services in 2011.

The Recovery Unit at Acomb Garth has just started working towards AIMS-Rehab accreditation with the Royal College of Psychiatrists.

## **Quality Assessment Framework - Specialised Supported Living Service**

A joint validation inspection by Leeds City Council, Adult Social Care and Supporting People was undertaken to Ivy Cottage within our Specialised Supported Living Service in February 2012. The assessment visit focussed on a specific part of the Quality Assessment Framework namely safeguarding and protection from abuse. The visit was extremely positive with staff demonstrating an excellent knowledge of the support and care needs of clients within the service. The service was validated at a Level A which means excellence and is associated with providers striving to be leaders in their field.



## **Implementation of E-Rostering**

We have successfully implemented and consolidated an e-Rostering system to 28 wards/departments within the Trust. Using e-Rostering has enabled us to ensure we have the right staff in the right place at the right time, allowed us to look at efficiencies in staff rosters and better utilise our substantive staff by reducing the need for temporary staff.

In 2012-13 we will be rolling out e rostering to all areas and staff groups within the Trust.

## **Access to Psychological Therapies**

The adult psychological therapy service has achieved a major success in clearing the waiting list for psychological therapies in Leeds. Traditionally, these services have long waiting times but the Leeds service has systematically reviewed, re-designed, improved and invested in its service in order to address this. This is a feat that few trusts in the country have been able to achieve.

## **Vulnerable Veterans and Adult Dependents (VVADs)**

VVADS is a bespoke Improving Access to Psychological Therapies (IAPT) service based at Catterick Garrison, the largest garrison in Europe. It specialises in working with veterans and dependants of serving personnel and aims to improve access to evidence based treatment for those who are experiencing common mental health difficulties. The service started to receive direct referrals in August 2010 and by the end of February 2012, it had received 570 referrals from the four surgeries that it covers. The service has offered over 2,800 patient contacts and over 1,700 hours of treatment. The service's performance continues to exceed national Improving Access to Psychological Therapy (IAPT) outcomes.

On the 1<sup>st</sup> April 2012, VVADs will reach the end of its two year pilot. It has been re-commissioned by the NHS and will be increasing its footprint to include RAF Leeming. A scoping exercise will also be undertaken to examine the mental health needs of Veterans throughout North Yorkshire.

## **King's Fund Project**

The Meadowfields Unit has been involved in a King's Fund Project to "Enhance the Healing Environment". The entire team has been involved in this initiative which has greatly improved the dining area and kitchen facilities. Signage has been improved throughout the unit and the staff have consulted with patients and carers to agree on the use of art work, with pictures of York being used to help orientate patients to specific areas of the unit. The project has had a positive impact on the patient experience and has improved team working within the service.

## **Healthy Living Service**

All service users referred to the healthy living team have an initial health assessment. This provides detailed information about our service users' health relating to the 4 areas of activity and exercise, smoking cessation, brief interventions for alcohol and healthy eating. Since its introduction there has been an increase in the number of referrals for smoking cessation and healthy eating advice. This information helps the

team to plan interventions and service development according to service user's needs.

### **Social inclusion**

We have focused on improving employment outcomes for people using our mental health services by co-locating Leeds Mind employment specialists in our community mental health teams. We have a partnership with the School of Healthcare at the University of Leeds to research what works well in supporting people towards employment. We have vocational leads in clinical teams who meet regularly to share good practice and plan for improvements to employment support.

### **Focus on Recovery**

A key part of our project to transform our clinical services, is to embed recovery principles within our day to day work. By recovery principles we mean a focus on three things: hope for the future; enabling people to take control of their lives; and supporting people to be active citizens in their communities. We ran a series of workshops in early 2011 to identify key priorities for embedding recovery principles and appointed a project worker to help us take them forward.

### **Arts and Minds**

Our first Love Arts Festival [www.loveartsleeds.co.uk](http://www.loveartsleeds.co.uk) took place in the Autumn with over 55 events held over seven weeks and a month of fringe activities at Kirkgate market. We developed partnerships with 38 arts organisations and recruited 63 volunteers who supported our events. We made direct contact with an estimated 100,000 people over the course of the festival and reached an estimated 10,000,000 through our media profile. We are currently planning our 2012 festival with sister events taking place in the York area.

### **Northern Film School**

We have developed a partnership with the Northern Film School to produce a series of short films challenging mental health stigma. This involved providing mental health awareness training to 60 students. A film-brief was given to the students who were required to pitch their film ideas to a panel of people with experiencing of using and working in mental health services and film experts. The films are due to be premiered in May 2012.

### **Communications**

We continued to embed new methods to engage and involve our staff in the development of our services. These include a monthly online barometer for staff views on particular topics, 'What our Directors Say' and 'What our Governors Say' briefings and a regular survey of staff views about communications. We have developed a monthly stakeholder e-bulletin to keep those interested in our organisation up-to-date with developments.

### **Fit For the Future Leadership & Management Programme**

In support of our purpose and strategy our Development Team ran an evidence based, needs led, accredited development programme for 130 staff. The programme

was aimed at our Band 7 staff and focused on Organisational Effectiveness and Service Improvement.

## 2.3. How we have prioritised our Quality Improvement Initiatives

We set out in our 2009-2010 Quality Accounts that our three priorities for quality improvement are consistent with our three strategic end goals and will remain in line with our Trust strategy until 2015.

Therefore our three top priorities for quality improvement remain as:

**Priority 1:** People achieve their agreed goals for improving health and improving lives

**Priority 2:** People experience safe care

**Priority 3:** People have a positive experience of their care and support

Each of these priorities, along with our initiatives for 2011-2012, are set out on the following pages.

Progress against our priorities set out in our 2010/2011 Quality Accounts are reported on the following pages and have been reported to our Trust Board of Directors through the monthly performance report, with each key priority reported upon on a quarterly basis. These are publically available documents and can be viewed on our website [www.leedspft.nhs.uk/about\\_us/performance](http://www.leedspft.nhs.uk/about_us/performance)

Progress against our priorities set out in our 2011/2012 Quality Accounts will continue to be reported to the Trust Board of Directors through the monthly performance report.



## **Priority 1      People achieve their agreed goals for improving health and improving lives**

### **Progress against 2011-2012 Initiatives**

- a) *We will continue to develop a systemic understanding of outcome measurement along with systems for implementing this across the organisation.*

The following initiatives are examples of work that have been undertaken within the Trust:

- Capability to deliver Clinical Outcomes in Routine Evaluation (CORE) is live on PARIS and a Core Net pilot is underway.
- A Recovery Star pilot tool is live on PARIS
- Therapy Outcome Measures (TOMS) is live on PARIS within the Learning Disabilities Directorate, and more widely amongst Occupational Therapy colleagues.
- Patient Reported Outcome Measure's (PROMS) are being developed by project leads and it remains likely that EQ-5D will become a national mandated PROM.
- Improved reporting structures are being designed in order to provide the appropriate outcomes measure data at service user, clinician, team, service and corporate level.
- The Trust's Payment By Results project has reviewed it's links with the Trust's outcome measures work to ensure the work being undertaken is aligned and mutually supportive.

- b) *We will further focus on weight management, nutritional health and smoking cessation to address the national prevalence of coronary heart disease amongst people with mental health and learning disabilities.*

The following initiatives are examples of work that have been undertaken within the Trust:-

- A consultant dietician has been employed to support the introduction of revised hospital menus which will include a "healthier choice" option in line with national guidelines.
- Updated hospital menus are currently being trialled at the Newsam Centre. A catering folder has been developed for dietitians to access nutritional analysis of all meals for specialist diets.
- The Healthy Living Service is running a project funded by NHS Leeds to support service users to use community leisure centres. Uptake of Leeds body line cards (membership cards) is being used as an outcome measure. There have been over 35 new referrals to this project.
- The Healthy Living Service and the Assertive Outreach Team are piloting a drop in physical health assessment clinic where Assertive Outreach Team service users who are not accessing primary care can have their annual physical health check and receive advice regarding healthy living, healthy eating and smoking cessation.

- c) *We are focusing on embedding recovery principles as we undergo a transformation project to further improve how we deliver services. We will hold a series of workshops and provide reports to our Board of Directors that enables us to assess our current position, set priorities and work towards them. We are involving people who use our services, carers, staff and partner organisations in this exciting project.*

Joint working initiatives include the following:

- Group work planning work streams for Community Mental Health Team's.

- Service user involvement with groups and evaluation.
- Proposal presented to the Transformation Board regarding Peer Support Workers roles.
- Recovery Module delivered by Trust staff and attended by those who use our services, volunteers, carers and staff with positive feedback being received. The first cohort will be completed in April 2012.
- The Refocus research project addresses how Recovery focused the Trust is perceived as and is a survey for team leaders, staff and service users. Results will be received in May 2013 with an action plan to follow.

Recovery Star Evaluation and the role of Recovery practitioners within the Trust is being evaluated by Leeds Metropolitan University.

A League of Champions is being developed to assist the Recovery and Social Inclusion team in delivering training to all teams within the Trust. Workshops will begin in September 2012.

The “Lived Experience Network” for staff has developed a “Barometer poll” to identify whether staff feel comfortable discussing their own experiences of emotional distress. A conference will be delivered by LYPFT in autumn 2012 to open up this topic for discussion.

- d) *We will be delivering training for managers to support mental health and wellbeing in our organisation. We are also developing bespoke training products, in partnership with Community Links to public and commercial organisations to encourage local employers to be positive about mental health.*

A number of initial meetings have taken place with public and private companies with a view to delivering training. A Time to Change ‘human library’ event took place at British Gas headquarters in November 2011.

- e) *We will extend the productive series into community services. A pilot is currently being conducted within the Learning Disabilities Directorate.*

Productive Community Services continues within 2 of the Trust’s Community Learning Disability Teams. The programme lead has engaged with colleagues in North Yorkshire & York services where a number of community teams have made good progress with the productive initiative. Networks have been established to share good practice across the organisation.

- f) *We will undertake further development of the Associate Practitioner Programme within the Higher Education Sector, with the formal employment of this new staff group as a key workforce development contributing to New Ways of Working.*

We have begun the process of recruitment to the 2012-2013 cohort.

#### **Initiatives to be implemented in 2012-2013:**

- i. We are involved in an exciting new research project examining the impact of leadership and culture on the effectiveness of teams and the quality of care received by adults who receive mental health services in the community. The research project, ‘Leading to Quality’, involves all NHS mental health provider organisations in Yorkshire and the Humber and will also form part of the evaluation of our Trustwide Transformation Project.

