MEETING OF THE LEICESTER, LEICESTERSHIRE AND RUTLAND JOINT HEALTH SCRUTINY COMMITTEE

DATE: **MONDAY, 6 FEBRUARY 2023**
TIME: **12:30 pm**
PLACE: **Meeting Rooms G.01 and G.02, Ground Floor, City Hall, 115 Charles Street, Leicester, LE1 1FZ**

Members of the Committee

Leicester City Council

Councillor Pantling (Chair of the Committee)
Councillor Aldred
Councillor Khan
Councillor Nangreave
Councillor O'Donnell
Councillor Sangster

Leicestershire County Council

Councillor Morgan (Vice-Chair of the Committee)
Councillor Charlesworth
Councillor Ghattoraya
Councillor Harrison
Councillor Hills
Councillor King
Councillor Newton

Rutland County Council

Councillor Ainsley
Councillor Waller

Members of the Committee are invited to attend the above meeting to consider the items of business listed overleaf.

For Monitoring Officer

Officer contacts:
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Leicester City Council, City Hall, 115 Charles Street, Leicester, LE1 1FZ

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If you have any queries about any of the above or the business to be discussed, please contact Anita James**, Democratic Support on (0116) 454 6358 or email anita.james2@leicester.gov.uk** or call in at City Hall, 115 Charles Street, Leicester, LE1 1FZ.

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USEFUL ACRONYMS RELATING TO
LEICESTERSHIRE LEICESTER AND RUTLAND JOINT HEALTH SCRUTINY COMMITTEE

Acronym	**Meaning**
ACO	Accountable Care Organisation
AEDB	Accident and Emergency Delivery Board
AMH	Adult Mental Health
AMHLD	Adult Mental Health and Learning Disabilities
BMHU	Bradgate Mental Health Unit
CAMHS	Children and Adolescents Mental Health Service
CHD	Coronary Heart Disease
CMHT	Community Mental Health Team
CVD	Cardiovascular Disease
CCG LCCCG ELCCG WLCCG	Clinical Commissioning Group Leicester City Clinical Commissioning Group East Leicestershire Clinical Commissioning Group West Leicestershire Clinical Commissioning Group
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CTO	Community Treatment Order
DTOC	Delayed Transfers of Care
ECMO	Extra Corporeal Membrane Oxygenation
ECS	Engaging Staffordshire Communities (who were awarded the HWLL contract)
ED	Emergency Department
EHC	Emergency Hormonal Contraception
EIRF	Electronic, Reportable Incident Forum
EMAS	East Midlands Ambulance Service
EPR	Electronic Patient Record
FBC	Full Business Case
FYPC	Families, Young People and Children
GPAU	General Practitioner Assessment Unit
HALO	Hospital Ambulance Liaison Officer
HCSW	Health Care Support Workers
HWLL	Healthwatch Leicester and Leicestershire

IQPR	Integrated Quality and Performance Report
JSNA	Joint Strategic Needs Assessment
NHSE	NHS England
NHSI	NHS Institute for Innovation and Improvement
NQB	National Quality Board
NRT	Nicotine Replacement Therapy
OBC	Outline Business Case
PCEG	Patient, Carer and Experience Group
PCT	Primary Care Trust
PDSA	Plan, Do, Study, Act cycle
PEEP	Personal Emergency Evacuation Plan
PICU	Paediatric Intensive Care Unit
PHOF	Public Health Outcomes Framework
PSAU	Place of Safety Assessment Unit
QNIC	Quality Network for Inpatient CAHMS
RIO	Name of the electronic system used by the Trust
RN	Registered Nurse
RSE	Relationship and Sex Education
SOP	Standard Operating Procedure.
STP	Sustainability Transformation Partnership
TASL	Thames Ambulance Service Ltd
UHL	University Hospitals of Leicester
UEC	Urgent and Emergency Care

PUBLIC SESSION

AGENDA

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1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

Members are asked to declare any interests they may have in the business on the agenda.

3. MINUTES OF PREVIOUS MEETING HELD ON 22ND NOVEMBER 2022 **Appendix A (Pages 1 - 12)**

The minutes of the meeting held on 22nd November 2022 have been circulated and the Committee is asked to confirm them as a correct record.

4. PETITIONS

The Monitoring Officer to report on the receipt of any petitions submitted in accordance with the Council's procedures

5. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer to report on the receipt of any questions, representations, or statements of case in accordance with the Council's procedures.

6. UHL HOSPITAL RECONFIGURATION UPDATE **Appendix B (Pages 13 - 18)**

Members to receive a report providing an update on the reconfiguration proposals for University Hospitals Leicester.

Members will also receive a report providing an overview of the planned move of the elective Dermatology service from Leicester Royal Infirmary (LRI) to the St Peter's Health Centre.

7. CARE QUALITY COMMISSION (CQC) WELL-LED INSPECTION OF UNIVERSITY HOSPITALS LEICESTER (UHL) **Appendix C (Pages 19 - 72)**

Members to receive a report providing details of the recent Care Quality Commission (CQC) Well-Led inspection at University Hospitals Leicester (UHL).

8. TRANSFORMING CARE - LEARNING DISABILITIES AND NEURO-DEVELOPMENTAL NEED UPDATE **Appendix D (Pages 73 - 82)**

Members to receive an update report on the work being done in partnership to improve the outcomes for people with a Learning Disability or Neuro-developmental need.

Members will be asked to note the successes and challenges within LLR and to champion joint focus on people who need support and the importance of supporting all people across LLR.

9. LEICESTER, LEICESTERSHIRE AND RUTLAND INTEGRATED CARE SYSTEMS, ORGANISATIONAL PROGRESS

Members to receive a verbal update on the organisational progress of the Leicester, Leicestershire and Rutland Integrated Care Systems.

10. ACCESS TO PRIMARY CARE REPORT **Appendix E (Pages 83 - 110)**

Members to receive a report updating on the current priorities and opportunities in Primary Medical Care across Leicester, Leicestershire and Rutland as well as a summary on the Primary Care Network (PCN) Enhanced Access services delivered by Primary Care Networks across Leicester, Leicestershire and Rutland.

11. WORK PROGRAMME **Appendix F (Pages 111 - 114)**

Members to receive and note the current work programme and consider any future items for inclusion.

12. ANY OTHER URGENT BUSINESS

13. DATE OF NEXT MEETING

To note that the administration of this joint committee is due to transfer to Leicestershire County Council for the start of the new municipal year 2023/24 and dates of future meetings will be circulated in due course.

Appendix A

Leicester
City Council

MINUTES OF THE MEETING OF THE
LEICESTER, LEICESTERSHIRE AND RUTLAND JOINT HEALTH SCRUTINY COMMITTEE

Held: WEDNESDAY, 16 NOVEMBER 2022 at 12 noon

P R E S E N T :
Councillor Pantling (Chair)
Councillor Morgan (Vice-Chair)
Councillor Ainsley
Councillor Harrison (substitute)
Councillor Khan
Councillor King
Councillor O'Donnell
Councillor Waller
Councillor Westley

In Attendance
Dr Janet Underwood – Healthwatch
Richard Mitchell CEO UHL
Lorraine Hooper Chief Financial Officer UHL
Kay Darby – CCG LLR

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18. APOLOGIES FOR ABSENCE

The Chair welcomed those present and led introductions.

Apologies for absence were received from Councillor Charlesworth; Ruth Lake; Becky Cassidy (UHL) and Julie Hoggs (UHL).

It was noted that Councillor Harrison was present as a substitute for Councillor Charlesworth.

19. DECLARATIONS OF INTEREST

Members were asked to declare any pecuniary or other interests they may have in the business on the agenda.

There were no such declarations.

20. MINUTES OF PREVIOUS MEETING HELD 27TH JUNE 2022

RESOLVED:

That the minutes of the meeting held on 27th June 2022 be confirmed as a correct record.

21. PROGRESS AGAINST ACTIONS OF PREVIOUS MEETINGS - NOT OTHERWISE ON THE AGENDA

The Chair referred to the discussion around dental services at the last meeting noting that a number of key partners had agreed to explore the issues raised, however there was no-one present at this meeting who could provide any further progress update to that.

It was noted that Councillor Hills had recently given a very good interview on the radio and spoke about his experience as a dentist.

There was a brief discussion about ongoing concerns over dentistry services, particularly across Rutland which had seen its main dental practice return its contract (25% NHS provision) and no other dentists taking NHS patients.

The Chair confirmed that following the last meeting a letter had been written to the Secretary of State and a response was awaited.

The Chair also advised that in relation to maternity services a further report outlining current provision and performance of the service had been requested to the City Health & Wellbeing Scrutiny Commission, since this was an important area and needed further assurance.

RESOLVED:

That an update report on Dental Services and provision across the area be brought to a future meeting.

22. CHAIRS ANNOUNCEMENTS

None at this time.

23. PETITIONS

The Monitoring Officer reported that no petitions had been received.

24. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer reported that no questions, representations or statements of case had been received.

25. UHL FINANCIAL ACCOUNTS FOR FINANCIAL YEARS 2019-20 AND 2020-21 REPORT

Members received a report containing details of the University Hospitals Leicester (UHL) Finances and Accounts for the financial years 2019-20 and 2020-21.

Lorraine Hooper, Chief Financial Officer, UHL, informed members that:

- The accounts for 2019-20 were finally adopted and published with a disclaimer opinion on 31st March 2022.
- The audited accounts for 2020-21 were adopted by the Trust Board on 9th September 2022 with an adverse opinion. Due to the Queens passing the Board met in private but did subsequently meet in public on 6th October to ratify that decision.
- In relation to the 2019-20 accounts, external auditor Grant Thornton had provided an updated audit findings report which included the restated balance sheet, this saw the deficit moving from £76.8m to £122.7m following adjustments agreed during the course of the audit.
- Grant Thornton recognised the considerable improvement in account process and culture within the finance team at UHL since their original audit findings report but also recognised some errors still to be addressed and work to do on financial statements to address risks to the Trust's financial sustainability.
- The 2020-21 draft accounts had been produced in line with the National timetable (June 2021) which was a significant step forward.
- The financial position in 2021 improved by £29.8m to £46.2m largely as a result of repatriation of expenditure into the previous financial year as a result of the 2019-20 balance sheet restatement.
- The current financial year (2021-22) accounts were on track and undergoing external audit with KPMG (new external auditor) and it was anticipated those accounts would be adopted in February 2023 by the Trust Board.

In relation to the issues uncovered around the 2019-20 accounts, members were informed that it was clear standards previously fell short of anything that was an acceptable standard, and since those challenges considerable change and improvement had been made across the whole organisation.

Members were advised that the Trust Board had been set up and in place for 14 months, the Board had a wider experience and a committee Chair who ensured challenge was robust. Governance had been revised across the Trust and financial decision making was much tighter and more robust.

The entire finance department had been restructured and a clear skills requirement for each grade had been put in place together with weighting of staff within the structure and a considerable amount of staff training. Mandatory training had been undertaken by budget holders and there was now in place a regular reporting system. All control processes had also been refreshed, reviewed, and rewritten where necessary.

Members noted that as a consequence of the financial challenges the Trust was placed in financial special measures and was now in a recovery support programme so there was additional oversight from NHS England and the Trust

was making good progress to be able to exit that programme.

The Chair invited members to comment which included the following points:

Members remarked that this was clearly a serious historical issue at the hospital and new people had been brought in to rectify the position, however it was queried whether it was internal or external processes that had led to the discovery of the huge financial issues and whether there was now confidence in all processes and procedures in place to avoid the same thing happening.

Members were astounded at the level and depth of financial incompetence and damage to the hospital and concerned as to whether the financial loss impacted on patient care and members sought absolute assurances that robust processes were in place to avoid a similar situation again.

Members stressed the importance of having confidence that UHL was not just delivering good healthcare but that they could handle the millions of pounds handed to them by government to deliver those services. As a consequence of the massive failure regarding public funds it was queried what happened to the people involved and whether any action against individuals was taken?

Members expressed serious concerns that the financial issues of almost 4 years ago were still being resolved and although it was appreciated the Trust were now making strides against the measures put in place there was a need to ensure that this sort of fundamental error could not happen again.

Members were not satisfied that the report provided the level of detail necessary to fully scrutinise what had happened. Members were keen to know more about the new processes in place as well as what the specific weaknesses and errors of accounting were that led to the failings.

Members enquired about the wider implications for the hospital financially, whether it was operating within its means and whether there would be other impacts e.g., upon the reconfiguration programmes.

Responding to the points raised members were informed that:

- In terms of whether internal or external process revealed the discrepancies it was the previous Chief Financial Officer (who came into post in 2020) who unearthed the financial issues and set about a process to put things right, he subsequently retired but the steps put in motion were continued by his successor.
- The current senior management were confident that processes were improving and that there were clear actions in place but recognised there was a need to do more. The process that the Trust had gone through was appropriate and proper oversight was now in place.
- As regards the financial mismanagement, there had been full reflection on how financial decisions were made and assurance was given that all decisions now went through a full and proper procedure which included impact and equality assessments.
- It was asserted that the financial circumstances had not prevented the

hospitals from being able to deliver and the reductions in elective surgery backlog was given as an example.

- In relation to confidence in the current administration, it was noted that the vast majority of the Board and team were new to the organisation over the last 18 months to 2 years and all came with professional skills to deal with the issues identified and were aware of the challenges which they continued to work through.
- In terms of the hospitals living within means, it was stated that this year UHL was delivering within part of its financial plan and working closely with ICB partners to ensure they maintained that over the financial year.
- As far as the recovery support programme, it was anticipated there would be sufficient progress to enable the Trust to exit that in Spring 2023 and it tied in closely to the current audit and 2021-22 financial accounts.

Richard Mitchell, Chief Executive Officer UHL apologised on behalf of the organisation and was regretful that this situation had arisen. Richard acknowledged the concerns raised, noting that the update given today had been shared previously in public, and he was optimistic that with the work they were doing they could evidence more increasingly that the Trust was improving. It was confirmed that the Chief Executive Officer, Trust Chair and Chief Financial Officers at the time of the financial issues occurring were all no-longer working in the NHS. As to whether any actions were taken against individuals Members were referred to the Trusts Annual Report which would provide that information and officers agreed to provide the link to that outside this meeting.

As regards to the reconfiguration programme it was stated that this issue bore no relation to the Trust's ability to access money for that programme and it was already well documented that there had been delays in that programme particularly due to Covid, but it was expected a more accurate update on the reconfiguration programme around quantum of monies UHL Leicester would receive should be available soon.

In relation to patient care, members were informed that like wider NHS partners the Trust were working to financial constraints, but the financial issues uncovered in the accounts had not affected that. Examples of improvements to patient care were given noting that no NHS Trust in the country had reduced their number of patients waiting over 2 years for surgery as UHL had and within the last 6 months UHL had also stepped into community provision with local partners to deliver services as well as opening a much needed minor injuries department.

The Chair invited any supplementary comments which included the following: Members suggested that in the interests of transparency and accountability UHL should take an innovative step of having their accounts open for feedback from the public domain and officers agreed to take that away for consideration.

Regarding the auditors adverse opinion for the 2020-21 accounts, Members were advised this was largely in respect of the UHL property plan and capital

expenditure and focused on how the Trust could verify its assets and show how assets under construction were accounted for, that was up to March 2021 and considerable work had been done since then so the remainder of outstanding matters were about smaller control issues which were all close to being completed.

Members referred to the report again, reiterating its lack of detail and requested that more information about the work still needed and how that was being done be provided along with data such as KPI's in an accessible format. Officers took on board the comments about accessibility and were agreeable to sharing a condensed version of data reports that went to the Trust Board if required. Officers agreed to provide members with an abridged version of the improvements required. Members noted that minutes of the Trust Board meetings were all in the public domain and could be accessed through UHL website.

Returning to the points made in relation to reconfiguration proposals, it was noted that since those proposals were put together and the bid submitted the economic situation and increased inflation had become a significant factor, and it would be a challenge to do what was said would be done. Members therefore requested that if UHL found itself having to make modifications to the original plans that impacted on the geographic community that those be brought to committee for discussion as soon as possible.

Members queried the deficit amount from the restated balance sheet and how that would be "paid back". There followed a brief a discussion around the deficit and how that was made up. The Chief Financial Officer clarified that the deficit would be held as part of the accumulated total carried forward and this would show as part of the cycle from being historically behind with accounts, she went on to explain how during the Covid pandemic the NHS went through a process in which NHS's debt was rebased, and debts were effectively written off. Officers agreed to provide a written summary of how that was worked out in practical terms for Members.

The Chair drew discussion to a close.

AGREED:

1. That UHL officers provide the link to the UHLs Annual Report for Members to access outside this meeting,
2. That in the interests of transparency and accountability UHL should consider having their accounts open for feedback from the public domain and to consider sharing those with this committee for scrutiny feedback,
3. That a written summary about the deficit and how that was to be worked out in practical terms be provided for Members outside this meeting,
4. That any potential modifications to the original UHL reconfiguration plans that impacted on the geographic community should be brought to committee for discussion as soon as they arise,
5. That a further update and full report on the UHL's financial recovery, to include an abridged version of the improvements required and the new

processes in place to address the specific financial weaknesses and errors of accounting identified in the financial years 2019-20 and 2020-21 be provided to a future meeting in 2023.

26. CORPORATE COMPLAINTS PROCEDURE REPORT

Members received a report highlighting the management and oversight processes of formal complaints, in University Hospitals of Leicester NHS Trust (UHL) including current performance and actions being taken to improve.

Richard Mitchell Chief Executive Officer UHL introduced the report and noted that the Trust had undertaken a review of its complaints process over the last 12 months and taken steps to improve the management and oversight of its complaints processes as it was felt the complaint process was not working as it should and had probably deteriorated throughout the Covid pandemic.

Members were informed that during the review it was found that it was difficult for patients and people to informally make complaints and so UHL were looking to open up drop in options at some sites across the city centre for people to come in and raise their concerns without the formality of writing a complaint.

It was also found to be difficult for some people to understand how best to contact the organisation and so the Trust was looking at dedicated phone lines that would be answered by people who understood what was being asked as well as making improvements to the website which was not always easy to navigate.

It was noted that 28% of people living in Leicester City did not speak English as their first language so UHL were aiming to take account of that when responding and looking at ways to ensure responses aligned to the diverse needs of population. UHL were working towards a clearer process for handling and responding to complaint letters in clear succinct language and recognised the importance of listening to views of patients and public. Some progress had been made although there was more to do and UHL were committed to engage with patients and communities.

Members welcomed the initiatives being taken forward to improve the complaint procedure and expressed interest in hearing about complaints that led to compensation and figures of money being paid out.

Members were impressed by the move to have drop in options to enable people to informally raise their concern and understood the motivation to reduce complaints although there was some hesitation that it may lead to an increase in “complaints” as more people were likely to drop in as most people don’t take the time to write complaints or did not have confidence to write a complaint.

It was commented that complaints should be resolved as quickly as possible

and if someone can't get what they expect then their feelings should at least be acknowledged.

Members noted that from an organisational point, complaints were opportunity to learn but it was also important to view them alongside any compliments received.

Richard Mitchell CEO agreed with the points made and commented that a primary reason for making the changes was to also ensure it was easier for those who were waiting months and couldn't make contact to be able to raise their concerns and reduce anxiety about waiting etc as well as making services more accessible.

In terms of learning from complaints raised, this was something that UHL did and information was triangulated into dashboards.

It was clarified that changing the way of working would not change or prevent the most serious concerns from being raised but it would help for those that just needed reassurance or an immediate response about being on a waiting list for example.

Members noted the frustrations with the UHL website and suggested improvements to that could help people access information without the need to raise a complaint.

Councillor O'Donnell left the meeting 1.30pm, meeting remains quorate.

Members noted that signage across UHL sites was a cause for complaint and it had previously been indicated that signage would be addressed to improve flow of people around buildings.

Members expressed some concern that communications for local NHS were still not what they should be, and that patient expectation had moved on in last 5 years, but the NHS hadn't moved at all in the way it communicates and one of the problems for people on waiting lists a long time was that they weren't kept updated leading to frustration.

Members asked about corporate patient safety and whether complaints around that showed any trends, increases or reductions.

It was brought to attention that a lot of patients and family members were scared to make complaints about their care as they felt future care would be adversely affected and assurance was sought that would not happen.

Responding to some of the points made it was stated that UHL were moving "complaints" into a wider conversation about patient experience. In relation to the number of complaints about corporate patient safety and trajectories that information was not to hand, and it was recognised there was a need for UHL to understand any trends or themes and it was agreed that as they established a new way of working it was highly likely the overall number of concerns being

raised would increase. UHL also expected that over time they could see concerns raised going up as confidence in being able to raise it but also more balance when things were working and other ways of bringing issues to attention could see a drop. Assurance was given that people's care would not be affected by them raising concerns and there was absolutely not a 2-tiered system of promoting those who "shouted loudest" up waiting lists over those less likely to raise concerns.

The Chair thanked officers for their comments and indicated that she would like to see a report with more narrative to understand how the complaints procedure works and for an update on how the procedure had moved on, including the whole idea of patient experience, and learning from complaints.

AGREED:

That a full report setting out how the complaints procedure works, how the procedure has moved on, including the patient experience and learning from complaints together with performance trends and dashboard data be provided to a future meeting to enable better understanding.

27. MEMBERS QUESTIONS ON MATTERS NOT COVERED ELSEWHERE ON THE AGENDA

Chair agreed to a change in the running order of the agenda to take members questions on matters not covered elsewhere on the agenda.

A question was raised about the possibility of nurses striking and the impact that might have on services across Leicester, Leicestershire and Rutland and any steps put in place to alleviate potential disruption.

Richard Mitchell, CEO UHL advised that a nursing union had balloted last week, and the outcome was to strike, however the criteria had not been met at University Hospitals Leicester, so in terms of this ballot UHL nurses were not striking.

Members were informed that the UHL Winter Plan included various contingencies and was about ability to maintain services. UHL had a responsibility to support people to choose, and it was noted one other union had gone out to ballot and there was also a Junior Doctor's ballot so if those voted to go out then UHL would be preparing to manage the situation through its contingency plan.

28. AUTUMN WINTER VACCINATION PROGRAMME UPDATE

Members received a report providing an update on the Autumn and Winter Covid-19 and flu vaccination programme across Leicester, Leicestershire and Rutland.

Kay Darby gave a brief summary of the report which included the following points:

- Reminder of the background policy framework and previous decisions.
- The Autumn campaign was greater than in previous campaigns, but the pattern of uptake was considerably lower and that was consistent across Leicester Leicestershire and Rutland.
- Teams had started to see slowdown in uptake figures, with Covid at around 2-3% per week, in response there was a concerted push towards Christmas to get people protected.
- Targeted approaches were also being taken to address inequalities and directing resources to areas of lowest uptake as well as specific initiatives for young people, and specific clinics for people with learning disability.

Members discussed the report which included the following comments:

Concerns expressed about low uptake levels across the City but also in Rutland where text messaging from GP's had caused confusion and there was a need to make people better aware of the options available. In response it was advised that vaccination programmes were not in a steady state so there were still different approaches to communication, and it was accepted there was still some confusion as there was not one consistent way of inviting people in.

Concerns had been raised by residents about family members on autistic spectrum and the need for different environments to get vaccinated noting that for Rutland residents the nearest facility catering for special needs was in Melton, which had costs of travel and time implications e.g. if a person finds it stressful then the length of journey is a time when those stress levels are increasing. Officers agreed to consider that point and look at what was being done for those with special needs.

Regarding accessibility for elderly or vulnerable people that had difficulty travelling it was noted that there was now an offer of transport using council vehicles and the team were engaging and co-ordinating efforts to create hubs and get the resources together to provide, targeted ward hubs for vaccination of these groups.

In terms of the issue about all GP surgeries not providing the Covid vaccination it was reminded the limitations, because the vaccine had to be specifical stored with specific expiry requirements which all GP surgeries could not meet, and it was important to avoid vaccine wastage which was monitored as it is an expensive vaccine to produce. It was noted that although vaccine producers were looking to develop the vaccine to be just one, they were not at that point yet.

As far as the issues of low take up in the city it was advised that was not through lack of trying and a lot work had been undertaken with public health colleagues but despite that some populations were particularly resistant. Other steps being taken to drive uptake included work with street teams, targeted campaigns and specific engagement activity around educating people why it is important.
They were also still holding webinars for people to directly ask questions or talk

through concerns with a GP. National guidance was not to engage with anti-vaxers or engage in conversation about that, so it was a challenge and there was certainly a greater degree of interest in the covid vaccine and people who were not persuaded by the science.

The Chair commented that a lot of well-known people and prominent people in theatre world were actually promoting the idea of how important the vaccination is too.

Members suggested a leaflet/poster in surgeries warning people about misinformation around vaccine might be helpful.

In relation to efficacy of newer vaccines and longevity of immunity it was advised this was well documented and people could be directed to that outside the meeting. It was noted that the Joint Committee on Vaccination and Immunisation (JCVI) used this data to decide who was vaccinated and reference was made to the Green Book Chapter 14 (b) Rationale and Thinking (HM Treasury issued guidance on appraising policies, programmes and projects). As for further campaigns JCVI were considering a spring campaign similar to that held this year but there was no formal announcement yet.

The Chair thanked officers for the report and answers to points raised.

AGREED:

That the contents of the report be noted.

29. WORK PROGRAMME

Members received and noted the updated work programme.

30. ANY OTHER URGENT BUSINESS

None notified.

31. DATE OF NEXT MEETING

To note the next meeting scheduled on Monday 6th February 2022 at 12.30pm.

There being no further business the meeting closed at 2.22 pm.

Appendix B

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPRT TO: **Joint Health Oversight and Scrutiny Committee**
FROM: **Simon Barton; UHL Deputy CEO and Programme SRO**
DATE: **6 February 2023**
SUBJECT: **Reconfiguration Programme Update**

Progress to date

1. Interim Reconfiguration

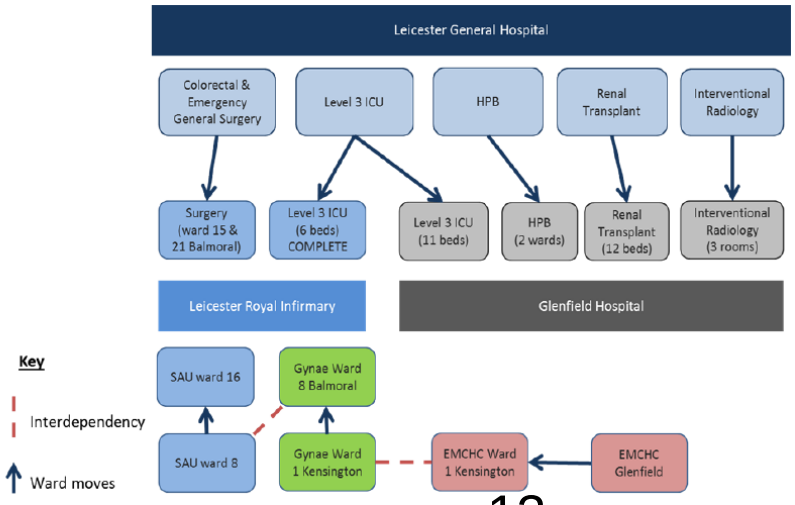
1.1. In August 2022 we completed the interim reconfiguration project which brings Level 3 critical care off the LGH and moves the associated surgical services between the sites. This programme of moves was discussed in detail at the JHOSC in October 2018, when the capital funding was announced by the Department of Health.

