Leicester
City Council

MEETING OF THE HEALTH AND WELLBEING SCRUTINY COMMISSION

DATE: **THURSDAY, 6 AUGUST 2015**
TIME: **5:30 pm**
PLACE: **Meeting Room G.01, Ground Floor, City Hall, 115 Charles Street, Leicester, LE1 1FZ**

Members of the Commission

Councillor Chaplin (Chair)
Councillor Fonseca (Vice-Chair)

Councillors Alfonso, Bhavsar, Dr Chowdhury, Sangster and Singh Johal

I unallocated Non-Group place.

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

G. J. Carey

For Monitoring Officer

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Leicester City Council, City Hall, 115 Charles Street, Leicester, LE1 1FZ

Information for members of the public

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- ✓ where filming, to (via the Chair of the meeting) ensure that those present are aware that they may be filmed and respect any requests to not be filmed.

Further information

If you have any queries about any of the above or the business to be discussed, please contact Graham Carey**, Democratic Support on (0116) 454 6356 or email graham.carey@leicester.gov.uk** or call in at City Hall, 115 Charles Street, Leicester, LE1 1FZ.

For Press Enquiries - please phone the **Communications Unit on 454 4151**

PUBLIC SESSION

AGENDA

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. MEMBERSHIP OF THE COMMISSION

To note the membership of the Commission for the 2015/16 municipal year.

Councillor Chaplin – Chair
Councillor Fonseca – Vice-Chair
Councillor Alfonso
Councillor Bhavsar
Councillor Dr Chowdhury
Councillor Sangster
Councillor Singh Johal

1 unallocated Non-Grouped Place.

4. TERMS FOR REFERENCE FOR THE COMMISSION

Appendix A (Page 1)

To note the Terms of Reference for the Commission.

5. DATES OF MEETINGS FOR 2015/16

To note that meetings of the Commission will be held on the following dates during the municipal year 2015/16:-

Thursday 6 August 2015
Monday 28 September 2015
Thursday 29 October 2015
Thursday 14 January 2016
Thursday 10 March 2016
Thursday 5 May 2016

All meetings are scheduled to take place at 5.30pm in Meeting Room G01 at City Hall.

6. MINUTES OF PREVIOUS MEETING **Appendix B (Page 3)**

The minutes of the meeting held on 25 March 2015 have been circulated and the Commission will be asked to confirm them as a correct record.

The minutes can be found on the Council's website at the following link:-

http://www.cabinet.leicester.gov.uk:8071/ieListMeetings.aspx?CId=737&Year=0

7. PETITIONS

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

8. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

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

9. HEALTHWATCH - UPDATE

David Henson, Executive Officer, Healthwatch Leicester, will give an update following Healthwatch being established as an independent body.

10. PUBLIC HEALTH BUDGET **Appendix C (Page 17)**

To receive a briefing paper from the Director of Public Health on national plans to make in-year savings on the ring fenced public health grant to local councils, following the Chancellor of the Exchequer's announcement on 5 June 2015.

11. LEICESTERSHIRE PARTNERSHIP NHS TRUST - QUALITY REPORT **Appendix D (Page 21)**

The Care Quality Commission's Quality Report on the services provided by Leicestershire Partnership NHS Trust (LPT). Representatives of LPT and Leicester City Clinical Commissioning Group (as commissioners of services) have been invited to the meeting.

12. SCRUTINY REVIEW OF THE LGBT COMMUNITIES **Appendix E (Page 73)**

A copy of the Overview Select Committee's scrutiny report on 'Equality Impact Assessments (EIAs) and Lesbian, Gay, Bisexual and Trans (LGBT) Issues is attached.

The Commission is requested consider the issues raised in the report and

respond in particular to the recommendation contained in paragraph 3.1.6 in relation to whether the needs of LGBT people are being adequately considered and responded to, particularly in relation to sexual and mental health.

Representatives of the Leicester LGBT Centre and Trade Sexual Health have been invited to the meeting for this item.

13. ANCHOR CENTRE - UPDATE **Appendix F (Page 99)**

To receive a briefing paper from the Director of Care Services and Commissioning and the Director of Public Health on the temporary relocation of the Wet Day Centre (Anchor Centre).

14. SUBSTANCE MISUSE SERVICES RE-PROCUREMENT **Appendix G (Page 103)**

To receive a briefing paper from the Director of Care Services and Commissioning on the Substance Misuse Services Re-Procurement. A copy of the Consultation Document is attached at Appendix G1 (Page 107)

15. LOCAL HEALTH MESSAGES DEVELOPMENT **Appendix H (Page 119)**

To receive a report from the Director of Public Health on Local Health Messages Development.

16. WORK PROGRAMME **Appendix I (Page 127)**

The Scrutiny Policy Officer submits a document that outlines the Health and Wellbeing Scrutiny Commission's Work Programme for 2015/16. The Commission is asked to consider the Programme and make comments and/or amendments as it considers necessary.

17. ANY OTHER URGENT BUSINESS

Appendix A

THE 6 PRINCIPLES OF EFFECTIVE SCRUTINY

In March 2014, the Health & Wellbeing Scrutiny Commission adopted 6 principles of effective scrutiny and subsequently agreed that these would be included on all agenda to enable anyone observing or attending meetings to be clear about the role of the Commission. These are:-

1. **To provide a 'critical friend' challenge to executive policy- makers and decision-makers.**

2. **To carry out scrutiny by 'independent minded governors' who lead and own the scrutiny process.**

3. **To drive improvements in services and finds efficiencies.**

4. **To enable the voice and concerns of the public and its communities to be heard.**

5. **To prevent duplication of effort and resources.**

6. **To seek assurances of quality from stakeholders and providers of services.**

TERMS OF REFERENCE OF SCRUTINY COMMISSIONS

Scrutiny Committees hold the executive and partners to account by reviewing and scrutinising policy and practices. Scrutiny Committees will have regard to the Political Conventions and the Scrutiny Operating Protocols and Handbook in fulfilling their work.

The Overview and Select Committee and each Scrutiny Commission will perform the role as set out in Article 8 of the Constitution in relation to the functions set out in its

Scrutiny Commissions may:-

i. review and scrutinise the decisions made by and performance of the City Mayor, Executive, Committees and Council officers both in relation to individual decisions and over time.

ii. develop policy, generate ideas, review and scrutinise the performance of the Council in relation to its policy objectives, performance targets and/or particular service areas.

iii. question the City Mayor, members of the Executive, committees and Directors about their decisions and performance, whether generally in comparison with service plans and targets over a period of time, or in relation to particular decisions, initiatives or projects.

iv. make recommendations to the City Mayor, Executive, committees and the

Council arising from the outcome of the scrutiny process.

v. review and scrutinise the performance of other public bodies in the area and invite reports from them by requesting them to address the Scrutiny Committee and local people about their activities and performance; and

vi. question and gather evidence from any person (with their consent).

Annual report: The Overview Select Committee will report annually to Full Council on its work and make recommendations for future work programmes and amended working methods if appropriate. Scrutiny Commissions / committees will report from time to time as appropriate to Council.

SCRUTINY COMMISSIONS will:-

- Be aligned with the appropriate Executive portfolio.
- Normally undertake overview of Executive work, reviewing items for Executive decision where it chooses.
- Engage in policy development within its remit.
- Normally be attended by the relevant Executive Member, who will be a standing invitee.
- Have their own work programme and will make recommendations to the Executive where appropriate.
- Consider requests by the Executive to carry forward items of work and report to the Executive as appropriate.
- Report on their work to Council from time to time as required.
- Be classed as specific Scrutiny Committees in terms of legislation but will refer cross cutting work to the OSC.
- Consider the training requirements of Members who undertake Scrutiny and seek to secure such training as appropriate.

Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING SCRUTINY COMMISSION

Held: WEDNESDAY, 25 MARCH 2015 at 5:30 pm

P R E S E N T :

Councillor Cooke (Chair)
Councillor Cutkelvin (Vice Chair)

Councillor Chaplin Councillor Sangster

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103. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Bajaj, Glover and Singh.

104. DECLARATIONS OF INTEREST

Members were asked to declare any interests they might have in the business on the agenda. No such declarations were made.

105. PETITIONS

The Monitoring Officer reported that no petitions had been submitted in accordance with the Council's procedures.

The Chair commented that a response to the petition submitted by Mr Ball in relation to the scrutiny of the Better Care Together Programme was being prepared in accordance with the Council's Petition Scheme.

106. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer reported that no questions, representations and statements of case had been submitted in accordance with the Council's procedures.

107. CONGENITAL HEART DISEASE REVIEW

Michael Wilson, New Congenital Heart Disease (CHD) Review Programme Director and Jon Gulliver, Local Service Specialist, Specialised Commissioning

- East Midlands attended the meeting to provide an update on the Congenital Heart Disease Review and answer members' questions. A copy of their presentation was previously circulated to Members with the agenda.

In addition to the comments set out in the presentation notes, Mr Wilson, made the following observations:-

a) External consultants, Dialogue by Design, had been commissioned by the NHS England to receive the responses to the consultation, analyse the response and produce a report, which had been published on 2 March 2015.

b) There had been 373 responses, from both organisations and individuals. The responses were mixed with approximately a third disagreeing with the proposals, a third agreeing and a third either not knowing or neutral to the proposals. Differing views were expressed by organisations to those expressed by individuals. The responses were currently being analysed to see if these differences in responses could be explained.

c) Although the presentation was giving a high level overview; the questions in the consultation had been aimed at testing whether the proposals were appropriate and, if not, what could be done to improve them.

d) NHS England had not yet formally considered its own view on the outcome of the consultation.

e) Approximately half of the responses were from patients or families of patients and approximately 20% of responses were from 18 year olds or under.

f) There were growing numbers of adults with a CHD and these numbers would continue to grow because of the success of the service. The service would, therefore, need to develop to keep pace with the increase in future demand and the likelihood of more patients requiring complicated forms of treatment as they grew older.

g) Most of the comments relating to teams of 4 surgeons undertaking 125 operations a year expressed views rather than indicating whether they were for or against the proposed standard.

h) Concerns about access to other services were also expressed as CHD patients often had other health conditions which required treatment.

i) In relation to the proposals for co-location, it was understood that it may take time to relocate services and this was reflected in the proposed standards.

j) After the responses had been analysed, the Clinical Advisory Group would be asked to determine if the standards were appropriate or

needed to be revised, whether any new evidence required the standards to be amended and whether any of the comments that didn't specifically relate to the proposed standards raised any issues which needed to be considered further.

k) Recommendations would then be made to the NHS England Task and Finish CHD Group and, following this, the proposal would go through an internal assurance process with the aim of the submitting the final proposals to the NHS England Board meeting in July. If this was not possible, it would be considered at the September Board meeting.

l) Commissioning models would then be designed for the standards specifications with the aim of commissioning services from October 2015 to March 2016 and services being in place from April 2016 onwards.

m) Work on the review in public has been paused during the pre-election period and it is intended to use this time for internal preparatory work and for the existing centres to work on their responses to the issues now asked of them by NHS England.

During the presentation Members made the following comments:-

a) The Commission's original submission to the IRP had also highlighted regional variations in demand which had resulted from catchment areas being ill-defined. This resulted in patients in Northamptonshire travelling to centres in the south, rather than to Leicester.

b) It was felt that the flows from catchment areas were determined more by consultants referring patients to other centres rather than the NHS determining that all patients in a catchment area should be referred initially to the local centre.

c) The consultation process had not been considered to be fully representative, as the consultation had followed a conventional approach. There had not been any specific targeted consultation with specific communities or hard to reach groups.

d) The Chair had raised similar issues at the meeting in Birmingham and had commented that, whilst local government was used to engaging in widespread consultation methods to reach all parts of the community, the NHS were more used to undertaking conventional consultation methods. It was suggested that the NHS should engage with the Local Government Association in future major consultation exercises to address these shortfalls.

e) There was a responsibility for public bodies under equal opportunities legislation to consult all groups in the community and, as half of the population of Leicester were from BME groups, it was surprising that targeted or pro-active sampling of these communities was not

considered.

In response to questions made by Members of the Commission during the presentation, Mr Wilson commented that:-

a) The issue of defined catchment areas had been recognised as an issue in the consultation documents, and differing views had been received, which required further consideration. It was recognised that the rules on competition were at variance with those on collaboration and centres were expected to undertake both. Views had also been submitted that there was sufficient case work for all surgeons in all the centres to achieve 125 operations per year if the NHS determined catchment areas for each centre. Trusts had also been asked to see how proposals to establish regional networks rather than a network based upon a single hospital could be achieved.

b) There were current variations in number of operations per year carried out by each surgeon. These varied from 70 - 200. There was a view expressed in the consultation that different complexities of operations should be weighted differently and not equally as at present. The Clinical Advisory Panel had been asked to look at this aspect again. Originally it was considered that there did not need to be a different weighting for each operation as there would be a natural mix of complexities undertaken by each surgeon. However, as this issue had been raised frequently during the consultation, it was felt appropriate to reconsider the original viewpoint.

d) It was recognised that the older and more experienced surgeons were carrying out more operations than less experienced surgeons, and, whilst there was no pressure being expressed to reduce these numbers; it had been suggested that mentoring of younger and less experienced surgeons by the more experienced ones should be considered.

e) It was recognised that not all providers of Congenital Heart Services would meet all the standards as currently proposed. The standards were seen as being aspirational and all services would be improved when the standards were eventually met. Currently, communications with patients and better management of end of life care could be improved.

f) The issues of not receiving care closest to the place where the patient lived were well understood. However, this issue was likely to remain whichever model was chosen.

g) The responses from BME communities to the consultation were not as high as it was expected to have been. Material in various languages was made available during the consultation process. Members' comments were noted and would be referred back to the group responsible for engagement.

h) An Equality Impact Assessment had been carried out and was available to the public on the website.

Kate Shields stated that the Review had made Leicester look at the provision of children's services on one site and whilst the de-minimus limits were good; a network solution would be needed to achieve the best service outcomes in Leicester.

RESOLVED:

That the presentation be received and Mr Wilson be thanked for his responses to Members questions.

108. IMPROVEMENTS TO INTENSIVE CARE PROVISION

Kate Shields, Director of Strategy University Hospitals of Leicester NHS Trust (UHL) attended the meeting to discuss the issue of the future provision of Intensive Care Units (ICUs) at UHL. A background briefing paper was circulated at the meeting and a copy is attached to these minutes.