- ii. In order to ensure that we are meeting the needs of our service users, we are taking a systematic approach to measuring clinical outcomes. We are using the three main clinical outcome measures (CORE, HoNOS, TOM's) to identify service user needs at the beginning of the care episode, and will use these to measure progress over time. Initial work has demonstrated that the Trust is helping people improve their wellbeing on these measures, and the next step will be to implement this work systematically across the organisation.
- iii. Within the North Yorkshire Forensic service, a tracking system that identifies the service user's pathway is in development and the service user will receive a "road map" identifying their agreed goals. The tracking system will allow monitoring of the care pathway for a person and help to continually monitor information and service provision and outcomes for staff and service users. This initiative is linked to implementation of the Shared Pathway, which is a national requirement for all secure services.
- iv. We have developed a 2012 membership campaign entitled 'What's your Goal?' to recruit new members and engage with our existing members. The campaign is inspired by the Olympic Games and Paralympic Games and explores the relationship between physical health and mental wellbeing. We are encouraging people to set a goal and represent that goal on a piece of bunting. In November 2012 we will be connecting all the pieces of bunting together in an attempt to break the Guinness World Record for the longest line of bunting. Our record breaking attempt is an effective way to gain public interest in our campaign and symbolises our aim to bring people together around a common purpose.
- v. We continue to focus on embedding recovery principles as we undergo a transformation project to further improve how we deliver services. We will continue to undertake work that enables us to assess our current position, set priorities and work towards them. We are involving people who use our services, carers, staff and partner organisations in this exciting project.

## Priority 2 People experience safe care

### Progress against 2011-2012 Initiatives

- a) *A nurse rotation programme proposal has recently been endorsed and is seen as a very creative and innovative approach to developing capable practitioners within nursing. A process of Higher Education Institution accreditation may be linked to this particular programme which will be developed in-house and managed within the Nursing Team with anything up to 60 staff in the rotation programme at any given time.*

Work continues with the development of the nurse rotation program, being led by the Associate Director of Nursing and the Clinical Standards Development Nurse. The programme itself is currently being finalised and supporting documentation being produced. As part of the programme the Trust's preceptorship package for newly qualified nurses has been reviewed and updated, based on Department of Health guidance and the 'Flying Start' programme. Discussions have taken place with Leeds Metropolitan University about the possibility of accrediting the nurse rotation programme as an "M" level module and work is being progressed in this area. Work remains on track to commence the nurse rotation programme in the early part of 2012.

- b) *Narrowing of the Board to Ward Experience: Rolling out of our "Quality Walk Arounds" for Board Members. These will take place within inpatient and community settings. Twelve "Walk Arounds" will be scheduled for 2011/2012 in collaboration with the "Meet the Boss" programme*

Currently five "Quality Walkrounds" have taken place during August to January 2012, based in a variety of settings across Adult, Older Peoples, Learning Disability and Specialist Services Directorates. These "Quality Walkrounds" have now been extended to include both Non-Executive Directors and Executive Directors.

- c) *Review the effectiveness of the current Core Trainee Doctor post in the Patient Safety Champion role in October 2011. Following this review it is anticipated to appoint a Foundation Year Doctor into a second Patient Safety Champion position for Doctors in Training.*

Following the success of the first Patient Safety Champion from Doctors in Training within the Trust (2010/2011), and positive feedback from the Associate Dean and Sub Dean of the Yorkshire and Humber Postgraduate Deanery, a further Patient Champion for Doctors in Training (2011/2012) was appointed in October 2011. With the support of the Patient Safety Manager and the Associate Director for Doctors in Training, specific projects are being prepared to run in conjunction with established work streams relating to the Patient Safety Agenda for the Trust.

- d) *Enhanced benchmarking for Patient Safety on a local, regional and national level. This will be undertaken through liaison with other healthcare providers to review local systems and processes within the reporting of Patient Safety events/issues*

We continue to use and enhance a variety of national and locally generated benchmark indicators for quality and patient safety, which include:

- NPSA "How do you compare to your peers" national and regional statistics of patient safety incidents.
- Statistical Process Control (SPC) on unexpected deaths of services users in receipt of Trust services.

- Incorporation of the extended NPSA “Never Events” into Board reporting
- Continuation of monthly reporting of the Trust’s “Trigger to Board” events

Discussions continue with neighbouring Mental Health and Learning Disability providers on the formation of benchmarking systems and processes. As each of the neighbouring trusts have now diversified the services they provide, it has been agreed to use the National “How do you compare to your peers” regional data as a benchmark rather than locally generated data sets.

*e) Expansion of proactive Patient Safety initiatives across the Trust.*

Patient Safety remains a top priority within the Trust. In order to continue advancing patient safety, a number of initiatives have commenced on an individual team, directorate and Trust wide basis. These initiatives are based around the following work streams and are monitored through Risk Management, the Trust’s Means Goal 1 & 2 Standing Group and Means Goal 5 Standing Group:

- Promotion of Best Practice
- Benchmarking standard of care
- Striving to be “An Organisation with a Memory”, through the lessons learned process.

**Initiatives to be implemented in 2012-2013:**

- Within the 2012 Nursing Strategy work plan focused work will take place on both records review and audit and Mental Health Act training development. Objectives will build upon the successful work carried out over the previous three years in relation to Essence of Care benchmarks, Medication Management, Infection Control standards and Safeguarding awareness and knowledge.
- Development and extension of the Section 136 service is aimed to increase both the physical space and capacity of the Section 136 service and also to provide a flexible care environment which will allow a greater range of therapeutic activities to take place. The suite will include bedrooms to allow service users who are not fit to be assessed when they are first brought to the unit to be nursed until assessment is possible. The suite will also allow service users requiring assessment by the Crisis Resolution Service to come to the Becklin Centre and receive care whilst they are waiting for assessment. This may be for short periods however will be beneficial for service users who may struggle to maintain their safety during this period.
- Continued expansion of proactive Patient Safety initiatives across the Trust.

### **Priority 3    People have a positive experience of their care and support**

#### **Progress against 2011-2012 Initiatives**

- a) *Through our Transformation Project we aim to achieve a pathway model of services that eliminates inequity and age discrimination and improves access to services.*

A new model for community mental health services has been developed following the analysis of existing services. The new model was informed by three implementation projects which considered the use of technology in the community, included an early implementer site at Aire Court to develop new ways of working and reviewed the medical input to out-patients and other clinical settings.

The new model will be delivered through locality based teams with clinical staff working together across all age ranges to ensure that service users receive the care and services they require. Plans to implement the new service are being developed for June 2012, allowing time to introduce a single point of access and urgent referral systems, in addition to closely aligned clinic and home treatment services.

Service users will follow an agreed care pathway which will ensure their needs are assessed, delivered and regularly reviewed. A core integrated care pathway (ICP) has been developed with clinical teams and is ready for final approval. Needs based pathways covering dementia, psychosis and common mental health problems are now being developed.

- b) *We are working with partners across the city to develop an on-line wellbeing hub for people who are interested in mental health issues and want to co-produce information and converse about relevant topics. The hub will be hosted by Leeds Mind.*

A city wide group is running a 'community journalist' course to a group of people with personal experience of mental health issues during March/April 2012. They will be supported to create blogs for the 'wellbeing web'. Funding is being identified to enable continuation of the project.

- c) *We are planning a city-wide six week arts and wellbeing festival that will be launched at an evening event on the 27 September 2011. We will deliver the festival in partnership with Yorkshire and Humber Arts Council and we aim to increase access to a huge variety of arts and cultural activity for people using our services.*

The Love Arts Festival took place between 27 September 2011 and 16 November 2011. The purpose of the festival was to raise awareness of mental health issues and our Time to Change campaign. A full evaluation report will be compiled. A further Love Arts festival will take place in October 2012 and will be part of a wider year long Olympic and Paralympic Games inspired 'What's your Goal?' campaign.

- d) *We have developed a partnership with Leeds Mind to develop a community arts centre in North Leeds. The Arts and Mind network will be based at the site and it will enable more creative activities to take place for people using our services as well as participating from the wider local community.*

The Inkwell Community Arts Centre conversion work has been finalised with space being developed for multi-functional use and room hire. Arts and Minds and our Time to Change project workers are based at the centre.



- e) *We will be signing up to the Information Standard to help us assess, deliver and evaluate our information to ensure it consistently achieves a high standard. The Standard has been established to help people make informed choices about their lifestyle, conditions and treatment/care options and by providing a recognised and trust quality mark that will indicate reliable sources of health and social care information.*

The Trust's "producing information policy" has been reviewed and an audit of information took place in December 2011 to assess compliance with the policy. We are now setting up a plan for all information to be reviewed and updated over the coming year. A procedure for all information to be edited and designed by the communications team is in the process of being developed.

### **Initiatives to be implemented in 2012-2013**

- i. Through our Transformation Project our aim continues to achieve a pathway model of services that eliminated inequity and age discrimination and improves access to services,
- ii. In order to improve the experience of service users and their carers and to improve the efficient use of resources we will be opening a new 17 bedded secure rehabilitation in-patient facility. Historically service users who have required this service have been placed in out of area units meaning that they have not received their care locally in Leeds. The new local unit will improve the ability for these service users to follow a local care pathway with a clear focus on recovery.
- iii. We are aiming to improve access to outside space for all service users at our older peoples inpatient unit in Leeds that will enable therapeutic activities.
- iv. Through the implementation of our equality objectives we aim to further develop our equality performance:-
  - a. We will undertake further analysis of service user survey results and complaints by protected characteristics to identify and address any variations in satisfaction rates.
  - b. We will develop a consistent approach across the local NHS economy in respect of equality leadership, staff empowerment and access to development opportunities.
  - c. We will further develop the involvement and engagement of protected groups and our "local interests" including service users, carers, staff, third sector, Clinical Commissioning Groups and the local authority.
  - d. We aim to improve access, experience and choice for service users from BME communities through the implementation of a joint action plan with Touchstone Community Development Service.
- v. We aim to further use development tools such as Dementia Care Mapping to underpin changes in practice to improve the experience of people with dementia within our services.

## **2.4. Information on the review of services**

During 2011/2012 Leeds and York Partnership NHS Foundation Trust provided 6 NHS services which were:

- Learning Disabilities
- Adult Mental Illness
- Forensic Psychiatry
- Old Age Psychiatry
- Child and Adolescent Psychiatry
- Improving Access to Psychological Therapies

Leeds and York Partnership NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these NHS services.

The income generated by the NHS services reviewed in 2011-2012 represents 100% of the total income generated from the provision of NHS services by Leeds and York Partnership NHS Foundation Trust for 2011-2012.

## **2.5. Participation in clinical audits and national confidential enquiries**

NICE defines clinical audit as “a quality improvement process that seeks to improve patient care and outcomes through the systematic review of care against explicit criteria and the implementation of change”. It is important that we have a good understanding about the quality of care, and outcomes of care, so that the necessary plans can be made to ensure that we are doing all we can to promote and support the health and well-being of our service users. A comprehensive programme of clinical audit is one way in which this understanding can be achieved. The Trust therefore uses an annual plan to prioritise topics for audit, with the topics being agreed by the different clinician groups as requiring investigation. Clinical audit activity and findings are reported through the clinical governance structure – reaching from ward to board, and across care services – so that knowledge is shared, and the implementation of change is monitored. In this way we are provided with assurance that service users and staff benefit from this activity.