1.2. The need to undertake this project as a critical necessity had been socialised with the HOSC since 2015. There had become an increasing risk of clinical sustainability on the intensive care unit at the LGH , as follows:

- Reduced opportunities for critical care staff to gain adequate experience had been affected by a reduction of Level 3 patients at LGH;
- Changes in the structure of medical training had led to the removal of training designation status at the LGH unit and therefore the ability to place trainees at LGH;
- Retirement of experienced consultant staff with recruitment to substantive posts at LGH failing repeatedly as posts became unattractive owing to the loss of training designation and the reduction in patient acuity;
- National shortage of experienced critical care nursing and medical staff compounding recruitment problems.

1.3. In addition to ensuring long term clinical sustainability from a staffing perspective, the project aimed to increase the efficiency and flow through the department, reduce elective cancellations, create a single site surgical take at the LRI and enhance Glenfield as a tertiary site with the addition of the hepatobiliary and transplant service moving there.

1.4. This was a complex set of moves as depicted below:



1.5. Unfortunately the pandemic hit in 2020 just as the moves were due to conclude. This delayed the moves, but the capacity created through the project was productively used to treat Covid patients in the interim, hence the conclusion of this project in Summer 2022.

1.6. Early clinical benefits have been realised, but a full review is underway, following a period of consolidation. These will be compared to the benefits identified in the original case and will be present back to the Regional NHSE team in Spring.

2. Elective Hub

2.1. UHL has one of the largest and longest waiting lists in the country with a stark difference in health outcomes between the most and least deprived areas in one of the most ethnically diverse cities in the UK. In order to mitigate this, we have been supported by NHSE to develop an Elective Hub on the LGH site. This development will offer additional ring-fenced capacity to protect elective care from emergency pressures; and will support the ongoing elective recovery and reduction in long waits. The hub brings with it the flexibility to adapt to the changing needs of the LLR population.

2.2. The project reflects a capital budget of c£41m; with the refurbishment of the Brandon Unit at the LGH, and two additional theatres being built alongside the unit. This will effectively strengthen the long-term use of the LGH. If we receive the capital for the main reconfiguration programme as planned, the LGH will be re-purposed to provide lower acuity health services: the Diabetes Centre of Excellence, Outpatients, Imaging and the Diagnostic Hub. The Elective Hub will sit alongside these latter services to provide a more comprehensive offer to patients in the locality.

2.3. We are being supported by NHSE to progress at pace; owing to the need to reduce our waiting lists. We have received capital to start the theatre development and early works in the Brandon Unit, such as energy and infrastructure, the soft strip and new roof and windows. The outline business case was approved by the ICB Board in January, and has been submitted for approval by the National Joint Investment Committee at the end of January 2023.

2.4. We are now undertaking detailed internal design of the building with a view to submitting the full business case for National approval in April.

2.5. The theatres will be the first phase to open in May 2023. Activity will be limited in the first year since only one theatre will be operational; the second theatre will act as the recovery area; but will treat an additional 1479 patients from the waiting list in the first year (2023/24).

2.6. The full development is due to open in October 2024.

3. Main Reconfiguration Programme

3.1. The UHL Reconfiguration Programme now sits within the delivery of a national programme of hospital developments, called the New Hospital Programme (NHP). This constitutes 48 hospital developments in five cohorts. Cohort 1 are already in construction, and cohort 2 are agile small hospitals that are being expedited. UHL sit in Cohort 3 as one of eight new hospital developments. It is cohort 3 hospitals that are expected to start to deliver a standardised building approach, such as net zero carbon, a digital hospital, optimum space

standards e.g. generic rooms and modern methods of construction. It is anticipated that savings can be achieved through this standardised approach, and construction times improved.

3.2. Work has been slowed down whilst the NHP develop these standards, and identify the additional cost to build the standardised hospital (called Hospital 2.0).

3.3. The NHP developed a Programmatic Business Case, which strengthened the case to Treasury in justifying the strategic, financial and economic rationale of the national hospital building programme and how the programme needed to organise itself and engage with the construction market to ensure delivery. This was first approved by the government's major projects review group (MPRG) in June 2022; but did not contain scheme specific detail on individual funding envelopes for cohort 3 and 4 developments.

3.4. The NHP then developed a further programme business case focusing on the cohort 3 and 4 schemes, the aim of which was to estimate the overall cost of delivering the programme and secure agreement to a programmatic approach to the design and delivery of all schemes to meet Hospital 2.0 standards. The updated programme business case was considered by the MPRG at its meeting on 6 December 2022. We understand that further work is required before the case to progress the programme is finally approved at the MPRG in March 2023; after which it is hoped that Ministers will approve the NHP telling trusts their capital envelope and delivery programme.

3.5. NHP will be sharing the first iteration of the requirements to deliver Hospital 2.0 in January; with 2 further versions later in 2023. Once we receive this, we can start to review how we optimise the Hospital 2.0 standards in our design brief.

3.6. Whilst we await the capital announcement, we are continuing to get ourselves into the best position from which to start design development. Recognising that it is two years since we started, we are:

- Refreshing the activity model, which includes the bed bridge and planned efficiencies and transformation;
- Confirming the operational working assumptions;
- Reviewing the level and depth of transformation in the new buildings, including digital – which has shown there are a lot more work to do in this area;
- Reviewing how we embed research and associated facilities within the new buildings with the University of Leicester and De Montfort University.

4. Enabling Works

4.1. We have submitted a request for fees to complete the outline business case for the enabling scheme in preparation for starting the LRI new build. This scheme relocates the occupants of the Knighton Street Campus, where we will develop our new maternity and ICU building. Planning permission to demolish the building will not be sought until the Outline Planning for the new build is submitted, which will be approximately a year after we receive confirmation of the capital funding.

4.2. We are expecting to hear that funding to progress the enabling scheme will be supported in early February.

5. **Funding Envelope**

5.1. The HOSC will recall that funding to progress with the LLR Reconfiguration Programme was confirmed in September 2019; following which a full public consultation process was undertaken in 2020.

5.2. At the time that funding was announced, £450m would have been sufficient to deliver the whole scheme. Since this time, there have been two pressures which have increased this cost of the scheme:

- The requirement to deliver a standardised scheme (Hospital 2.0) including net zero carbon;
- and inflation which has had a significant impact on the cost of the scheme.

5.3. The NHP are expecting that a programmatic approach to the delivery of new hospitals nationally will give financial benefits to offset some of the increased cost of meeting net zero carbon, a digital hospital etc.; and they have confirmed that the Treasury will manage inflation centrally.

5.4. Whilst we are committed to delivering the full extent of reconfiguration as per the consultation; we recognise that this may need to be reviewed in light of a reduced funding envelope. If this transpires, further engagement will be essential with our stakeholders.

Programme

5.5. This is a complex programme to deliver with a number of interdependent projects on both the LRI and GH. As such, once we are given approval to proceed, it will take eight years to complete, so at this stage we are looking at 2030 before the programme concludes.

Appendix B

Name of meeting:	**Joint Health Overview & Scrutiny Committee**		
Date:	6 February 2023	**Paper:**	
Report title:	Dermatology Service Move		
Presented by:	Rachael Briggs, Associate Director of Operations (UHL)		
Report author:	Rachael Briggs, Associate Director of Operations (UHL)		
Executive Sponsor:	Jon Melbourne, Chief Operating Officer (UHL)		

To approve ☒	**For assurance** ☐	**To receive and note** ☐	**For information** ☐
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Purpose and summary of the report:

Purpose
This paper is to provide the Health Oversight and Scrutiny Committee with an overview of the planned move of the elective Dermatology service from Leicester Royal Infirmary (LRI) to the nearby St Peter's Health Centre.

Context
Reducing ambulance handover delays, and the clinical risk that this presents across the community, is a key priority for UHL. To address the ongoing challenges, one of our key interventions is creating more capacity for emergency care. Moving the elective aspect of the Dermatology service from one of UHL's acute sites to St Peter's Health Centre, a health facility in Leicester City Centre, will enable us to expand our emergency floor capacity.

Summary
The Dermatology service at UHL provides elective (including cancer) and emergency care; with approximately 25,000 appointments per year taking place in an outpatient setting. The intention is to move the elective part of the service from LRI to St Peter's. The move is a temporary transfer of part of the service; and is aligned with the Building Better Hospitals to separate elective and emergency services.

Aspects of the Dermatology service will remain at the LRI; this will be an on-call service provision for all inpatients as well as some outpatient clinics for patients who have accessibility issues or are more complex patients needing to be seen at an acute site.

Colleagues working in the service will be brought together to one main location to provide elective care for patients. The modern facilities at St Peter's will provide an improved service for patients and there is sufficient space for all elements of the elective service to be provided at the centre.

Benefits
- Provides modern facilities to co-locate the elective Dermatology service
- Improve multi-disciplinary team working and access for patients to a multi-disciplinary team in one visit
- The dedicated space provides the flexibility to increase the number of sessions and patients seen
- The modern and well-maintained facilities are a significant improvement in environment for patients and staff
- Releases capacity on the emergency floor at the LRI which will facilitate an improvement in ambulance handover times
- Aligned to clinical and estates strategies to separate acute and elective services

Key Risks & Mitigations
Access
St Peter's Health Centre is located less than 2 miles from its current location at the LRI, and therefore

risks around patients being able to access the facilities are felt to be able to be mitigated.

Colleagues in Estates & Facilities have negotiated both patient and staff parking. St Peter's is located near three public car parks, has some on street parking and sufficient dedicated staff parking. In addition, the site is located near public transport routes that are similar to accessing the LRI. The communications team have developed patient information to support their choices with regards to travelling to St Peter's with specific information on parking and public transport details. In addition, changes to information on electronic-Referral Service have been made to ensure they have information at the point of referral.

Impact assessment
A full equality impact assessment (EIA) has been carried out to ascertain risks that require further mitigation outside of the project planned works. The key aspects which are being focussed on are the patient and public communication and engagement as well as adjustments to service provision for patients who may not be able to access St Peter's. Following the EIA, minor works are being carried out to St Peter's and the maintenance of a small number of clinical sessions at the LRI to accommodate patients who have such as those with restricted mobility.

Communication
A detailed communication plan has been developed which describes a coordinated approach to communicating with both patients and staff. This will include communication through different mediums, including letter, social media, press releases, telephone calls and videos.

The report is helping to deliver the following strategic objective(s) – *please tick all that apply***:**		
1. Health outcomes	Increase the health outcomes of the Leicester, Leicestershire and Rutland population.	☒
2. Health inequalities	Reduce health inequalities across the Leicester, Leicestershire and Rutland population.	☐
3. Reduce variation	Reduce the variation in health outcomes across the Leicester, Leicestershire and Rutland population.	☐
4. Sustainable finance plan	Deliver a sustainable system financial plan, ensuring funding is distributed to where services are delivered.	☒
5. NHS Constitution	Deliver NHS Constitutional requirements.	☒
6. Value for money	Develop and deliver services with providers that are evidenced based and offer value for money.	☒
7. Integration	Deliver integrated health and social care.	☐

Appendix C

Meeting title:	Joint Leicester, Leicestershire and Rutland HOSC
Date of the meeting:	06 February 2023
Title:	UHL Well Led inspection
Report presented by:	Richard Mitchell, Chief Executive
Report written by:	Richard Mitchell, Chief Executive and Becky Cassidy, Director of Corporate and Legal Affairs

Action- this paper is for:	Decision/Approval		Assurance		Update	x

Acronyms
UHL – University Hospitals of Leicester
CQC – Care Quality Commission
KLOE – Key Line of Enquiry
F2SU – Freedom to Speak Up

Purpose of the Report

The purpose of this report is to provide the LLR joint HOSC with an update on the recent CQC Well Led inspection at UHL.

Summary

On 1 and 2 September 2022 UHL welcomed the inspection team from the CQC to conduct a Well Led inspection. The Trust's rating reduced from "good" to "requires improvement" for the well led domain. Overall, the Trust has a CQC rating of "requires improvement".

The report published in November 2022 followed a comprehensive inspection of surgery at Glenfield Hospital between June and September and the well led inspection in September. The outcome of the inspection was shared with the Trust in November 2022 and this was discussed through our public Board in December.

The CQC well led inspection followed its usual approach in assessing the organisation against the 8 KLOEs; Leadership, Vision and Strategy, Culture, Governance, Risk and Performance Management, Information Management, Engagement, and Learning, continuous improvement and innovation.

The UHL Board believes the findings within the report are fair and balanced and fully accepts the report's assessment. The two main reasons for the deterioration relate to UHL remaining in Financial Special Measures since 2020 and the increase in our elective waiting times linked to Covid. UHL remains "good" for caring which recognises the efforts of colleagues who continue to care for people in challenging circumstances. The report also notes the growing strength, diverse skills and experience of the UHL's Board, improved financial governance, increased visibility of the leadership

team and a renewed optimism among colleagues that things are beginning to improve. Despite the challenges, the Board are heartened by the many things that are done well every day and the progress made over the last year.

As a Board we fully recognise that it will take time to make fundamental and long-lasting change but we are committed to making UHL a great organisation to receive care in and a great organisation to work for.

Highlights from the report

The full report is provided in appendix 1. UHL would like to highlight the following items from the report.

- There have been significant changes at Trust Board level which had further extended the skills and abilities, acknowledging the team is still developing. Proactive recruitment into the senior leadership had taken place to support the executive team, however, more work to do to ensure sufficient capacity and capability to deliver against the Trust priorities
- Staff throughout the trust have acknowledged positive change. Feedback recognised the leadership team were "cohesive, visible and transparent" and were "taking staff with them on the improvement journey"
- We were pleased the senior leadership team was more ethnically diverse since the last inspection in 2019, and, there were more female members of the Board since the last inspection in 2019.
- UHL urgent and emergency care pathway required significant improvement, some of this required system support but some was within the abilities of UHL. The Trust had some of the highest backlogs of patients waiting for cancer care and elective procedures. It was acknowledged the work ongoing to establish additional capacity to address these issues.
- The CQC stated the existing strategy did not reflect the current Trust priorities. It was acknowledged the priorities had been refreshed for 22/23 and aligned to national priorities. The Trust's strategy is currently undergoing a refresh and is expected to be finalised by summer 2023
- The Trust had a challenging but realistic financial plan for 2022/23 which set the future financial priorities.
- Having an open and transparent culture, where staff feel safe to speak up about bad practice and poor behaviours is key to the Board. The CQC acknowledged the good work of the FTSU service, but stated it was not sufficiently resourced to appropriately support an organisation with 17,000 staff. The Trust agreed with this and steps to address this were already in place.
- Staff health and well-being was recognised within the report and the ongoing work to support an exhausted workforce and the commitment to expand the support package offer to staff.
- The Trust has been, and continues to be, on a journey to further strengthen governance arrangements. The need for lean governance which avoids duplication is a priority for the Trust. The recently reviewed and refreshed Board Assurance Framework, signed off by the Board in September, aligned with Trust priorities and focused on the main strategic risks to the Trust

- The Audit Committee had been focused mainly on statutory financial issues with more limited oversight of its additional responsibilities. The Trust acknowledged this was the case as the Trust was in the depths of addressing their financial issues, however, we were able to evidence there had been change in the agenda where there was focus on items outside of statutory recommendations and addressed core Audit Committee business. The CQC noted the high number of outstanding internal audit recommendations. The Trust continues to address these recommendations with oversight by the Audit Committee.
- The Trust has been through a challenging period around its finances, and it is important to recognise the CQC stated "*the trust had improved the financial management and financial governance arrangements following previous financial concerns which led to financial special measures*". There is still more to do but showing positive progress is key.
- The number and engagement with patient partners had reduced since Covid and the Trust agreed with this. The Trust is committed to strengthening our work with patient partners and our communities overall.
- The quality improvement methodology was in place but wasn't evident throughout the Trust. Having reviewed the approach and discussed through the Quality Committee in August, the Trust is now revising its plans to roll out and embed our quality improvement journey.

The "should do" actions issued in the report are being addressed alongside the wider CQC actions and are overseen through our internal governance.

University Hospitals of Leicester NHS Trust

Inspection report

Trust HQ, Level 3 Balmoral
Leicester Royal Infirmary
Leicester
LE1 5WW
Tel: 01162588940
www.leicestershospitals.nhs.uk

Date of inspection visit: 28, 29 June 2022 and 1 and 2 September 2022
Date of publication: N/A (DRAFT)

Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

We award the Use of Resources rating based on an assessment carried out by NHS Improvement. Our combined rating for Quality and Use of Resources summarises the performance of the trust taking into account the quality of services as well as the trust's productivity and sustainability. This rating combines our five trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of Resources rating.

Overall summary

What we found

Overall trust

University Hospitals of Leicester NHS Trust was created in April 2000 with the merger of the Leicester General Hospital, Glenfield Hospital and Leicester Royal Infirmary. University Hospitals of Leicester NHS Trust is one of the biggest and busiest NHS trusts in the country, serving the one million residents of Leicester, Leicestershire and Rutland and increasingly specialist services over a much wider area.

The trust has a Children's Hospital and one emergency department on its Leicester Royal Infirmary site and 126 inpatient wards across the trust; 1991 inpatient beds, including 200 day-case beds and 179 children's beds. Each week the trust runs 1224 outpatient clinics.

The trust's nationally and internationally - renowned specialist treatment and services in cardio-respiratory diseases, ECMO, cancer and renal disorders reach a further two to three million patients from the rest of the country.

The trust also provides services from 20 other registered locations including St Mary's Birth Centre.

The trust operates acute hospital services from three main hospital sites:

- Leicester Royal Infirmary
- Leicester General Hospital
- Glenfield Hospital

The trust employs around 17,000 staff and has an income of £1.3bn for the current financial year 2022/23.

Our findings

The trust had set a financial plan to break even in 2022-23. The achievement of this plan was recognised as being a challenge and risks had been identified with system partners committed to develop a collaborative approach to managing any financial risk that emerges throughout the 2022/23 year. There was also a system approach to managing the urgent care pathway.

In April 2022, we conducted an unannounced inspection of urgent emergency care and medical care core services at Leicester Royal Infirmary using our focused methodology as we had concerns about the quality of services in these core services. Following the inspection we served a warning notice to the trust requiring them to make improvements to their urgent and emergency care services, to address safety concerns in respect of staff deployment, flow in, through and out of the emergency department, timely and consistent medical in reach processes, privacy and dignity, clarity in respect of clinical responsibility when patients were referred to speciality services and triage processes.

As part of that inspection, we had an additional focus on the urgent and emergency pathway across Leicester, Leicestershire and Rutland. This was to assess how patients' risks were being managed across health and social care services during increased and extreme capacity pressures.

Between June and September 2022, we conducted a comprehensive inspection of surgery at Glenfield Hospital (28 and 29 June 2022) because we had concerns about the quality of the service provided. These included the number of patients awaiting elective surgery which were breaching 104 weeks. Cancer performance was also a challenge with 31 and 62 day waits continuing on a downward trend, which provided special cause for concern. We also inspected the well-led key question for the trust overall.

We did not inspect any other services at the trust because our monitoring process had not highlighted any concerns. We will re-inspect these services as appropriate.

NHS England System Oversight Framework (SOF) provides the framework for overseeing systems including providers and identifying potential support needs. The framework looks at five national themes: quality of care, access and outcomes, preventing ill health and reducing inequalities, finance and use of resources, people and leadership and capability.

Based on information from these themes, providers are segmented from 1 to 4, where 4 reflects providers receiving the most support, and 1 reflects providers requiring the least support. As of April 2022, the trust's SOF score was 4.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level within the trust. Our findings are in the section headed 'is this organisation well-led'. We inspected the well-led key question on 1 and 2 September 2022. NHS England also conducted a financial governance review at the same time as the well-led inspection. A separate 'Use of Resources' assessment was not conducted for this inspection.

Our rating of well-led went down. We rated them as requires improvement because:

- The trust had not always taken effective action to mitigate some risks to patients which were within their ability to improve, with the impact on patient care not yet fully realised in response.
- The trust's vision and strategy did not accurately reflect current priorities.
- Although action was being taken to improve the culture in the trust not all cultural issues had yet been fully addressed.

Our findings

- Not all staff, including those with protected characteristics under the Equality Act, felt they were treated equitably.
- The trust's current governance arrangements resulted in duplication which meant there was duplication in the flow of information through to the executive boards and board committees.
- The audit committee was focused mainly on statutory financial issues with more limited oversight of the other responsibilities.
- The process to identify, escalate and mitigate all current trust risks was not always robust. There were significant delays from referral to treatment for patients waiting for elective care and treatment.

However:

- Leaders had the skills and abilities to run the trust with relevant experience and capability to deliver sustainable care.
- There were the same number of board members from an ethnically diverse background as at the last inspection. There were more women on the board and the senior management team was more diverse.
- The emphasis on the safety and wellbeing of staff within the trust was improving.
- The trust was improving governance structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services.
- The trust now had clear plans and timeframes to implement the new strategy.
- All staff were committed to continually learning and improving services.
- Leaders encouraged innovation and participation in research.

Use of resources

A use of resources assessment was not completed as part of this assessment.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with 1 legal requirement. This action related to surgical services at Glenfield Hospital.

Trust wide

- No regulatory breaches

Glenfield Hospital

Surgery

Our findings

- The trust must ensure that medical devices are maintained in line with manufacturer's recommendations. Regulation 12 – safe care and treatment.

Action the trust SHOULD take to improve:

Trust wide

- The trust should ensure that their process for identifying current risks are robust. Regulation 17 – good governance.
- The trust should ensure all documents relating to recruitment practices are retained in line with the trust policy. Regulation 17 – good governance.
- The trust should ensure all Disclosure and Barring Service (DBS) checks are up-to-date and stored correctly in staff employment records. Regulation 17 – good governance.
- The trust should consider increasing the capacity of the Freedom To Speak Up Guardians (FTSUG) to sufficiently support all staff at the trust.
- The trust should consider continuing to improve the promotion of equality and diversity within and beyond the organisation.
- The trust should ensure that patients waiting for elective and cancer care and treatment receive this in a timely manner.
- The trust should continue its work to improve the culture throughout the trust.
- The trust should continue the work to further develop effective governance systems and processes.

Glenfield Hospital

Surgery

- The trust should ensure that they continue to increase staffing levels by improving the recruitment and retention of nursing staff. Regulation 18 – good governance.
- The trust should ensure that staff are trained to monitor fridge temperatures and take appropriate action if medicines have been stored outside of their required parameters. Regulation12– safe care and treatment.
- The trust should ensure that full, partly full, and empty oxygen cylinders are segregated. Regulation12– safe care and treatment.
- The trust should consider improving entertainment and communication facilities for patients.

Is this organisation well-led?

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Our findings

The trust had not always taken effective action to mitigate some risks to patients which were within the trust's ability to improve. However, the trust were developing a full understanding of the priorities and issues the trust faced and how to address them. Leaders had the skills and abilities to run the trust. They had the experience and capability to deliver sustainable care. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The trust executive and non executive directors had the skills, knowledge and experience to run the trust. There had been a significant number of trust board changes since 2021 which had further extended the skills and abilities of leaders although they recognised they were still developing as a team. The trust chair joined the trust in April 2021. There had been four changes to the remaining non-executive director (NED) posts with the introduction of three new posts of associate NEDs. The NEDs provided a range of skills and experience and the introduction of the associate NEDs had enabled specific skills such as IT to be broadened further. Several experienced executive directors had also recently joined the trust. The chief executive started in October 2021, the chief operating officer and the chief finance officer in January 2022, the chief nursing officer in May 2022 and the deputy chief executive in June 2022.

There had been proactive recruitment into deputy director roles and the teams supporting the executive leadership team. The trust acknowledged that there was further work to do to ensure there was sufficient capacity at executive level. The aim was to ensure they had the capacity and capability to deliver against the current priorities and confidence the current level of progress could be sustained in the long term. They had successfully recruited experienced leaders into existing vacancies and had created new roles to deliver against their 2022-23 trust priorities.

Staff throughout the trust acknowledged positive changes in response to the new chief executive starting in September 2021 and the leadership changes. Feedback regarding the new leadership team recognised they were a cohesive, visible and transparent leadership team who had brought a sense of optimism to the trust and were taking staff with them on the improvement journey of the trust.

Staff we spoke with during the core service inspection confirmed the leadership team were approachable and visible. The chief executive officer (CEO) regularly visited areas across the site. There were mixed views regarding the visibility of the executive team during the COVID-19 pandemic however it is acknowledged that the majority of the team joined the trust in the last six months.

Leaders showed an empathetic and compassionate leadership style where there was a clear emphasis on supporting the wellbeing of staff. We attended the trust's public and private board on 1 September 2022 as part of the well led inspection. Leadership was demonstrated on a highly complex agenda with care, compassion and humility as well as direction and driving for improvements whilst keeping the trust safe and engaging staff, patients and partners.

The trust had a clear operational structure. This consisted of seven clinical management groups; each included a leadership team of a clinical director, head of nursing and head of operations. The team reported to the chief operating officer.

When considering the trusts whole senior leadership team it was now more ethnically diverse than during our last inspection in 2019.

The trust had prioritised making the trust board and overall leadership team more effective particularly since the current CEO had started at the trust in October 2021.

Our findings

The trust board had the same number of members from a black and minority ethnic group as at the previous inspection of the trust in 2019. There was one (8%) director and two (22%) of non-executive directors, including associates from black and minority ethnic groups.

The trust board now had a higher representation of female members than at the previous trust inspection in 2019. Of all the executive members of the trust board, six were female, six were male and a female Director of Communications and Engagement had joined the trust in October 2022.

Leaders were developing a full understanding of the challenges to quality and sustainability the trust faced. The newly formed trust board and executive team were working together collectively to understand these. However, in some areas the trust had not implemented effective actions to address some of the main challenges they faced. For example, the longstanding pressures to its provision of urgent and emergency care were still a concern. Whilst these improvements required a system wide approach, some parts of these issues were within the trusts ability to improve. The trust also had some of the highest backlogs of patients waiting for cancer care and elective procedures in England. They were working with a range of providers to establish additional capacity to address this. The trust's performance against the cancer standards continued to be a concern, with overall trust performance for two weeks, 31 and 62 days still not improving. In addition, the overall waiting list was continuing to grow. As of 26 September 2022, there were a total of 119 admitted elective patients and 48 non-admitted patients waiting between 100 and 109 weeks for procedures at the trust.