Before considering the briefing paper, the Chair circulated and extract from the 'Guidance to support Local Authorities and their partners to deliver effective health scrutiny, published in June 2014'. This is reproduced below:-

Local Authority Health Scrutiny - Extract from page 24 & 25

4.5 When consultation is not required

4.5.1 The Regulations set out certain proposals on which consultation with health scrutiny is not required.

These are:

a) Where the relevant NHS body or health service commissioner believes that a decision has to be taken without allowing time for consultation because of a risk to safety or welfare of patients or staff (this might for example cover the situation where a ward needs to close immediately because of a viral outbreak) – in such cases the NHS body or health service provider must notify the local authority that consultation will not take place and the reason for this.

b) Where there is a proposal to establish or dissolve or vary the constitution of a CCG or establish or dissolve an NHS trust, unless the proposal involves a substantial development or variation.

c) Where proposals are part of a trusts special administrator's report or draft report (i.e. when a trust has financial difficulties and is being run by an administration put in place by the Secretary of State) – these are required to be the subject of a separate 30-day community-wide consultation.

Following consideration of the guidance, the Chair commented that the Commission's role was not to approve the proposals, but to understand them and to fulfil their obligations under the guidance, particularly those relating to paragraph a) above.

The briefing paper outlined the proposal to reduce the current three ICUs at each of the three hospital sites into two 'super' ICUs at the Royal Infirmary and Glenfield Hospital. There was not enough capacity at the Royal Infirmary and Glenfield Hospital to provide level 3 care, whilst there was over capacity at the General Hospital. Difficulties in recruiting staff for level 3 care had been difficult as the trust was no longer able to provide training and the volume and mix of cases at each site was not attractive to potential staff. In addition, 3 consultants had given notice to retire in the near future. The details of the proposal were being subjected to external review to validate that the proposal was safe and sustainable. It was intended to have the two level 3 care units in place by December 2015. The General Hospital would become a High Dependency Unit providing a higher level of care than a ward but not as specialised as a level 3 care ward (ICU).

In response to members' questions the following responses were noted:-

a) Transport arrangements would be put in place to ensure that any patient requiring level 3 support on the three hospital sites would have access to them.

b) A plan would be required to ensure that the level 2 care facility at the General Hospital could be maintained in the future.

c) It was estimated that there would be 150 bed activity at the Royal Infirmary and Glenfield Hospital and this was currently undergoing a "confirm and challenge" process.

d) Plans were also being currently developed to free up surgical beds through efficiency measures. This included day case patients not being admitted before operations and being discharged earlier. Discussions were also taking place with Leicestershire Partnership Trust as part of the process of freeing up surgical bed availability.

e) The proposal was not associated with delivering the Better Care Together Programme, but was concerned with continuing to provide a service. A level 3 care ward was necessary to support multiple organ support and ventilation and, if this level of ICU was not available, then surgical operations involving renal care, kidney transplants, gall bladder and liver conditions would need to cease shortly after December 2015. Whilst the current proposal may not be ideal, it was nevertheless considered safe and sustainable for the foreseeable future.

f) There would be 2 units of 6 beds close to each other at the Royal

Infirmary.

RESOLVED:

1) That it be noted that the University Hospitals of Leicester NHS Trust (UHL) had determined that it was necessary to proceed with the proposal without engaging in a full public consultation exercise, as they felt this was in the best interests of patients in order to provide ICU facilities after December 2015.

2) That UHL continue to present periodic updates on the progress with the proposal and the consequence of the changes.

109. EMAS - DEVELOPING KEY STRATEGIES

East Midlands Ambulance NHS Trust attended the meeting to discuss a number of key strategies to help them to achieve their long term plans, allowing them to give people the right care, with the right resources, in the right place, at the right time.

The strategies were being developed together and in line with the strategic objectives contained in their Better Patient Care and draft five year plans, so that the full set will support what they wish to do.

The strategies were:

- Clinical and Quality Strategy
- Workforce Strategy
- Fleet Strategy
- Information Management and Technology (IM&T) Strategy
- Estates Strategy

The final strategies would then be presented to the EMAS Executive Board and they would then wish to come back at a later date to discuss future developments.

A copy of a report, a briefing and a presentation had previously been circulated to Members with the agenda.

RESOLVED:

That EMAS be thanked for their presentation and it was pleasing to see that the new management structure was providing improvements and allowing the service to move forward in

responding to the current challenges.

110. PHARMACEUTICAL NEEDS ASSESSMENT

The Commission received a report on the outcomes of the consultation carried out on the Pharmaceutical Needs Assessment (PNA) which was carried out from 29 September 2014 to 12 December 2014. The Report was also being submitted to the Health and Wellbeing Board at its meeting on 26 March 2015 requesting approval of the final PNA Assessment. The final PNA Assessment for approval had previously been circulated to Members.

The Commissions views on the report and the final PNA are requested.

In response to questions, it was noted that:-

a) The final PNA was a based on a prescribed format to comply with legislative requirements.

b) Although there were adequate pharmacies for the needs of the total population, not all areas of the city received the same level of service.

c) The PNA would be available for Commissioners to use when services were commissioned.

d) NHS England commissioned pharmacy services and the Council would request additional services be provided by pharmacies in different areas of the city that reflect each area's health needs.

e) The number of pharmacies in a ward did not necessarily mean better health outcomes in the ward. Commissioning different services from pharmacies according to local health needs could potentially have an effect on health outcomes. Pharmacies were also required to report on the usage of various services through the commissioning arrangements.

RESOLVED:

That the Commission supports the Recommendations to the Health and Wellbeing Board to:-

a) Approve the final PNA for publication.

b) Note the need to update the PNA by March 2018, as set out in the Pharmaceutical Regulations.

c) Note and approve the ongoing responsibilities with respect to the publication of an up-to-date map of all pharmacy provision and the arrangements that have been proposed to ensure that this takes place.

111. HIGHFIELDS MEDICAL CENTRE - SCRUTINY REVIEW REPORT OF FINDINGS

The Commission received a 2nd Draft final report for approval. The first draft was originally considered at the Commission's meeting on 10 March 2015.

The Chair reported that a response had been received from NHS England to the report's recommendations and these were incorporated under paragraph 4.3.

RESOLVED:

1) That the 2nd draft report be received and approved for final issue including the response made by NHS England.

ACTION

1. The Scrutiny policy Officer to arrange for the report to be issued in its final form to all those taking part in the review and to those organisations and individuals requested to take action in the report.

2. That the organisations and individuals requested to take action in the report also be requested to submit a formal response to the recommendations.

112. REVIEW OF MENTAL HEALTH SERVICES FOR YOUNG BLACK BRITISH MEN

The Commission received a 2nd Draft final report for approval. The first draft was originally considered at the Commission's meeting on 10 March 2015. Comments received since the meeting had been incorporated into the 2nd draft report.

A representative of LAMP attending the meeting and submitted the following comments based upon her experiences:-

a) Young black British Men could start to face isolation and mental health issues in earlier school life, through unintentional institutional racism, through a mixture of lack of resources and training for professionals who were not aware of the isolation and social issues faced by different cultures.

b) Children from mixed race marriages could face social isolation as they could feel that they were not fully accepted or felt able to fully integrated into either of their mixed races. This could make them vulnerable to mental health issues in their later life.

c) Often young black British pupils were underachieving as a result of their isolation issues, but there were no specific initiatives to address this. Often, pupils were more likely to be seen as obstructive and troublesome and, as a result, they were more likely to be excluded either form lessons or from school, which further increased their isolation. Exclusion from lessons did not count towards the formal figures for 'excluded pupils' but often had the same effects of isolation for the individuals concerned.

d) There was an under representation of African-Caribbean teachers in the workforce.

e) There was a need for a young peoples' specialist advocacy service in Leicester for mental health for all young people and not just for one specific community.