This report covers the clinical audit activity for the former Leeds Partnerships NHS Foundation Trust (LPFT) only, due to the integration of North Yorkshire and York Services taking place towards the end of the reporting year. All future reports will provide feedback on clinical audit activity for all services within Leeds & York Partnership NHS Foundation Trust.

During 2011/2012 two national clinical audits and one national confidential enquiry covered NHS services that Leeds and York Partnership NHS Foundation Trust provides.

During 2011/2012 the Trust participated in 100% of the national clinical audits (agreed by the Trust as appropriate based on information provided by the national audit project leads) and 100% of the national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

### **National Clinical Audits and National Confidential Enquiry**

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in and participated in during 2011/2012 are as follows:

- Prescribing Observatory for Mental Health (POMH-UK)
- National Audit of Schizophrenia



- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness

The national clinical audits and national confidential enquiries that the Trust participated in during 2011/2012 are as follows:

- POMH-UK
- National Audit of Schizophrenia
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness

The national clinical audits and national confidential enquiries that the Trust participated in, and for which data collection was completed during 2011/1012 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:

Audit	Participation	% Cases submitted
POMH-UK (a) Topic 1f&3f-High Dose Anti-Psychotic Prescribing (b) Topic 6c-Side Effects of Anti-Psychotics (c) Topic 7c-Lithium Monitoring	Yes	See Note 1
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness	Yes	
National Audit of Schizophrenia	Yes	84%

**Note 1**

It is not possible to provide a percentage figures for cases submitted to either the POMH-UK projects, or the National Confidential Inquiry, due to the way in which the samples are generated. However, it can be confirmed that:

- (a) Samples for each POMH-UK project is representative of all those to whom the topic is applicable, and
- (b) information is submitted for 100% of cases identified by the National Confidential Inquiry team as potentially meeting their inclusion criteria – between 20-25 cases per annum.

The reports of 4 national clinical audits were reviewed by the provider in 2011/12 and the Trust intends to take the following actions to improve the quality of healthcare provided:

#### **POMH-UK Topic 6 Side effects of depot antipsychotics**

This national audit aimed to assess practice against targets for the assessment of side effects of depot antipsychotics. An action plan to support improvement in key areas is being developed.

#### **POMH-UK Topic 7 Monitoring of patients prescribed lithium**

This national audit aimed to assess practice against standards for monitoring patients prescribed lithium. An action plan to support improvement in key areas is being developed.

### **POMH-UK Topic 9 Antipsychotic prescribing in people with a learning disability**

This national audit aimed to assess practice against standards for prescribing antipsychotics to people with a learning disability. Actions are in place to improve the systematic monitoring of side effects of anti-psychotic medication by (1) providing laminated copies of summary tables in clinic rooms and on wards, and (2) including a copy of the guideline in the Doctors in Training Induction Pack.

### **POMH-UK Topic 11 Antipsychotic prescribing in people with dementia**

This national audit aimed to assess practice against standards for prescribing antipsychotics to people with dementia. An action plan to support improvement in key areas is being developed

### **Local Clinical Audits**

The reports of 22 local priority clinical audits were reviewed by the provider in 2011/12 and the Trust intends to take the following actions to improve the quality of healthcare provided. Only those projects that had action plans agreed within the reporting period are included in this report.

### **Efficiency of Electroconvulsive Therapy (ECT) Machines**

This project aimed to assess clinical practice relating to the threshold dose delivered by the ECT machines (old and new) in use in the Trust since March 2000. Actions are in place to ensure that every Electroconvulsive Therapy (ECT) session adheres with the new ECT titration chart and to explore the option of treating all patients with ultra-brief pulse stimulus.

### **Compliance of high-dose antipsychotic monitoring (Red Cards)**

This project aimed to assess clinical practice relating to the compliance of high-dose antipsychotic therapy monitoring within forensic services as detailed in the Royal College of Psychiatrists Consensus Statement. Actions are in place to implement baseline monitoring for all service users prior to initiation of antipsychotic therapy, devise alert stickers, produce patient information leaflets and provide training/briefing sessions to further educate staff.

### **Self-administration of medicines guidelines audit**

This project aimed to assess clinical practice care relating to the 'Self-administration of Medicines Policy' being adhered to in practice on elderly acute mental health wards. Actions are in place to redesign key forms (assessment, monitoring and review) to create a more user friendly format, to further develop the guidelines and to produce patient information leaflets.

### **Medical Management of Seclusion in Learning Disabilities (LD) Inpatients**

This project aimed to assess clinical practice relating to the medical management of secluded patients at Parkside Lodge. Actions are in place to include information on staff roles and responsibilities in the Seclusion Record Book and to include the seclusion policy and guideline within the new trainee induction programme.

### **Use of Antipsychotics in Care Home Dementia Patients (Towngate House)**

This project aimed to assess clinical practice relating to dementia patients in care homes diagnosed with non cognitive symptoms and behaviour that challenges and who have been started on antipsychotics. Actions are in place to organise teaching sessions to all care home staff, educate doctors about clear documentation of the indications, alternatives considered and plans for reduction and cessation of antipsychotics and, review all care home dementia patients on antipsychotics in order to consider stopping the medication.

### **Audit of adherence to antipsychotic prescribing guidelines in management of challenging behaviour with Learning Disability & anti-social disorder**

This project aimed to assess clinical practice relating to adherence to standards of care in antipsychotic prescribing for the management of challenging behaviour in adults with learning disabilities and anti social disorder. Actions are in place to present the findings at a Royal College of Psychiatrists annual meeting, develop recommendations within Consultant Psychiatrist meetings and discuss further at a Regional Psychiatric Forum.

### **Use of patient group directions (PGDs) for the supply of medications within the Crisis Resolution Home Treatment (CRHT)**

This project aimed to assess clinical practice relating to the use of patient group directions. Actions are in place to retrain staff as per the Medicines Management Code and support the use of patient group directions by medics to supply one-off doses of specific medicines.

### **Benzodiazepine prescribing in Becklin inpatients**

This project aimed to assess clinical practice relating to compliance with the current guidelines set out in the British National Formulary (BNF) regarding doses and length of benzodiazepine prescribing. Actions are in place to disseminate and share findings with doctors and relevant governance groups within the Trust.

### **Audit of the NICE Guideline for Depression**

This project aimed to assess clinical practice relating to compliance with the key priorities for the NICE Guideline for Depression. Actions are in place to review, at least annually and document a discussion/best interests assessment of the risks and benefits of continued antidepressant treatment, developing a NICE prompt system for all guidelines for clinicians, improve clinical notes and GP letters to inform of the rationale for choice of depressants, support the use of the Psychological/Vocational/Occupational Therapy framework and to explore a suitable additional outcome measure that can be introduced in the clinic setting.

### **Audit of the NICE Guideline for Bipolar Disorder**

This project aimed to assess clinical practice relating to compliance with the key priorities for the NICE Guideline for Bi-Polar Disorder. Actions are in place to prompt to advise of

common/serious side effects and to use the choice and medication website as part of medicines management core pathway.

#### **Audit of the NICE Guideline for Anxiety**

This project aimed to assess clinical practice relating to compliance with the key priorities for the NICE Guideline for Anxiety. Actions are in place to ensure a formal review of current and past treatment and advice regarding the potential benefits of psychological and pharmacological treatments is included in the initial holistic assessment and to promote the incorporation into care pathways.

#### **Audit to assess adherence to adequate medication dispensing recording within Crisis Resolution Home Treatment (CRHT)**

This project aimed to assess clinical practice relating to the recording of medications dispensed by CRHT practitioners to patients on home based treatment. Actions are in place to ensure bank staff are aware of procedures at the start of their shift and to ensure reminder notices remain in place across locations

#### **Documentation of initiation and monitoring of antipsychotic medication**

This project aimed to assess clinical practice relating to the weekly Multi Disciplinary Team reviews in in-patient settings of service user on a trial of antipsychotic medication in order to establish adherence to NICE guidelines. Actions are in place to organise a “standard approach” for documentation in ward rounds.

#### **Monitoring of prolactin levels in patients prescribed anti-psychotics**

This project aimed to assess clinical practice relating to monitoring prolactin levels in inpatients at the Becklin centre, on anti-psychotic medication, in accordance with the Maudsley Guidelines. Actions are in place to raise awareness of findings and guidelines and to inform the Pharmacy department of the audit findings.

#### **Project 442 Section 136 documentation**

This project aimed to assess clinical practice relating to Section 136 documentation. Action are in place to ensure one individual is responsible for ensuring forms are fully completed following each assessment, review the number of Crisis Resolution Home Treatment staff, improve communication between the service and the police as well as providing further knowledge and awareness of mental illness for the police.

#### **Essence of Care**

This project aimed to assess clinical practice within each team relating to care provision and clinical practice adherence to the Essence of Care benchmarks. Actions are in place to develop a local working group to improve the support and input available to people with continence issues, to continue to sign post people and carers towards services and resources that enable them to manage aspects of self care, to provide a wider choice of support for clients pre-treatment on the care pathway to achieve improved outcomes for health and well being and to provide a specific service area within the outpatients waiting area to improve environment issues relating to health and wellbeing.

### **Referrals for Service to the Children and Young People's Social Care**

This project aimed to assess clinical practice relating to referrals made by our staff to Children and Young People's Social Care. Actions plans are in place to create and share a checklist and; make other safeguarding practitioners in health and social care aware of necessary guidance.

### **Annual Suicide Audit**

This project aimed to assess clinical practice relating to all suicides occurring within a specified time period within our Trust. Actions are in place to continue to incorporate suicide prevention into our governance plans and to maintain the current levels of risk management training within the Trust.

### **Clinical Supervision**

This project aimed to assess clinical practice of engagement in clinical supervision over a one-year period. Actions are in place to engage all staff in the appraisal process, to remind staff of the requirement to maintain written discussions through business/management meetings and to ensure joint completion of the Trust's evaluation of clinical supervision every 6 months.

### **Care Programme Approach Quality Standards**

This project aimed to assess clinical practice relating to the standards for Care Programme Approach. Actions are in place to ensure the correct contact details of the care co-ordinator are included in the care plan, to further improve completion and documentation of the annual physical health checks and, ensure those meeting the Green Light criteria can be identified.

### **Monitoring side effects whilst prescribing antipsychotics at Malham House**

This project aimed to assess clinical practice relating to physical monitoring in service users on antipsychotics. Actions are in place to implement the use of monitoring proformas, assess the viability of a monthly monitoring clinic, pursue approval for direct access to blood results and liaise with the Leeds General Infirmary for walk-in electrocardiogram service and GP practices by informing them of audit results.

### **Occupational needs assessments**

This project aimed to assess clinical practice relating to the assessment of occupational needs of our client group following admission to the acute inpatient services. Actions are in place to have a system of regular reporting on the number of occupational therapy assessments activity and improve the quality of documented references to occupational issues in treatment plans/assessments.