A total of 3861 admitted patients were waiting over 10 weeks for their procedure at the trust (892 patients at Glenfield Hospital, 1862 patients at Leicester General Hospital and 1107 patients at Leicester Royal Infirmary. A total of 119 admitted patients had been waiting between 100 and 109 weeks for their elective procedures (8 patients at Glenfield Hospital, 28 patients at Leicester General Hospital and 82 at Leicester Royal Infirmary.) A total of 27980 non-admitted patients were waiting over 10 weeks for their elective procedures to be conducted at the trust (6398 patients at Glenfield Hospital, 7326 patients at Leicester General Hospital and 14526 patients at Leicester Royal Infirmary). A total of 48 day case patients had been waiting between 100 and 109 weeks for their elective procedures (10 patients at Glenfield Hospital, 21 patients at Leicester General Hospital and 17 patients at Leicester Royal Infirmary).

The trust also acknowledged that it would be a challenge to have no patients waiting more than 78 weeks by the end of March 2023 in line with the national guidance.

The trust had clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership which included leadership development programmes and leadership succession planning. The trust had a board development programme with external support available to enable the effectiveness of the board to develop further. As a new board they recognised the board development sessions were key to their future as a team, in addition to improving the decision- making structure, governance systems and processes and decluttering diaries. The programme showed a clearly set out schedule planned for up to and including December 2022. There was a correlation between what was set out in this schedule with what was fed back as part of the well-led inspection interviews for the development of the new trust strategy and consideration of risk reviews aligned to the development of the new Board Assurance Framework. The trust had also started their succession planning to strengthen their clinical leadership team. They were working with local educational organisations to further develop their leadership development programmes.

The trust had not ensured all records supported the employment of fit and proper directors. We reviewed six personnel files in line with the Fit and Proper Persons Requirement (FPPR): Directors (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014 and found most employment checks had been made. However, one non-executive director did not have a disclosure and barring service (DBS) check on file. This was raised with the trust and

they took action to ensure a valid DBS check was carried out following our inspection. A further issue with the FPPR documentation related to documentation in respect of recruitment processes. We reviewed three files for executive directors and found interview notes were not retained in the staff files. However, interview notes had been retained electronically.

The trust was beginning to focus on priorities for ensuring sustainable, compassionate, inclusive and effective leadership. The chief nurse was the trust executive lead for adult and child mental health, learning disability and autism. They were supported by an experienced and specialised team. As a result, systems and processes were implemented to ensure staff could anticipate adjusted care needs. Through liaison with the local NHS mental health trust, patients living with learning disabilities and autism were made known to the trust and recorded and flagged on the trust's electronic patient records system. This enabled the trust to make reasonable adjustments, such as arranging for carers to accompany/stay with patients overnight. Initiatives to help meet the needs of patients had also been implemented, which included the psychiatric liaison service situated within the trust's emergency department. The specialist teams across mental health, learning disability and autism were also working with colleagues and groups across the Integrated Care System to develop a strategy to improve the care and treatment provided to these patients.

Vision and Strategy

The trust's vision and strategy were due a refresh as they did not accurately reflect current priorities. The current strategy did not evidence the trust was focused on sustainability of services and aligned to local plans within the wider health economy. However, the trust now had clear plans and timeframes to implement the new strategy.

The trust's vision and values and strategy did not reflect trust current priorities. The current trust strategy had been developed in 2018 and its implementation had been significantly impacted by the COVID-19 pandemic. The trust had set out their priorities for 2022/23 which were in line with the national priorities. The trust had started their co-production of a new strategy with patients, the local population, stakeholders, and trust colleagues. The trust aimed for this to be in line with the priorities of the Leicester, Leicestershire and Rutland Integrated Care Board who were also redeveloping their strategy for this time period. The trust aimed to complete this by the end of March 2023.

The trust values and vision to 'become the best' had both been developed around ten years ago. At the time of the last CQC well led inspection in 2019, the trust had a newly launched their three-year quality strategy which was for the period 2019 - 2022. In this time period, the trust had faced several significant challenges such as the COVID-19 pandemic in addition to unprecedented pressures on its urgent and emergency services and cancer and elective services. The trust had clear plans and timeframes to take the strategy forward which was due for completion by 31 March 2023. They had plans to coproduce the strategy with their communities, patients, staff and partners for the next financial year. The trust actions document for 2022-2023 clearly identified what actions were needed to deliver this strategy which included priorities aligned to the Leicester, Leicester and Rutland Integrated Care System such as reducing health inequalities and working with system partners to develop an integrated care system across the health and social care sector.

Not all senior staff within the senior leadership team were aware of the current trust strategy and how it aligned to their divisions. However, leaders felt the chief executive and chair had given the executive team a clearer vision and believed the momentum of changes could be maintained. However, there was little evidence of robust monitoring, reviewing or providing evidence of progress against the strategy.

Due to significant financial issues the trust had been placed in financial special measures in July 2020. This had now been replaced by the Recovery Support Programme as a result of a single oversight finance score of 4.

Our findings

The trust had submitted a challenging but realistic financial plan for 2022-23 to set the future financial priorities. The trust's financial forecast was balanced in terms of challenge and support to management in improving patient care.

The executive team understood the importance of addressing challenges in the health and social care system and were working together with the integrated care system (ICS) to ensure all priorities were met. Senior leaders were aware of the benefits of working as part of the system to drive forward future improvements for patients particularly as the trust was the main acute provider for the Leicester, Leicester and Rutland Integrated Care System.

The clinical strategy was being aligned and planned to meet the needs of the relevant population. The trust was part of the East Midlands Provider Network, which had helped to promote partnership working and had strengthened haematology and ear, nose and throat services regionally. The trust was collaborating with a local NHS trust to strengthen and deliver paediatric and rheumatology services. This approach enabled the two trusts to secure funding through specialist commissioning, which had previously been unavailable. The trust had also worked with six other local NHS providers to standardise cardiac surgery pathways to ensure consistency for patients. As part of this work, the trust was also coordinating with other providers to introduce an aortic dissection rota to enable availability of treatment at all six trusts. The trust was heavily involved in a system flow group to look at urgent and emergency care and discharge across the health care system. The group was chaired by the trust's chief executive officer. The group was being used to look at how risk could be shared across the treatment pathways.

Culture

The equality, diversity and inclusion agenda was in its infancy and there was limited strategic direction to comply with legislation and meet the equality standards. Not all staff, including those with protected characteristics under the Equality Act, felt they were treated equitably. Although action was being taken to improve the culture in the trust not all cultural issues had yet been fully addressed. However, the majority of staff felt respected, supported and valued and were focused on the needs of patients receiving care. Staff felt able to raise concerns without fear of retribution

Timely and appropriate action was not always taken to address behaviour and performance that was inconsistent with the trust's vision and values. Some of the management of behaviour and performance had become protracted which had led it to lose some of its effectiveness. The trust was aware that their current policies and practices were not always effective in achieving timely or constructive outcomes. In response, they were implementing an agreed approach based on a 'Just and Restorative culture' which would be supported by appropriate training to improve outcomes. The trust was also working closely with Staff Side colleagues and learning from other partners to address this.

The capacity of the Freedom To Speak Up Guardians (FTSUG) was insufficient to support around 17,000 trust staff, especially as they did not have FTSUG champions to support them. There was only one whole time equivalent Freedom To Speak Up Guardian (FTSUG) for the whole trust which was a job share between two staff members. However, staff had informed us during our core service inspections that they felt able to raise concerns. In addition, staff responses regarding staff not experiencing harassment, bullying or abuse from managers and bullying or abuse from other colleagues were both better than the national average in the latest staff survey. The number of contacts made to the FTSUGs during 2021/22 was relatively low considering the size of the trust at 231. Most contacts to the FTSUGs (170) came directly through the FTSUG route. Whilst there were several ways staff could raise concerns to the FTSUGs, the executive team had already started improvements to ensure Freedom To Speak Up resources were available and used by all groups of staff. The trust had plans to increase the numbers of guardians and champions as part of their planned

restructuring of the trust governance structures and committees. They had recently agreed an interim 12-month plan to support the changes in the FTSUG provision which was due to be discussed at their People Committee in October 2022 before reporting to the trust board. The trust had also gained support from another NHS trust to learn how to further improve their Freedom To Speak Up service.

Leaders had acted on previous concerns that staff within the trust's finance team had felt unable to raise concerns regarding financial governance due to fear of retribution. Significant efforts, including changes in the leadership of the finance team had been made to ensure finance staff now felt comfortable to raise concerns with their leaders.

The trust's equality, diversity and inclusion (EDI) agenda was still in its infancy. The executive team were working to improve the promotion of equality and diversity within and beyond the organisation. The trust had recently appointed a new head for equality, diversity and inclusion to support this promotion who started in May 2022. They were co-ordinating with the current staff networks to develop them further and to strengthen their voice within the trust. However, the governance structures supporting the staff networks was inconsistent which meant escalation of information was variable. The trust had an equality advisory group to help inform decisions about services. It was recognised the membership was not representative of the community members and so work was being carried out to review the make-up of the group, its terms of reference and its direction.

Not all staff, including those with protected characteristics under the Equality Act, felt they were treated equitably. Since being appointed, the head for equality, diversity and inclusion had conducted a gap analysis to assess whether the trust was meeting the requirements under the Equality Act. Gaps had been identified from this process and as a result the trust had engaged with staff to understand their experiences. Action plans were also implemented to address compliance. This process was in its early stages and so further work was required to achieve all the trust's targets. This work had the support of the entire board and included a review of recruitment practices, the trust's sickness absence policy and promotion opportunities. It was acknowledged by members of the executive team there were barriers to creating opportunities for staff from different ethnic backgrounds to lead and for promotion, but they were dedicated to removing them. In some areas of the trust, action had been taken to address this, but progress was slow. Areas of improvement included the emergency department, which had encouraged shared decision making and given those from different ethnic backgrounds opportunities to lead. This had led to an increase in diversity amongst band 6 nurses. It was hoped learning from the emergency department could be shared to promote improvement across the trust. The trust had initiated a leadership programme specifically for those from different ethnic backgrounds, but applications had been low.

During our well led interviews, leaders were open and compassionate. They were passionate about supporting staff wellbeing and the need to be inclusive and compassionate leaders. Staff stated there had been positive changes in culture particularly over the last few months. They felt when the executive team promised to deliver changes to improve staff wellbeing they ensured they were successfully implemented. For example, staff were concerned about the cost of living and a food bank had been set up and food in the canteen was subsidised. In addition, staff had been raising concerns about their safety whilst walking alone to the car park in the evening and during the night and the trust now provided escorts. There had been an improvement in the trust's finance and human resources team responsiveness in both quality and timeliness to pay queries. Staff felt the previous trust sickness policy was excessively harsh and the revised draft policy was much more compassionate. Overall, staff were positive about the changes in the culture across the trust however, some staff were not yet sure it had had changed sufficiently at all levels to yet be truly focused on resolution. It was noted that the joint consultative and negotiation committee was not yet running. Some staff were also anxious about whether these cultural changes would be sustained.

Our findings

The executive team demonstrated their emphasis on the safety and wellbeing of staff within the trust was improving. They were concerned about and recognised that their workforce was exhausted following the COVID-19 pandemic and the current work required for them to re-establish services to pre-pandemic levels. This was reflected in the latest national NHS survey in 2021 for the trust as 'the organisation takes positive action on health and well-being' was included in their most improved survey scores. The leadership team ensured continued wellbeing support packages were available to staff. Actions had been taken to improve medically led occupational health services and counselling for staff. Workshops had also been undertaken to improve education for staff on invisible disabilities. Attempts had been made to deliver initiatives in line with the national people plan and workstreams had been developed, but further work was required to ensure the fundamentals were right. Positive steps had been taken to understand and address support for in work poverty.

The executive team were driving to nurture a culture which centred on the needs and experience of people who use services. However, the trust was at an early stage in developing a strategy to deliver it. The trust had appointed a director of health equality and inclusion to lead on developing and delivering a strategy to address health inequalities.

This addition to the leadership team had the potential to positively impact the trust's culture but work was still in its infancy and there was not yet an infrastructure below director level to support them in the delivery of this work. Positive initiatives to address health inequalities had been implemented and positive outcomes had been achieved. However, the initiatives were not part of a quality improvement programme and the lack of formal processes for supporting, funding and delivering the initiatives meant progress and success could not be guaranteed.

The trust results for the most recent national staff survey conducted in Autumn 2021 were mixed. This was 18 months into the COVID-19 pandemic and the NHS nationally saw declining scores in many of the domains. The trust's response rate had improved from 33% in 2020 to 45% in 2021 and was comparable with the national average. The organisation had a higher than average percentage of respondents from people from a black and minority ethnic group. The scores that had declined the most were: having enough staff to do my job properly; recommending the organisation as a place to work; happy with the standard of care provided if a friend/relative needed treatment satisfied with recognition for good work. These had also declined nationally but the trust was below the national average for all of these. Most improved scores were that the organisation takes positive action on health and well-being; last experience of physical violence reported; not experienced harassment and feeling secure raising concerns about unsafe clinical practice, however these remained slightly worse than the national average. Although there was disparity between white respondents and people from a black and minority ethnic group for all but one of the workforce race equality standards at the trust, the percentages were better than the national average. The results for the disability equality standards were more mixed with half better and half worse than the national standards.

Governance

The trust's current governance arrangements resulted in duplication which meant there was replication of information through to the executive boards and board committees. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The trust was working to improve governance across the whole trust including reconfiguring processes within the governance framework to ensure reporting provided assurance and meetings ran in a way which meant all agenda items had equal focus.

Our findings

The trust's current governance structure resulted in duplication which meant information was repeated at various meeting in flow through the executive boards and board committees. Work had begun to address this as the director of corporate and legal affairs was taking a paper through to the audit committee to discuss the plans to conduct a review of the trust's existing governance arrangements, to ensure it enables efficient and robust decision making, openness and transparency.

In addition, they were also reviewing the terms of reference and supporting work plans for the board committees and redefining the purpose of the executive board and the work plan to support this. There has been some improvement already by establishing agenda setting meetings with committee chairs and executive leads. These helped to ensure more scrutiny over agenda items and their purpose.

The board assurance framework had recently been revised. The need to revisit this was recognised with the development of the new trust strategy.

The audit committee was focused mainly on statutory financial issues with more limited oversight of the other responsibilities. There was no current work plan made available from the monthly audit committee meetings despite them being established for some time. We were therefore not assured the current board assurance framework (BAF) was representative of the main risks faced by the trust. The BAF did not support leaders to shape the trust's future work plan and the wider issues it needs to secure independent assurance for. The trust had revised its board assurance framework, which was approved at their September 2022 public board meeting, which focused on the main strategic risks to the organisation.

The trust had an unusually high number of outstanding audit recommendations at around 80 in September 2022 from previous audits and years. Approximately half related to audit findings of a financial nature and 10% related to high priority recommendations. Staff from the finance team reported concerns relating to the payroll and purchase to pay systems (accounts payable). These ranged from reliance on manual systems and workarounds to concerns about the way the systems operated. This also correlated with internal audit findings in these areas. The trust had improved the financial management and financial governance arrangements following previous financial concerns which had led them to be put into financial special measures in 2020. Significantly restructuring and investment had taken place for the trust's finance function. However, leaders recognised further improvements were required to ensure current financial issues improved and previous financial issues would not reoccur.

The combination of audit findings, outstanding audit follow up and staff concerns about financial systems, indicated that key components including accounts payable and payroll of the trust's financial systems require further improvement and likely investment in order to remove any control weaknesses and improve workflow.

Observation of trust board meetings and review of minutes of the quality committee demonstrated there was of challenge from all NEDs and ANEDs including on carer, patient and staff experience as well as performance. Equally there was respectful challenge from the CEO and between the executives.

Management of risk, issues and performance

Processes to identify, escalate and mitigate all current trust risks was not always robust. Patients with cancer and patients waiting for elective and non-elective procedures were not always treated in a timely way. The impact of this for patients had not yet been realised. The trust had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Our findings

The trust had full awareness of the risks relating to their backlog in both elective and non – elective procedures. By the end of July 2022, the trust had cleared their 104 -week waiters except those choosing to wait and some of those awaiting complex procedures.

However, the numbers of patients still waiting for elective, non-elective and cancer procedures was increasing and still remained high. As of 26 September 2022, there were a total of 119 admitted elective patients and 48 non-admitted patients including cancer patients waiting between 100 and 109 weeks for procedures at the trust. For these patients, clinical risk assessments were being undertaken to review potential harm and prioritise treatment. It had been identified that action needed to be taken to create long term capacity to reduce the risk of future issues with elective waiting times. As a result, the trust had started the process for building an elective hub which would be used to perform general and musculoskeletal surgery. When completed, this would create two additional theatres and an outpatient theatre. The modular theatres were in development and should be read by the end of the 2022/2023 financial year. The project was anticipated to be complete in two years. The trust had projected 3,000 patients to be treated in the first year of implementation. The plans for the project had been developed with the clinical management groups.

Cancer patients were not always treated in a timely way in line with waiting time standards. The trust had one of the worst backlogs for treating patients with cancer in England. The trust had seen an increase in the numbers of referrals and conversion rates. They were working with other providers in an attempt to reduce the number of patients waiting for treatment. However, the impact of these risks and whether these actions would improve referral to treatment rates for patients was yet to be seen.

The trust also took part in an East Midlands Cancer summit to discuss the safety and harm risks around these patients and to try and find ways to reduce it.

The trust had a risk register which was regularly reviewed but risks were inconsistently scored. Following the trust's implementation of the risk committee, issues had been identified with risk scoring consistency, risk target setting and evidence gaps in respect of mitigating actions. For example, for some risks on the risk register, the actual and target score were the same. The focus of the next round of risk committee meetings was to address the identified issues. The trust recognised the risk register needed further reviewing to ensure this was addressed. The aim of the trust's risk committee was to review high level risks and understand the trust's controls and mitigations. This was to ensure there was sufficient focus on improving the trust's overall oversight and management of risks.

The trust had a backlog of actions following internal audits. This meant risks may not be mitigated in a timely way. The trust had begun to change the approach to responding to internal audit recommendations by ensuring the audit committee was fully sighted and held the executive team to account for responding and implementing the actions. The trust acknowledged that much improvement was still required with this process however, they we confident they will improve over the coming year and track evidence that their internal control has improved from their head of internal audit.

There were comprehensive assurance systems and performance issues were escalated appropriately through clear structures and processes, but it was acknowledged improvements could be made. Each of the seven clinical management groups (CMG) produced a monthly performance report which was reviewed at each monthly PRM.

The CMG leadership team, which was the clinical director, head of nursing and head of operations attended the PRMs, were chaired by the chief operating officer and were attended by the executive team. At the PRM, the CMG leadership teams were held to account for their performance but were also supported in developing and implementing plans to make improvements. The PRMs concentrated on the areas of highest risk and empowered CMGs to raise issues and take

ownership of their performance. When actions were identified, owners were allocated and they would be accountable for their progress. It also provided a forum to share performance across the trust, as the performance of some CMGs impacted on others. It was acknowledged that the trust was not where they needed to be in respect of reviewing and improving productivity. The PRM process was welcomed in all CMGs but the shift towards CMG ownership and decision had led to some discomfort. We were assured that when this had been identified, support had been put in place.

There were processes to manage current and future performance. For example, the trust used a live dashboard for monitoring performance with the emergency department and for reviewing flow across each site.

The clinical speciality risk registers were regularly updated and escalated up through the relevant committees in line with the trust's policy. Risks within CMG, which were scored 15 or above, were escalated to the risk committee for further review. Any new or emerging risks were escalated to the risk committee for approval.

There was an alignment between the recorded risks and what staff said was 'on their worry list'. Executives were able to articulate the highest risks related to their portfolios and their descriptions and mitigations matched those on the risk register. There was an acknowledgement that some risks have remained high for a prolonged period and would remain so for the foreseeable future. For example, workforce was scored as a high risk within multiple specialities in each CMG, and across the trust in general, and would remain so but was being mitigated within each specialty with varying degrees of success. To gain assurance CMGs were safe, intelligence reports were produced from multiple data sources. This process was used to identify where the worry areas across the trust were. Following production of the reports, mock inspections within CMGs were carried out to understand the reasons why services might not be performing as well as expected. This process was used to review compliance with regulation and accreditations. Outcomes were reported through the executive quality board.

There was a centralised process to maintain oversight of incidents which were graded moderate or above. This served as a quality assurance process as each serious incident (SI) was reviewed by the patient safety team. This provided challenge and support to clinical management groups (CMG) to produce reports of sufficient quality. The patient safety team also provided each CMG with a report outlining the number of SIs they had outstanding.

We reviewed four serious incidents and found these to be investigated and managed in line with the trust's procedures.

Processes for identifying, disseminating and embedding learning and actions from serious incidents across the trust were improving. The trust had implemented an adverse event committee which reviewed open and closed serious incidents. Leads for each serious incident investigation presented their reports at the committee to share the lessons learnt and the actions identified. The committee maintained an action tracker which was reviewed to identify any overdue actions. This was then fed into clinical management group board reports and escalated to the executive board, dependent upon severity. The overdue actions were also reported through the performance review meetings on a monthly basis to ensure there was consistent and frequent oversight.

Information Management

The trust was improving arrangements to ensure that the information used to monitor, manage and report on quality and performance was accurate, valid, reliable, timely and relevant. The information systems were integrated and secure.

Our findings

The trust was in the process of developing and rolling out an electronic patient record system across the organisation. The aim of this was to ensure that all clinical patient information is stored together and made easily accessible to staff across all care settings. In addition, the trust aimed to promote good practice and reduce their reliance on paper records whilst also enabling patients to receive appropriate care and treatment. This is due to be rolled out across the trust by the end of 2023/24 and features integration with the local shared care record in collaboration with system partners.

Processes had been implemented to include relevant data within monthly performance review reports and clinical management group (CMG) board reports, including service performance, complaints and incidents. When there were gaps in this information or actions needed to be taken, clinical management groups were contacted to improve compliance. The performance review reports were produced by the operations team to minimise the amount of administrative time for CMGs.

The trust was beginning to collect and review productivity data within clinical management groups and across the trust to assess whether actions being taken were having the desired improvements. The trust had started to assess the impact on productivity when investment in workforce or changes to how services were delivered were made. This was being done within oncology and cardiology services.

The trust had robust arrangements for cyber security controls in place. The trust had recently experienced a cyber attack on a key system supplier. They had demonstrated appropriate action had been taken to ensure other hospital systems were not compromised and to mitigate against the risk of further impact. This was a combined approach between the trust's IT team and the service provider for technology services at the trust.

Engagement

Leaders had improved engagement with patients, staff, equality groups, the public and local organisations to plan and manage services but recognised there was more work to do. They collaborated with partner organisations to help improve services for patients.

The trust was proactively engaging with staff to drive the future strategies and vision for the trust.

The trust used patient partners to inform their work to give the patient view however, this had reduced due to the COVID-19 pandemic.

The profile of the workforce at a more senior level did not reflect the local community. The trust was aware of this. Staff networks were in place however, the trust had recognised they were not consistently run and had identified plans to refresh them.

The trust was proactively building positive and collaborative relationships with external partners to build a shared understanding of the challenges within the system and the needs of the relevant populations. However, work to deliver services to meet those needs was in its early stages. Patient and community engagement leads were working with colleagues across the Leicester, Leicestershire and Rutland Integrated Care System (ICS). A new system wide strategy was being implemented leads across the system met monthly to progress it.

The trust's engagement with the local integrated care system was in its infancy and a clearer focus on working together as a system to improve care for patients through their whole patient pathway was required. However, the executive team recognised the importance of wider partnership working to ensure patients care across the whole of the patient pathway was improved.

Our findings

The trust generally had a good response rate for the NHS Friends and Family Test (FFT) particularly in inpatients, accident and emergency, maternity and outpatient services. In May 2022, 98% would recommend inpatient services, 79% would recommend emergency services, 97% would recommend maternity services and 94% would recommend outpatient services.

People's views and experiences were starting to be gathered and acted on to shape and improve the services and culture. This included people in a range of equality groups. The heads of patient community engagement and patient experience were both working on strategies for both patient experience and public involvement respectively, but they were not going to be signed off until the Director of Communications had taken up their post in October 2022. Work was in progress and therefore, the strategy was not finalised and any processes, for gathering views and experiences of service users, were not yet embedded.

People who used services, those close to them and their representatives were being actively engaged and involved in decision making to shape services and culture. The head of community engagement held nine listening events over the past 12 months with carers, and with organisations that supported carers. The head of community engagement was working with the head patient experience to look at the themes within the feedback to produce an action plan to improve engagement and its effectiveness. This was going to be used to collaborate with carers to co-produce actions which were aligned with system partners. It was envisaged the action plan will be shared in October/November 2022.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research. However, the quality improvement methodology within the trust was not clear as it was not evident if this was consistently used throughout the organization.

Leaders expressed learning, continuous improvement and innovation whilst encouraged was only evident in some areas. There were several quality improvement specialists available to go into clinical areas and work with the teams to drive improvement. Project examples included work in the cardiac catheter laboratory and reducing length of stay in gynaecology. However, quality improvement was not embedded through the trust. The processes for identifying, supporting and funding new ideas and improvements was inconsistent and informal with little governance to support their success.

The approach to quality improvement was discussed at the quality committee in August 2022 and plans were being revised to roll out and embed quality improvement with consideration of engaging with an external partner to support and accelerate this.

The trust had a strong focus on research with an average of 12,000 people taking part in research every year and 500 members of the public have joined the trusts research register to hear about opportunities to take part in research.

The trust's website displayed information for patients and those close to them to access support for them to make a complaint regarding services at the trust in line with the trust's complaint's policy.

Between August 2021 and August 2022, the trust investigated and responded to complaints in accordance with the trust's complaint policy. During this time period, 93% of formal complaints were acknowledged within 3 working days. However, the trust's responses to formal complaints was not always timely enough and in line with the trust's complaints policy. During this period the performance for meeting formal complaint deadlines for 10 working days was 49%, 44% for 25 working days and 38% for 45 working days.

Our findings

The trust did not have a patient advice and liaison service instead it has a patient information and liaison service which filtered and managed all enquires, information requests and complaints and concerns. The demands on this service were therefore quite high and this was under review.

We reviewed complaints files and found some of the responses to be quite clinical and transactional in tone rather than empathetic.

The review of complaint responses did show the trust were discharging their responsibilities appropriately under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Duty of candour. This regulation requires registered providers and registered managers (known as 'registered persons') to act in an open and transparent way with people receiving care or treatment from them.

From August 2021 to August 2022, the trust had received a total of 327 compliments across all services and hospital sites. The trust reviewed compliments for themes and for which services the compliments were received. From the data received the following top three themes of the compliments included: compassionate care and kindness, staff thanked for listening to patients and staff going above and beyond to care for patients. The top three specialities that had received compliments in this data period were the emergency department, critical care and maternity.

The trust had a mortality review committee, chaired by the medical director which met monthly and reported quarterly to the board. The trust's latest Summary Hospital Level Mortality Indicator (SHMI) for 2021/22 was 104 and the *Hospital Standardised Mortality Ratio (*HSMR) was 97.9 and both within the expected range. The crude mortality for 2022/23 to date was similar to pre COVID pandemic rates (1.2%).