The Chair commented that, whilst a number of the comments were outside the specific narrow terms of the review, he recognised that the impact of the issues raised could have a later impact upon the group that were the subject of the review. He also recognised that interventions at an early stage may have had an effect upon the current picture.

It was noted that the Royal College of Paediatrics and Child Health had an on-line educational resource called 'MindEd' which provides practical e-learning sessions when and wherever they're needed, quickly building knowledge and confidence to identify an issue, act swiftly and improve outcomes for children and young people. The resource can be found at the following link:-

http://www.rcpch.ac.uk/minded

The project were working with schools to give them have the resources and tools to recognise mental health issues at an early stage. A similar resource for parents was also being developed.

The importance of having a service such as CAMHS was also recognised.

RESOLVED:

1) That the 2nd draft report be received and that the comments made at the meeting be noted.

2) That the Chair revisits the recommendations in the report to make them more robust and 'active' clearly indicating individuals or organisation which should take action to address them. The revised recommendations be sent to the Commission Members for comment before the final report is issued in mid-April.

ACTION

1. A copy of the report and an extract of the minutes be forwarded to the Children and Young Persons Scrutiny Commission, to allow then to feed issues into their work programme.

2. That the Chair revisits the recommendations with the report author and sends the revised recommendations to the Commission members for comment before the final report is issued.

113. SUGGESTED ITEMS FOR FUTURE HEALTH SCRUTINY

The Scrutiny Support Officer submitted a document that listed suggestions for future health scrutiny.

The Chair commented that Members could suggest further items by e-mailing the Scrutiny Support Officer if they wished.

RESOLVED:

That the list of suggested items for future health scrutiny be received and Members be invited to e-mail any further suggestions to the Scrutiny Policy Officer.

ACTION

Members inform the Scrutiny Policy Officer of any other additional items for future health scrutiny.

114. PRIMARY MEDICAL SERVICES

The Acting Director of Public Health provided an update on the proposed funding changes to GPs Primary Medical Services contracts and the implications this might have for health care in the City.

It was noted that:-

a) There were currently 17 GP practices in the City with a Primary Medical Services contact. This represented approximately 26% of GP practices in the City on this type of contract compared to 40% of GP practices nationally. A growing number of GP practices in the City were converting to General Medical Services Contracts.

b) The average financial loss to GPs with a Primary Medical Services contract as a result of the funding changes is estimated at approximately £10,000 per annum per practice. The money saved by these changes

would be retained within the health economy and it was intended to redistribute them to GPs practices that needed additional resources. These payments had been made previously to all Primary Medical Services GP practices, some of which would have been in more affluent areas and would not have needed the extra support.

c) The Minimum Practice Income Guarantee, which was used to top up practices core funding, had also been removed. This could have a further impact upon some City GP practices.

d) NHS England would be expected to redistribute the monies through the new co-commissioning arrangements with the CCG.

RESOLVED:

That the report be noted and the Acting Director of Public Health undertake further work to determine the impact upon each GP practice in the City affected by these proposals and report back to a future meeting.

ACTION

The Acting Director of Public Health undertake further work to determine from NHS England the impact upon GP practices in the City affected by these proposals and report back to a future meeting.

115. UPDATE ON PROGRESS WITH MATTERS CONSIDERED AT A PREVIOUS MEETING

The Commission received an update on the following items that had been considered at a previous meeting:-

It was noted that:-

a) Healthwatch Leicester were still on target to be established as an independent body.

b) No formal individual apology had yet been issued to the Directors of Healthwatch who had previously resigned, following VAL's refusal to novate the contract to Healthwatch Leicester.

116. ITEMS FOR INFORMATION / NOTING ONLY

A Healthier Future for the East Midlands

A copy of a report issued by the East Midlands Councils which examined a number of issues of importance when reviewing health outcomes and practice

in the East Midlands Region. Four priority areas were highlighted as set out below:-

Inequalities ii Health outcomes.

Inequalities in funding for health care.

Recruitment and retention of the health workforce.

The need for collective leadership.

The report made a number of recommendations to support further work between councils and MPs, the NHS, Public Health England and wider health partners.

RESOLVED:

That the report be noted.

117. CLOSE OF MEETING

The Chair declared the meeting closed at 8.05 pm.

Appendix C

Health and Wellbeing Scrutiny Commission Briefing

Public health Budget

Lead director: Ruth Tennant

Ward(s) affected: All

Report author: Ruth Tennant, Director Public Health

Author contact details: ruth.tennant@leicester.gov.uk

1.0 Purpose of Briefing

To provide the Health and Wellbeing Scrutiny Commission with a briefing on national plans to make in-year savings on the ring-fenced public health grant to local councils.

2.0 Background

In 2013, responsibility for public health transferred from the NHS to upper-tier councils. Public health is funded through a ring-fenced allocation from the Department of Health.

This funding supports a number of public health services and programmes including school nursing, the national child measurement programme, drugs and alcohol services, stop smoking services, healthy weight and physical activity, sexual health, NHS Health-checks.

The grant supports nationally mandated requirements to provide public health advice to the NHS and to protect the public from threats to health. It also gives councils discretion to allocate funding on the basis of local needs and local priorities: locally, for example, this funding has been used to pay for outdoor gyms.

From October 2016, public health will also take responsibility (and associated funding) for local health visiting services.

The public health allocation is based on a number of factors, including local health need and historical spending on public health. Leicester's public health allocation in 2015/16 was £21.9 million.

3.0 Changes to the public health allocation in 2015/16

On the 5th June, the Chancellor announced proposals to make a £200 million cut to "non-NHS services" funded by the Department of Health. This is equal to a 7.4% cut in the public health ring-fenced allocation to local councils. Locally, this would amount to approximately £1.7 million pounds. This would apply to the current year's allocation.

This proposal is subject to consultation. The consultation has not yet started but is due to take place over the Summer.

4.0 Response to proposals

The national Association of Directors of Public Health, as has the Deputy City Mayor,

have made representation against these changes and have raised a number of risks with the Department of Health:

- The majority of the grant allocation is in contracts with NHS organisations and other providers, including the voluntary sector. Financial commitments have therefore been made for the duration of the financial year.
- The public health allocation supports national commitments to invest in prevention, set out in the NHS's Five Year Vision. This makes it clear that investment in prevention is essential to reducing the burden of ill-health and to the financial stability of the NHS.
- Contrary to national announcements, the ring-fenced allocation funds key front-line services, such as drug and alcohol treatment services and screening programmes such as NHS Healthchecks.

5.0 Key issues

At this stage, there are a number of uncertainties:

- If the in-year savings will go ahead
- If so, whether these will be one-off savings or recurrent
- Whether any savings would apply to the full financial year

6.0 Next steps

In advance of the consultation, all public health spending is under review to identify where savings could be made in-year if the anticipated savings need to be made. This is being done by:

- Reviewing the effectiveness of all public health programmes to identify which have the most and least impact on health outcomes
- Reviewing activity in public health contracts to identify where in-year savings could be made
- Developing options for consideration by the Executive on the outcome of the consultation is known later this year.