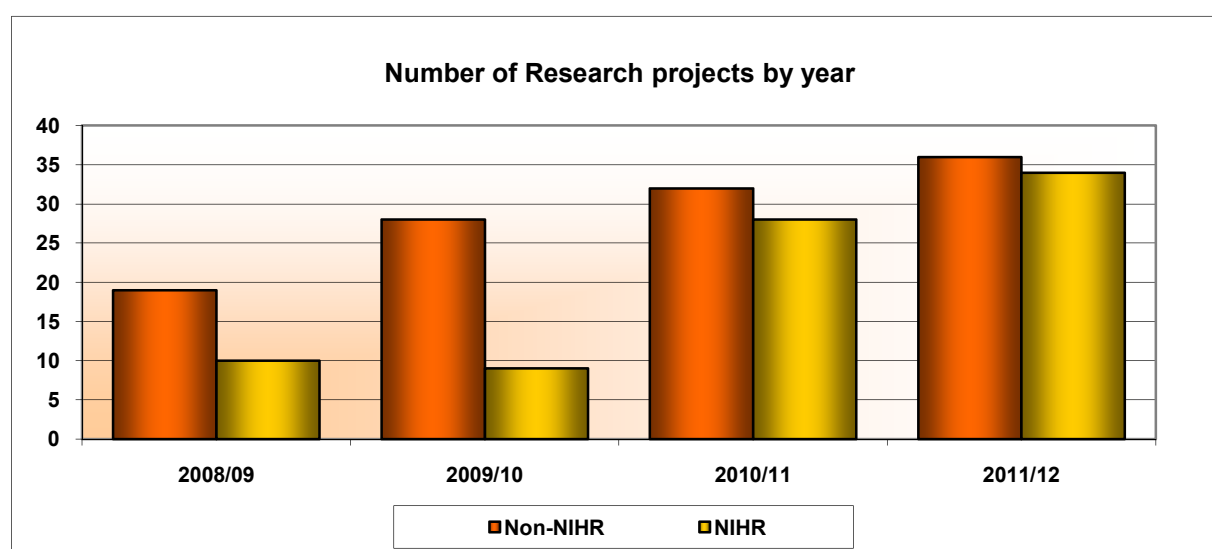
## 2.6. Participation in Clinical Research

The number of patients receiving NHS services provided or sub-contracted by Leeds and York Partnership NHS Foundation Trust (LYPFT) from 1 April 2011 to 31 March 2012, that were recruited during that period to participate in research approved by a NHS Research Ethics Committee was 1384.

Total recruitment was made up of:

- 694 patients recruited to National Institute of Health Research (NIHR) adopted studies,
- 690 recruited to non-NIHR adopted studies ie local and student.

Leeds and York Partnership NHS Foundation Trust was involved in conducting 70 clinical research studies in mental health and learning disabilities in 2011/12. Of these, 34 were National Institute of Health Research (NIHR) adopted studies. This compares favourably with previous years, illustrated by the graph below. This increasing number of clinical research studies demonstrates our commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff keep abreast of the latest treatment possibilities and active participation in research leads to successful patient outcomes.



We continue to maintain and develop our profile in learning, teaching and research. The newly integrated Trust, incorporating experienced research-active NHS staff from North Yorkshire and York services, will promote high quality research in the field of mental health and learning disabilities across the Yorkshire and Humber region.

The following research achievements are examples of the Trust's commitment to improving the quality of care we offer:

- We host the West Yorkshire Comprehensive Local Research Network (WYCLRN) funded posts of Research Clinical Lead and Clinical Studies Officer working on NIHR projects in mental health. These posts have facilitated an important link with the Mental Health Research Network (MHRN) hub in Newcastle, and provided access and support to Trust staff wishing to engage with MHRN supported studies. Five further WYCLRN funded posts have also been secured. These developments provide a significant

opportunity to increase the level of NIHR portfolio activity within LYPFT, previously outside this network's activity.

- We continue to engage service users in research design, identifying research priorities, interview panels for research staff, participating in research projects and research governance
- Leading to Quality is a research project funded by Yorkshire and the Humber Strategic Health Authority in which we are participating. The project examines the impact of leadership and culture on the effectiveness of teams and the quality of care received by adults who receive mental health services in the community and demonstrates our commitment to clinical research that improves patients' health and lives.
- During 2011/2012 we had 103 clinical staff participating in mental health and learning disability research approved by a research ethics committee
- We are working in partnership with York University as part of the Leeds, York and Bradford Collaborations for Leadership in Applied Health Research and Care (CLAHRC) on a number of addictions research projects and to implement the National Institute for Health and Clinical Excellence's (NICE) guideline on core interventions in the treatment and management of schizophrenia to ensure patients experience safe care.
- Our engagement with a range of clinical research as the lead site for seven NIHR funded projects also demonstrates our commitment to testing and offering the latest medical treatments and techniques. These projects cover unrecognised bipolar disorder; a new self-harm intervention; an early parenting intervention for families with young children showing severe attachment problems; validation of an outcome measure for those treated for substance dependence; cognitive behavioural therapy for depression in adolescents; translation of the strengths and difficulties questionnaire into British Sign Language and autism spectrum social stories in schools.

The challenging financial climate means that research and innovation are even more important in identifying the new ways of understanding, preventing, diagnosing and treating disease that are essential if we are to increase the quality and productivity of services in the future.



## 2.7. Commissioning for Quality and Innovation (CQUIN)

A proportion of Leeds and York Partnership NHS Foundation Trust's income in 2011-2012 was conditional upon achieving quality improvement and innovation goals agreed between Leeds and York Partnership NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2011/2012 and for the following 12 month period are available online at

[http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/\\_openTKFile.php?id=3275](http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275)

For Leeds and York Partnership NHS Foundation Trust, the monetary total for the amount of income conditional upon achieving quality improvement and innovation goals was £1,425,495 (Leeds services) and £83,000 (North Yorkshire & York). The monetary total for the associated payment in 2011-2012 was £1,508,495.

In 2011-2012 we were required to participate in local and forensic CQUIN (Commissioning for Quality and Innovation) schemes. Progress against our CQUIN indicators was reported to our Trust Board of Directors on a quarterly basis through our Trust performance report which can be found on our website at [www.leedspft.nhs.uk](http://www.leedspft.nhs.uk).

Our Executive Team also received a progress report on a monthly basis. Any risks to performance were identified within the reports and actions in place to improve performance were documented.

In 2012-2013 we will be required to report performance against a national CQUIN and local CQUIN's, which have been agreed with our main commissioner and are aligned with our Trust Strategy. We will also be required to report against CQUIN's to the Specialist Commissioning Group for the following services:

- Child and Adolescent Mental Health Services
- Low Secure Services
- Perinatal services
- Gender Services
- Eating Disorder Services
- Personality Disorder Services

Details of our 2012/2013 CQUINs and our performance against these will be reported to the Trust Board of Directors on a quarterly basis and will be available publicly through our Trust Performance report which is available on our website at [www.leedspft.nhs.uk](http://www.leedspft.nhs.uk).

Plans are in place to ensure that we meet our 2012/2013 CQUINs and continue to further improve the quality of care for people who use our services.



## **2.8. Care Quality Commission**

### **Registration Status**

Leeds and York Partnership NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is fully registered.

The Care Quality Commission has not taken enforcement action against Leeds and York Partnership NHS Foundation Trust during 2011-2012.

Detailed assessments of compliance are undertaken on a quarterly basis, with sign off from Leads and Lead Directors. Assessments of compliance are reported on a quarterly basis to the Trust Board of Directors via the Trust performance report. Compliance with Care Quality Commission Registration forms a key area of the service directorate and corporate directorate performance reviews.

In order to further strengthen and maintain our position of compliance internal mock inspections are planned across services.

The Trust will continue to ensure that compliance against each registration requirement is monitored and maintained.

### **Care Quality Commission Reviews**

The Trust has participated in 5 special reviews by the Care Quality Commission relating to the following areas during 2011-2012:-

#### **Ward 40, Liaison Psychiatry Service:**

The Care Quality Commission carried out a responsive review to Ward 40 on the 4th May 2011 based on concerns identified during a Mental Health Act Commissioner visit. The CQC found Ward 40 to be compliant with Outcome 1: Respecting and Involving People who use Services and Outcome 21: Records. Minor concerns were identified with Outcome 7: Safeguarding People who use Services from Abuse and Outcome 13: Staffing. A moderate concern was identified with Outcome 4: Care and Welfare of People who use Services, regarding the absence of policies and training for staff about the application of the Mental Health Act, and a compliance action was received.

An action plan was put in place, addressing the issues raised at the inspection and the Care Quality Commission was informed by the Trust at the end of June that all actions had been addressed.

A follow up visit was carried out by the Care Quality Commission to Ward 40 on the 14th October. The Care Quality Commission confirmed that significant improvements had been made to all areas identified and the Trust was found to be compliant with all the outcomes reviewed. The Care Quality Commission did issue an improvement notice around the storage of oxygen and the medicines drug box to ensure these had been risk assessed. Risk assessments are undertaken on a three monthly basis.

#### **Learning Disability Service - Parkside Lodge**

The Care Quality Commission carried out a responsive review to Parkside Lodge on the 17 August 2011 based on an anonymous telephone call they had received regarding restraint practices. The main findings of the review were that:

- The Care Quality Commission found Parkside Lodge to be compliant across all areas, with no areas of concern
- Systems were found to be in place for planning and delivering care
- People using the service are safe and have a nutritionally balanced diet which supports their health and meets their needs
- There are systems and processes in place to help ensure people using the service are protected from abuse, or risk of abuse and their human rights upheld
- The environment at Parkside Lodge is comfortable and safe for people who live on the unit
- Staff have induction training and additional training is provided regularly to make sure they are able to understand and meet people's needs.

A recommendation was suggested by the CQC with regard to Outcome 4 on ensuring service user and/or their representatives are included in reviews of risk assessments and care needs in the weekly Multi Disciplinary Team meetings. The team addressed this recommendation and Multi-Disciplinary Team attendance is incorporated into patient weekly activity plans.

### **Learning Disability Service - 3 Woodland Square**

As part of the targeted inspection programme to services that care for people with learning disabilities the Care Quality Commission (CQC) carried out a visit to 3 Woodland Square on the 25<sup>th</sup> and 26<sup>th</sup> October 2011. The CQC identified moderate concerns with Outcome 4: Care and Welfare of People who use Services and Outcome 7: Safeguarding People who use services from abuse relating to the updating of records and two compliance actions were received.

An action plan was put in place, addressing the issues raised at the inspection, with all actions being completed by the end of January 2012.

A follow up visit was carried out by the Care Quality Commission to 3 Woodland Square on the 6<sup>th</sup> March 2012, where 3 Woodland Square was found to be fully compliant with both Outcome 4 and Outcome 7.

### **Low Secure Forensic Service – Ward 3, Newsam Centre**

As part of the targeted inspection programme to services that care for people with learning disabilities the Care Quality Commission (CQC) carried out a visit to Ward 3 Newsam Centre on the 5<sup>th</sup> and 6<sup>th</sup> December 2011. Ward 3 Newsam Centre is a low secure forensic inpatient ward for patients who may have been involved with the criminal justice system. Five of the beds offer a service to patients with forensic mental health needs and learning disabilities.