The mortality review process was in line with what would be expected. Appropriate deaths were being reviewed although there were some delays, this being addressed and improving. There was good working processes which involved the medical examiners and colleagues undertaking structured judgement reviews. The mortality lead had good oversight of the data and information which was being recorded and this was appropriately being reviewed and analysed. Information was used for improvement and earning lessons and shared across the trust.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ➔➔ Nov 2022	Good ➔➔ Nov 2022	Good ➔➔ Nov 2022	Requires Improvement ↓ Nov 2022	Requires Improvement ↓ Nov 2022	Requires Improvement ↓ Nov 2022

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute locations	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Overall trust	Requires Improvement ➔➔ Nov 2022	Good ➔➔ Nov 2022	Good ➔➔ Nov 2022	Requires Improvement ↓ Nov 2022	Requires Improvement ↓ Nov 2022	Requires Improvement ↓ Nov 2022

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
St Mary's Birth Centre	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
Leicester Royal Infirmary	Requires improvement Jul 2022	Good Jul 2022	Good Jul 2022	Requires improvement Jul 2022	Requires improvement Jul 2022	Requires improvement Jul 2022
Glenfield Hospital	Requires Improvement ➔➔ Nov 2022	Requires Improvement ➔➔ Nov 2022	Good ➔➔ Nov 2022	Requires Improvement ↓ Nov 2022	Requires Improvement ➔➔ Nov 2022	Requires Improvement ➔➔ Nov 2022
Leicester General Hospital	Requires improvement Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020	Requires improvement Feb 2020	Requires improvement Feb 2020
Overall trust	Requires Improvement ➔➔ Nov 2022	Good ➔➔ Nov 2022	Good ➔➔ Nov 2022	Requires Improvement ↓ Nov 2022	Requires Improvement ↓ Nov 2022	Requires Improvement ↓ Nov 2022

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for St Mary's Birth Centre

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018

Rating for Leicester Royal Infirmary

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement Jul 2022	Good Jul 2022	Good Jul 2022	Requires improvement Jul 2022	Requires improvement Jul 2022	Requires improvement Jul 2022

Rating for Glenfield Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires Improvement ➔➔ Nov 2022	Good ➔➔ Nov 2022	Good ➔➔ Nov 2022	Requires Improvement ↓ Nov 2022	Good ➔➔ Nov 2022	Requires Improvement ↓ Nov 2022
Overall	Requires Improvement ➔➔ Nov 2022	Requires Improvement ➔➔ Nov 2022	Good ➔➔ Nov 2022	Requires Improvement ↓ Nov 2022	Requires Improvement ➔➔ Nov 2022	Requires Improvement ➔➔ Nov 2022

Rating for Leicester General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020	Requires improvement Feb 2020	Requires improvement Feb 2020

Glenfield Hospital

Groby Road
Leicester
LE3 9QP
Tel: 03003031573
www.uhl-tr.nhs.uk

Description of this hospital

Our rating of this surgical service went down. We rated it as requires improvement because:

- Many wards did not have enough nursing staff to be able to spend time with their patients and met their individual needs. There was a high reliance on bank and agency nurses.
- There were numerous examples of medical devices that were past their next service date and staff were not checking this themselves before use.
- People could not always access the service when they needed it and sometimes had to wait too long for treatment.
- Staff did not always appropriately monitor room temperatures and take appropriate action if medicines have been stored outside of their required parameters.
- Staff did not always ensure that full, partly full and empty oxygen cylinders are segregated.
- Several patients who spent a long time in hospital complained that there were no entertainment facilities in their rooms.

However:

- The service had enough staff to keep patients safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.

Our findings

- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Surgery

Requires Improvement ● ↓

Is the service safe?

Requires Improvement ● →←

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up-to-date with their mandatory training. Across all subjects and staffing groups training completion figures were high and above the trust target with most at 100% or in excess of 95%.

The information senior staff provided on the wards corresponded to this. On ward 37, the transplant ward, senior staff said they were mostly up-to-date, but Basic Life Support (BLS) training had been difficult to conduct with staff throughout the pandemic. However, this training was now being rolled out as face-to-face meetings had been reinstated across the trust. Only three staff on the ward were now required to complete this training. On the cardiac surgery ward, all the staff we spoke to were fully up-to-date with BLS training.

Not all staff were always given enough protected time to complete their mandatory training. We spoke to a foundation year two doctor who said they were up-to-date with their mandatory training. However, they had to complete it in their own time because wards were so busy, and they could not be released to do the training

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training covered the appropriate subjects including safeguarding, resuscitation, infection prevention and control and moving and handling.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Staff could access support from specialist teams and nursing staff when needed. However, staff feedback about some aspects of this training was mixed.

Managers monitored mandatory training and alerted staff when they needed to update their training. Nursing staff told us managers gave them six weeks warning through the trust's electronic training system that they needed to update a training module and that they were always given support to access the training.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff were knowledgeable about safeguarding and some could give examples of when they had needed to act to safeguard patients.

However, a foundation year two doctor on ward 31 said they had received safeguarding training, but they were not aware of the term Female Genital Mutilation (FGM) and said they had had no training about it. Female genital mutilation/cutting is defined as the partial or the total removal of the female external genitalia for non– medical reasons.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were aware of information on wards to guide them about when and who to contact to make a safeguarding referral and staff knew about this.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Theatre staff demonstrated a good knowledge of safeguarding and had completed the appropriate levels of safeguarding training. They understood how to support patients from abuse in their surgery department.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They usually kept equipment and the premises visibly clean. However, the service did not currently have local audit systems for surgical site infections.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. There were recently refurbished wards which had been designed to the latest national standards and included, for example on the transplant ward, positive pressure side rooms which protected occupants from airborne infection.

The older wards were sometimes short of space and this led to clutter which can make cleaning tasks more difficult.

On ward 31 one patient said bathrooms were “superficially clean” but that there was often urine on toilet seats. Another patient on ward 31 commented on the lack of cleanliness in the toilets and that there was food on the walls of their bed space when they arrived. However, the inspection team did not see evidence of a lack of cleaning.

The service generally performed well for cleanliness. On ward 26, a thoracic surgery ward we were shown how thoracic patients were screened for Methicillin-Resistant Staphylococcus Aureus (MRSA) before admission with the exception of patients arriving at the hospital as emergencies from home or as transfers from another hospital. These patients were placed in side rooms and additional measures were taken until their MRSA status was known. There was good signage which indicated the status of the patients and the precautions to be taken.

Staff used records to identify how well the service prevented infections. During the last two years the requirement to complete the Infection Prevention Annual Programme had been suspended as part of the Emergency Preparedness, Resilience and Response (EPRR) arrangements for the trust and COVID-19 management. A reduced programme was delivered but the auditing of wards and departments was suspended. As part of the restoration and recovery programme for infection prevention MSRA screening was due to be reinstated during quarter two of 2022/23 and the next audit would be conducted in July 2022. The MRSA policy was due to be reviewed and this would consider data from the July 2022 audit.

We also understood that antimicrobial audits had also been suspended for the same reasons and were just about to be resumed at the time of the inspection. However, the trust had continued to monitor for any concerns, and none had been noted that required action.

Surgery

Staff followed infection control principles including the use of Personal Protective Equipment (PPE). Staff were seen to wash hands, use antibacterial gels and PPE. Masks were worn in line with trust policy. Some patients told us that staff always washed their hands and wore PPE.

On the transplant ward where some patients were immunosuppressed there was enhanced Infection Prevention and Control (IPC) including temperature checks, enhanced PPE and entry restrictions. All staff on this ward were face fit tested to ensure patients were as protected as possible form infections.

Theatre areas were noted to be suitably clean and procedures adhered to including those enhanced for COVID-19. However, we noted that some senior staff were wearing jewellery in contravention of the trust's IPC policy. They were wearing scrubs within the theatre suite but were carrying out management tasks and not patient care.

Staff cleaned equipment after each patient contact and labelled equipment with "clean" stickers to show when it was last cleaned.

While staff worked effectively to prevent, identify and treat surgical site infections the trust did not have a current Surgical Site Infection Programme to support reporting to the Surgical Site Infection Surveillance Service other than those mandated for certain surgical procedures which did not form part of the activities carried out at the Glenfield site. Voluntary surveillance had been paused because of COVID- 19 but we understood that a business case to reintroduce a site wide programme had been approved and was being recruited to.

The Board Assurance Framework for Infection Prevention and Control had some recorded gaps in assurance such as reduced capacity to carry out audit, deep cleaning and the ability to ventilate for COVID-19 due to other risks such as fire and security and lack of side rooms. There were no risks that appeared uncontrolled or unmitigated.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment mostly kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, there were significant numbers of medical devices that had gone past their service by date.

All the wards were suitable for their purpose, but some were more crowded than others with limited storage space. On ward 31 a patient told us that they were concerned about tripping over equipment on the ward.

We examined the bathrooms on ward 31. We found damage to a wall in a female bathroom which had been partially mended. We did not see anything of concern in the two male bathrooms.

Three wards, 35, 36 and 37 were newly refurbished and provided a good environment for patients and staff with staff rooms, day rooms, kitchen and changing facilities. Staff told us they were pleased with the improved facilities.

However, aspects of the newbuild that were not yet complete including oxygen storage racks and the provision of patient entertainment including televisions.

On the transplant ward, ward 37 we noted that a fire exit to an adjacent area had been blocked off using a lightweight privacy screen to prevent people using it as a cut through because of infection concerns. The member of staff in charge

of the ward assured us that this had been approved as a temporary measure by the trust's fire officer as part of their fire risk assessment on 6 June 2022. The recommendation from the fire officer was that the ward investigate appropriate door controls so that the screen can be removed. This action was on-going and owned by the ward sister, who was in discussion with the estates department to rectify this.

There was a maintenance backlog across all theatre suites including the one at the Glenfield Hospital site. This posed a risk that if it was not addressed this could result in a failure to meet the required safety standards. It was also of note however that this was also due to increasingly stringent standards since the theatres were built. We also noted that there were plans to develop temporary modular theatres to allow work to take place.

Patients could reach call bells and staff responded quickly when called. Patients on ward 35 said staff responded quickly although there were occasional delays when everyone rang at once. However, on ward 31 patients gave inconsistent feedback about the responsiveness of staff to call bells.

Overall, the design of the environment followed national guidance. However, we noted that ward 31 had multiple entrances and was often used as a thoroughfare between other wards. This was referenced as a security risk on the divisional risk register with plans to introduce door controls. We also saw that the staff room was very small with no windows, tables and sink.

Staff carried out daily safety checks of specialist equipment. We checked resuscitation trolleys on wards 31, 34, 36, 37 and in the theatre suite. Daily checks were completed correctly on all wards except for on ward 34 where for five days in the month the records were not fully completed.

We did a full check of one resuscitation trolley on ward 35 and in theatre and the trolleys were secure with all equipment and supplies present and in date.

The service had suitable facilities to meet the needs of patients' families. On ward 31, where adult patients with learning disabilities were often treated patients were given side rooms so relatives could stay with them to offer support

Staff disposed of clinical waste safely. The service had enough suitable equipment to help them to safely care for patients. Wards had access to specialist mattresses and chairs to reduce the risk of pressure ulcers for those patients who needed them. On ward 26, staff told us that they usually had enough equipment and consumables. However, there was sometimes a problem obtaining chest drains but staff had raised this with senior staff and a solution to allow more people to be able to order these was being put in place to rectify this.

We noted that there was only a single model of infusion device in use on ward 31 and all staff had been signed off as competent to use them However, this ward had a variety of vital signs monitors which had been acquired from other wards when they had closed which may cause confusion to staff using them.

Throughout the wards there were no air outlets present in line with recent guidance in the prevention of inadvertent connection of equipment needing oxygen to air supplies. There was a syringe driver that was in date and labelled as being in a safe modification state in line with recent Medical and Healthcare Products Regulatory Agency (MHRA) alert. This demonstrated that this requirement had been implemented.

During the inspection, we checked samples of medical devices to ensure they had been serviced within the required timescales. We found several examples of where equipment must conform to had not been regularly serviced in line with the trust policy.

On ward 31, there were three out of nine vital signs monitors which beyond their due date for a service. Two were out of date by six months and the other by nine months. Ward 35 had a hoist in a corridor space that was six months beyond its next service date. Staff told us it was out of use but there was no labelling to indicate this and there was a safety risk as staff could still try to use it. On ward 26 there was a transfer chair that was beyond its service date by six months.

Overall, we looked at 24 devices and 5 were out-of-date representing some 20% of the equipment checked. It was also of concern that staff were using out of date devices either without checking or knowing they required maintenance.

On ward 31, we noted that some oxygen cylinders were stored loose adjacent to racked cylinders and one of these was empty. Empty cylinders should not be stored with usable cylinders as they can be selected in error and fail in use.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Records showed that staff had used the early warning scoring system that the trust used to correctly record, calculate and review patients for signs of deterioration as required. The trust supplied data to demonstrate that an audit programme took place to ensure that staff followed the trust's early warning and sepsis scoring protocols.

All patient observations were entered into the trust's Electronic Patient Record (EPR) system and compliance with this was audited. The system automatically screened for patients at risk from sepsis and an alert was sent to the nurse or doctor's mobile device. They then have the authority to deescalate through their clinical judgement or continue on the sepsis pathway. The system then monitored required actions, such as the administration of antibiotics were carried out in a timely way. Patients flagged for sepsis were reported to the nurse in charge and the trust's Deteriorating Adult Response Team.

The above process was regularly audited and data that showed when concerns were noted harm reviews took place.

The emergency and urgent operating theatre provision to fulfil the recommendations of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report was provided according to a standard operating procedure. A system provided access to an emergency theatre through the next available elective slot within 30 minutes. There was provision to make a second theatre available should it be needed. This system was under review as the recent move of services to the Glenfield Hospital site had changed the demand for emergency surgery.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. We looked, in detail at sets of records across four wards and theatres which were a combination of paper and digital records on the trust's EPR system. We noted that they were usually fully completed, accurate and legible. Those assessments that the trust required to be done on admission were always completed.

We observed the World Health Organisation checklist for safe surgery (WHO checklist) being used and noted good practice in that patients were checked in by both the surgeon and anaesthetist. We looked at five records for patients in theatre during our inspection and the WHO checklist was correctly followed and recorded in all cases. The service carried out regular audits of the use of the checklist and for the last three months compliance with the use of the checklist was at 100%.

Staff knew about and dealt with any specific risk issues. A foundation year doctor on ward 31 knew about the sepsis protocols and gave a recent example of when they had followed the appropriate protocol and carried out all steps before their consultant's review.

Patients were risk assessed for venous thromboembolism (VTE) risk on admission and pre-admission and where appropriate suitable prophylaxis was given. The trust audited compliance with this requirement and the most recent overall compliance rate, from March 2022 was 98% with some wards scoring 100% and no ward was below 76% compliance. This excluded those wards that had recently moved.

Patients were risk assessed and reassessed for pressure area concerns using a suitable tool and patient records showed that actions were taken in response.

The service had 24-hour access to mental health liaison teams and specialist mental health support. Records showed a patient with mental health concerns and their notes indicated when and how staff could seek assistance to support them.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. On ward 26, handovers took place at 7am and 7pm with a safety huddle at 11am. We observed a handover and saw that staff identified patients with diabetes, drains, catheters and those at risk of falls. On ward 26 they were trialling new nameboards for patients to flag the need for observations and repositioning, risk of falls, nutritional needs and diabetic status to staff. Handovers were supported using briefing documents to ensure consistent messages across shifts.

Out-of-hours the theatre was staffed from 5:30pm to 3am with an on-call arrangement from 3am to 8am with a specialist registrar designated for each of hepatobiliary, vascular and renal areas. There was a separate on-call team covering cardio thoracic emergencies.

Several staff had expressed concerns about the on-call system, and we noted that a review was underway.

Nurse staffing

The service had staffing vacancies which sometimes compromised the levels of patient care staff could provide to patients. However, the service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not have enough nursing and support staff.

Overall, there was evidence of high nursing staff vacancy rates, high sickness rates and a reliance on agency and bank staffing to keep the service safe. While this presented a risk, we did not identify avoidable harm to patients. However, patients told us that they had to wait for personal care and that call bells were not always answered quickly because of short staffing.

On ward 35 a patient told us that the staff seemed "stretched" and things that were promised did not happen. They said they had to buzz several times before staff came.

Surgery

Theatres were established to Association for Perioperative Practice (AfPP) guidelines. Senior staff told us that nurse staffing vacancies were an issue across all theatres particularly since additional specialities had been brought over to Glenfield Hospital from other hospitals in the trust. Some specialities were affected more than others, for example there were five whole time equivalent vacancies in the thoracic team.

This was having an effect in that lists were reduced, and operations were cancelled due to lack of staff. The service was addressing its significant staffing challenges by using a specialised staffing agency and we were told that this would be in place and resolving the issue by July 2022.

This meant that there was a high reliance on bank and long-term agency staffing in order to provide a safe service while recruitment was being carried out. However, this was not the case in recovery where only bank staff were used.

Other staff and managers told us that staff were frequently moved between wards to maintain safe staffing levels. Staff told us this could be unsettling but that it was not unsafe.

Many people told us that staff had left or were leaving. The reasons they gave were the stress caused by the pandemic but also that some staff had found the move of wards from other sites to Glenfield inconvenient. Conversely some staff said it suited them better.

Theatre staff told us that the lack of staff on wards 35 and 36 resulted in them having to return patients to the ward themselves as staff could not leave the ward. While this was consistent with safe staffing guidance to spread risk across the site it added pressure to the already stretched theatre teams.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The ward manager could adjust staffing levels daily according to the needs of patients.

In theatres staff used a staffing tool to help plan the number of staff required on each shift. There was a staffing board in reception showing who was on duty. On the transplant ward we were told that the tool did not meet their specific needs and was being revised. They also said that they never used agency staff, only bank staff because of the specialist skills needed and the risk of infection.

Managers discussed the varying needs of the different wards at the site bed meeting at 8am and arranged for staff to be redeployed in order to keep the service as safe and effective as possible. They clearly knew the staffing needs of each ward and any shortfalls or extra capacity in ward staffing. This meant they were able to work together to deal with immediate staffing issues such as sickness, emergency admissions and patients who were more acutely unwell than expected. We noted the effectiveness of this process. A “tactical matron” was assigned each day to manage these issues across the site. This ensured there was a single consistent view and freed up other senior nurses for their core duties.

When we attended the ward 31 handover, they discussed that a Registered General Nurse (RGN) had called in sick. We noted that the whole team shared ownership of the risk by discussing whether they would need to request support or could cope.

The number of nurses and healthcare assistants did not always match the planned numbers. During our inspection we noted that on ward 35 the staffing did not meet the planned levels. For all shifts on the 29 and 30 June 2022 the staffing board showed there were two nurses less than the planned number.

Surgery

Shift fill rate data supplied by the trust validated our concerns about the staffing levels on wards 31, 35 and 36. The trust provided a commentary that demonstrated reasons for this which were long term sickness, staff redeployment and staff leaving as a result of the recent site relocation.

On ward 26 staff and managers told us that they were never short of staff but that this was achieved through using agency. Cover for the shifts on the ward confirmed this. There were six high dependency beds in a separate area of the ward, and these were staffed with properly skilled personnel through an agency.

The service had high vacancy and turnover rates

Data supplied by the trust demonstrated high vacancy rates on some wards, primarily the hepatobiliary, transplant wards for which the vacancy rate was 10% and the breast ward for which the rate was 20%. However, the hepatobiliary ward was demonstrating improvement.

The figures also demonstrated significant shortfalls in the theatre establishment with a 20% shortfall in Cardiac and General Surgery and almost 50% in recovery. However, because of the ongoing reconfiguration the figures were not completely accurate, and staff were being deployed across the theatre suite to meet staffing needs in accordance with patient acuity.

In theatres we were told that staff who were working alongside better paid agency staff were leaving to join those agencies and returning as agency staff.

The service had a workforce plan overseen by a project team to address staffing in theatres. This included rolling recruitment, open days and targeted advertising. The plan also considered the staff survey in depth as well as flexible working and professional development to improve staff retention.

Several staff told us that staff had left, often for retirement, because of stresses associated with COVID-19. However, some staff had left as they were not happy frequently moving wards to accommodate staffing pressures.

Some staff told us of travel pressures following the transfer of services to Glenfield Hospital. Conversely other staff found this site it more convenient.

Senior staff told us that there was an expectation that rising community COVID-19 levels would have a further negative impact on staff sickness rates.

The service provided exception reports and a narrative for those wards having sickness over 10% which were wards 31 & 35.

For those wards reporting high levels of sickness these often included staff on long-term sickness. Ward 31 and the transplant ward were particularly affected by this.

The service had high rates of bank and agency nurses.

The trust provided data that demonstrated high use of bank and agency staff on wards 23, 35 and 36. Staff also confirmed this.

Managers requested bank and agency staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service.

In theatres we were shown how all agency staff were given an induction. All staff new to the surgical wards told us they had a supernumerary induction period and bank staff on ward 31 told us they had received an induction. Managers had no problems accessing the trust and clinical induction for new starters.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service had enough medical staff to keep patients safe. The service had a good skill mix of medical staff on each shift and the medical staff matched the planned number. On ward 26 staff told us that there was always a doctor on the ward during the day and that out-of-hours, the junior doctors who were responsible for three wards were "generally responsive" to requests.

Out-of-hours there was a registrar grade medic and consultant anaesthetist on call who resided on site. Consultant surgical cover was available 24 hours a day, seven days a week. Junior medical staff were supported by more senior staff if needed.

On ward 31 we were told that there was sufficient medical support with very good presence on the ward. Foundation year doctors were always available and there were good consultant numbers and consultants conducted pre- and post-operative ward rounds each day.

Nursing staff commented that the computerised system for allocating tasks to junior medical staff worked well.

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work.

The service always had a consultant on-call during evenings and weekends. Cardiothoracic anaesthetic consultants were on site from 8am to 6pm from Monday to Friday while general cover was provided until 8pm. Outside of these times there was a non-resident consultant on call for these specialities.

Consultants were on-site for the cardiac, thoracic, renal transplant and vascular specialities from 8am to 6pm Monday to Friday. They were also present to review patients on weekend mornings from 9am to 12pm, and in the case of cardiac from 5pm to 6pm. Outside of these times there was a non-resident consultant on call for these specialities.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. When patients transferred to a new team, there were no delays in staff accessing their records. Records were stored securely. We reviewed twelve sets of patient records across four wards and theatres which were a combination of paper and digital records on the trust's Electronic Patient Record (EPR) system. We noted that they were fully completed, accurate and legible. Those assessments that the trust required to be done on admission were always completed.

Recommended Summary Plan for Emergency Care and Treatment (RESPECT) and Do not Attempt Cardio Pulmonary Resuscitation DNACPR records were properly recorded for patients who needed them.

Medicines

The service used systems and processes to safely prescribe, administer and medicines. However, some medicines were not always stored correctly.

Staff followed systems and processes to prescribe and administer medicines safely. Patient records showed good documentation of patient's allergies including positive documentation of no known allergies.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff completed medicines records accurately and kept them up-to-date. Staff followed national practice to check patients had the correct medicines when they were admitted. Medicines recorded on both paper and digital systems for the twelve sets of records we looked at were fully completed, accurate and up-to-date.

Staff usually stored and managed all medicines and prescribing documents safely. In theatres, Controlled Drugs (CD) were kept securely and staff checked them twice a day. Similarly, drugs that needed to be kept cool were kept in a locked fridge and were found to be in date. Fridge temperatures were recorded daily, and no concerns were noted by the inspection team.

Temperature records on ward 31 were completed however, we noted that the room temperature on the day of our inspection was 25.7 degrees Celsius which was very slightly above the threshold of 25 degrees. There had been repeated examples of temperatures higher than this over the previous two weeks. We spoke to member of staff who did not know what action to take and another member of staff said they would usually put a fan on to cool the room, but they had been taken away because of COVID-19 precautions. While the use of a fan might even out the temperature in a room it will not cool the room down.

We spoke to the Nurse in Charge who was aware of the correct protocol to contact the pharmacy and took the matter in hand.

The medicines fridge temperatures on ward 31 were accurately completed and within limits.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the trust policy. Staff received feedback from investigation of incidents, both internal and external to the service. On ward 31 we noted a positive incident reporting culture and evidence of learning from incidents through our discussions with staff. We also saw boards and notices in the staff room demonstrating this. On ward 31 we saw recent incidents reviewed and actions shared at handover.

In theatres there was a good awareness of incidents with senior and junior staff able to describe learning following recent events.

Surgery

Examples included late starts for breast surgery being reduced by changing start times and the disruption of late finishes in cardiac surgery being mitigated by the introduction of some long days.

The service had one never event on the wards and theatres that we inspected. Managers shared learning about never events with their staff and across the trust. All senior staff with whom we discussed the matter and most junior staff were aware of the most recent never event and previous never events and the actions being taken to prevent reoccurrence.

Managers shared learning with their staff about never events that happened elsewhere. Nursing and medical staff were aware of a recent never event outside of the inspected activities and told us how it had been discussed and learning disseminated.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff particularly on wards 31 and 35 were very knowledgeable about the duty of candour

There was evidence that changes had been made as a result of feedback. Staff on ward 31 explained and gave examples of additional training implemented following a medication incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers debriefed and supported staff after any serious incident. Across theatres matrons reviewed incidents for trends and took action when necessary to ensure patient safety.

Is the service effective?

Good

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The provider had comprehensive policies, procedures and guidance which were aligned with that of national bodies such as the National Institute for Health and Care Excellence (NICE) and specialist bodies.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Handover meetings showed individual needs of patients were discussed. Our patient records reviews showed that patients' psychological and emotional needs were recorded.

Surgery

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Menus were very varied with a wide choice of meals. They met the specialist nutritional needs of people in hospital as well as cultural and personal dietary preferences well aligned to the local communities. In addition to providing comprehensive nutritional information the menus were very well presented in a restaurant style with appetising descriptions of the food.

Patients on ward 31 told us they were happy with the menu choices and that water was always available.

Patients in recovery in the theatre suite had their nutrition and hydration needs, including mouthcare met.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Housekeeping staff received nutrition training through a dedicated training day and they told us this enabled them to support nursing staff in meeting patient's needs. A patient on ward 31 said they catered for his individual preference for soya milk and another told us that despite being on a low-fat diet they still got plenty of choice. However, a patient on ward 31 said they had seen some patients struggle to eat and that there was not enough staff to support them.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Patients' notes showed that patients who needed their fluid intake and nutrition monitored had this done by staff.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Patients' notes showed that all patients had their nutritional needs assessed on admission and further assessments carried out as necessary. This included their weight.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. There were pain assessment tools for patients who had difficulty communicating. Learning disability support staff used these to assist patients. Patients received pain relief soon after requesting it. On ward 31 a patient told us staff were responsive to their pain relief needs. The service carried out pain audits and the results from this demonstrated that patients were largely satisfied.