Details of Scrutiny

Leicestershire Partnership NHS Trust

Quality Report

Trust Headquarters,
Lakeside House
4 Smith Way
Grove Park
Enderby
Leicester LE19 1SX
Tel: 01162950816
Website: www.leicspt.nhs.uk

Date of inspection visit: 9 to 13 March 2015
Date of publication: 10/07/2015

Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units	The Bradgate Mental Health Unit	RT5KF
Community-based mental health services for adults of working age	Trust Headquarters - Lakeside House	RT5X1
Community-based substance misuse services for adults of working age	Trust Headquarters - Lakeside House	RT5X1
Child and adolescent mental health wards	Oakham House	RT5FD
Community mental health services for children and young people	Trust Headquarters - Lakeside House	RT5X1
Community-based mental health services for older people	Trust Headquarters - Lakeside House	RT5X1
Community mental health services for people with learning disabilities or autism	Trust Headquarters - Lakeside House	RT5X1
Forensic inpatient / secure wards	The Bradgate Mental Health Unit	RT5KF

Summary of findings

Mental health crisis services and health-based places of safety	Trust Headquarters - Lakeside House	RT5X1
Mental health crisis services and health-based places of safety	The Bradgate Mental Health Unit	RT5KF
Long stay/rehabilitation mental health wards for working age adults	Stewart House (Narborough)	RT5KE
Long stay/rehabilitation mental health wards for working age adults	The Willows	RT5FK
Wards for older people with mental health problems	Evington Centre	RT5KT
Wards for older people with mental health problems	The Bradgate Mental Health Unit	RT5KF
Wards for people with learning disabilities and autism	The Agnes Unit	RT5NH
Wards for people with learning disabilities and autism	Short Breaks – Farm Drive	RT5FP
Wards for people with learning disabilities and autism	Short Breaks – Rubicon Close	RT5FM
Community health services for adults	Ashby and District Community Hospital	RT5YC
Community health services for adults	Coalville Community Hospital	RT5YD
Community health services for adults	Hinckley and Bosworth Community Hospital	RT5YF
Community health services for adults	Loughborough Hospital	RT5YG
Community health services for adults	Melton Mowbray Hospital	RT596
Community health services for children, young people and families	Melton Mowbray Hospital	RT596
Community health services for children, young people and families	Loughborough Hospital	RT5YG
Community health services for children, young people and families	Hinckley and Bosworth Community Hospital	RT5YF
Community health services for children, young people and families	Ashby and District Hospital	RT5YC

Summary of findings

Community health inpatient services	Feilding Palmer Community Hospital	RT5YE
Community health inpatient services	Coalville Community Hospital	RT5YD
Community health inpatient services	Melton Mowbray Community Hospital	RT596
Community health inpatient services	Hinckley and Bosworth Community Hospital	RT5YF
Community health inpatient services	Rutland Memorial Hospital	RT5YJ
Community health inpatient services	Evington Centre Leicester General Hospital	RT5KT
Community End of Life Care	Loughborough Hospital	RT5YG
Community End of Life Care	Coalville Community Hospital	RT5YD
Community End of Life Care	St Luke's Hospital	RT5YL
Community End of Life Care	Feilding Palmer Community Hospital	RT5YE
Community End of Life Care	Charnwood Mill	RT5YE

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for services at this Provider	Requires improvement 
Are Services safe?	**Inadequate** 
Are Services effective?	**Requires improvement** 
Are Services caring?	**Good** 
Are Services responsive?	**Requires improvement** 
Are Services well-led?	**Requires improvement** 

Mental Health Act responsibilities and Mental Capacity Act/Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however, we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

This report describes our judgement of the quality of care provided by Leicestershire Partnership NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Leicestershire Partnership NHS Trust and these are brought together to inform our overall judgement of Leicestershire Partnership NHS Trust.

We rated Leicestershire Partnership NHS Trust as Requires Improvement overall because:

- Not all services were safe, effective or responsive and the board needs to take urgent action to address areas of improvement.
- While the board and senior management had a vision with strategic objectives in place, staff did not feel fully engaged in the improvement agenda of the trust.
- Morale was found to be poor in some areas and some staff told us that they did not feel engaged by the trust.
- We found that while performance improvement tools and governance structures were in place these had not always brought about improvement to practices.
- We had a number of concerns about the safety of this trust. These included unsafe environments that did not promote the dignity of patients; insufficient staffing levels to safely meet patient's needs; inadequate arrangements for medication management; concerns regarding seclusion and restraint practice: insufficient clinical risk management.
- We were concerned that information management systems did not always ensure the safe management of people's risks and needs.
- Some staff had not received their mandatory training, supervision or appraisal.
- A lack of availability of beds meant that people did not always receive the right care at the right time and sometimes people were moved, discharged early or managed within an inappropriate service.
- We were concerned that the trust was not meeting all of its obligations under the Mental Health Act.

However:

- Overall we saw good multidisciplinary working and generally people's needs, including physical health needs, were assessed and care and treatment was planned to meet them.
- Staff showed us that they wanted to provide high quality care, despite the challenges of staffing levels and some poor ward environments. We observed some very positive examples of staff providing emotional support to people.
- Procedures for incident management and safeguarding where in place and well used.

Summary of findings

The five questions we ask about the services and what we found

We always ask the following five questions of the services.

Are services safe?

Inadequate

We rated Leicestershire Partnership NHS Trust as inadequate overall for this domain because:

- We found a number of environmental safety concerns. We found potential ligature risks and that the layout of some wards did not facilitate the necessary observation and safety of patients. We were concerned about the design of seclusion facilities at some units.
- We found concerns about incidents of restraint and seclusion at the trust. We found that the policies and procedures did not meet guidance. We found restrictive practices that amounted to seclusion that were not safeguarded appropriately.
- We were concerned that staffing levels were not sufficient at a number of inpatient wards and community teams across the trust.
- There was a heavy reliance on bank staff particularly in the acute services and the end of life care service.
- Not all clinical risk assessments had been undertaken or reviewed meaning patients risks and needs were not always known or addressed.
- Arrangements were not adequate for the safe and effective administration, management and storage of medication across the trust.
- Levels of mandatory training in life support were not good across the trust and not all emergency resuscitation equipment had been checked.
- We found a large number of concerns about information management systems. Some had resulted in potential harm to patients.

However:

- The trust had policies and processes in place to report and investigate any safeguarding or whistleblowing concerns. Most staff told us that they were able to raise any concerns that they had and were clear that improvement would occur as a result of their concern.
- The trust had systems in place to report and investigate incidents, usually these would result in learning and changes to practice.
- The trust had processes in place for the safety of lone workers.

Summary of findings

Are services effective?

Requires improvement

We rated Leicestershire Partnership NHS Trust as requiring improvement overall for this domain because:

- Care plans and risk assessment were not always in place or updated were people's needs changed in the forensic and substance misuse services. Peoples' involvement in their care plans varied across the services.
- Staff did not always respond to the needs of patients in community inpatient services.
- Not all services used evidence based models of treatment.
- There was limited access to psychological therapy and there were some issues with accessing physical healthcare.
- Not all staff had received an appraisal or mandatory training. Delays in induction training could place some staff and patients at risk.
- Systems were not robust to ensure compliance with the Mental Health Act (MHA) and the guiding principles of the MHA Code of Practice. There were insufficient processes for the scrutiny of MHA documentation. Patients had not always received their rights, and capacity and consent procedures were not always well managed. Leave was not always granted in line with the MHA requirements. Staff did not always recognise and manage people's seclusion within the safeguards set out in the MHA Code of Practice.
- Procedures were not always followed in the application of the Mental Capacity Act. However, there were good levels of training and understanding of the Mental Capacity Act.

However:

- Generally people received care based on a comprehensive assessment of individual need.
- People's needs, including physical health needs, were usually assessed and care and treatment was planned to meet them.
- Overall we saw good multidisciplinary working.

Are services caring?