The review focused on two outcomes; Outcome 4: Care and Welfare of People who use Services and Outcome 7: Safeguarding people who use services from abuse. As a result of the review a moderate concern was identified with Outcome 4 and a major concern identified with Outcome 7 and compliance actions were received by the Trust. An action plan has been implemented to address the actions required and has been submitted to the CQC. To ensure that our compliance actions are removed as quickly as possible all actions are due to be completed by the end of April. Work is on track to achieve this timescale.

## **Learning Disability Service - White Horse View**

As part of the targeted inspection programme to services that care for people with learning disabilities the Care Quality Commission (CQC) carried out a visit to White Horse View on the 20<sup>th</sup> and 22<sup>nd</sup> December 2011. The review focused on two outcomes; Outcome 4: Care and Welfare of People who use Services and Outcome 7: Safeguarding People who use Services from Abuse. The draft report has been received from the CQC, which finds White Horse View to be fully compliant with Outcome 7 and identifies minor concerns with Outcome 4, meaning that people who use the service are safe but are not always experiencing the outcomes relating to this essential standard. An action plan is currently being developed and will be submitted to the CQC.

## **2.9. Information on the Quality of Data**

### **NHS Number and General Medical Practice Code validity**

Leeds and York Partnership NHS Foundation Trust submitted 1,913 records during 2011/12 (April to Dec 2011) to the Secondary Uses Service for inclusion in the Hospital Episodes Statistics which are included in the latest published data. The percentage of records in the published data:

- Which included the patient's valid NHS Number was 99.8% for admitted patient care, 99.9% for outpatient care and 99.6% for all service users as submitted in the mental health minimum dataset.
- Which included the patient's valid General Medical Practice Registration Code was 100% for admitted patient care, 100% for outpatient care and 99.2% for all patients as submitted in the mental health minimum dataset.

### **Information Governance (IG) Toolkit attainment levels**

Leeds and York Partnership NHS Foundation Trust's Information Governance Assessment Report overall score for 2011-2012 was 79% and was graded Green.

The Trust has an ongoing programme of IG training which is now refreshed annually. From a basis of 97% of all staff having received IG training in the past, the Trust has now delivered new or 'Refresher' IG training to 47% of all staff (including bank staff and staff within North Yorkshire and York services) in the last 12 months. Annual refresher training is being actively pursued and improves monthly.

We have once again closed the financial year without a reportable Serious Untoward Incident data breach, based on the 'David Nicholson' incident grading scale. This includes data from North Yorkshire and York services for which we have 'data controller' status from 01/02/2012.

Our commitment to providing a quality service on Freedom of Information Act (FoIA) has resulted in all incoming requests being processed within the statutory timescales. 2011 saw a slight reduction in overall FoIA requests over the year in comparison to 2010.

### **Statement on Data Quality**

Leeds and York Partnership NHS Foundation Trust has taken the following actions during 2011/12 to improve data quality:

- The procedures covering the collection and input of data to the PARIS clinical information system have been updated to reflect evolving good practice. Corporate procedures for data quality assurance have also been revised.
- The Data Quality Policy has been amended to include the CPD system used by York services.
- Awareness raising initiatives have been pursued to promote awareness of the importance of data quality, and the policy and procedures.
- We have exceeded the target contained both in our Trust strategy and our service contract with NHS Leeds, to ensure that commissioning datasets reconcile to local contract monitoring reports within +/- 4%.

Leeds and York Partnership NHS Foundation Trust will be taking the following actions to further improve data quality during 2012/13:

- Improving awareness of data quality issues, including the policy, amongst Trust staff based within North Yorkshire and York services.
- Implementing data quality improvement initiatives for North Yorkshire and York services data.
- Maintaining the data quality assurance processes that are in place Trustwide.

### **Clinical Coding Error Rate**

Leeds and York Partnership NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2011-2012 by the Audit Commission.

### 3.1 Our selected measures

For each of our strategic end goals and strategic means goals we have set ourselves some measures of success. These measures were developed through wide consultation with staff, service users and carers, the Trust Board of Governors and third party organisations

To ensure our Quality Accounts measures are in line with the strategic direction of the Trust and local quality schemes a review of our 2010-2011 Quality Accounts measures took place to ensure that these are aligned with our strategy measures and 2012-2013 local CQUIN (Commissioning for Quality and Innovation) measures.

As a refresh of our Trust Strategy is planned for September 2012 our Governor's performance group and our Executive Team agreed that the Strategy measures included within our 2010/2011 Quality Accounts would remain in place for our 2011/2012 Quality Accounts to enable progress to be demonstrated.

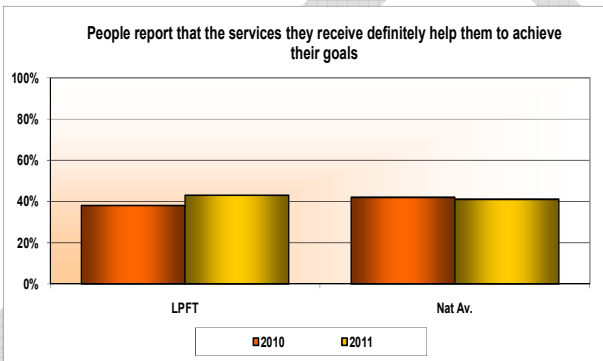
Our measures are set out under each priority on the following pages. The source of the measure demonstrates whether this is one of our strategy measures or one of our 2012-2013 local CQUIN (Commissioning for Quality and Innovation) measures.

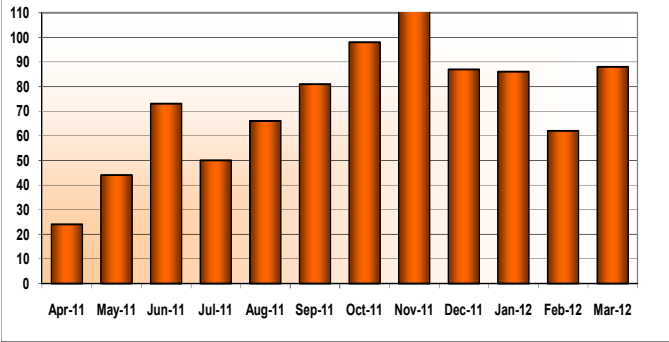
Progress against our measures set out in our 2010-2011 Quality Accounts were reported to our Board of Directors through the monthly Trust performance report, with each measure reported upon on a quarterly basis. These are publically available documents and can be viewed on our website [http://www.leedspft.nhs.uk/about\\_us/performance](http://www.leedspft.nhs.uk/about_us/performance)

Progress against measures set out in our 2011-2012 Quality Accounts will continue to be reported to the Trust Board of Directors through the monthly performance report. These measures also form part of our Service Directorate and Corporate Directorate Performance Reviews.

**Priority 1: People achieve their agreed goals for improving health and improving lives**

**Performance of Trust against selected measures:**

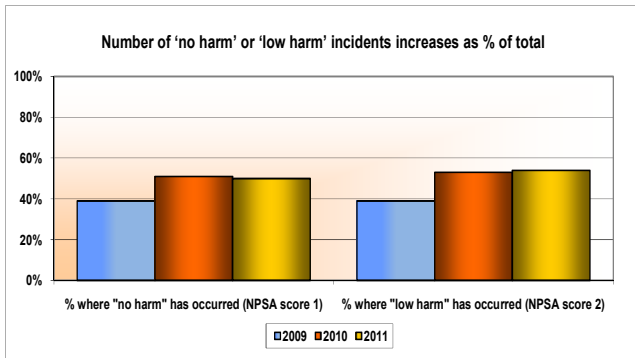
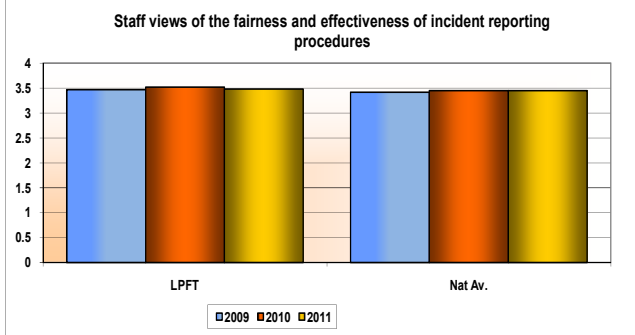
Measure		Source	Performance	Comments
1.	People report that the services they receive definitely help them to achieve their goals	Strategy Measure / National Community Service User Survey	 <p>586 service users from our Trust responded to the 2011 national community user survey.</p>	<p>The 2012 national community mental health service user survey is currently underway.</p> <p>We are currently putting internal systems in place to regularly survey our service users on this measure.</p> <p>Actions have been undertaken and are in place to support clinicians in agreeing goals with service users and planning care, support and treatment to facilitate this, including</p> <ul style="list-style-type: none"> <li>- Care planning documentation and care programme approach (CPA) training has been revised to support personal goal setting and measurement</li> <li>- Quality of care planning is to be monitored via case load management.</li> <li>- Post review questionnaire results compare favourably with the Trusts 2011 National Service User Survey Results with 75% of service users reporting that their care plan definitely sets out their goals.</li> </ul>
2.	Staff job satisfaction	Strategy Measure / National NHS Staff Survey (2011)	Graph to be included showing 2009-2011 performance	<p>Feedback from staff continues to be collected through a variety of means including barometer polls and on-line surveys for volunteers and temporary staff. A review is taking place on implementing local quarterly staff surveys to enable this information to be collected on a more frequent basis.</p> <p>A Health and Well being Action Plan has been developed and implemented across the Trust.</p>

Measure		Source	Performance	Comments
3.	All patients with a learning disability will have their clinical outcomes measured by a validated outcome measurement tool to improve patient care	CQUIN	 <p>The number of TOM's completed by month during 2011/2012</p>	<p>The 2010/2011 measure focused on implementation of the Therapy Outcome Measure (TOM's) tool within Learning Disability Services. The graph demonstrates a significant increase in the amount of TOM's that have been completed over 2010/2011.</p> <p>The 2011/2012 CQUIN will further develop this measure to focus on capturing and reporting outcomes for service users within our Community Learning Disability Services.</p>
4.	To improve the health and wellbeing of service users in adult rehabilitation community units in the following health domains: smoking cessation, weight management and substance misuse (alcohol)	CQUIN	2012/2013 will be the baseline year	A questionnaire will be developed with service users which will ask about current need in the areas of smoking cessation, weight management and substance misuse (alcohol) and if people's needs are being met. Recommendations from the results of the questionnaire will be implemented across the services.
5.	Carers report that their own health needs are recognised and they are supported to maintain their physical, mental and emotional health and well-being	Strategy Measure	To be determined by April 2012	A carers questionnaire is in place, which asks carers for feedback in relation to the Leeds Carers Charter. Initial response rates to the questionnaire have been too low to use for baseline setting. To improve response rates the questionnaire will now be included in the same pack as the patient experience survey for any carers to complete.