Staff prescribed, administered and recorded pain relief accurately. Patient records showed pain relief needs and medication was recorded correctly.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Surgery

The service participated in relevant national clinical audits. Managers and staff used the results to improve patients' outcomes. This included those audit and monitoring programmes relevant to the specialised surgery carried out at the hospital such as those carried out by National Institute for Cardiovascular Outcomes Research (NICOR)

Outcomes for patients were positive, consistent and met expectations, such as national standards. Mortality meetings took place and we were made aware of how recent meetings had discussed a contentious topic of the allocation of cases to either the unit or individual surgeons.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers used information from the audits to improve care and treatment and made sure staff understood information from the audits. The service conducted several audits including the theatre audit bundle, five moments of hand hygiene, health and safety, surgical site infections, uniform standards and the care of drains and cannulae.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff told us they had sufficient training and support to care for patients.

Band seven staff in theatres were monitored to make sure 50% of their duties were clinical to ensure they kept their clinical skills and experience up-to-date.

However, many staff expressed concern that senior and experienced staff were leaving due to "burn out", COVID-19 and to join agencies. This meant that experience across the hospital was reducing.

Managers gave all new staff a full induction tailored to their role before they started work. When we spoke to recently recruited staff they all told us they had received a full induction.

Across theatres recruitment difficulties meant many staff were newly qualified or new to the NHS and they were given a twelve-week supernumerary period supported by practice development nurses and targeted educational support.

Staff felt supported by managers supported staff to develop through yearly, constructive appraisals of their work. Managers identified poor staff performance promptly and supported staff to improve. All staff and managers told us that they received yearly appraisals.

However, the appraisal data we requested from the trust for surgical services at Glenfield Hospital was difficult to interpret. The data was up to May 2022 and demonstrated a range of values from 100% down to 75% although most were around 90%. It was difficult to draw conclusions as, for example while the data showed ward 37 to have the worst rate of 75% our conversations with the ward manager showed that this was out of date and the current figure was around 90% as the service recovered from COVID-19 and accommodated the staff changes as a result of the recent move.

A newly qualified nurse told us that they received additional support and mentoring including more frequent appraisals. Another member of staff who had recently graduated told us they were still in their induction period and getting the support they needed. They said they had no worries and found more experienced staff approachable and supportive.

Surgery

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Notes were taken at meetings and made available to all staff to ensure they kept up-to-date

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Clinical educators supported the learning and development needs of staff. The service promoted good practice in the use of the Specific Theatre And Recovery Training (START) days. This was an initiative to promote training over and above mandatory training and replaced the previous Essential To Role (ETR) training. The programme was a fresh start to ensure staff were up to date following the disruptions of COVID-19 and allowed them to train as a team in a relaxed and enjoyable environment.

Where theatre lists or individual operations were cancelled the theatre was used for enhanced staff training in order to make teams more flexible and able to staff the specialist theatres.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. There were programmes in place across theatres to develop existing nursing and other staff at all levels through development opportunities including apprenticeships and registered associate programmes. Many registered staff to whom we stoke gave examples of how they were in their current job as a result of personal development from other roles. Some staff told us that vacancy rates gave enhanced opportunities for them.

Managers made sure staff received any specialist training for their role. We noted staff who were given specialist “link” roles such as for infection prevention and control (IPC) and transplantation. Staff in both these roles told us they had enough time to fulfil their responsibilities.

However, staff in the theatre suite staff expressed concern that there was not always a fully trained member of staff on duty to operate a “cell saver” device. This is piece of equipment that can recover blood lost by a patient and return it to them. We asked the trust about this and they demonstrated that five members of staff were trained but did not show how these staff were deployed to ensure there was always a staff member able to provide this support.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. The complexity of much of the surgery that took place as well as the patient’s illness meant that multidisciplinary work was embedded into the care provided.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Staff had access to mental health specialists and that there was good consideration of patient’s individual mental health needs and anxieties of patients receiving specialist surgery such as transplantation.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including at weekends. Patients are reviewed by consultants depending on the care pathway. On wards 26 and 31 there were registrar-led ward rounds from 8:30am each day and consultants came around after theatre in the afternoon.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Out-of-hours the theatre was staffed from 5:30pm to 3am with an on-call arrangement from 3am to 8am with a specialist registrar designated for each of hepatobiliary, vascular and renal.

There was a separate on-call team covering cardio thoracic emergencies. Several staff told us they had expressed concerns about the lack of on-site staff between 3am to 8am and we noted that this had been acknowledged by managers and that a review was currently underway.

Diagnostic imaging was readily available and staff said the diagnostic service was responsive to their needs. There was always an on-call pharmacist available.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards. The nature of much of the surgery provided by the unit meant patients needed to change aspects of their lifestyle either to prepare for or to take best advantage of the planned treatment. Patients told us that this was discussed in depth pre-operatively and they were given good support and guidance.

Printed material relevant to healthier living generally as well as specific to surgery was available on the unit.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Where appropriate patients were given pre-operative physiotherapy and exercise programmes to ensure they were fit for surgery and better able to carry out their post-operative rehabilitation.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Overall, staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Overall, staff gained consent from patients for their care and treatment in line with legislation and guidance. Most patients consistently told us that the risks and benefits of surgery were explained well and that they gave their explicit consent for surgery and any emergency procedure that might be needed. We were also told how relatives were invited into the discussions if desired.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Theatre staff demonstrated good knowledge of the Mental Capacity Act (MCA), the Deprivation of Liberty Safeguards (DoLS) and consent. A member of staff told us about their training and they confidently discussed how capacity was affected under the influence of anaesthesia and sedation. Another member of staff gave a recent account of when DoLS had been implemented within the theatre suite.

Patient's notes showed all patients had a record of their capacity and psychological welfare on admission and where an assessment was needed this had been completed.

Surgery

Staff clearly recorded consent in the patients' records. The recording of consent in patient's notes was to a high standard.

Is the service caring?

Good  

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients and treated them in a respectful and considerate way.

Staff interactions with patients was good. Staff maintained unconscious patients' dignity in theatres.

Patient feedback demonstrated high levels of satisfaction for the compassion received from staff and almost all responses were good or very good. There were high scores in the Friends and Family Test survey for patients being treated with dignity and respect and individual comments often made reference to staff being friendly.

Patients said staff treated them well and with kindness. Almost all the eight patients reported that they were treated with kindness. However, one patient on ward 35 told us that the attitude of staff was variable with some needing a better "bedside manner".

Staff followed policy to keep patient care and treatment confidential. Throughout our visit we observed staff being suitably discreet when caring for patients. During the handover on ward 31, patients were allocated to nurses in the handover by the nurses' station then they moved to the day room to discuss individual patients to maintain patient confidentiality.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patient feedback demonstrated high levels of satisfaction for the emotional support received from staff and almost all responses were good or very good. A patient on ward 35 said that they had been "down", but staff had been supportive and helpful.

Staff were encouraged to spend time with patients through the a "compliments" system but again this was compromised in some areas by low staffing levels.

Surgery

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. However, patient feedback regarding the emotional support they had received was mixed. A patient on ward 31 said that their pre-op visit was very helpful. Another patient on that ward said the surgeon was quite matter of fact in explaining their operation and that they would have wished for more emotional support.

There was a relative's room in the theatre reception area which had been setup by a member of staff under their own initiative after they had seen worried relatives did not have a dedicated waiting area and had to wait in the corridor area outside the theatre suite. It was also used as an occasional quiet space for staff.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff consistently made sure patients and their families understood their care and treatment. On ward 31 a patient told us that there was very good communication with their spouse by staff on the ward. The patient notes included information about patients' relatives and evidence of when the hospital had communicated with them on the patient's behalf. Another patient said staff had explained their care and treatment well. Their spouse confirmed they had been involved in the conversations and that this had put their mind at rest.

Transplant coordinators provided specialist support for those patients having transplants and their organ donors.

Visiting times on the surgical wards were later than on other wards across the trust to allow patients who had had surgery to, where possible, receive visitors on the same day.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. The department had a specialist team who supported adult patients with learning disabilities who were undergoing surgery for congenital heart disease

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service had surveys including "Friends and Family Test" and "message to matron" to collate patient, their families and staff feedback.

Patients gave positive feedback about the service. Feedback was generally positive. The latest Friends and Family Test report for the previous three months showed positive comments about support staff provided to families and the transplant ward scored 100% for positive feedback.

Is the service responsive?

Requires Improvement ↓

Our rating of responsive went down. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Surgery

Managers planned and organised services, so they met the needs of the local population. The specialised surgical services provided by the hospital served patients across a wide geographical area. The trust provided remote clinics to patients from further away to reduce the burden of travelling for people whose illness made that difficult. Systems were also being trialled to conduct post discharge reviews remotely to further support patients who had difficulty travelling.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Because the surgical wards knew which patients would be admitted to the wards or coming through from critical care or surgery they were able to plan bed spaces and manage those patients that arrived as emergencies so there had been no mixed sex breaches during the year before our inspection. We noted that there was a mixed sex bay on ward 26 but as a level two area this was permitted.

There was provision on ward 34 for male breast cancer patients and it was well managed and no mixed sex breaches had occurred.

Facilities and premises were usually appropriate for the services being delivered. No wards were unsuitable but there was a notable contrast between those wards that had been recently refurbished and those that had not. They were in the process of reconfiguring and improving the surgical services estate.

Staff could access emergency mental health support 24 hours a day seven days a week for patients with mental health needs and learning disabilities. The service had systems to help care for patients in need of additional support or specialist intervention. There were specialised outreach services to help manage deteriorating patients as well as a specialist team to support cardiac patients with learning disabilities.

Managers monitored and took action to minimise missed appointments. Managers ensured that patients who did not attend appointments were contacted.

The service relieved pressure on other departments. During the “tactical meeting” that we attended during the inspection specialities were aware of patients who might be moved to the surgical wards from the Emergency Department (ED). They took the initiative to admit these patients which improved safety, the patient’s experience and reduced pressure on the ED.

Meeting people’s individual needs

Due to the nursing staffing vacancies, there were sometimes not enough staff for them to be able to spend time with their patients and met their individual needs. Many patients expressed dissatisfaction with a lack of entertainment and communication facilities

However, the service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. However,

Staff often did not have enough time to interact with patients and those close to them which impacted on the care patients received. Almost all patients reported positive experiences of care from staff often giving examples, but on ward 35 staff commented that they did not have enough time and some reported that they felt guilty when patients made specific requests they could not accommodate due to staffing pressures. This was confirmed by some staff who were frustrated by this. However other wards, such as the transplant ward were well staffed and could therefore meet patients individual need more effectively.

Surgery

The provider was working towards better meeting the accessible information standards through a programme of work under the direction of the trust's Equality, Diversity and Inclusion Board.

Staff made sure patients living with mental health problems and learning disabilities received the necessary care to meet all their needs. Staff supported patients living with learning disabilities by using 'This is me' documents and patient passports. Examples of these were used in transplantation and surgery for congenital heart conditions. Staff on the specialist wards were complimentary of the team that supported patients with a learning disability.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The service had information leaflets available in languages spoken by the patients and local community which included Punjabi in addition to leaflets available in an easy read format. We understood other languages were also available relevant to the local population.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. There was provision for face-to-face interpreters and these translators were booked in advance for elective patients. British Sign Language interpreters could also be booked. Staff had access to clear visors and masks with clear panels so patients could lip read while staff still adhered to COVID-19 PPE requirements.

In an emergency staff had access to a telephone translation service and there was a list of staff with fluency in other languages who had agreed to act as translators.

Relatives could translate for day-to-day matters such as meal choices, but professional interpreters were used for all clinical decisions in line with good practice.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Menus were very varied with a wide choice of meals. They met a variety of cultural and personal dietary preferences and were well aligned to meet the needs of local communities.

Staff had access to communication aids to help patients become partners in their care and treatment. The cardiac surgery service worked with the specialist congenital heart disease service that supported both children and adults. Some of the patients of this service were adults with learning disabilities associated with their underlying conditions and staff on ward 31 spoke highly of the cross-site admission coordination service for these patients.

This service provided person centred admission support to people living with learning disabilities. Staff appropriately conducted best interest decision making and mental capacity assessments.

However, all the patients we spoke with on the refurbished wards were disappointed that television sets had not yet been installed and that internet and phone signals were poor. They told us that they were often bored.

On ward 31 a patient said a mobile telephone signal was only available in some areas meaning communication with family and friends was difficult. On ward 31 a patient told us that their television did not work despite them having paid for it. On ward 35 a patient told us, that their television had not been fitted which we confirmed. Another patient on ward 35 patient told us the phone and wi-fi very poor and they could not contact home.

Surgery

Access and flow

Despite the service working innovatively in an attempt to treat as many people as possible, people could not always access the service when they needed it and receive the right care promptly. Patients had to wait long periods of time to receive treatment. Waiting times from referral to treatment were not in line with national performance.

Managers monitored waiting times. However, patients could not always access services when needed and not all patients received treatment within agreed timeframes and current national targets. As of 26 September 2022, the largest group of patients were those waiting for elective cardiology surgery at Glenfield Hospital at 1686 patients.

With 13 admitted patients waiting over 100 weeks, 100 patients waiting over 70 weeks and 379 over 50 weeks (as at 26 September 2022) the service knew it would be very challenged to meet the 78 weeks target by 31 March 2023. In line with national trend waiting lists were continuing to increase.

Providing timely cancer services was also challenging whist the two week wait for breast and lung was meeting the target, the 62 day target was not met and was lower than the England average.

We understood that the COVID-19 pandemic had had significant effects on the service's ability to carry out surgery. For example, some cardiac operations had not gone ahead because the intensive care beds needed by patients after their operations were occupied by very ill COVID-19 patients.

The service was using other providers to support its recovery of activity with, for example two cardiac surgeons doing a full day of lists every other week for NHS patients at a local private hospital. Managers told us that the recovery of their activity levels was going well.

During the pandemic, transplant services had been paused on several occasions due to staffing and due to the particularly vulnerable nature of the patients whose surgery required that their immune systems be suppressed which made them vulnerable to COVID-19. The renal services were catching up post COVID-19 with a waiting list for procedures such as hernias, access including access to veins for dialysis and removal of the thyroid gland.

Vascular surgery activity was also very low during the pandemic and this had resulted in a large backlog of patients needing surgery. Again, theatre sessions in the independent health sector were being used to address the waiting lists.

The service held mortality reviews and serious incident reviews where patients had died whilst waiting for their surgery or their condition had significantly deteriorated due to the delays.

Managers and staff worked to make sure patients did not stay longer than they needed to. The service participated in national monitoring and audit of which the length of stay for specific types of surgery was measured.

Managers made sure they had arrangements for surgical staff to review any surgical patients on non-surgical wards. Managers worked to minimise the number of surgical patients on non-surgical wards. Few patients from the surgical specialities we looked at were cared for outside of the surgical speciality. At the time of inspection, five patients from ward 31, a cardiac surgical ward were being cared for on the adjacent ward 32. This was a cardiology ward and they were nursed by cardiac nurses and overseen by a surgical consultant.

The trust had a standard operating procedure that prescribed when and how patients could be accommodated on wards of a different speciality whilst waiting for an available bed on the admitting speciality ward.

Surgery

Managers worked to keep the number of cancelled operations to a minimum however the number of operations cancelled on the day of surgery was 1.5% against a target of 1% (year to date).

When patients had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible. When we discussed the management of theatre lists with senior staff we learned that elective lists were locked down two weeks in advance and those that were urgent 72 hours beforehand. Bookings were arranged via the individual consultant's secretaries as there was no central booking team but there was a surgical flow coordinator who monitored ward capacity.

Non-clinical cancellations were all reviewed and reported as incidents. These were mostly due to emergencies, staffing and theatre availability.

We heard several patient stories about cancelled operations. On one of our inspection days there had been an emergency surgical admission that was taking a lot of resources in theatre as well as surgeon's time resulting in several cancellations. A patient on ward 26 told us their operation was cancelled three times because of emergencies. They were understanding but they had experienced a week in hospital waiting to be operated on. A patient on ward 31 told us their operation had been cancelled once because of an emergency and a second on that ward said their operation too had been cancelled.

During our inspection, staff and managers told us that they were seeing a rise in patients admitted both for and with COVID-19. The trust was starting to put in place arrangements to cope with this increase. These measures, such as opening "Covid wards", would have a negative impact on the activity levels the service would be able to provide.

The service based its view on previous experiences in September 2021 when a surge of COVID-19 resulted in cancelled operations due to a lack of staff.

We were also told that lack of access to the hybrid theatre facilities were sometimes a barrier to the number of operations that could be performed. This was due to the need to access specialist equipment in that operating suite but also due to staffing challenges among nursing and anaesthetic staff. This was, to some extent, because it was early in the services reconfiguration programme and there was competition for theatre resources. Senior managers recognised that this was stressful for staff.

Thoracic surgery had low staffing levels which was affecting the service's ability to meet the targets for treatment carried out by 21 and 62 days after diagnosis of lung cancer.

Managers and staff started planning each patient's discharge as early as possible. Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. Because of the nature of the specialist surgery at Glenfield patients were usually able to be discharged to their own homes once they were well enough. As a result, discharge was not dependent on access to adult social care resources and the most usual external factor to preventing discharge was slight delays in patient transport.

The ward 31 handover meeting that we attended discussed discharge arrangements for the following day and the trust tactical meeting asked leaders to ensure that patient transport was booked well in advance.

Staff supported patients when they were referred or transferred between services. We noted that the specialist surgical services worked to identify patients waiting in A&E or other emergency portals that should be transferred to their unit.

Surgery

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. There were advice leaflets and posters on how to complain displayed prominently throughout the wards.

There was also material encouraging patients to share positive and negative comments through other routes such as the Patient Information and Liaison Service (PILS) and initiatives such as “Message to Matron”.

Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. The trust carried out analysis of complaints and had put in measures to address the most common or significant. An overview of complaints data showed that the majority of complaints were about standards of care, staff interactions and cancelled or delayed treatment.

There was work taking place to address staffing which was a common reason for delay or cancellation of operations as described elsewhere in this report. We also saw that there was an initiative to keep patients on waiting lists better up-to-date to reduce anxiety and therefore complaints.

Board meeting notes showed the trust was not meeting its performance targets for complaints investigations. However, this information was not specific to surgery at Glenfield Hospital and we could therefore not determine the individual performance for this service as a result.

Managers shared feedback from complaints with staff and learning was used to improve the service. Amongst some of the specialities work was in progress to ensure that individual wards considered complaints and feedback to better improve patients’ experience.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

While some staff reported lack of visibility from the executive team during the pandemic, they were positive about the presence of leaders at a divisional level or below. There was a “matron of the day” initiative across the Glenfield Hospital site which meant there was someone available to respond to events without having clinical or other managerial responsibilities.

Surgery

The trust had introduced a system to support staff who had undergone traumatic experiences known as Trauma Risk Management (TRiM). This was a response, in part to the stresses imposed on staff due to their work during the COVID-19 pandemic.

Staff whose wards had recently moved across from other hospitals told us that they had had good support from their departments, managers and matron.

Staff were positive about their leaders and co-workers and leaders spoke highly of their staff. For example, a new nurse on ward 31 told us very well supported by manager and colleagues and a staff member on ward 26 said they had a very supportive matron including for personal issues and COVID-19. Senior managers told us they were proud of how staff were working to recover surgical services.

Senior staff in theatres told us that the recent transfer of services continued to be a challenge including the maintenance of a safe emergency theatre service. There were options being looked at and staff were being consulted as to their views.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.

There was a clear three-year plan at trust level that identified quality strategies and priorities across the whole organisation.

The provision of surgical services at the Glenfield site formed a key part of this strategy as it was recognised that following the bringing together of three hospitals to form the trust the configuration of the services was a matter of accident not planning.

As part of the reconfiguration some specialist surgical services were being consolidated on the Glenfield site. At the time of our inspection a new base for cardiovascular surgery was being established with the recent move of vascular surgery to join the established cardiac service and transplantation had also recently moved.

There were ambitious plans to create a treatment centre and provide additional level two and three intensive care capacity to support the additional surgery.

Established regional and national services for Lung Volume Reduction Surgery (LVRS) and Laser Metastasectomy were to be retained and innovation such as robotic thoracic surgery introduced.

This was to be underpinned by changes to staffing including additional consultants as well as staff development and education initiatives.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff survey results across the management groups which included surgery at Glenfield Hospital indicated some dissatisfaction with staff reporting “burnout”, work related stress, low health and wellbeing and emotional exhaustion. There was also a desire to get back to normal after the stressful and distressing times during COVID-19.

The notes of divisional board meetings showed the organisation took these concerns very seriously and were working to understand the root causes and respond. They also clearly recognised the impact on staffing and ultimately performance and the quality of patient care.

Feedback about the attitude of medical staff in the department was mixed. A senior nurse in one of the theatre specialities told us that medical staff were sometimes “sharp” with staff who were new to the trust. However, instances were recorded as incidents and dealt with by the management team. Other nursing staff reported medical staff to be “approachable” and an assistant practitioner on ward 26 said they felt confident approaching surgeons for advice.

Senior staff in theatres told us that they ran an open-door policy and that the most recent staff survey demonstrated an improvement in staff engagement. Junior staff said that the culture was good and that they were able to approach management and escalate concerns.

They said that there had been a lot of disruption and apprehension as a result of the service moves but issues were discussed and there was support.

Staff and managers told us that because staff were frequently moved from their usual ward to cover on other wards some of them found this stressful.

Some nurse managers said that while they were supportive of their staff, they thought that there could be better provision for nurses who had joined the trust from overseas outside of their line management structures.

We discussed how any conflict and behaviours that did not meet the values of the trust within teams was addressed and were given an example of how this could be done with external support to discuss individual staff behaviours and communication.

A foundation year doctor on ward 31 told us they felt very supported as a junior by seniors and also the nursing staff and physiotherapists. They contrasted this with experiences in other areas and hospitals. They also said they were supported to progress to their desired speciality.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a complex but clear and rational management structure in place across the surgical specialties that we inspected. There were four management groups which had responsibilities over and above the location and the services we inspected across the rest of the trust. These management groups were The Cancer, Haematology, Urology, Gastroenterology and General Surgery (CHUGGS), Intensive care, Theatres, Anaesthesia, Pain and Sleep (ITAPS), Musculoskeletal and Specialist Surgery (MSS) and the Renal Respiratory and Cardiovascular (RRCV) groups.

The notes of recent management group meetings showed that for the Cancer, Haematology, Urology, Gastroenterology and Surgery (CHUGGS) board they were trialling the integration of quality and safety boards which were currently separate for each management group to avoid repetition and save time.

The various groups used differing approaches to their governance which was evidenced through their meeting agendas. However, they all demonstrated an open discussion of matters with responsibilities allocated to named individuals or groups and reporting of progress.

Across the theatre suite there were daily briefings at 8am and outside of this there were noticeboards and all staff emails. The matrons met monthly and liaised with the head and deputy head of nursing.

The trust carried out a programme of monthly nursing metrics covering observations, nutrition and hydration, infection prevention and control (IPC), hand hygiene and the prevention of falls and pressure ulcers. We were provided with the figures for the previous three months. Through the trust's colour coding mechanism 62% of the audits were green indicating these metrics were in line with performance targets, 32% where amber denotes some metrics are being met but not all and 6% were red as they were below the targets set. There were associated action plans when shortfalls were noted.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

We discussed systems that the service had in place for assuring safety during operations. We were told that the service had recognised that these needed improving as a result of never events that had taken place. Senior managers were familiar with these incidents and spoke authoritatively about their causes and the measures taken to prevent a repeat.

These included a strengthening of Local Safety Standards for Invasive Procedures (LocSSIPs) that are local implementations of national safety standards. Staff in theatres confirmed this.

Managers discussed the varying needs of the different wards at the site bed meeting at 8am and arranged for staff to be redeployed in order to keep the service as safe and effective as possible. This meant they were able to work together to deal with immediate issues such as sickness, emergency admissions and patients who were more acute than expected. These conversations covered the acuity of individual patients, staff absence, emergency admissions and theatre throughput. A further meeting took place at 1pm.

The meeting which was chaired by the deputy chief nurse allowed staff to raise safety concerns which could be dealt with.

There was a site matron of the day who was responsible for troubleshooting and had both the individual authority and access to senior staff to deal with issues.

During our inspection, the trust was becoming increasingly pressured from an emerging COVID-19 wave as well as other respiratory viruses and flu. There was a coordinated response across the site as managers worked to reintroduce measures such as the enhanced wearing of masks and the reintroduction of COVID-19 wards. Although the measures were not yet enforced staff were tasked to make sure their areas, staff and patients were prepared. Managers were also reminded to ensure that COVID-19 screening of patients took place according to the trust protocols as a dip in performance it had been noted.

A further tactical meeting covered the whole trust and as well as the issues in the trust discussed external factors such as available ambulance resources. We noted that the specialist surgical services worked to identify patients waiting in the emergency department or other emergency portals that should be transferred to their unit.

Teams shared responsibilities for decision making. For example, at a handover on ward 31 there was a team discussion on whether they would need to request additional staffing support or could cope in response to a member of the nursing team being off sick

The service held risk registers at a divisional level which were aligned with the issues staff and managers raised with us on the inspection. They were in a suitable format and clearly described the issue, risk, mitigations, remedies and the current status of action plans.

In theatres, senior staff told us the greatest risks on their register were the theatre environment and staffing and this was well documented in the associated risk register which was annotated with mitigation and resolution plans.

Mortality meetings took place and we were made aware of how recent meetings had discussed a contentious topic of the allocation of cases to either the unit or individual surgeons.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required.

Information technology systems were used to monitor and improve patient care. The service had suitable clinical and managerial information systems to provide information for patient care, and both day to day and strategic management.

Service performance measures were reported and monitored. Managers and senior staff had access to these reports and relevant and appropriate service performance information.

Returns were made to the relevant bodies as required.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The plans for the development of specialist surgical services that demonstrated that they were prepared in collaboration with local and national commissioners as well as charities, other providers and academic institutes. This was clearly done in the context of many of the surgical services provided being centres of excellence for research, innovation, specialist training and care of the sickest patients.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research. Staff within the CHUGGS management group used a project management methodology to set up projects to improve quality and experiences for patients and staff. This ensured that such work was properly scoped and managed and prospective benefits were balanced against risks and costs.

Staff helped to alleviate patient's anxiety by holding pre-operative visits with the surgical recovery team and ensuring they woke up to a staff member they were familiar with.

Surgery

There was an ongoing trial of remote post discharge clinics. The service had a newly introduced database to analyse mortality data and ensure the correct management of complex and unit cases in cardiac surgery.

Staff participated in local, national and international research.

There was a longstanding tradition of innovation and tradition involving the surgical provision at the Glenfield site including the development of ground-breaking innovations. This continues through the involvement of staff as authors of papers in world class peer reviewed journals.

LEICESTER, LEICESTERSHIRE AND RUTLAND
JOINT HEALTH SCRUTINY COMMITTEE
6th February 2023

Subject:	Learning Disability and Neuro-disability Update
Presented to the Leicester, Leicestershire & Rutland Joint Health Scrutiny Committee by:	David Williams. Executive Director of Strategy and Business Development. Leicestershire Partnership NHS Trust.
Author:	Mark Roberts. Assistant Director. Leicestershire Partnership NHS Trust.