Good

We rated Leicestershire Partnership NHS Trust as good overall for this domain because:

- Staff showed us that they wanted to provide high quality care, despite the challenges of staffing levels and some poor ward environments. We observed some very positive examples of staff providing emotional support to people.
- Most people we spoke with told us they were involved in decisions about their care and treatment and that they and

Summary of findings

their relatives received the support that they needed. We saw some very good examples of care plans being person centred however, not all care plans indicated the involvement of the service user.
- We heard that patients were well supported during admission to wards and found a range of information available for service users regarding their care and treatment.
- The trust has a user engagement strategy which set out the trust's commitment to working in partnership with service users. The trust told us about a number of initiatives to engage more effectively with users and carers.
- Results from the friends and family test indicated a good level of satisfaction with the service.
- Advocacy services were available and promoted.

However:

- Arrangements for visits from families were not always appropriate, particularly in respect of children visiting mental health units.

Are services responsive to people's needs?

Requires improvement

We rated Leicestershire Partnership NHS Trust as requiring improvement overall for this domain because:

- The trust was not meeting all of its targets in respect of the delivery of community services. Some teams had significant waiting lists.
- We were told that there was a shortage of beds in acute, PICU and CAMHS services.
- Out of area placements were high for acute services and the PICU was unavailable to female patients as it did not meet the guidance on mixed sex accommodation.
- A lack of available beds meant that people may have been discharged early or managed within an inappropriate service. However, staff worked well with other services to make arrangements to transfer or discharge patients.
- We were also concerned about the operation of the referral line for the crisis service. Performance information had also not been available this service.
- We found that the environment in a number of units did not reflect good practice guidance and had an impact on people's dignity or treatment.
- Within three acute wards and the PICU there were no female only lounges as required by the Mental Health Act Code of Practice and Department of Health guidance.

However:

Summary of findings

- We found a range of information available for service users regarding their care and treatment and many of the leaflets were available in other languages.
- A process in place to address peoples' complaints. However, improvement is required to ensure all complaints are captured at trust level and learned from.
- Most units that we visited had access to grounds or outside spaces and generally had environments that promoted recovery and activities.
- Interpreters were available and we observed some very good examples of staff meeting the cultural needs of their patients.

Are services well-led?

Requires improvement

We rated Leicestershire Partnership NHS Trust as requiring improvement overall for this domain because:

- We reviewed the risk registers for the trust and directorates and noted that while some of the concerns we found had been highlighted others had not been flagged.
- The trust had not met all its strategic objectives.
- The trust had failed to ensure all required improvements were made and sustained at the acute services at the Bradgate Unit following compliance actions made in 2013.
- We were concerned that the trust had not always delivered safe and quality care despite a well organised governance structure and quality system. Our findings indicate that that there is room for improvement to ensure that lessons are learned from quality and safety information and that actions are embedded in to practice.

However:

- The trust board had developed a vision statement and values for the trust and most staff were aware of this.
- The trust had undertaken positive engagement action with service users and carers.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Dr Peter Jarrett

Head of Inspection: Julie Meikle, Head of Hospital Inspection (mental health) CQC

Team Leaders: Lyn Critchley, Inspection Manager (mental health) CQC and Nin Yaing, Inspection Manager (acute and community) CQC

The team included CQC managers, inspection managers, inspectors, Mental Health Act reviewers and support staff, supported by variety of specialist advisors and experts by experience that had personal experience of using or caring for someone who uses the type of services we were inspecting.

Why we carried out this inspection

We inspected this trust as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information we hold about Leicestershire Partnership NHS Trust and asked other organisations to share what they knew.

We carried out an announced visit between 9 March and 13 March 2015. Unannounced inspections were also carried out on 19 March and during the night of 23 March 2015. We also conducted an unannounced MHA visit on 25 March 2015.

Prior to and during the visit the team:

- Held service user focus groups and met with local user forums.
- Held focus groups with different staff groups.
- Talked with patients, carers and family members.
- Attended community treatment appointments.
- Looked at the personal care or treatment records of a sample of patients and service users.
- Looked at patients' legal documentation including the records of people subject to community treatment.
- Observed how staff were caring for people.
- Interviewed staff members.
- Interviewed senior and middle managers.
- Attended an executive team meeting and leadership conference.
- Met with the MHA assurance group and Hospital Managers
- Reviewed information we had asked the trust to provide.
- Attended multi-disciplinary team meetings.
- Met with local stakeholders and user groups.
- Collected feedback using comment cards.

We visited all of the trust's hospital locations and sampled a large number of community healthcare and community mental health services.

We inspected all wards across the trust including adult acute services, psychiatric intensive care units (PICUs), secure wards, older people's wards, and specialist wards for people with learning disabilities and children and adolescents. We also inspected all the wards providing physical healthcare treatment to adults. We looked at the trust's place of safety under section 136 of the Mental Health Act. We inspected community services including all of the trust's crisis services, integrated delivery teams

Summary of findings

and older peoples' teams, and a sample of teams for people with a learning disability, children and adolescents and physical healthcare teams providing community treatment and end of life care.

The team would like to thank all those who met and spoke with inspectors during the inspection and were open and balanced with sharing their experiences and their perceptions of the quality of care and treatment at the trust.

Information about the provider

The trust was created in 2002 to provide mental health, learning disability and substance misuse services. In April 2011 it merged with Leicester City and Leicestershire County and Rutland Community Health Services as a result of the national Transforming Community Services agenda. The merger resulted in the full integration of physical, mental health and learning disability services. The trust operates in three divisions: adult mental health and learning disability, community health services, and families, children and young people.

The trust is aiming to become a Foundation Trust during 2015/16.

The trust works closely with the three local authorities: Leicestershire County Council, Rutland County Council and Leicester City Council. The Trust is commissioned by three local Clinical Commissioning Groups: West Leicestershire, East Leicestershire and Rutland, and Leicester City.

The trust provides services for adults and children with mental health needs, a learning disability or substance misuse needs, and people with some physical healthcare needs who live in the city of Leicester and the neighbouring counties of Leicestershire and Rutland. They also provide secure mental health services across the region and work with the criminal justice system. A number of specialist services were also delivered including a community based eating disorder service and community based support, in partnership with other agencies, to those whose needs relate to drug or alcohol dependency.

The trust serves a population of approximately one million and employs over 5,500 staff including nursing, medical, psychology, occupational therapy, social care, administrative and management staff. It had a revenue income of £280 million for the period of April 2013 to March 2014. In 2012/13, the trust staff saw over 60,000 individuals. The trust services are delivered from almost 200 different buildings.

Leicestershire Partnership NHS Trust has a total of 21 locations registered with CQC and has been inspected 26 times since registration in April 2010. At the time of our visit there were two locations were compliance actions were in place following previous visits. These were at HMP Leicester and the Bradgate Mental Health Unit.

We had last visited the Bradgate Mental Health Unit in November 2013 and it was found to be non-compliant in five areas. These were: care and welfare, cooperating with other providers, management of medicines, staffing and assessing and monitoring service provision. These issues were looked at as part of this inspection.

What people who use the provider's services say

The Care Quality Commission community mental health survey 2014 was sent to people who received community mental health services from the trust to find out about their experiences of care and treatment. Those who were eligible for the survey where people receiving community care or treatment between September and November 2013. There were a total of 260 responses, which was a response rate of 31%. Overall, the trust was performing about the same as other trusts across most areas.

However, respondents stated that the trust was performing worse than other trusts in relation to crisis care and other areas of care. This specifically related to questions about the response people received in a crisis or in relation to information provided about other support services.