## Priority 2: People experience safe care

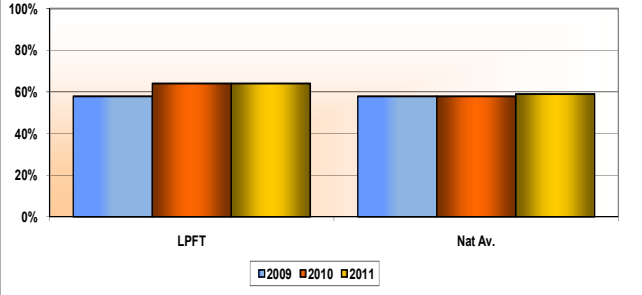
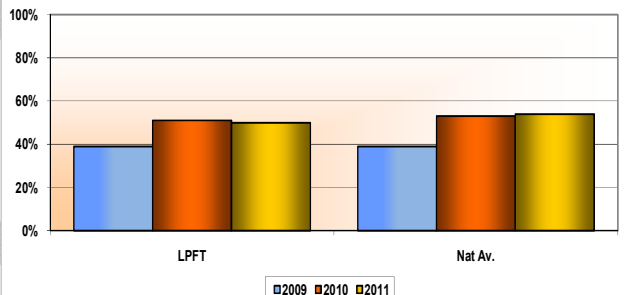
### Performance of Trust against selected measures:

Measure		Source	Performance	Comments
1.	People who use our services report that they experienced safe care	Strategy Measure	To be determined by April 2012	We are currently putting internal systems in place to regularly survey our service users on this measure.
2.	Number of 'no harm' or 'low harm' incidents increases as % of total: <ul style="list-style-type: none"> <li>% where 'no harm' has occurred (NPSA score 1).</li> <li>% where 'low harm' has occurred (NPSA score 2).</li> </ul>	Strategy Measure / NPSA	 <p>Number of 'no harm' or 'low harm' incidents increases as % of total</p> <p>All service user incidents – inpatient &amp; community</p>	The "First Do No Harm" document continues to outline our direction and aspirations in the delivery of safer therapeutic care. On review of incidents, we have a high level of reporting and a low degree of harm when incidents occur. Organisations with a high rate of reporting indicate a mature safety culture. This maturity enhances openness and provides a truer reflection of current practice which allows for more robust action planning
3.	Staff views of the fairness and effectiveness of incident reporting procedures	Strategy Measure / National NHS Staff Survey (2011)	 <p>Staff views of the fairness and effectiveness of incident reporting procedures</p> <p>Trust score is based on 425 staff who took part in the 2011 National NHS Staff Survey</p>	Feedback from staff continues to be collected through a variety of means including barometer polls. A review is taking place on implementing local quarterly staff surveys to enable this information to be collected on a more frequent basis.

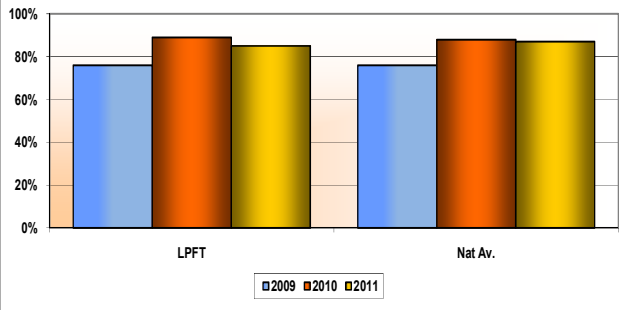
Measure		Source	Performance	Comments
4.	Evidence that we meet national guidelines for clinical care and treatment relevant to our Trust within 2 years of publication	Strategy Measure	In 2011/2012 the Trust achieved this target for 100% of newly published clinical guidelines.	Current performance will be maintained by continuing to receive national guidance through the Clinical Guidelines and Clinical Outcomes Standing Support Group which considers relevance and assesses compliance with the guideline including consideration of the evidence to support compliance.  Adherence to NICE Guidance is a central part of the Trust's Clinical Audit Plan
5.	NHS Safety Thermometer: Improve the collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter and Venous thromboembolism (VTE)	CQUIN	To be determined by end of April 2012	The Trust will revise our current data collection systems and implement the NHS Safety Thermometer to contribute towards establishing a national baseline of performance on the four identified areas of pressure ulcers, falls, urinary tract infection in patients with catheters and VTE.
6.	Improving the implementation of action plan goals following a serious untoward incident which relates to a community patient suspected suicide	CQUIN	To be determined by end of April 2012	A quarterly trajectory of achievement will be set in Quarter 1 and quarterly reports will be produced detailing compliance and exception reporting.

### Priority 3: People have a positive experience of their care and support

#### Performance of Trust against selected measures:

Measure		Source	Performance	Comments
1.	People who use our services report overall rating of care in the last 12 months very good/excellent	Strategy Measure / Mental Health Community Service User Survey	<p>People who use our services report overall rating of care in the last 12 months very good/excellent</p>  <p>586 service users from our Trust responded to the 2011 national community service user survey</p>	<p>The 2012 national community mental health service user survey is underway.</p> <p>We are currently putting internal systems in place to regularly survey our service users on this measure.</p> <p>Mental health data is triangulated through service user feedback tools and people's stories that provide in-depth feedback about their experiences of our services.</p>
2.	People who use our services report that their views were definitely taken into account when deciding what was in their care plan	Strategy Measure / Mental Health Community Service User Survey	<p>People who use our services report that their views were definitely taken into account when deciding what was in their care plan</p>  <p>586 service users from our Trust responded to the 2011 national community service user survey.</p>	<p>The 2012 national community mental health service user survey is underway.</p> <p>We are currently putting internal systems in place to regularly survey our service users on this measure.</p> <p>In order for the Trust to improve in this area, the following supports collaborative working with service users and co-production of care plans:-</p> <ul style="list-style-type: none"> <li>• City Wide Care Programme Approach (CPA) policy</li> <li>• Trustwide CPA training available as well as directorate specific</li> <li>• CPA documentation revised and implemented August 2011</li> </ul>

Measure		Source	Performance	Comments
3.	Engaging service users in older people inpatient settings in structured activity	CQUIN	2012/2013 will be the baseline year where a programme of structured activity will be further developed in Older People inpatient settings. Uptake of structured activity and service user feedback will be gathered and monitored.	A programme will be established in Q1 and implemented during Q2. A report on uptake will be produced in Q3 and a report of patient experience produced in Q4.
4.	Improving the service user experience at Care Programme Approach (CPA) reviews	CQUIN	<p>Results from the local survey showed:</p> <ul style="list-style-type: none"> <li>• 52% of people said they were definitely given a choice about how their review would be held</li> <li>• 80% of people said they were given a chance to talk to their care co-ordinator before the review about what would happen.</li> <li>• 69% of people said they were told they could bring a friend, relative or advocate to their review</li> <li>• 80% of people said they were given a chance to express their views at the review</li> <li>• 75% of people said they were definitely involved in agreeing the goals in their care plan</li> <li>• 84% of people said everything was said in a straightforward way at the review.</li> <li>• 85% of people reported they were asked how they were feeling at the review</li> <li>• 65% of people reported they definitely found the review helpful</li> </ul>	<p>The questionnaire is being extended across all appropriate community teams during 2012/2013.</p> <p>Action plans have been developed and implemented based on the 2011/2012 local survey results.</p>

Measure		Source	Performance	Comments
5.	Staff feeling satisfied with the quality of work and patient care they are able to deliver	Strategy Measure / National NHS Staff Survey (2011)	 <p>Trust score is based on 425 staff who took part in the 2011 National NHS Staff Survey</p>	Feedback from staff continues to be collected through a variety of means including barometer polls. A review is taking place on implementing local quarterly staff surveys to enable this information to be collected on a more frequent basis.

## 3.1 Performance Against Key National Priorities

### Performance Monitoring

Progress on performance against Monitor requirements, Care Quality Commission registration, our contractual performance requirements with NHS Leeds and our local requirements are presented on a monthly basis to the Trust Board of Directors, through the monthly performance report. Any risks to performance are identified within the report and any necessary actions in place to ensure compliance and improvement are documented. This report is routinely shared with our main commissioners and can be found on our website [http://www.leedspft.nhs.uk/about\\_us/performance](http://www.leedspft.nhs.uk/about_us/performance)

As part of the Trust's performance framework a cycle of Service Directorate performance reviews and Corporate Directorate Performance Reviews are in place which provide a detailed focus on performance across each of our service and corporate directorates. These reviews focus on performance against our external regulatory requirements including Monitor targets and Care Quality Commission registration and performance against our internal quality measures including progress against our annual plan objectives and progress against our strategy measures. The reviews are led by a panel of Executive and Non Executive Directors and are in place to further enhance assurance at a Board level of our Trust performance and quality of our services. The reviews also provide the opportunity for common themes to be identified and for directorates to showcase their achievements allowing for the sharing and learning of good practice.

Our five year Trust Strategy sets out our Trust end goals, our means goals and our stretch quality measures for quality improvement. Progress against the strategy action plan and performance against milestones and measures is reported to the Trust Board of Directors on a quarterly basis through the performance report.

We have a robust system of clinical governance in place which ensures that clinical services provide evidence based, quality and safe services. We have robust processes in place for responding to and learning from complaints and serious untoward incidents. All critical incidents are reviewed and lessons learned are disseminated Trust wide.

### Infection Prevention and Control

We are fully registered with the Care Quality Commission across both our health and social care services for Regulation 12: Cleanliness and Infection Control

The Trust's 2011-2012 C.difficile threshold agreed with our main commissioner is not to exceed nine new cases of C.difficile infections during the year. The table below demonstrates that Leeds services performed well below the threshold with one new case of C.difficile infection reported during 2011-2012. The figures also demonstrate an improvement since 2010/2011. For every C.difficile infection that takes place a full root cause analysis investigation is carried out

We have clear procedural guidance in place to direct staff with implementing the effective management of service users who are suspected or confirmed of having a C.difficile infection. The monitoring of "Essential Steps" is expected to further raise the Infection Prevention and Control standards across the Trust and reduce further the likelihood of such infections occurring.

Our Infection Prevention Control Team (IPCT) continues to facilitate an increased focus on practice, improving education and assessment standards, as well as a continuing improvement of environmental cleaning.

To date there have been zero cases of MRSA, MSSA (Methicillin-sensitive *Staphylococcus aureus*) or E.Coli bacteraemia within our Trust. Our IPCT closely monitor MRSA colonisation results, feeding back to both the Infection Prevention and Control Committee and the Professional Advisory Forum on a monthly basis. The IPCT is working closely with our Pharmacy Department to ensure that the treatment is completed in order to further reduce the risk of MRSA in all of the Trust's inpatient areas.

Healthcare Associated Infections:	2009-2010	2010-2011	2011-2012
Number of cases of MRSA Bacteraemia	0	0	0
Number of new cases of Clostridium Difficile	5	2	1

The IPCT is responsible for setting a programme which incorporates all Department of Health standards. The IPCT over the last year has ensured that:-

- Families and service users have been able to access information and make informed choices.
- Screening and diagnostic services have been effective and carried out to a high standard.
- Results are communicated to staff, service users and families effectively.
- Service users and staff are given comprehensive support pre and post-diagnosis.