EXECUTIVE SUMMARY:

Local Authorities and the NHS have been working in partnership to improve the outcomes for our people with a Learning Disability or Neuro-developmental need.

These arrangements have made significant improvements in the services provided, in October 2022 a Collaborative was formalised between the Integrated Care Board and Leicestershire Partnership NHS Trust to further strengthen our collective response.

Our work builds on successes in 2021 and 2022 in progressing the Transforming Care Programme.

This programme seeks to:

- Reduce the number of people with a learning disability and autistic people being cared for in hospital,
- Ensure timely learning through LeDeR reviews of the lives and deaths of people that die, and
- Ensure people with a learning disability access their Annual Health Checks (AHCs).

The number of adults in hospital has reduced substantially; ensuring many more people are able to live in a less restrictive setting and experience more fulfilling lives, closer to family and friends in their own community. We recognise that we have more joint working to reduce the number of children in hospital.

LeDeR reviews are consistently undertaken and learning is being actively shared across the local system through a series of thematic reviews; stimulating further improvement in services.

In the financial year 2021/22 over 74% (national target is 70%) of people accessed an Annual Health Check with their GP in LLR and year on year performance is being exceeded in 2022/23.

In 2023/24 will continue:

- Our joint working and focus on reducing the numbers of adult and young people in hospital
- Continue to deliver the annual health checks prevention programme across primary care
- Continue to review every death of a person in LLR with a learning disability and neuro developmental need.
- Develop a programme of work to ensure we can apply the quality principles we have in hospitals in our community services to ensure everyone has access to high quality care.

We would welcome committee support to:

- Champion our joint focus on people who need our support; this helps ensure people receive timely and high-quality care enabling people to lead a fulfilling life.
- Champion the importance of supporting all our people across LLR.

A short presentation is attached to this paper providing a summary of our achievements and priorities.

RECOMMENDATIONS:

The Committee is requested to:

1. Note the successes and challenges within LLR.
2. Champion our joint focus on people who need our support; this helps ensure people receive timely and high-quality care enabling people to lead a fulfilling life.
3. Champion the importance of supporting all our people across LLR.

LLR LEARNING DISABILITY AND NEURO-DISABILITY PROGRESS UPDATE

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

LEICESTER, LEICESTERSHIRE AND RUTLAND INTEGRATED CARE SYSTEM

6th February 2023

A clear LLR vision

- All people with a learning disability and/or a neurodisability will have their fundamental right to live good fulfilling lives, within their communities with access to the right support from the right people at the right time

Collective Leadership

- Through a multiagency team, ensuring strong community care that reduces admissions & improves discharge

Delivering

- Prevention through annual health checks and learning from previous deaths
- More people living in the community, less people living in hospital long term
- Sharing learning and working together to improve care

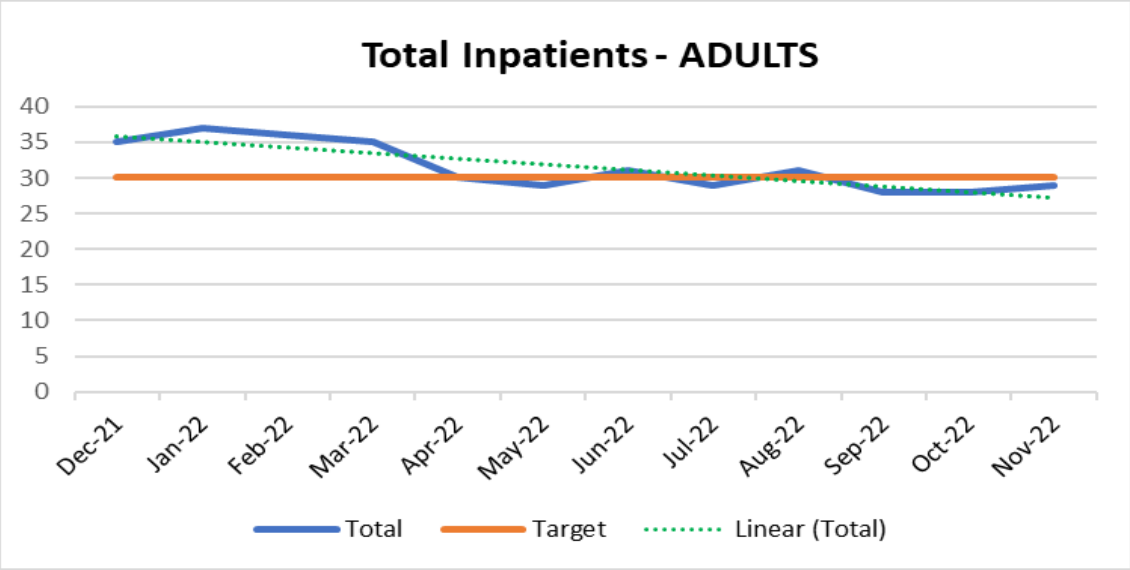
Our way of working

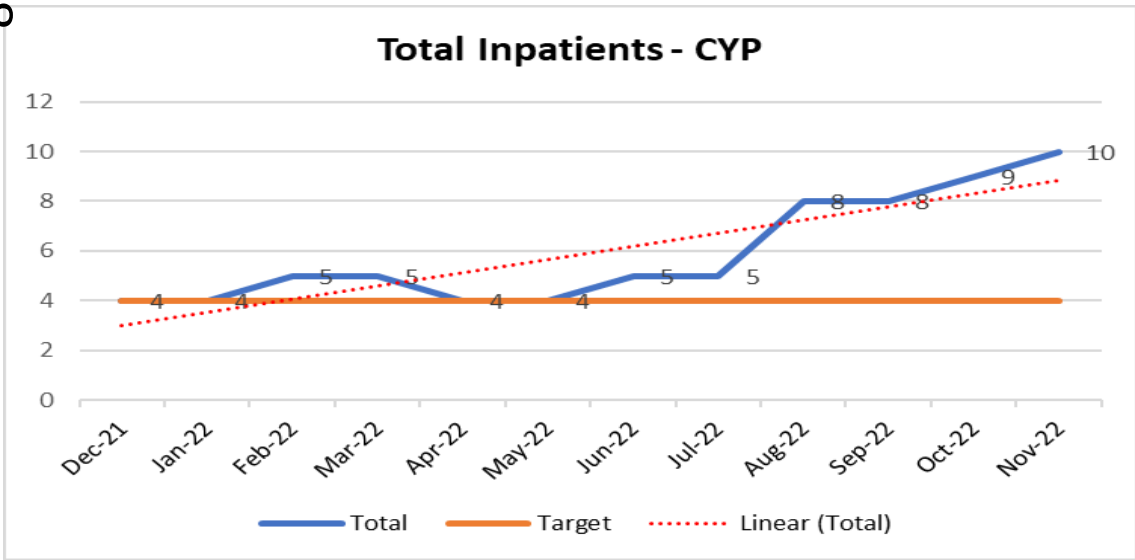
- A formal agreement between LPT and the ICB, and a focus on joint leadership between local government and the NHS
- Working continuously to commission, deliver and improve services; reduce variation and inequality, and improve outcomes

Our strengths

- Combining our skills and resources, and aligning NHS & LA plans to increase our impact
- Including our communities; supporting community champions and enabling people to deliver change; from inpatient care, community services and care providers to the voluntary and community sector
- Structured benchmarking and planning

Reducing the need for inpatient care





Successes

- Fewer adults in hospital
- Fewer LLR people in hospital beyond LLR
- Bespoke arrangements developed in partnership for the most complex care to enable discharge

Challenges

- The number of children in hospital is increasing, all of these children have neurodiversity not learning disabilities
- Several young people are ready to leave hospital but limited community placements are available that will meet their needs
- Lack of staff in community placements with specialist knowledge and skills

Opportunities

- Increasing focus with Children's Services on avoiding hospital care through a greater range of community care
- Wider range of specialist inpatient beds in LLR through re-focussing the Agnes Unit in Beaumont Leys
- Developing Community care providers to ensure high quality care that meets needs now and in the future

Learning from the lives and deaths of people with a learning disability

Learning about Aspiration Pneumonia:

- A review identified that Aspiration Pneumonia was a factor in 29 cases over multiple years.
- Aspiration pneumonia occurs when food or liquid is breathed into the airways or lungs, instead of being swallowed.
- The following actions are now being implemented from this learning:

1. People diagnosed with Aspiration Pneumonia to be reviewed by a specialist multi-disciplinary team

2. Risk of Aspiration Pneumonia to be added to people's hospital passport where this is an identified risk

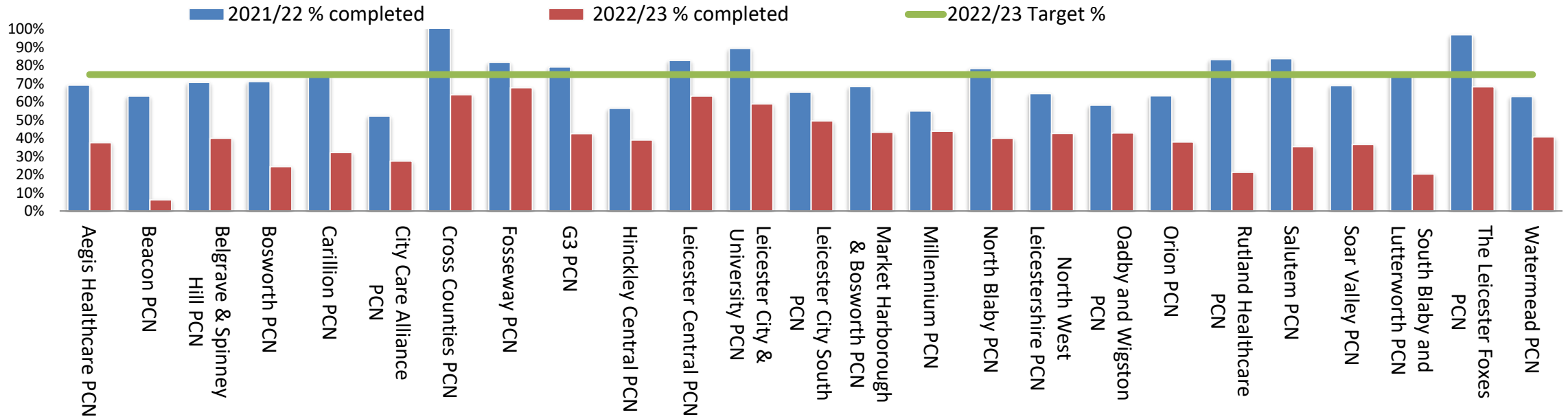
3. Learning to be shared across LLR and this shared learning will also be of benefit to other people, including people with Dementia

4. NHS England are reviewing the LLR learning and considering how it may inform national guidance

- **C.65 people in LLR die each year who have a Learning Disability or Autism recorded on NHS systems**
- **Timely** –100% of our reviews have been completed within the prescribed 6 month timeframe
- **COVID-19 thematic analysis** – report scheduled for end of February 2023
- **Ethnicity inequality thematic analysis –** scoping exercise underway, scheduled for March 2023

Annual Health Checks for people with a learning disability

- Annual Health Checks are a key part of our prevention agenda and provide a regular opportunity to help prevent ill health. 5046 (aged 14+) in LLR are eligible in 2022/23.
- Performance is ahead of 2021/22 with 44.49% (end Dec 2022) completed since April 2022; GP practices often focus on these checks January to March, so performance increases rapidly during this period. Minimum expectation is 75% of people eligible have a check.
- Of 200 identified people who did not have a check in 2021/22, 82 (end Dec 22) have had a health check in 2022/23.
- Continued focus to improve uptake across LLR



Benchmarking for quality improvement

To support people in both hospital and in the community, we have developed a quality framework. This takes the learning from:

- Baroness Hollins Report
- Clive Treacy Independent Review
- LLR Safe & Wellbeing Thematic Review
- 117 Aftercare Review
- Learning from Complaints
- Cawston Park Safeguarding Report
- Out of Sight -Who Cares?
- Building The Right Support Commitments

Through this quality improvement programme we:

- Aim to improve the experience of care
- Set clear standards and engage care teams with the findings
- Inform our future planning

Summary

- While fewer local adults are requiring care in hospital, together we need to ensure the same support for our young people with neurodiversity.

- Continue our joint focus on the needs of people who need support; to ensure they receive timely and high quality health and care is essential to enable people to lead a fulfilling life.

- Continue to champion the support for all our people across LLR.

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

PRIMARY MEDICAL CARE IN LEICESTERSHIRE, LEICESTER & RUTLAND

REPORT OF THE CHIEF OPERATING OFFICER – INTEGRATION AND TRANSFORMATION, LEICESTER, LEICESTERSHIRE AND RUTLAND INTEGRATED CARE BOARDS (ICB)

Purpose of the Report

1. In June 2022, a report was presented to the Health Overview and Scrutiny Committee highlighting the current priorities and opportunities in Primary Medical Care across Leicester and Leicestershire. The purpose of this report is to provide an update on these key priority areas, outlining the current position, next steps, including any challenges and opportunities.

2. In addition, this report provides a summary on the Primary Care Network (PCN) Enhanced Access services delivered by Primary Care Networks across Leicester and Leicestershire from October 2022 and the types of services offered.

3. The report also provides a brief outline the work undertaken by the Integration and Transformation Team in the implementation of the Fuller Stock Take report and timescales for implementation of Integrated Neighbourhood Teams.

4. The report is presented for information and update.

Policy Framework and Previous Decisions

5. This is a Health report on Primary Medical Care in line with NHS five year forward view and the NHS Operational Plan. The report does not relate to the budget and policy framework.

LLR Primary Care Plan Update

6. In the Primary Medical Care report presented in June 2022, it was noted that over the last two years, there has been an unprecedented demand for health and social care services. During this period, considerable work had been undertaken in Primary Care to adapt in response to increasing demand, which included collaborative working with system partners. However, it was noted that Primary Care faced a number of challenges, of which the following four areas were considered as key priorities to address:

    - **Access**: Tackling the variation in appointments, this includes how people can access an appointment and options available
    - **Workforce**: Challenges with recruitment and retention therefore promote use of a wider skill mix (clinical and non-clinical staff) to support the delivery of the right care
    - **Delivery on key Long-Term Conditions** (LTC) and reducing prevalence gap by optimization in primary care.
    - **Quality**: Reducing variation in quality and experience for our patients and aiming for overall improvement of patient experience. Improving resilience and sustainability of LLR practices.

7. Outlined within this report is a summary on each of the four priority areas and the current position following the previous report.

Access in General Practice

8. The GP Appointment Dashboard (GPAD) website was developed for general practice in March 2021 and provides useful information on appointments offered by General Practice. The GPAD data is based on the GP appointment category used which is then extracted via the practice system and presented on the GPAD website.

9. The GPAD website provides practices with an overall view of the appointment types and clinical staff activity during the month. Practices are encouraged to review the data and design their clinics based on demand and capacity from information on the website.

10. Though the ICB do not have access to the GPAD website, NHS England provide a summary report which supports triangulation of information on access and recovery pre-pandemic. Example of the information provided includes:
    - Appointment type
    - Healthcare professional
    - Recovery from pre-pandemic

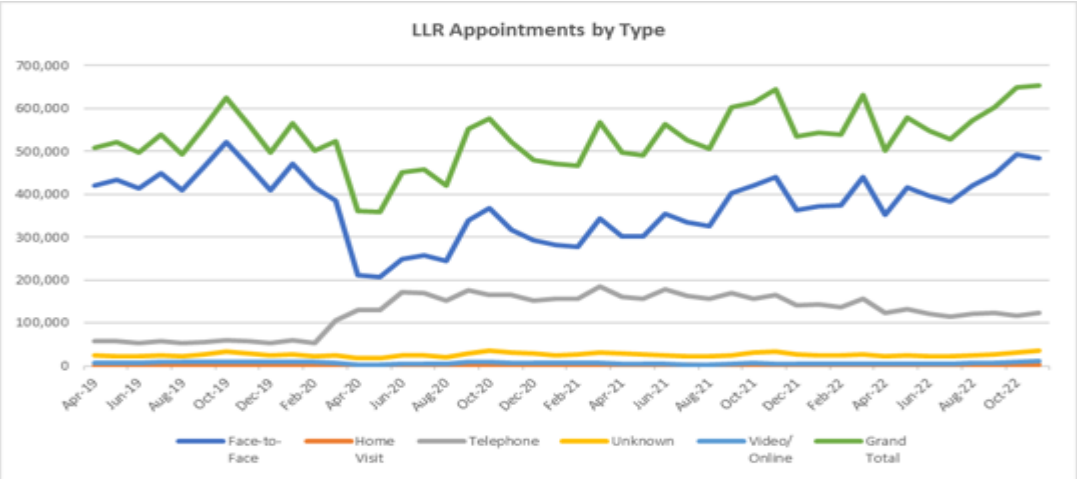
11. Unfortunately, the national monthly data reports from NHS England were discontinued from 20-Oct-2022 and data will now be available through NHS Digital. This has created a time lag in the data reporting.

Monthly data

12. Graph 1 shows the monthly number & type of general practice appointments from April 2019 to November 2022.

13. There was 0.6% increase in the total appointments provided in the latest month (from Oct to Nov 22), which follows a 7.8% increase the previous month.

Graph 1 – Total appointments across LLR



14. GPAD data also provides a summary of the proportion of GP face to face appointments from January 2022 to October 2022; with an average increase of 8.09%.

Table 1; GP Face to Face Appts: Jan – Oct 22

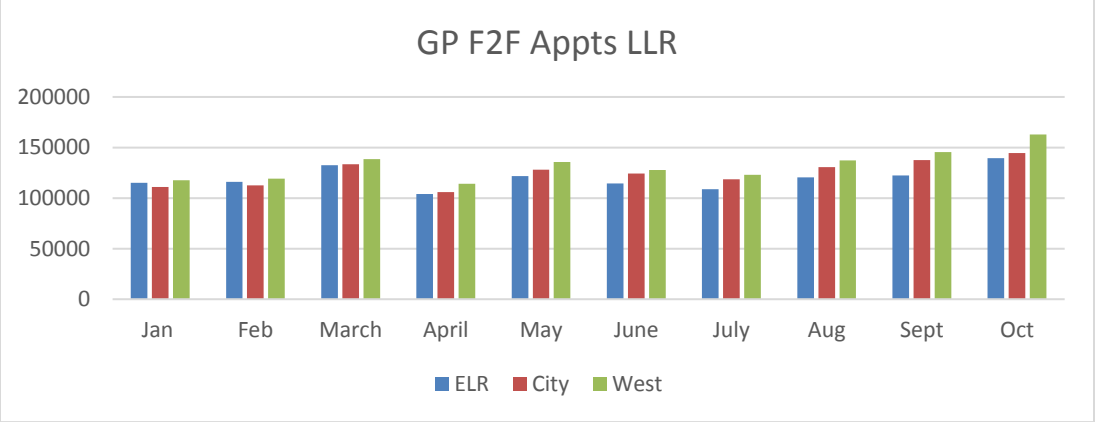
	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct
ELR	115005	116000	132586	104073	121659	114495	108794	120420	122381	139607
City	110840	112435	133589	105812	127927	124162	118637	130497	137498	144567
West	117629	119197	138421	114078	135598	127798	123027	137360	145463	163026

15. Total GP Face to Face appointments from January to October 2022 was 3,762,581 as outlined in Table 2;

Table 2; Total GP Face to Face appointments in LLR

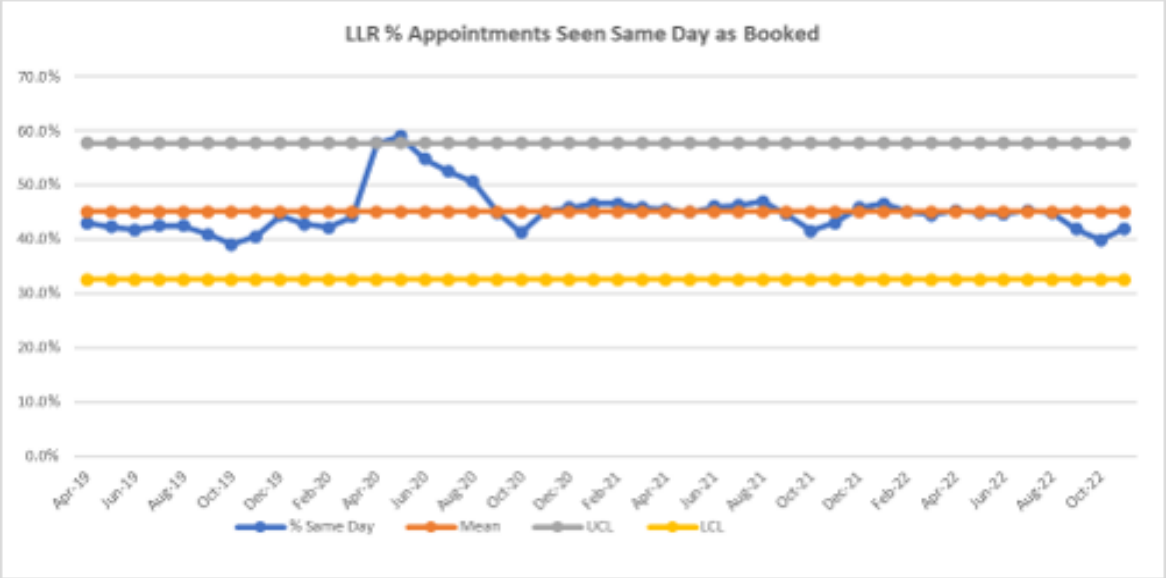
	Total Appts
ELR	1195020
City	1245964
West	1321597
Total	3762581

Graph 2; GP Face to Face Appointments in LLR (Jan – Oct 22)



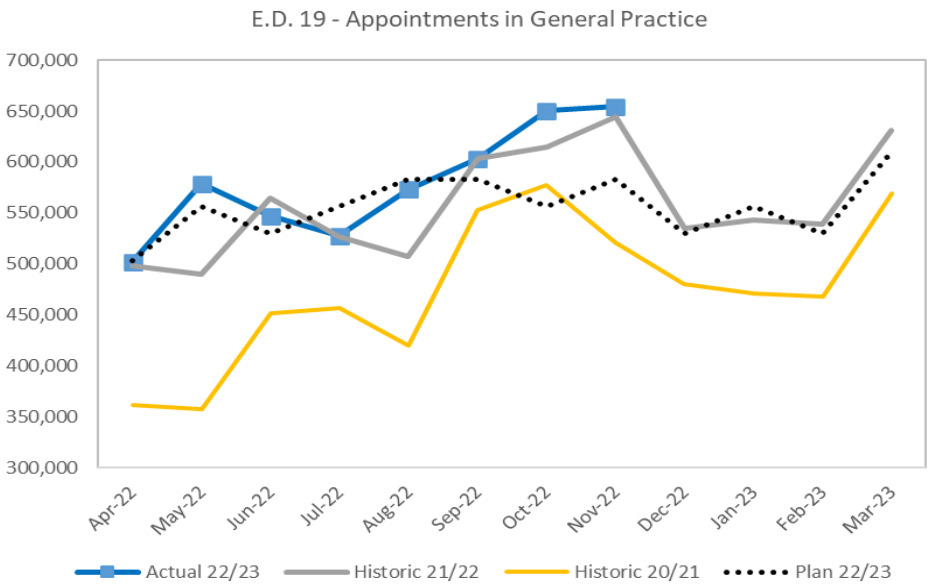
16. The graph below shows the percentage of appointments that took place on the same day they were booked. There has been little variation over the last two years (since Sept 2020), although there has been an increase in Nov 22, to 41.9% from 39.9% in Oct 22.

Graph 3 – LLR % appointments seen same day as booked



17. Graph 4 shows overall there has been an increase in the number of appointments offered in 2022/23 compared to 21/22 and 20/21. In addition, the actual number of appointments on average are above the planned recovery for 22/23.

Graph 4 Appointments in General Practice



18. Table 3 compares the past 4 November's monthly appointments which shows this year's figure is higher than previous year's. In November 2022 an additional 10k appointments were offered comparted to November 2021. This shows a positive trend in access across general practice. The number of appointments is also greater than pre-pandemic (Nov-19).

Table 3 – Total Appointments in November compared to 2019 to 2021

All Appointments	Total
Nov-19	562,391
Nov-20	521,001
Nov-21	643,907
Nov-22	654,370

Enhanced Access

19. As part of the Primary Care Network Contract Directed Enhanced Service, Primary Care Networks (PCNs) across LLR have signed up and delivering Enhanced Access from 1st October 2022 offering appointments as a PCN to the patient population. These appointments are offered from Monday to Friday 18:30-20:00 and Saturdays 09:00-17:00.

20. A mix of services are available within these additional hours with access to the range of health professionals working in the primary care team, these professionals can include GPs, Advanced Nurse, Health Care Assistants, Clinical Pharmacists, Social Prescribers, Paramedics, ANP, etc. Each PCN has designed the services they offered based on their population health needs and therefore use a multi-skilled team to address those key requirements.

21. The Enhanced Access appointments are structured to promote focus on Long Term Conditions and Preventive care management, these also include an offer of same day access.

22. Appointments range from Acute and non-Acute GP appointments, Long Term condition management, Screening, Vaccinations and Immunisation, Cytology, Medication Reviews, Social Prescriber, Health and Wellbeing, NHS Health Checks, Preventive care, Sexual Health Services, COVID Vaccinations, Cervical Screening, Diagnostic review, Joint injection clinics, First contact clinics, wound care, etc.

23. There is a choice of ways to access appointments depending on clinical need, such as telephone, video appointment, online consultation, or face to face. PCNs also offer video consultations for large groups to support health promotion or self-care management sessions and Online Consultations.

24. Details on the service provided are outlined in Appendix 1, however these are variable giving PCNs the flexibility to deliver care based on patient needs. The exact mix of what is provided through the enhanced access offer will be aligned to local health needs, current usage of out of hours services and the views of patients.