A review of people's comments placed on the 'patient opinion' and 'NHS choices' websites was conducted ahead of the inspection. 26 comments were noted on

Summary of findings

NHS choices of which 6 were partly of wholly positive. Positive comments included that staff were kind, compassionate and helpful, and that Loughborough Hospital was excellent. Issues raised were about access and response in a crisis, staff attitude, misdiagnosis, ward conditions, support for carers and CAMHS services. Both positive and negative opinions were also noted on the patient opinion website.

The trust launched the Friends and Family Test in 2013. The Friends and Family Test seeks to find out whether people who have used the service would recommend their care to friends and family. At February 2015 there had been almost 6000 responses. Of these 91% have been positive about the trust services.

Prior to the inspection we spoke with services users and their carers across the trust. This included meetings with independent user led local organisations and attendance at user and carer groups linked to the trust. We also facilitated focus groups at three inpatient services. During these sessions we heard both positive and negative comments about the trust services. Generally people stated that staff were caring. However, a number of people stated that access to services, particularly in a crisis, was difficult. People told us of a shortage of beds and that staffing could be limited and effect treatment, leave and activities.

During our inspection we received comment cards completed by service users or carers. We also received a large number of phone calls and emails directly to CQC from service users, carers and voluntary agencies supporting service users. Throughout the inspection we spoke with over 300 people who had used inpatient services or were in receipt of community treatment.

People who use inpatient services generally felt safe and supported. However, at some units people told us that staff shortages could impinge on the availability of activities and access to leave. People also told us that access to inpatient care close to home was not always possible.

Most people who use community services told us that staff were good and supportive. A number told us that there had been significant changes within the teams and that this had caused uncertainty and poor communication. Some people told us that they did not always know what to do in a crisis and others reported a poor response from crisis teams. Most welcomed changes to the operational model of the crisis team.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that medicines prescribed to patients who use the service are stored, administered, recorded and disposed of safely.
- The trust must ensure that the use of syringes and needles meet the Health and Safety Executive regulations.
- The trust must ensure that action is taken so that the environment does not increase the risks to patients' safety.
- The trust must ensure that action is taken to remove identified ligature risks and to mitigate where there are poor lines of sight.
- The trust must ensure that all mixed sex accommodation meets guidance and promotes safety and dignity.
- The trust must ensure that staff and patients have a means to raise an alarm in an emergency.
- The trust must ensure that emergency equipment is checked on a regular basis.
- The trust must ensure that seclusion facilities are safe and appropriate and that seclusion and restraint are managed within the safeguards of the MHA Code of Practice and national guidance. The trust should ensure it meets the guidance on restraint practice set out in Department of Health guidance.
- The trust must ensure there are sufficient and appropriately qualified staff at all times to provide care to meet patients' needs.
- The trust must ensure that there is appropriate access to medical staff where required.

Summary of findings

- The trust must ensure that people receive the right care at the right time by placing them in suitable placements that meet their needs.
- The trust must ensure that there are not significant delays in treatment.
- The trust must ensure that all risk assessments and care plans are updated consistently in line with changes to patients' needs or risks.
- The trust must carry out assessments of capacity and record these in the care records.
- The trust must ensure all staff including bank and agency staff have completed statutory, mandatory and, where relevant, specialist training
- The trust must ensure all staff receive regular supervision and annual appraisals.
- The trust must ensure that proper procedures are followed for detention under the Mental Health Act and that the required records relating to patient's detention are in order.
- The trust must ensure that arrangements for patients taking section 17 leave are clear and in line with the Mental Health Act for their safety and that of others.
- The trust must ensure that patients who are detained under the Mental Health Act have information on how to contact the CQC.
- The trust must ensure that procedures required under the Mental Capacity Act are followed.
- The trust must ensure access is facilitated to psychological therapy in a timely way.
- The trust must ensure that there are systems in place to monitor quality and performance and that governance processes lead to required and sustained improvement.
- The trust must review its procedures for maintaining records, storage and accessibility.

Action the provider SHOULD take to improve

- The trust should ensure that all complaints are recorded and that themes from informal complaints are reviewed to ensure appropriate learning.

Leicestershire Partnership NHS Trust

Detailed findings

Mental Health Act responsibilities

Reporting to the quality assurance committee the mental health act assurance group (MHAAG) has overall responsibility for the application of the Mental Health Act (MHA) and the Mental Capacity Act (MCA). An annual report is presented to the board, to inform the executive of performance and required actions across this area. This group also carries out the role of the 'hospital managers' as required by the MHA.

We attended a meeting with the hospital managers and were informed that the hospital managers receive a rigorous induction with training on the MHA and MCA and an induction shadowing other hospital managers.

The MHAAG provides a forum for reviewing and ensuring compliance with the legal and statutory requirements of the MHA. It performs a number of key functions, including:

• monitoring all aspects of MHA performance,

• receiving MHA reviewer reports,

• monitoring actions and responses,

• escalating any outstanding issues and raising issues of concern for resolution to the quality assurance committee (QAC).

There was some confusion regarding whether Mental Health Act (MHA) training was mandatory at the trust. The quality assurance committee (QAC) agreed MHA training was mandatory in April 2014 and a module was planned to begin in September 2014. Training was available but, we found varying levels of understanding across the MHA and different services where unclear regarding whether this training was mandatory. For example, we noted that staff in the crisis services were trained and knowledgeable but staff in acute services had no specific training.

The process for scrutinising and checking the receipt of documentation was not clear. MHA administrators have recently started a new system in order to scrutinise documentation but not all of the documents we looked at had been scrutinised and, whilst the majority of documents were in place and accurate, we identified concerns.

On the wards the MHA documentation relating to the patients' detention was generally available for review and appeared to be in order. However, some documents were missing from some files. In the rehabilitation service there were incomplete photocopies of MHA documents on files and some renewal papers were not available. Reports carried out by the approved mental health professional (AMHP) were not always available in the ward files or the MHA administration files. We could find no record of action taken to obtain the reports.

Patients were usually provided with information about their legal status and rights under section132 at the time of their detention or soon afterwards. The forms used to record the information were brief and we saw many examples where they were incomplete. For example, patients' understanding of their rights was not always recorded. In four of the core services, where detained patients were being treated, patients' understanding of their rights was not reassessed. We also found that, irrespective of their understanding, patients were not reminded of their rights on a regular basis. A patient on one

of the secure wards had only had their rights explained once in twelve months. Files at the MHA office did not routinely include details about whether a person had been provided with their rights under the MHA.

Most of the wards displayed posters about the independent mental health advocate (IMHA) service. However, across all services there were examples where patients had not been informed of, or did not understand, their right to access an IMHA. The exception was the older person's service, where patients were automatically referred to an IMHA if they were unable to understand their rights.

Assessment and recording of patients' capacity to consent at the start of their treatment varied across the core services. There were limited records of discussions between patients and their responsible clinicians (RC) to show patients' understanding of their prescribed medicines and their consent or refusal to take it.

On some of the wards we found treatment was not being given in line with the MHA Code of Practice. On two wards we found T2 certificates, to evidence patients' consent to taking their medication, were not signed by the current RC. On two wards not all prescribed medicines were included on the T2 certificate, which meant patients were being given medication they had not consented to. Similarly, we found examples of medication being given which had not been approved by a second opinion appointed doctor (SOAD) if the patient lacked capacity, or refused to consent to taking medication.