We collect key performance data on infection prevention and control which enables us to observe trends, benchmark our performance, monitor improvements and compare ourselves against national standards. We undertake monthly mini-audits to ensure that our standards of infection control remain high within our clinical areas and are continually reviewing our processes to ensure these remain robust and effective.

### Improving Access:

We have maintained a position of compliance throughout 2011/2012 with the Monitor targets, admission to inpatient services having access to Crisis Resolution and Access to Healthcare for people with a learning disability. We have also exceeded our milestones on our strategy measures; assessments carried out by our Crisis Resolution team within 4 hours and the number of non acute adult patients seen within 14 calendar days of referral.

### Safeguarding Adults

We have continued to further improve and ensure a robust response to safeguarding alerts throughout the year. Through CQC reviews of our services and the new draft Quality Assurance Framework, which is being developed by the Leeds Safeguarding Adults Partnership Board, we have put further processes in place to continuously improve the capturing and recording of all our safeguarding data.

We have further built on our staff awareness with safeguarding adults by continuing to provide level1 training in the classroom and also establishing an online training programme. A key important aspect of improving awareness is also through the learning which comes from staff actively participating in the safeguarding processes. Our Safeguarding Enquiry

Coordinators and Safeguarding Leads guide teams through the safeguarding processes and their relationships with the Mental Capacity Act and Deprivation of Liberty Safeguards. Through this support the quality of referrals and the understanding demonstrated by staff has further improved.

Our integrated Trust now incorporates a geographical area embracing three Safeguarding Adults Boards, which we have representation upon. We are in the final stages of recruiting a safeguarding officer to further strengthen the integrated safeguarding service across our whole organisation.

## **Safeguarding Children**

We have contributed extensively over the past year to the OFSTED inspection process. This work took place over the summer period during which we supported our health colleagues within Leeds Teaching Hospital Trust and NHS Leeds in contributing to the health component of the review process. We were very pleased with the OFSTED report which indicated a move forward and overall demonstrated a marked improvement on the previous year's report.

The Named Nurse Safeguarding Children contributes to a number of Leeds Safeguarding Children Board Sub-Groups within the city and with the integration of services from North Yorkshire and York we now have representation on three Safeguarding Children's Boards across the geographical patch. The Named Nurse Safeguarding Children has also assumed the role of Domestic Violence Lead for the Trust. We have achieved the Domestic Violence Quality Mark Level 1 and we are currently working towards Level 2.

A network of named nurses from mental health trusts has been established to share and improve practice. The Named Nurse for Safeguarding Children for LYPFT is a member of this group. The focus of 2012 is to work together on standards for training and supervision.

The Care Programme Approach (CPA) has been adapted to encourage staff to 'think family' and consider the needs of the child and this won a National CPA award in 2011. The Safeguarding Children team continue to work closely with the CPA team within the Trust ensuring there is a formal record of child safeguarding concerns, when appropriate, within this process.

A care pathway on safeguarding children is currently being developed in line with the Transformation process which will further ensure staff receive clear guidance in relation to safeguarding children.

Safeguarding children sections have been added to the record keeping and supervision audits and 2 separate audits have been undertaken this year on quality of referrals to social care and attendance at case conferences. Action plans are put in place as a result of audits to further improve the quality of our services.

Over the last year we have strengthened our training delivery with the provision of an in house monthly level 1 classroom based session together with an e-learning option. Specific teams have also received training delivered in their own areas to ensure we continue to maintain a high standard of compliance with basic awareness training.

## **Eliminating Mixed Sex Accommodation**

We are pleased to confirm that we remain compliant with the Government's requirement to eliminate mixed-sex accommodation.



Service users admitted to any of our inpatient facilities will have their own room and if rooms do not have en-suite facilities then same-sex toilets and same-sex bathrooms will be close to their bed areas. The sharing of bathroom facilities with members of the opposite sex will only happen when clinically necessary, for example where patients need specialist equipment such as in our Learning Disabilities Respite Service for people with Complex Multiple Impairment. In our mixed sex wards female service users have access to female only areas.

Success in this area will continue to be measured by the Care Quality Commission inpatient survey, our local patient satisfaction surveys, Essence of Care Benchmark Audits, Clinical Governance groups and Board Reports. If our care should fall short of the required standard, we will report it. We have in place a monthly audit mechanism to make sure that we do not misclassify any of our reports and we will publish the results of the audit quarterly.

### **Patient Environment Action Team Assessment (PEAT)**

PEAT is the annual inspection of inpatient units with 10 beds or above covering Environment, Food/Food Hydration, Services and Privacy and Dignity. The scores for each section are assessed and the results are returned from the National Patient Safety Agency (NPSA). Every Trust is therefore benchmarked and a scored performance obtained. The tables below show our 2010 and 2011 PEAT scores.

#### **Leeds Services**

<b>2011</b>			
<b>Site Name</b>	<b>Environment Score</b>	<b>Food Score</b>	<b>Privacy &amp; Dignity Score</b>
Aire Court	Unit closed to in-patients		
The Mount	Excellent	Excellent	Excellent
Asket Croft	Good	Excellent	Excellent
St. Mary's Hospital PCT Unit	Excellent	Excellent	Excellent
Peel Court	Unit closed		
1-5 Woodland Square	Excellent	Excellent	Excellent
Towngate House	Unit closed to in-patients		
Millside CUE	Good	Good	Excellent
Newsam Centre	Good	Good	Excellent
Asket House	Good	Good	Excellent
Becklin Centre	Good	Good	Excellent
Parkside Lodge	Excellent	Good	Excellent

2010			
Site Name	Environment Score	Food Score	Privacy & Dignity Score
Aire Court	Excellent	Excellent	Excellent
The Mount	Good	Good	Excellent
Asket Croft	Good	Good	Excellent
St. Mary's Hospital PCT Unit	Excellent	Excellent	Excellent
Peel Court	Good	Good	Excellent
1-5 Woodland Square	Good	Good	Excellent
Towngate House	Unit closed to in-patients		
Millside CUE	Excellent	Good	Excellent
Newsam Centre	Good	Good	Excellent
Asket House	Good	Good	Excellent
Becklin Centre	Good	Good	Excellent
Parkside Lodge	Excellent	Good	Excellent

#### North Yorkshire & York Services

2011			
Site Name	Environment Score	Food Score	Privacy & Dignity Score
Bootham Park Hospital	Acceptable	Good	Excellent
Clifton House	Good	Excellent	Excellent
Worsley Court	Acceptable	Excellent	Good
Limetrees	Good	Excellent	Excellent
Meadowfields CUE	Good	Excellent	Good
Mill Lodge CUE	Good	Good	Good
Peppermill Court	Acceptable	Good	Excellent
Acomb Garth	Acceptable	Excellent	Good

2010			
Site Name	Environment Score	Food Score	Privacy & Dignity Score
Bootham Park Hospital	Acceptable	Good	Acceptable

2010			
Site Name	Environment Score	Food Score	Privacy & Dignity Score
Clifton House	Acceptable	Good	Excellent
Worsley Court	Acceptable	Good	Good
Limetrees	Good	Good	Good
Meadowfields CUE	Good	Good	Good
Mill Lodge CUE	Acceptable	Good	Acceptable
Peppermill Court	Acceptable	Acceptable	Excellent
Acomb Garth	Acceptable	Good	Excellent

### Service User and Carer Involvement

Involving the people who use our services, their families and friends, is something that is at the heart of our strategy. We have made the commitment to improve health and improve lives, and this can only be done through working in partnership. Through a wide variety of involvement opportunities we encourage people to share their experiences of our organisation, and we are committed to learning from listening to their stories. Carers are considered as vital partners helping to influence the provision of services, and as a commitment to carers we have developed 4 new constituencies of foundation trust membership to ensure that the carer's voice is heard. People who have used our services and carers are involved, consulted and encouraged to work in partnership with us across the organisation, through the recruitment of staff, the development of services and policies, and the monitoring of our strategy. We are currently exploring new social media ways of communicating with our partners, and are rolling out a trust wide experience questionnaire to ensure we receive the best kind of feedback possible.

**Below are a few examples of the ways in which we involve people who use our services and carers in the Trust:**

- Our Transformation project has had a large amount of discussion, consultation, imagination and engagement with both service user and carer involvement. This has significantly influenced the different elements of the project moving forward into the future.
- "Your Views" meetings in the in-patient ward areas continue to provide a rich source of views and ideas for service improvement. Daily activities and patient facilities are regularly reviewed in these meetings and any changes which take place are fed back at each meeting.
- The Trust Board of Directors continues to invite people to come along and tell their stories as part of the Boards' development. The directors have heard stories from service users and carers over the last twelve months, and have found these to be an extremely helpful source of feedback.
- The Patient Opinion Website continues to be a useful forum for feedback and postings. Over this year the Organisation has been acknowledged by Patient Opinion for its commitment to responding in a personal and timely fashion to every posting.

- The expansion of our services into North Yorkshire and York (NY&Y) has involved service users, carers and members of the public in consultations on the appropriate direction of travel for the organisation. The Board of Directors consulted on the name of the new organisation and the future development of partnership working across the wider patch.
- Our quarterly corporate involvement events “Building Your Trust”, “Everything you need to know about...” and the “Diversity and Social Inclusion Forum” continue to generate feedback. These events are evaluated and the findings are reported regularly in our membership newsletter “Building New Foundations”, and on the Trust website. We are looking for opportunities to develop these initiatives in NY&Y
- Working in partnership with people who have used services in NY&Y an initial involvement meeting has been set up for the establishment of an involvement network.
- Our procedures for Involvement have been revised in line with the new governance arrangements and an Involvement Leaders Forum takes place regularly. This forum ensures that service improvement ideas and feedback are all facilitated appropriately, and provides an arena for those with involvement responsibility to share good practice and support each other. This will be rolled out across NY&Y services over the next few months.

### **NHS Litigation Authority (NHSLA) Risk Management Standards**

Prior to the date of transfer of services in North Yorkshire and York both organisations had achieved a Level 1 in relation to the NHS Litigation Authority (NHSLA) Risk Management Standards assessment. On the basis that both organisations were at a Level 1 the integrated organisation’s current position is a Level 1.

An informal visit by the NHSLA assessor was carried out to the Trust on the 23<sup>rd</sup> February 2012 and a formal re-assessment at level 1 has been arranged for the 12<sup>th</sup> and 13<sup>th</sup> February 2013. In preparation for the formal reassessment an action plan will be developed and implemented.

### **Serious Untoward Incidents**

Serious Untoward Incidents are investigated using Root Cause Analysis methodology and reports are presented to the Trust Incident Review Group (TIRG).

Monthly reports are presented to the Trust Board of Directors following each meeting of the Trust Incident Review Group which provide an overview of the incidents, investigation and any lessons learnt.

Systems and process have been introduced by the Risk Management Team through 2011/12 to improve communication with the Coroners office and working closely with NHS Airedale, Bradford and Leeds to improve the timescales for the completion of investigation and learning from serious incidents.