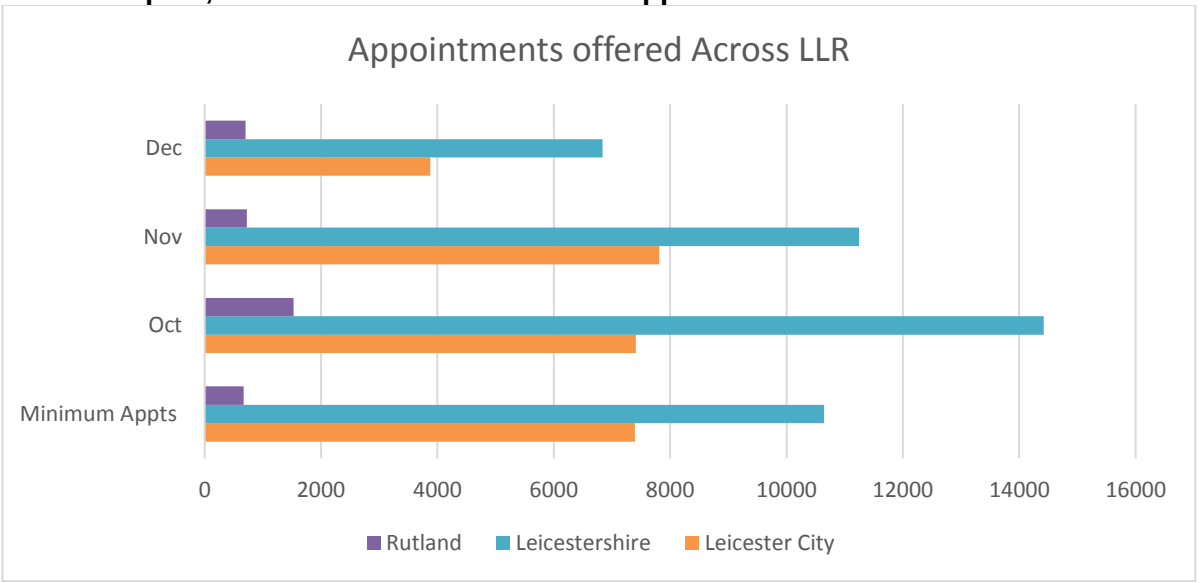
25. Outlined below is the total number of appointments offered across Leicester Leicestershire and Rutland which shows an increase each month.

26. For December 6 PCNs in Leicester City and 4 PCNs in Leicestershire are yet to submit their December Enhanced Access monitoring template due to the winter pressures. Once this data has been received, the projection on total appointments should show a further increase:

Table 4: Number of EA Appointments Oct – Dec 2022

	Minimum Appts	Oct	Nov	Dec
Leicester City	7396	7412	7812	3877
Leicestershire	10647	14423	11245	6836
Rutland	672	1529	726	702
Total appointments offered	18715	23364	19783	11414
% offered above minimum requirement		125%	106%	61%

27. **Graph 5, below shows the increase in appointments each month across LLR**:



28. As part of the Enhanced Access, each PCN has been assigned their contracted hours they are required to provided across their member practices which equates to 4679 hours per month.

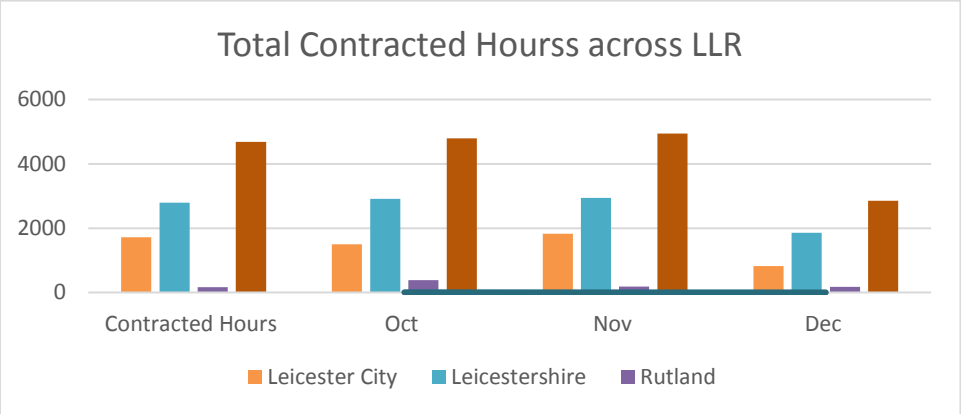
29. Outlined below is a summary of the total contracted hours for PCNs across LLR. As shown a number of PCNs are delivering hours above their contracted hours, based on the service requirements of the patient population and their health needs.

30. December data does not truly reflect the number of the actual total hours offered as 10 PCNs are yet to submit their EA Monthly return and aim to submit these by the end of January due to winter pressures.

Table 5 – number of contracted hours

	Contracted Hours	Oct	Nov	Dec (outstanding returns)	
Leicester City	1718	1501	1823	825	*6 outstanding returns
Leicestershire	2793	2909	2941	1853	*4 outstanding returns
Rutland	168	382	182	176	0 outstanding
Total Hrs	4679	4793	4946	2854	
% of hours provided above the contracted hours		102%	103%	58%	10/ 26 Outstanding returns

31. Graph 6 presents Enhanced Access hours across LLR, noting that December data is not completely reflective and pending 10 returns; on average PCNs across LLR are providing 4700 additional appointments.



Next Steps

32. The ICB will continue to monitor monthly activity reports submitted by PCNs and follow up with those who are delivering sessions under the contracted hours. Often this may be related to DNA or Workforce pressures, however the PCN will be required to adhere to their contract requirement.

33. Encourage PCNs to continue to review their local population health needs and design their appointments to capture these populations.

34. Promote sharing of best practice and successful outcomes across LLR; therefore encouraging other PCNs to adapt their appointments to meet similar health needs.

35. PCNs advised to provide more information in the monthly returns regarding the type of appointments offered, outline any barriers, challenges, benefits, feedback from staff and patients; this will enable the ICB to capture how EA is working across the system.

36. Enhanced Access data will be available via GP Appointment Dashboard from April 2023. The ICB will work collaboratively with PCNs to triangulate this information to ensure population health needs are central in designing appointments and services.

Workforce

37. As part of the Additional Roles Reimbursement Scheme (ARRS), PCNs across LLR continue to recruit to the roles under the scheme. In August and October 2022, PCNs were required to submit their Workforce Plans to NHSE to indicate which roles they had recruited to and those roles they were intending to recruit.

38. Table 6 shows the number of GPs, Nurses, Direct patient Care Roles such as ARRS and other clinical roles were recruited or planned from April to November:

Table 6 – Clinical Staff Plan, Actual and Growth

	Position	Base	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022
Plan	GPs (excluding registrars)	524	527.8	527.8	527.8	531	531	531	534.2	534.2
Actual			524.4	521.6	524.2	521.7	527.0	531.1	532.4	529.7
Variance WTE			-3.4	-6.2	-3.6	-9.3	-4.0	0.1	-1.8	-4.5
Planned Growth %			0.7%	0.7%	0.7%	1.3%	1.3%	1.3%	1.9%	1.9%
Actual Growth %			0.0%	-0.5%	0.0%	-0.5%	0.5%	1.3%	1.5%	1.0%
Plan	Nurses	281	282	282	282	284.9	284.9	284.9	284.5	284.5
Actual			280.6	275.9	279.7	282.1	284.3	279.2	277.7	279.2
Variance WTE			-1.4	-6.1	-2.3	-2.8	-0.6	-5.7	-6.8	-5.3
Planned Growth %			0.4%	0.4%	0.4%	1.5%	1.5%	1.5%	1.3%	1.3%
Actual Growth %			-0.1%	-1.7%	-0.4%	0.5%	1.3%	-0.6%	-1.1%	-0.6%
Plan	Direct Patient Care roles (Claimed ARRS)	277	324	324	324	371	371	371	418	418
Actual			333.4	351.1	354.8	392.4	391.9	403.7	422.9	410.8
Variance WTE			9.4	27.1	30.8	21.4	20.9	32.7	4.9	-7.2
Planned Growth %			15.4%	15.4%	15.4%	32.1%	32.1%	32.1%	48.9%	48.9%
Actual Growth %			20.4%	26.7%	28.1%	41.7%	41.5%	45.7%	52.7%	48.3%
Plan	Direct Patient Care roles (not ARRS funded)	307	313	313	313	320.6	320.6	320.6	330.1	330.1
Actual			310.0	313.7	321.1	319.7	318.1	319.2	320.7	327.7
Variance WTE			-3.0	0.7	8.1	-0.9	-2.5	-1.4	-9.4	-2.4
Planned Growth %			2.0%	2.0%	2.0%	4.4%	4.4%	4.4%	7.5%	7.5%
Actual Growth %			1.0%	2.2%	4.6%	4.1%	3.6%	4.0%	4.5%	6.7%
Plan	Other – admin and non-clinical	1357	1383.7	1383.7	1383.7	1401	1401	1401	1407.8	1407.8
Actual			1363.1	1359.4	1381.3	1382.8	1391.9	1395.4	1383.6	1393.6
Variance WTE			-20.6	-24.3	-2.4	-18.2	-9.1	-5.6	-24.2	-14.2
Planned Growth %			2.0%	2.0%	2.0%	3.2%	3.2%	3.2%	3.7%	3.7%
Actual Growth %			0.4%	0.2%	1.8%	1.9%	2.6%	2.8%	2.0%	2.7%

39. Based on plans submitted to NHSE

- GP workforce numbers is below plan as of November 2022
- Nurse workforce numbers was -6.8 WTE below plan in October and is now -5.3 WTE behind plan in November.
- ARRS role claims are on plan which is set quarterly and need to achieve 418 WTE by December 22 and was reported at 422 in October.
- Direct Patient Care roles (Non ARRS) are only 3 WTE behind plan.

40. This demonstrates the challenges faced by general practice from a workforce perspective across LLR. Particularly in Leicester there are challenges in recruiting to GP Workforce which makes the delivery of services challenging.

41. PCNs continue to be supported with recruitment of the ARRs roles and other clinical support required. Working with the PCNs we have a workforce plan that focuses on how we support PCNs with recruitment, training and very importantly retention.

42. The table below outlines the number of clinical staff over the 8 months of 2022/23 financial year:

City

- GP numbers in Leicester were declining from the start of 2022. GP numbers dropped in October and increased by 0.9 WTE in November and the overall number remains below Jan 22.
- Growth YTD is at 0.2%. Growth is falling far behind Leicestershire and Rutland which is showing growth and at a much higher rate.
- Nurse numbers in Leicester have seen a decline since January 2022 but remained static for September, October and November 2022

Table 7 – Leicester City GP Workforce data

City Primary Medical Care (Non ARRS)	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022
GPs excluding registrars	169.0	168.5	167.8	166.1	163.9	162.0	162.2	165.1	166.7	165.0	165.9
GP registrars	53.9	49.6	50.0	45.4	46.1	45.9	46.7	66.9	68.2	67.6	65.5
Nurses	76.6	75.4	75.4	75.3	74.7	74.6	74.6	76.5	73.8	73.8	73.6
Direct Patient Care roles (Non ARRS funded)	88.7	86.3	88.5	91.0	91.2	92.0	92.0	88.6	90.8	92.7	96.0
Other – admin and non-clinical	444.5	446.9	447.6	450.0	451.6	454.1	454.2	453.2	452.7	446.8	445.1
Total excluding registrars	**779**	**777**	**779**	**782**	**781**	**783**	**783**	**783**	**784**	**778**	**781**
Cumulative Growth		-0.2%	0.1%	0.5%	0.3%	0.5%	0.5%	0.6%	0.7%	-0.1%	0.2%

Leicestershire & Rutland

- In November 2022 Leicestershire & Rutland the number of GP's decreased by 2.5 WTE.
- YTD growth has been 5.1% which exceeds Leicester growth.

Table 8 – Leicestershire and Rutland GP Workforce Data

County Primary Medical Care (Non ARRS)	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022
GPs excluding registrars	354.9	356.5	356.5	358.3	357.7	362.2	359.5	361.9	364.4	367.3	363.8
GP registrars	114.5	115.8	112.2	115.8	113.3	111.8	108.1	133.0	133.2	130.6	126.9
Nurses	204.0	206.1	205.4	205.3	201.2	205.1	207.5	207.9	205.4	203.9	205.6
Direct Patient Care roles (Non ARRS funded)	210.3	212.1	218.5	219.0	222.6	229.1	227.6	229.5	228.4	228.0	231.6
Other – admin and non-clinical	895.0	909.3	909.4	913.1	907.9	927.2	928.6	938.8	942.6	936.8	948.5
Total excluding registrars	**1664**	**1684**	**1690**	**1696**	**1689**	**1724**	**1723**	**1738**	**1741**	**1736**	**1750**
Cumulative Growth		1.2%	1.5%	1.9%	1.5%	3.6%	3.5%	4.4%	4.6%	4.3%	5.1%

43. Our workforce risks centre around recruitment and retention of GPs and Nurses and this remains a greater challenge in Leicester compared to Leicestershire and Rutland.

44. Though workforce continues to remain an ongoing challenge across primary care, the Workforce Team continue to develop and promote innovative ways to addressing the workforce shortages by designing training and fellowship schemes in partnership with other organisations.

45. To address these challenges, over the course of 2022/23 the LLR Primary Care Training Hub have delivered the following schemes to support staff retention and development:

- Introduced 33 GP Fellows across LLR across through the Cohort programs
- The Active Mentoring Program has been designed to support GP Fellows and new GP including GPs returning after a period of absence.
- Introduced the 'New to Practice Programme' specifically for newly qualified nurses or those new to primary care through a fully funded access program with De Montfort University General Practice Nursing Fundamentals course. Since commencement, 26 nurses have completed the fundamentals programme and are working in general practice.
- Introduced the Health Care Assistant upskilling programme, which provides staff opportunity to enhance their skills and address workforce gaps.
- Development and expansion of the Student Nursing Associate programme for primary care. This includes the development of a 'fast track' prequalification to enable people new to the NHS to access these roles. These programs address the recruitment shortages in general practice through enabling potential students the opportunity to gain first-hand experience in the field.
- The Training Hub was successful in securing funds from Health Education England to support a GP trailblazer fellow in a large inner-city practice. Once implemented, the learning will be shared.
- Designed, developed and delivering a bespoke primary care induction programme tailored to meet the needs of colleagues entering into the Primary Care Network (PCN) Additional Roles Reimbursement Scheme (ARRS) and other primary care roles for the first time. This induction program is delivered at scale across LLR and promotes integration of these new roles into primary care.
- Physician Associates who are either newly qualified or new to primary care are offered a funded preceptorship program facilitated through the Training Hub as an opportunity to support their induction into primary care.
- Provision of a locally designed and developed 'Continuing Professional Development Calendar of Events' offered by the LLR training hub clinical leads to promote CPDs across primary care.
- Delivery of a non-clinical upskilling programme designed to attract and support people into an administrative role in primary medical care.
- Support for practices and PCNs to recruit to apprenticeship roles (clinical and non-clinical, including pharmacy technicians, student nurse associates and administrative roles)

<u>Primary Care Workforce Strategy</u>

46. The Workforce Team are developing a Primary Care Workforce Strategy which will span across the next 5 years. It will seek to address the challenges and optimise the opportunities to enable workforce growth by examining and confirming the direction of travel for workforce recruitment, retention, attraction, and supply. Whilst striving to balance the day-to-day workforce challenges and possible solutions.

47. The strategy will be underpinned by the outcomes of the:
    - The LLR Primary Care Estates Strategy.
    - The Joint Forward Plan.
    - Fuller Stock Take Report by embedding Primary Care within the wider system workforce planning initiatives and the development of Integrated Neighbourhood Teams.
    - The NHS People Plan
    - The NHS Long Term Plan
    - Triangulation and incorporation of the local population health needs
    - 2023/24 Priorities and Operational Planning Guidance

48. Our Place Led Delivery plans will describe workforce priorities for each of our PCNs and for each Place and how we co-design and co-develop workforce strategies to get to our 5-year projections in terms of the type and quantity of Primary Care Workforce required. The implementation of these strategies will be supported by the following principles:

    - Local jobs for local people to support a local thriving economy.
    - Connective recruitment between graduates and local vacancies.
    - Data informed and evidence-based decision making.
    - Attractive and supportive employment packages.
    - Sustainable workforce solutions linked to our LLR people and communities.
    - Learning, training to be at the heart of developing our people.
    - Partnership working with all educational and training providers.

49. It is recognised that some of the drivers to achieve the above will be organisational culture, development, and leadership within Primary Care. This will require time to transform and change in order to deliver the above.

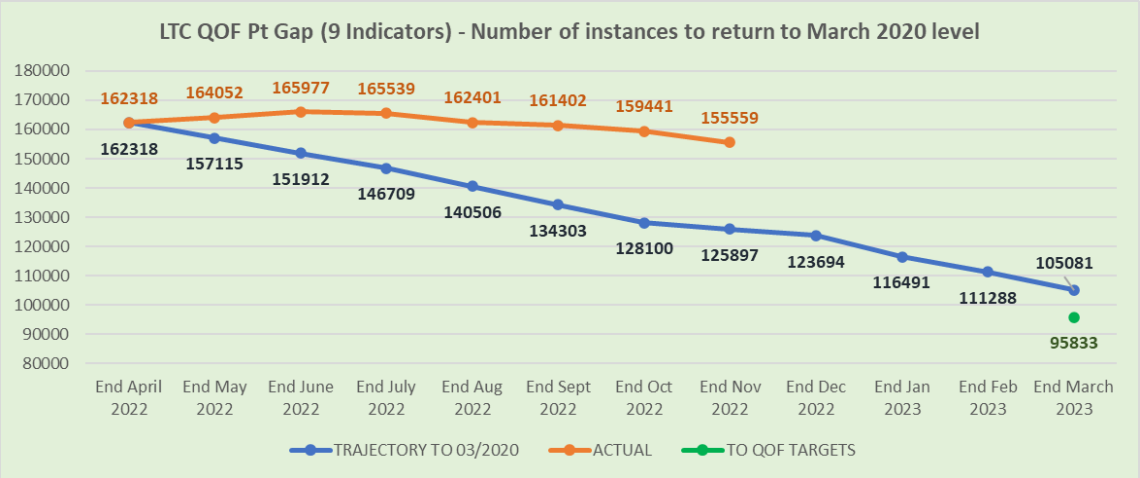
Delivery of key Long-Term Conditions (LTC)

50. The system vision continues to promote the delivery of right care to the right person at the right time, wherever they live, by providing seamless care across our system through;
    - Reducing the prevalence gap through early detection, implementation of Core20Plus5 and improved case findings and coding.
    - Improve Optimisation of LTCs by closing the QOF gap, transform pathways, promote patient self-care
    - Support digital enablement through remote monitoring, facilitate care closer to home, use of virtual wards, progress transformation at scale
    - Reduce Health inequalities by delivering Core20Plus5, making every contact count (MECC), reduce variation of care.

51. Graph 7 indicates General Practice performance, for the whole of LLR, across 9 QOF (Quality Outcomes Framework) indicators.

52. The indicators include performance around Asthma, COPD, Diabetes, Heart Failure and Hypertension.

Graph 7– LTC QOF patients



- The orange line shows our actual monthly performance and counts how many patient optimisation targets haven't been met by our practices.

- The blue line shows a monthly trajectory for us to meet if we were to recover QOF to pre-Covid levels. It shows how many patient optimisation targets weren't met by our practices in March 2020, just before Covid took hold.

- The green number is how many patient optimisation targets we would miss if we met all of the QOF targets, i.e., 70% for asthma patients optimised or 90% for COPD.

53. Although we are currently above our trajectory, our monthly figure shows a downward trend. And, with the traditional QOF activity between now and the end of March 2023, we will continue to improve our position.

54. We have now developed a comprehensive plan for Long-term conditions which is detailed in Appendix 2. Our key focus is based on prevalence data continues to be on the following key areas:

    - Diabetes
    - Cardio-vascular Disease
    - Respiratory
    - Weight management
    - Hypertension

Quality

55. Following on from the report presented in June 2022, an update on each of the following key areas is outlined within this report:

    - Care Quality Commission (CQC) Notifications
    - General Practice Quality and Operations Group/Risk Share Group – Primary Care Quality Dashboard
    - LLR GP Access Variation Group Update
    - Publication of Practice Level Appointment Data

- LLR General Practice OPEL (Operational Pressures Escalation Level) Reporting
- Royal College of General Practitioners Support Offer
- General Practice Patient Survey 2022

Care Quality Commission (CQC) Notifications

56. CQC inspections are currently being carried out for new registrations, scheduled follow ups from special measures or requires improvement ratings and where immediate risk has been identified. The CQC are moving to a new single assessment framework and the frequency and schedule for inspections may change.

57. In Quarter 2 of 2022/23, the CQC inspected 6 GP Practices across LLR; 4 GP Practices were rated as Overall Good, and 2 were rated as Overall Inadequate.

58. Areas of good practice included:
    - Staff had the skills, knowledge, and experience to carry out their roles.
    - There was a system in place to monitor compliance with staff training.
    - Staff were encouraged and supported to develop their skills and knowledge
    - Staff with dealt patients with kindness, respect and patience and involved them in decisions about their care.

59. Notable themes and areas of improvement identified include:
    - Increase uptake and promotion of childhood immunisations and cervical screening - a task and finish group has been set up with our clinical lead for inequalities to identify what the issues are and what actions need to be undertaken to improve uptake
    - Patients prescribed high risk medicines without the appropriate reviews taking place will be addressed through conversations with the Clinical Pharmacy team and Medicines Optimisation Team.
    - Monitoring of patient's long-term conditions and associated treatment plans not being done on a regular basis – we have developed a comprehensive plan to address the issues – particular in areas of low prevalence.
    - Promotion and development of the patient participation group (PPG) – the engagement team have been working with practices to revitalize their PPGs. The team have set up quarterly meetings with PPGs and the ICB to support the engagement work and the team are working with those practices who have not had PPGs set up – detailed further in this report.

60. These themes were shared with GP Practice staff at the most recent CQC grab and go session delivered by the ICB Training and Development team and CQC which included discussion on steps to improve, promote and manage risk.

61. To support GP Practices further in these areas, an improvement plan has been devised. This plan is monitored by the ICB's GP Quality Oversight Group.

General Practice Quality and Operations Group/Risk Share Group – Primary Care Quality Dashboard

62. The Nursing and Quality Team and the Integration and Transformation Primary Care Team continue to work closely to review and update the Primary Care Quality Dashboard. Within this dashboard a range of data is collected for all Leicester Leicestershire and Rutland

Practices and PCNs. The data is collected from a range of national and local sources and used as a tool to support with triangulation with an objective to facilitate early intervention, support and identification of vulnerable practices or PCNs.

63. The Dashboard is developed and updated monthly information from national and local data sources which include information on the following:
    - Workforce - All Admin FTE per 1000 Nov 2022
    - QOF Overall Achievement / Prevalence 21/22
    - Personalised Care Adjustment 21/22
    - Serious Incidents Reported 2020/21
    - Patients' complaints to NHSE 2022/23
    - CQC Inspection and Reporting
    - GP Survey Results
    - Clinical information - Screening, Seasonal Flu, Prescribing, Child Immunisation, LD Health Checks,
    - Urgent Care Activity
    - OPEL Reporting
    - GP Appointment Data (GPAD)

64. The Primary Care Quality Ops Group and The Risk Share Group work collaboratively to review the data and triangulate the information to support vulnerable practices or identify those with resilience or sustainability concerns and offer early intervention.

65. The LLR GP Access Variation Group was established in July 22 with membership that includes Workstream Clinical Lead, Place Leads, LMC representative, Quality, Contracting, and Patient Engagement Team and other Workstream Leads.

66. The purpose of this Group is to review GP Access with particular focus on the data published by NHSE on GP Appointments and triangulating this information with other relevant information, for example in hours ED and Urgent Care/Treatment Centre attendance, with the aim of: -
    - Understanding apparent variation and actual impact on access and patient experience
    - Enabling informed response to System challenges with a focus on primary care
    - Identifying actions for System partners, e.g., patient/public facing communication and information
    - Recommending System initiatives to support access and optimize capacity, e.g., the strategic deployment of specialist nurses
    - Identify those vulnerable practices that would benefit with support which can include:
        a) Help these practices reduce variation - if it is indeed unwarranted or having negative impact
        b) Help practices prepare or respond to the increasing number and scope of CQC inspections and reviews
        c) Help practices prepare for or respond to "Healthwatch" visits

67. Using the GP Appointment Dashboard (GPAD) data provided to ICB from NHSE, (Nov 22) the group have: -
    - Undertaken 7 individual practice interventions (6 in City and 1 Leicestershire and none in Rutland)

- Planned 4 individual practice interventions for January 2023 (2 in Leicestershire and 2 in Leicester City and none in Rutland)

68. Emerging themes from the interventions so far include: -
    - Issues with appointment coding and mapping; how to recognise longer appointments, tasks that become patient contacts – this is to be clarified with regional NHSE team and asked to re-issue practice guidance
    - Support to "kick start" PPGs/Patient engagement – this has already commenced and progressing well.
    - Learning from different "same day"/triage models – sharing of good practice across PCNs has been progressed and promoted.
    - System level deployment of specialist staff (beyond ARRS)

Publication of Practice Level Appointment Data

69. On 24 November 2022, NHS Digital published practice level appointment data which:
    - Supported the Government's commitment in "Our Plan For Patients", making more information available on how many appointments each practice is delivering.
    - Included information on Time between booking and appointment date.

70. Nine (9) LLR practices were identified by NHSE as being in the "bottom 20" in the Midlands region for specific indicators (5 Leicester City, 4 Leicestershire, none in Rutland).

71. A support plan has been developed for these 9 practice which includes;
    - Opportunity to understand each practices access data "in the round" – e.g., low % of same day is not 'bad' if more patients are getting planned appointments
    - Once the above has been clarified, the team are looking at 'soft intelligence/local knowledge' for any practices identified to then look at what specific support is required.
    - Desktop review for remaining practices – triangulating the data with current 3 access metrics, ED usage, quality dashboard, resilience information/reporting.
    - ICB Comms team to continuously engage with practices to support them with queries that might be raised from the public / Health Watch – joint approach or initiatives working with LMC.

    - In preparation for 2023/24 the LLR GP Access Variation Group will be focusing on the following:
    - Undertake the planned practice conversations/interventions as above in January
    - Continue to Track/monitor GPAD and Practice Appointment Data for the practices who have had interventions to assess impact – currently awaiting further data from NHSE dashboards
    - Implement support proposal for the 9 practices identified via published data
    - Subject to receiving/accessing new data, continue to review for all LLR practices as described and continue to offer individual or more generic support/development

LLR General Practice OPEL (Operational Pressures Escalation Level) Reporting

72. The ICB in 2022 implemented a System Level Reporting process designed to understand the demand, pressure in general practice across LLR. It can alert the System of risks, or

forthcoming challenges and helps with planning, promotes partnership/ collaborative working, potentially mitigations can be developed and addressed accordingly.

73. Practices are asked to report reflective OPEL status at least once a week, but can also report any day, any time if an individual practice needs assistance/ support to enable them to provide a safe level of patient and employee care on that day. LLR OPEL reporting levels are outlined in the figure below.

74. Figure 1 – OPEL Reporting Levels

OPEL Level	Description	Support Required
Level 1 Low Pressure (Green)	• Business as usual	None required
Level 2 Moderate Pressure (Yellow)	• Busier than usual but coping • Managing within available resources • Performance deterioration, mitigating actions taken at individual practice level	None required
Level 3 Severe Pressure (Amber)	• Busier than usual and struggling to cope • Increased significant deterioration in performance and quality, majority of mitigating actions taken at individual practice level	PCN Level Support Required and/or Federation/ CCG support
Level 4 Extreme Pressure (Red)	• Unable to cope, only able to meet urgent demand • Risk of service failure, all available mitigating actions taken and potentially exhausted	Whole system support required (CCG Co-ordination required)

75. The OPEL report is monitored and checked every day by 9.00 am, and throughout the day.

76. Table 9 provides an overview of the OPELs reported in November and December 2022 and key themes which have been captured and escalated accordingly.