## Monitor Assessments

Monitor is the independent regulator of Foundation Trusts. Using its assessment framework the Trust's overall 2011-2012 performance (to Quarter 3 to date) is shown below along with the Trust's previous performance.

Prior to 2011-2012 for both annual risk assessment and in-year monitoring, Monitor assigned a risk rating in three areas - finance, governance and mandatory goods and services. From 2010 onwards the provision of mandatory goods and services is included in the governance risk rating.

Risk ratings	Annual Plan 09/10	Q1 09/10	Q2 09/10	Q3 09/10	Q4 09/10
Financial	4	4	4	4	4
Governance	Green	Green	Green	Green	Green
Mandatory services	Green	Green	Green	Green	Green

Risk ratings	Annual Plan 10/11	Q1 10/11	Q2 10/11	Q3 10/11	Q4 10/11
Financial	4	4	5	5	4
Governance	Green	Green	Green	Green	Green

Risk ratings	Annual Plan 11/12	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12
Financial	4	4	4	4	
Governance	Green	Amber-Red	Amber-Red	Amber-Red	

The Trust is currently maintaining a Monitor amber-red governance risk rating and a financial risk rating of 4. The amber-red risk ratings have been due to compliance actions being received by the CQC as a result of inspections. The Trust currently has 2 compliance actions in place as a result of the recent CQC inspection to Ward 3 Newsam Centre. An action plan has been implemented to address the actions required and has been submitted to the CQC. To ensure that our compliance actions are removed as quickly as possible all actions are due to be completed by the end of April. Work is on track to achieve this timescale and once these actions have been completed and the CQC confirm compliance the Trust will return to a governance risk rating of 'Green'.

## MONITOR TARGETS

The table below shows the Trust's performance against Monitor targets. Due to the successful transfer of services from North Yorkshire and York on the 1<sup>st</sup> February 2012 performance is shown separately by Leeds services and as an integrated organisation from the 1<sup>st</sup> February onwards. (LYPFT).

Monitor Target	2011-12	Threshold
7 day follow up achieved: We must achieve 95% follow up of all discharges under adult mental illness specialities on Care Programme Approach (CPA) (by phone or face to face contact) within seven days of discharge from psychiatric inpatient care.	<p>We have maintained a position of compliance throughout 2011-2012.</p> <p><b>Leeds Services</b> –Performance remains compliant for February 2012 at 96.6%</p> <p><b>LYPFT</b> –LYPFT is compliant with the Monitor target for February 2012 with performance at 96.2%.</p>	95%
Care Programme Approach (CPA) patients having formal review within 12 months: We must ensure that at least 95% of adult mental health service users on Care Programme Approach (CPA) have had a formal review of their care within the last 12 months.	<p>We have maintained a position of compliance throughout 2011-2012</p> <p><b>Leeds Services</b> – Performance remains compliant for February 2012 at 96.3%.</p> <p><b>LYPFT</b> – Performance at the end of February 2012 is at 77.9%.The Trust agreed a trajectory with Monitor that we would be compliant with the target by the end of June 2012. Work is underway to ensure this trajectory is achieved. .</p>	95%
Minimising delayed transfers of care: We must achieve no more than 7.5% of delays across the year. Monitor excludes delays attributable to social care.	<p>We have maintained a position of compliance throughout 2011-2012.</p> <p><b>Leeds Services</b> - we have continued to maintain compliance for February 2012 with a cumulative average of 0.6%.</p> <p><b>LYPFT</b> – At 5 March 2012 LYPFT is compliant with the Monitor target with estimated performance at 3.3%.</p>	No more than 7.5%
Access to Crisis Resolution: We must achieve 90% of adult hospital admissions where the service user has had a gate keeping assessment from Crisis Resolution Home Treatment services. Monitor allows for self declaration where face to face contact is not the most clinically appropriate action.	<p>We have maintained a position of compliance throughout 2011-2012</p> <p><b>Leeds Services</b> –February 2012 figures demonstrate a 92.9% compliance rate.</p> <p><b>LYPFT</b> –LYPFT is compliant with the Monitor target for February 2012 with performance at 91%</p>	90%
Data Completeness: Identifiers: We must ensure that 99% of our mental health service users have valid recordings of NHS Number, Date of Birth, Postcode, Current gender, Registered General Practitioner organisational code and Commissioner organisational code.	<p>We have maintained a position of compliance throughout 2011-2012</p> <p><b>Leeds Services</b> - we have continued to maintain compliance for February 2012 with performance above the threshold at 99.9%.</p> <p><b>LYPFT</b> – LYPFT is compliant with the Monitor target for February 2012 with performance at 99.9%.</p>	99%

Monitor Target	2011-12	Threshold
Data Completeness: Outcomes: We must ensure that 50% of adult mental health service users on Care Programme Approach (CPA) have had at least one Health of the Nation Outcome Scale (HoNOS) assessment in the past 12 months along with valid recordings of employment and accommodation.	<p>We have maintained a position of compliance throughout 2011-2012</p> <p><b>Leeds Services</b> - We have continued to maintain compliance for February 2012 with performance above the threshold at 80%.</p> <p><b>LYPFT</b> – LYPFT is compliant with the Monitor target for February 2012 with performance at 55%.</p>	50%
Access to healthcare for people with a learning disability: We must self certify on a quarterly basis whether we are meeting six criteria based on recommendations set out in Healthcare for All (2008) from 1-4 (with 4 being the highest score)	<p><b>Leeds Services</b> - for the 6 recommendations 5 have been assessed as a level '4' (the highest rating) and 1 at a level '3'.</p> <p><b>North Yorkshire &amp; York LD Services</b> - for the 6 recommendations 3 have been assessed as a level '4' (the highest rating) and 3 at a level '3'.</p>	Not Applicable as set out in the Compliance Framework 2011/2012
Meeting Commitment to Serve New Psychosis Cases by Early Intervention Teams	The Monitor target 'Meeting Commitment to Serve New Psychosis Cases by Early Intervention' is only applicable to NY&Y services as Early Intervention is provided by Aspire within Leeds. The Monitor target sets out that Trusts must meet 95% of the commissioner contract value, which is 34 new cases of psychosis supported by Early Intervention Teams for NY&Y services. Data provided for April 2011 – February 2012 demonstrates LYPFT has exceeded the contract target and is compliant with the Monitor target, with 47 new cases of psychosis supported by the Early Intervention Team year to date.	95%

## **Annex: Statements from Primary Care Trusts, Local Involvement Networks and Overview and Scrutiny Committees**



## **Annex: Statement of directors' responsibilities in respect of the quality report**

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## Report of Head of Scrutiny and Member Development

### Report to Scrutiny Board (Health and Well-Being and Adult Social Care)

**Date: 16 May 2012**

### Subject: Reducing Smoking in Leeds – draft Scrutiny Board report

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Are there implications for equality and diversity and cohesion and integration?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Is the decision eligible for Call-In?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

### Summary of main issues

1. Reducing Smoking in the over 18s is identified in the Scrutiny Board's Terms of Reference. At its meeting on 22 July 2011, the Board agreed that the Board work should also include consideration of reducing smoking in the under 18s.
2. At its meeting in January 2012, the Scrutiny Board considered the draft Leeds Tobacco Action Plan and heard from the Joint Director of Public Health and representatives from West Yorkshire Joint Services (Trading Standards).
3. The Scrutiny Board has also received information associated with tackling smoking prevalence through other work areas including health inequalities and performance monitoring. Details from the work of the Board are being used to draft a report (to follow) to be presented at the meeting.

### Recommendations

4. To amend and/or agree the draft Scrutiny Board report and any associated recommendations on Reducing Smoking.

### Background documents <sup>1</sup>

<sup>1</sup> The background documents listed in this section are available for inspection on request for a period of four years following the date of the relevant meeting. Accordingly this list does not include documents containing exempt or confidential information, or any published works. Requests to inspect any background documents should be submitted to the report author.

- Scrutiny Board (Health and Well-Being and Adult Social Care) – Terms of Reference (May 2011)
- Health and Wellbeing City Priority Plan (2011-15) – draft Priority Action 1: Help protect people from the harmful effects of tobacco



Report author: Steven Courtney  
Tel: 24 74707

## Report of Head of Scrutiny and Member Development

### Report to Scrutiny Board (Health and Well-Being and Adult Social Care)

Date: 16 May 2012

### Subject: Transformation of Health and Social Care Services in Leeds – draft Scrutiny Board report

Are specific electoral Wards affected?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
If relevant, name(s) of Ward(s):		
Are there implications for equality and diversity and cohesion and integration?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Is the decision eligible for Call-In?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Does the report contain confidential or exempt information?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
If relevant, Access to Information Procedure Rule number:		
Appendix number:		

### Summary of main issues

1. The Transformation of Health and Social Care Services is identified in the Scrutiny Board's Terms of Reference. At its meeting on 22 July 2011, the Board agreed to include this matter within its work scheduled for 2011/12..
2. Throughout the year, the Scrutiny Board has consider a number of matters associated with this aspect of work, including update reports on the work of the Transformation Board and a range of reports about the integration of health and social care services.
3. Details from the work of the Board are being used to draft a report (to follow) to be presented at the meeting.

### Recommendations

4. To amend and/or agree the draft Scrutiny Board report and any associated recommendations on the Transformation of Health and Social Care Services in Leeds.

### Background documents <sup>1</sup>

None

<sup>1</sup> The background documents listed in this section are available for inspection on request for a period of four years following the date of the relevant meeting. Accordingly this list does not include documents containing exempt or confidential information, or any published works. Requests to inspect any background documents should be submitted to the report author.

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Report author: Steven Courtney  
Tel: 24 74707

## Report of Head of Scrutiny and Member Development

### Report to Scrutiny Board (Health and Well-Being and Adult Social Care)

**Date: 16 May 2012**

### **Subject: Reducing Health Inequalities in Leeds – draft Scrutiny Board report**

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Are there implications for equality and diversity and cohesion and integration?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Is the decision eligible for Call-In?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

### **Summary of main issues**

1. At its meeting on 22 July 2011, the Scrutiny Board agreed to include Reducing Health Inequalities in Leeds within its work scheduled for 2011/12.
2. Throughout the year, the Scrutiny Board has consider a number of matters associated with this aspect of work, including the development of the Joint Strategic Needs Assessment (JSNA) 2012 and a series of working group meetings examining the draft priority action plans from the developing Health and Wellbeing City Priority Plan 2011 to 2015.
3. Details from the work of the Board are being used to draft a report (to follow) to be presented at the meeting.

### **Recommendations**

4. To amend and/or agree the draft Scrutiny Board report and any associated recommendations on Reducing Health Inequalities in Leeds.

### **Background documents <sup>1</sup>**

None

<sup>1</sup> The background documents listed in this section are available for inspection on request for a period of four years following the date of the relevant meeting. Accordingly this list does not include documents containing exempt or confidential information, or any published works. Requests to inspect any background documents should be submitted to the report author.

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