Table 9- OPLE reporting Nov and Dec

November	159 practice responses (109 County Responses) Level 1 – 76 Level 2 – 70 Level 3 – 12 Level 4 – 1	**Key Themes** IT Issues and Workforce.
December	139 practice responses (93 County Responses) Level 1 – 37 Level 2 – 66 Level 3 – 33 Level 4 – 3	**Key Themes** Workforce and High demand, frequently a combination of both, i.e., increased demand on/of a reduced workforce. In December the Primary Care Team escalated the following to the LLR System: • Overall LLR General Practice OPEL status • Increasing demand - specifically from ARI and Strep A • Longer term recruitment and retention issues • NHSE 111 barriers

77. Collaborative working with LLR Local Medical Council (LMC) to encourage practices in LLR to report “winter pressures”.

78. Continue to work with the LMC, General Practice colleagues and representatives to refresh and re-launch LLR General Practice OPEL reporting process in January 2023.

Royal College of General Practitioners (RCGP) Support Offer

79. Aim of the RCGP Practice Support for LLR practices, includes:
    - Diagnostic Review – our service will place two RCGP advisors in each practice to undertake a diagnostic review; to understand the specific challenges and the areas of focus for sustainable quality improvement
    - Forward Development Action Plan - bespoke for the practice, based on the onsite visit and designed to address practice specific needs
    - Direct Targeted Support – The RCGP advisor team will continue working with the practice to help support the implementation of the Forward Development Action Plan

80. All 26 places commissioned have been taken up by LLR Practices and positive feedback received on the process and impact from practices nearing completion.

81. As the RCGP are not able to work with all 26 practices at the same time, they will undertake a diagnostic review and create a plan, thereby crucially supporting these practices with implementation during the 18 months with an aim to complete all 26 practices.

82. Monthly meetings are held with the RCGP Team for progress updates and to monitor and assess timescales for delivery.
83. Themes of learning are shared across practices; for example, best practice for on-boarding for new non-clinical staff.

84. Summary on RCGP Program across LLR:
    - The RCGP process commenced in May 2022 and 26 practices implemented on the programme.
    - As the 5 Practices approach completion and where practices give permission, RCGP will be able to share the learning.

85. Positive feedback has been received from these practices stating how supported and helpful the RCGP team were in understanding their position and working with them to address it.

General Practice Patient Survey (GPPS) 2022

86. The analysis for the 2022 GPPS results focused on the questions which the CQC use to assess and monitor variance of patient experience. Of those questions, it was evident that the highest variance in results from 2021 related to access; appointment times and experiences of making an appointment. Once patients had an appointment with their GP Practice, the confidence and trust in clinician/health care professional was considerably closer to the national average, with less variance from 2021 results.
87. The largest variance across LLR was ease of getting through via telephone, with a considerable range of satisfaction for this question (3%-97%).

88. Initial work has been to work with those practice that have high levels of satisfaction and share the learning with practices who have considerably lower performance. Furthermore, understanding the limitations for the practices in relation to their telephone systems, digital options and local challenges related to size of practice and estates. Where we are able to we have been supporting practices to move to cloud-based telephony and working with practices to adopt more digital approaches where this works better for their patients.

89. The engagement team have committed to supporting those practices with really poor experience of access with a tailored package of support including:

- Website development and enhancement
- Utilisation of digital technologies – viewing records online, ordering prescriptions online, NSH app etc.
- Engagement with targeted local community groups, i.e., local mosques, community group, and Voluntary sector organisations
- Support with translation services
- Promotion of active signposting, awareness of CPCS, and increasing access options for self-help and support outside of GP practices
- PPG engagement, networks, and benefits
- Review displayed materials within GP practice
- Targeted communication to frequent inappropriate users of A&E high attenders
- Action Google reviews
- Look at targeted text messages for patients on System One / EMIS
- Review phone message and recommend alternative

Engaging and communicating with our people

90. The Leicester Leicestershire and Rutland (LLR) Integrated Care Board (ICB) has an operational plan for 2022-23 focusing on five key priorities for primary care – access, workforce, long-term conditions, Primary Care Network development and quality. Alongside this our LLR People and Communities Strategy 2022-2024, approved in June 2022, outlines how we will work in partnership to put the voices of people and communities at the heart of decision making resulting in the improvement of the health and wellbeing of our local communities.

91. The strategy outlines 17 key priorities for the system, 6 of which directly link to improvements in GP primary care services to respond to negative patient experiences and attitudes. These include:

- Create a primary care engagement framework to work with and involve people and communities to co-deliver the best possible health and wellbeing outcomes.
- Develop a strong and mutually beneficial relationship with the voluntary, community and social enterprises, individual communities, and the volunteering infrastructure to tackle health inequality and empower communities.
- Develop plans for the systematic and effective delivery of engagement activities and public consultation, ensuring that legal requirements are adhered to and the views of our communities, including those with protected characteristics, the vulnerable, those living in areas of deprivation and those living across our borders, but dependent on services, are sought using multiple engagement techniques and methods and that their views influence decision making.
- Enable partners to move away from compartmentalised engagement and involvement

to system co-design, outlining a systematic process to ensure that process of involving people starts at a formative stage on all programmes of work.

- Support the development of a framework for engaging with families, carers and children, young people and families, ensuring that they have a voice and their views influence decision making across health and care.
- Ensure that post-decision making that the impact that insights and business intelligence have made on service design and delivery are clearly fed back to the public without exception – to ensure a 'you said, we did' culture.

Reinvigorate Patient Participation Groups (PPGs)

92. To support the reinvigoration of PPGs and engagement opportunities in general, the ICB has developed a Primary Care Engagement Framework. This Framework would work at practice, PCN, place and system level to ensure that communities are engaged with in a way that fits their needs, and their voices are heard and impact service design and delivery. Joint work with patients, carers, practices and Primary Care Networks is vital to develop the primary care engagement framework. The framework would ensure that PPGs are revitalised and linked into their GP practice, their Primary Care Network and the ICB.

93. During 2022 an audit was undertaken with general practice to support with development of the Primary Engagement Framework and reinvigorating PPGs

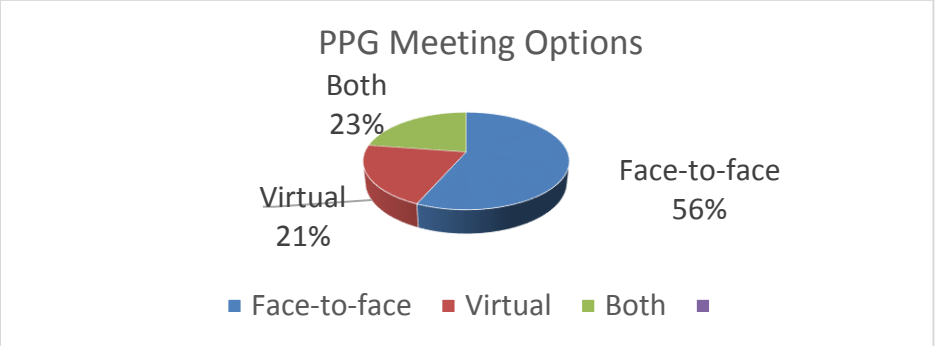
94. Outlined below is a summary of the findings from the audit undertaken:

- As of 6/12/22 there has been 78 responses across LLR and more work will be undertaken to obtain 100% returns.
- From the 78 responses received, 67% had established PPGs while 32% were in the process and welcomed ICB support to progress these.

Table 10 outlines the number of responses received from practices within LLR who have either established PPGs or not:

ICB	No of Practices - Active PPGs	No of practices – Not Active PPGs
Leicester City	18	10
West Leicestershire	18	11
East Leicestershire	15	4
Rutland	2	0

- Majority of practices welcome support from the ICB to help establish their PPG, expressing concerns as to how difficult it is to recruit and attract people to meetings.
- The 67% that had established PPGs offered a variety of meeting options:



95. The key findings from the audit indicates:

- A significant number of practices do not have an established PPG and those that have a PPGs are not fully active
- The majority of practices have resumed face-to-face meetings, with some practices using both virtual and face-to-face
- A high percentage of GP Practices are involved with their PPG, which is good for relationship building
- A low number of PPGs are involved with other PPGs in the same PCN as them
- A high number of practices would welcome ICB support when engaging with and recruiting their PPG

96. Ongoing progress and utilisation of the following areas:

i. **Routes of access**: practices continue to offer online booking options as an alternative to phoning the practice.

ii. **Awareness of alternatives to a GP – the Multi-disciplinary team**: Practices are promoting self-awareness amongst patients on the options available when booking appointment to see the appropriate health care professional. Examples these skill mix include appointments with:
   - Clinical Pharmacists to carry out medication reviews
   - Physiotherapist for Musculoskeletal conditions
   - Dietician for weight management
   - Social Prescribing and Care Coordinators to support with social care referral links and support in the community

iii. **Promoting the use of self – referral services:** Through the 'Talking Therapies', patients can refer to the Podiatry and Musculoskeletal self-care service using an App.

iv. **Community Pharmacy Consultation Scheme (CPCS):** Practices across LLR are encouraged to promote the utilisation and referral of patients to the Community Pharmacy for aliments that can be reviewed in the pharmacy. If a patient's symptoms can be resolved by a booked consultation with the pharmacist instead of the GP, patients will be given a same-day referral to a pharmacy of their choice. In some circumstances the pharmacist can prescribe. Across LLR a number of practices have promoted this service and working collaboratively with their local community pharmacies to improve access.

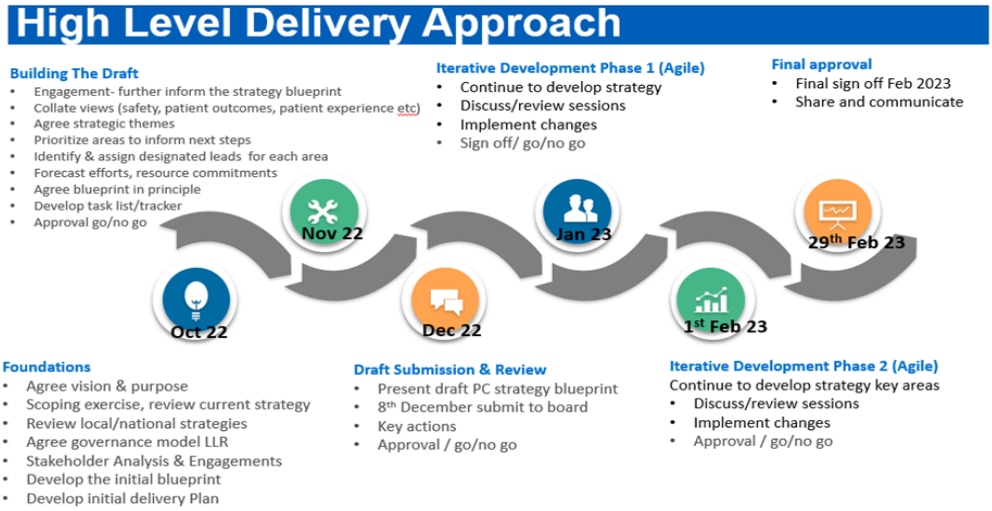
v. **Active signposting/care navigators:** Active signposting continues improve effective collaborative working with system partners to enable patients receive the appropriate care and service from within the community. The ICB Training and Development Hub continues to promote this services within primary care and promotes sharing of best practice.

vi. **Social Prescribing Event** held across LLR promotes integrated development session which includes colleagues from Local Authority to focus on how the needs of the local population can be addressed.

vii. **NHS App:** Ongoing work undertaken to promote the use of NHS App. The App provides access for patients to a range of NHS services including heath advice, ordering a prescription and manage appointments.

viii. **Primary Care Strategy:** Our Primary Care strategy needs a refresh and development in light of the recently published Fuller Stock Take and as we reframe our ambitions as an ICB. We will build on our place led plans, ensuring we direct effort and resource to where it is needed most. Tightening our alignment to better plan and co-ordinate the delivery of not just primary care, but the wider transformation of health and care across LLR. Figure 2 outlines our high-level delivery approach

Figure 2 – High Level Delivery Approach



ix. **Fuller Stocktake Report** – The ICB Fuller Steering Group designed to progress the implementation of the Fuller Stocktake Framework and includes representatives from Primary Care Estates and Workforce, Local Authority, Place Leads, Population Health Leads, LMC, Communication and Engagement, Quality and Integration and Transformation. The purpose of the Steering Group is to progress on delivery of each of the domains within the report and facilitate integrated working across system, place and neighborhood.

97. During the winter period, significant challenges have continued to impact on the level of demand and capacity across primary care. Despite this in LLR our GP Practices have continued to deliver more appointments than the previous 3 years. Access continues to remain challenging, and the work outlined in this report has enabled the ICB to identify where the variation in practice exists.

98. We have undertaken targeted work with practices where we have significant variation to support improvements in those practices where patient experience of access and care has been challenged. We continue to have significant workforce challenges. These are being faced by most regions across the country but in LLR we have specific challenges to nursing and GP workforce particularly in Leicester. Therefore, the focus of our workforce plan is to support retention in Leicestershire and Rutland and work to attract the workforce in Leicester and support training programmes that supports how we 'grow our own'.

99. Finally, the Development of the LLR strategy for Primary Care which will outline a clear vision on how we integrate Primary Care and deliver at Place and Neighbourhood to change the experience of access that tackles the inequality and variation but also supports sustainable and viable primary medical care model in LLR.

Officer to Contact

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Appendix 1 – Enhanced Access Services across Leicester, Leicestershire and Rutland from October 2022

These services may change as they are tailored around the population health needs.

EA PCN Summary_.pptx

EA Summary Excel (1).xlsx

Appendix 2 – Summary of Long Term Condition Plan

Project area	Summary of key deliverables	Expected outcome	Trajectory - 2023/24
Diabetes	• **Diabetes Enhanced Service - (Primary Care)** • **Diabetes Virtual Ward (UHL- step up &step down)** • **Improving Diabetes management - Housebound and care homes** • **Technology - Ensuring people with diabetes can access glucose monitoring (NICE Guidelines 2022)**	• Improvements in 9 care process, reduction in variation of diabetic care • Decrease in patients experiencing an inpatient stay. • Improved diabetes and insulin control in care home residents • Increase • Reduction in frail and elderly admissions to hospital, reduce workload of community nursing team • Improved self management, reduce health inequalities	• All practices/PCNs to be enhanced by March 2024 • Expected to have 30 beds a month by March 2023 • Revised Care home hypo pathway in place by Match 2023, training and care home roadshows delivered before March 2023 • Business Case to be finalised and presented by Nov 2022
Cardiology	• **AF, HF and Early discharge post STEMI Virtual Ward** • **Community Cardiology Service** • **National Cardiac Pathway Improvement Programme (CPIP) (Clinical Stewardship for Heart Failure** • **Implement DOAC (DPP) across 17 PCNs (run by Meds Optimisation Team)** • **Through BP Optimisation Programme, improve uptake of HTN Proactive Care @ Home Framework**	• Reduce length of stay, Improved patient pathway, Offering higher quality of outcome and improve patient experience, Early identification of deterioration / support optimisation of rate control, Reduce outpatient waits and unnecessary investigations, Reduce hospital admissions, presentations and transfers • Provide care closer to patients homes • Reallocation of resources to	• AF - expansion of virtual ward to onboard patients direct from ED at LRI to reduce ambulance transfer to CDU at GH. • HF -Review “step up/step down” opportunities by March 2023 • STEMI - • Community cardiology service to be scoped with Business case by end of March 2023 • Completion of clinical stewardship programme by March 2023

Project area	Summary of key deliverables	Expected outcome	Trajectory - 2023/24
		where interventions have better impact	
Respiratory	**Respiratory Winter Plan (Top Priority)** **Virtual wards – COPD, Asthma, Bronchiectasis and Pneumonia** **PCN Respiratory Diagnostics (spokes through CDH)** **Pulmonary Rehab Expansion – NHSE 5-year programme** **Referral Support Service (RSS) for COPD** **Spirometry Training and accreditation** **Long COVID Assessment / Treatment / Rehab** **Long COVID – health inequalities - Core20Plus5**	• Improve COPD and Asthma prevalence • Proactively manage high risk patients to reduce need for acute through a MDT approach • Ensure staff are appropriately trained to deliver quality assured spirometry • Patients experiencing long covid, understand the condition, know where to access services, and get the support they need	Achieve 100% estimated prevalence in COPD and close Asthma variation Save bed days through virtual ward programme 5 PCNs delivering spirometry in primary care by March 23 Increase in no. of patients that are seen for spirometry within 6 weeks as per national indicator Clear spirometry backlog in UHL by end March 2023 Achieve better than March 2020 baseline figures for COPD/Asthma QOF Reduced Emergency Admissions with respiratory conditions as 1st/2nd diagnosis
ICKD (integrated Chronic Kidney Disease)	• **CKD education strategy for health care professionals - Ongoing, scheduled CKD education to include new therapies, research, development, guidelines and changes in clinical management.** • **CKD education materials (videos) for patients and the public** • **CKD shared care and joint patient management: patient optimisation in multi-professional primary care clinics with specialist input**	• Raise public awareness and understanding of CKD, promote kidney health, increase heath literacy and support patient activation • Upskilled clinical teams across LLR primary care, better equipped to deliver CKD optimisation • Collaborative working across the LLR system, better healthcare resource utilisation, delivering patient optimisation in the most appropriate setting • Improved health outcomes	• 1st 3 videos by end of November. Next 3 by the end of January • PCN education sessions timetable TBC by end of November • Ongoing through MDT clinics pilot sites. Timeline for additional MDT development TBC by end of November 2022 • Project funded from ERF until March 2023. Outputs will enable the development of business case for 2023/24 submission

Project area	Summary of key deliverables	Expected outcome	Trajectory - 2023/24
	• **Introduce the use of novel therapies (SGLT2i, finerenone, roxadustat) for the treatment of CKD and its complications in LLR** • **Improvement of CKD specialist referral process in LLR process through updated PRISM form, launch *NEW* CKD FAQs and secondary care triage of referrals**	through safe, cost-effective use of SGLT2i, finerenone and roxadustat • Optimised LLR CKD pathway, unnecessary outpatient appointments avoided, primary care clinical workforce adequately supported to deliver CKD optimisation	
Hypertension (inc. BP Optimisation)	• **Complete BP Optimisation Programme – target practices and action plans (use LTC Champs)** • **Strengthen the use of the Community Pharmacy Case-finding Service** • **Continue to maximise the use of BP@Home monitors and processes** • **Update and recirculate LLR Hypertension pathway document**	• Reduction in the number of strokes and heart attacks for LLR patients • Improved under-75 mortality rate for cardiovascular diseases and all persons • Improved life expectancy at age 65 • Reduced Emergency Admissions with Hypertension as 1st/2nd diagnosis • Increase patient satisfaction in their care • Reduce inequalities for Hypertension care across LLR	• Achieve 80% of estimated Hypertension prevalence in LLR • Reduction in Hypertension prevalence gaps for practices • Achieve better than March 2020 baseline figures for Hypertension QOF (HYP003 & HYP007) • Improve Hypertension optimisation in the top 20% most deprived areas in LLR • Reduce the number of high-risk Hypertension patients (UCLP searches) • Achieve IIF indicators – CVD-01 and CVD-02 • Increased use of Comm Pharmacy HTN service
Anticipatory Care (multimorbidity / complex care)	• **LLR Anticipatory Care Implementation Plan and Delivery Framework .** • **6-8 Early Adopter sites will support with winter respiratory plan by targeting**	• Vulnerable COPD patients supported to stay healthy at home during winter 22/23. • System supported with resources to embed anticipatory care.	• Plan and delivery framework completed by end December 2022 (subject to national guidance). Early Adopter sites to commence November 2022, with expected decrease in risk of admission and volume of care plans. Evaluation/business case for MDT Facilitators

Project area	Summary of key deliverables	Expected outcome	Trajectory - 2023/24
	vulnerable patients with COPD. • **Proof of concept for MDT Facilitators completed.**		by end February 2023.
Weight Mangement	• **Tier 3 weight management service**	• Increase in weight loss and reduction in complications related to severe obesity	• T3 Weight Management approved. Service provision phased over 3 years. • Year 1: establish service and test model of care
Cholesterol Management (pending succesful bid)	• **Use UCLP Size of the Prize for Cholesterol** • **Improve statin use in primary care** • **Familial Hypercholesterolaemia – NICE recommended service** • **STF Bid to support the implementation of the LLR Lipid Pathway**	• Reduction in the number of strokes and heart attacks for LLR patients • Improved under-75 mortality rate for cardiovascular diseases, FH and all persons • Improved life expectancy at age 65 • Reduced Emergency Admissions with Cholesterol as 1st/2nd diagnosis	• Reduce the number of high-risk Cholesterol/FH patients (UCLP searches) • Achieve relevant IIF indicators around statins • Improve QOF optimisation around statins for Diabetic and SMI pts
Primary Care LTC (Proactive Care @ Home)	• **Complete a practice process guide for QOF/LTC Management** • **Recruit and utilise LTC Champions to improve practice processes and reduce variation in LTC management** • **Create practice income packs to show how much more they could receive if their prevalence is increased**	• Reduction in the number of strokes and heart attacks for LLR patients • Improved under-75 mortality rate for cardiovascular diseases, respiratory diseases and all persons • Improved mortality rates from preventable causes • Improved life expectancy at age 65 • Reduced Emergency	• For relevant CVD-R QOF indicators, return to (better than) March 2020 optimisation levels – all QOF targets met • Reduce total LLR QOF gap for the relevant indicators • Achieve 85% of estimated AF prevalence in LLR • Achieve 100% of estimated prevalence in LLR for COPD and HF • For Asthma and Diabetes, bring lower practice prevalence figures to LLR average • Reduce the number of high-risk patients for all

Project area	Summary of key deliverables	Expected outcome	Trajectory - 2023/24
	• **Optimise the use of Ardens, including for those practices who haven't yet purchased it** • **Run Webinars for practices staff – disease/role specific**	Admissions with CVD-R conditions as 1st/2nd diagnosis • Increase patient satisfaction in their care • Staff satisfaction in secondary care – seeing appropriate patients • Increase in competencies / knowledge in Primary Care in LTC management	areas (UCLP searches) • Achieve IIF indicators – CVD-03, CVD-04, CVD-05, CVD-06, AC-02, RESP-01 and RESP-02 • Increase in number of practices with Ardens functionality • Increase in number of practice staff trained on the Proactive Care principles

Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee
Work Programme – 2022/23

Date	Topic	Notes	Actions/Progress
27 Jun 22	1. Update on Dental Services 2. UHL Finances and Accounts for 19-20 and 20-21 3. Leicester, Leicestershire, and Rutland Integrated Care Systems Update 4. Covid-19 Vaccination Programme Update 5. Maternity Services	1. Recovery of services post COVID19 across LLR and access to dentistry. 2. This item will be taken to the Committee this year as reports will be decoupled and approved at separate Board Meetings over the last few months. 3. Update on organisational arrangements before implementation date of 1 July 22. 5. Item to include information on Maternity Services and any self-assessment conducted by UHL, given the recent media interest (Kirkup and Ockendon inquiries)	1. Complete; to return in 12 months' time. Letter to Secretary of State for Health sent in November '22. 2. To be considered in Nov 2022. 3. Progress update in March 2023 4. Updates will be provided where appropriate. 5. Updates will be provided where appropriate.
16 Nov 22	1. UHL accounts for 19-20 and 20-21: both accounts need to be looked at in unison 2. Corporate Complaints Procedures 3. Autumn/Winter Vaccination Programme Update	1. As agreed previously, the committee will inspect the accounts from the previous two years. 2. This will provide an opportunity to examine the current UHL Corporate Complaints Procedures. 3. This will cover the latest position with the programme across the region – for both COVID and Flu.	1. A written summary of the budget deficit to be provided to members separately and a further comprehensive report be brought to a meeting later in 2023. 2. That a full report setting out how the complaints procedure works including the patient experience be provided to a future meeting

Date	Topic	Notes	Actions/Progress
6 February 23	1. UHL Hospital Reconfiguration Update/Dermatology Service Update 2. Outcome of Well-led CQC Inspection 3. Transforming Care – Learning Disabilities and Autism Update 4. Leicester, Leicestershire, and Rutland Integrated Care Systems – Organisational Progress Update 5. Access to Primary Care – including Enhanced Access to GP Surgeries	1. A holding update in relation to the UHL reconfiguration along with an update on the Dermatology Service. 2. Inspection report and action plan to be provided. 3. Comprehensive report requested by the Commission with a joint LLR overview. 4. Follow up to the Committee on the implementation of the ICS. 5. A broad report on primary care access that provides data for the three LA areas.	

Other Suggested Items for 2023/24

Agenda item	Organisation/Officer responsible	Notes
1. EMAS - Clinical Operating Model and Specialist Practitioners	Russell Smalley, EMAS	This item was last presented in March 2022 and an update was requested once the model has been implemented further. This will be provided during the 2023/24 municipal year.
2. Update on Dental Services	Thomas Bailey, NHS England	This item was presented in July 2021 and September 2021 and June 2022 on the recovery of dental services following COVID and general access to dentistry across LLR. Update in 12 months' time (approx. June 2023)
3. UHL Finances and Accounts for 19-20 and 20-21	UHL	On 16 November 2022, a number of information requests were sought, and that a further report be brought back in 2023.
4. Maternity Services (including Black Maternal Healthcare and Mortality)	UHL	An item on maternal healthcare (Kirkup and Ockenden reports) was taken in June 2022, with a view to receive future updates.

Agenda item	Organisation/Officer responsible	Notes
5. Covid-19 Vaccination Programme Update	ICS	This was a standing item in the previous municipal year and relevant updates in 2023 may be requested, where required.
6. Leicester, Leicestershire, and Rutland Integrated Care System	ICS	This item was last taken in February 2023. Further updates to be scheduled accordingly.
7. Corporate Complaints Procedure	UHL	This item was taken in November 2022. It was requested that a full report setting out how the complaints procedure works, how the procedure has moved on including the patient experience and learning from complaints together with performance trends and dashboard data be provided to a future meeting.
8. Outcome of LPT CQC inspection	ICS	This was taken at the special meeting in Feb 2022 with a follow up update in March 2022 regarding the dormitory accommodation. Anticipated that an update on inspection outcomes may return to the Committee this year – potentially February 2023.
9. Findings and analysis of the Step Up to Great Mental Health Consultation - Leicester, Leicestershire, and Rutland	ICS	Consultation about proposals to invest and improve adult mental health services for people in LLR was discussed in Feb 2022 and March 2022. Anticipated that the progress on the implementation of the outcomes on the Step Up to Great Mental Health programme may return to the Committee this year – potentially in early/mid 2023.
10. Re-procurement of the Non-Emergency Patient Transport Service (NEPTS)	ICS	Deferred from February 2023. To be taken in the 2023/4 municipal year (possibly the first meeting).
11. Transfer of Haemodialysis Unit	UHL	A paper to be brought later in 2023