The system for recording section 17 leave did not adhere to the MHA Code of Practice in any of the core services. There were a number of incomplete leave forms. There was a lack of records to show patients were provided with copies of the forms. Several of the wards did not record risk assessments prior to patients going on leave. The outcome of the leave, including the patient's view, was not always recorded in the clinical notes. On one of the wards the leave authorisation was not signed by the patient's current responsible clinician. In the rehabilitation service we saw some leave forms were completed up to twelve months in advance, which meant leave was not being reviewed regularly.

Seclusion was practiced at a number of the services we visited. Generally seclusion paperwork was not fully completed in accordance within the Mental Health Act Code of Practice. We looked at the process of seclusion, including a review of the environment and paperwork in the acute service. We found overall that the record keeping and scrutiny was poor.

We found good practice with regard to seclusion on the wards for people with learning disabilities and autism. On other wards we found seclusion practices did not always follow the Code of Practice or trust policy. For example, on one ward we found a patient was being nursed in a low stimulus area on constant observations. The doors were locked and the patient was prevented from leaving. However, the seclusion safeguards, such as regular reviews, were not taking place.

Mental Capacity Act and Deprivation of Liberty Safeguards

The trust has a policy in place on the application of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS). Reporting to the quality assurance committee the mental health act assurance group (MHAAG) has overall responsibility for the application of the Mental Capacity Act (MCA). An annual report is presented to the board, to inform the executive of performance and required actions across this area.

The trust told us that training rates for staff in the Mental Capacity Act were good with just over 90% of staff trained at the end of December 2014. Staff confirmed that they had received this training and updates were provided as part of ongoing safeguarding training. Generally most staff had an awareness of the Mental Capacity Act and the Deprivation of Liberty Safeguards. However, this was not the case within the forensic service or the older people's community teams.

At a number of mental health services, particularly learning disability, forensic and older people's services mental capacity assessments and best interest decisions had not always been carried out where applicable.

Deprivation of Liberty Safeguards applications had usually been made when required. However, records were inconsistent in recording these and staff were not always aware of when an authorisation was in place.

Inadequate

Are services safe?

Staff had a clear understanding of their responsibilities in relation to the Mental Capacity Act in community healthcare services. They were able to differentiate between ensuring decisions were made in the best interests of people who lacked capacity for a particular decision and the right of a person with capacity to make an unwise decision.

In end of life care services we looked at "do not resuscitate cardio pulmonary resuscitation" (DNACPR) forms in use in the trust. We saw that the trust was proactive in arranging these forms to be completed early in a patient's care. We reviewed five forms and saw all of these had been completed in full. However, we noticed that the form the trust used did not have an area for staff to document that a multidisciplinary discussion had taken place. This meant that it was not clear as to which professionals contributed to the discussion around DNACPR for the patients.

Inadequate

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

We rated Leicestershire Partnership NHS Trust as inadequate overall for this domain because:

- We found a number of environmental safety concerns. We found potential ligature risks and that the layout of some wards did not facilitate the necessary observation and safety of patients. We were concerned about the design of seclusion facilities at some units.
- We found concerns about incidents of restraint and seclusion at the trust. We found that the policies and procedures did not meet guidance. We found restrictive practices that amounted to seclusion that were not safeguarded appropriately.
- We were concerned that staffing levels were not sufficient at a number of inpatient wards and community teams across the trust.
- There was a heavy reliance on bank staff particularly in the acute services and the end of life care service.
- Not all clinical risk assessments had been undertaken or reviewed meaning patients risks and needs were not always known or addressed.
- Arrangements were not adequate for the safe and effective administration, management and storage of medication across the trust.
- Levels of mandatory training in life support were not good across the trust and not all emergency resuscitation equipment had been checked.
- We found a large number of concerns about information management systems. Some had resulted in potential harm to patients.

However:

- The trust had policies and processes in place to report and investigate any safeguarding or whistleblowing concerns. Most staff told us that they were able to raise any concerns that they had and were clear that improvement would occur as a result of their concern.
- The trust had systems in place to report and investigate incidents, usually these would result in learning and changes to practice.
- The trust had processes in place for the safety of lone workers.

Inadequate

Are services safe?

Our findings

Track record on safety

We reviewed all information available to us about the trust including information regarding incidents prior to the inspection. A serious incident known as a 'never event' is where it is so serious that it should never happen. The trust had reported one 'never event' in August 2014. In this case a patient was prescribed a daily dose of the drug methotrexate that should be administered weekly. We found the trust had investigated the never event, actions regarding medicines management and prescribing had been implemented and learning had been disseminated to staff throughout the directorate. We did not find any other incidents that should have been classified as never events during our inspection.

Since 2004, trusts have been encouraged to report all patient safety incidents to the National Reporting and Learning System (NRLS). During 2014 the trust had reported 7199 incidents to the NRLS. There were 29 incidents categorized as death during the period and a further eight had resulted in severe harm.

Since 2010, it has been mandatory for trusts to report all death or severe harm incidents to the CQC via the NRLS. There were 190 serious incidents reported by the trust between January 2014 and December 2014. The largest number of these reports had related to unexpected death including suicide or suspected suicide at 37%. Pressure ulcers were the second largest category equating to almost 33%. There were also two homicides reported during this period. This was within the expected range of incidents for a trust of this type and size. Overall, the trust had improved its reporting rates and had been a good reporter of incidents during 2014 when compared to trusts of a similar size.

The National Safety Thermometer is a national prevalence audit which allows the trust to establish a baseline against which they can track improvement. During the 12 months to October 2014 it was noted that there was large fluctuation in the rates of falls resulting in harm, and catheter and new urinary tract infection rates.

Every six months, the Ministry of Justice published a summary of Schedule 5 recommendations which had been made by the local coroners with the intention of learning lessons from the cause of death and preventing deaths. A concern was raised about the trust in 2014 in relation to housing for those with severe mental illness who have been evicted from a care placement.

Learning from incidents

Arrangements for reporting safety incidents and allegations of abuse were in place. Staff had access to an online electronic system to report and record incidents and near misses. Most staff had received mandatory safety training which included incident reporting and generally were able to describe their role in the reporting process. Staff were encouraged to report incidents and near misses and most felt supported by their manager following any incidents or near misses. Some staff told us that the trust encouraged openness and there was clear guidance on incident reporting.

We were told that all serious incidents are reviewed by the patient safety group which reports to the quality assurance committee. Meeting minutes confirmed that the board also receive regular updates about actions undertaken as a result of serious incidents.

Where serious incidents had happened we saw that investigations were carried out. The trust had trained a large group of staff to undertake incident investigations. Most investigations were carried out within the timescales required.

Team managers confirmed clinical and other incidents were reviewed and monitored through trust-wide and local governance meetings and shared with front line staff through team meetings. Most were able to describe learning as a result of past incidents and how this had informed improvements or service provision. We saw some particularly good examples of positive change following incidents within the community health care services. However, we heard of some occasions within mental health services were incidents had not led to changes in practice.

Staff received email bulletins and alerts following learning from incidents in other parts of the trust. Generally staff knew of relevant incidents, and were able to describe learning as a result of these. The majority of staff felt that they got feedback following incidents they had reported. However, in the end of life care teams and the child and adolescent mental health community teams' staff told us that they did not always receive feedback.

Inadequate

Are services safe?

In 2014 a CQC regulation was introduced requiring NHS trusts to be open and transparent with people who use services and other 'relevant persons' in relation to care and treatment and particularly when things go wrong. The trust had undertaken an audit to understand any improvements required to meet this duty of candour. Following this a number of actions were undertaken including duty of candour considerations being incorporated into the serious investigation framework and report. Minutes of directorate and locality governance groups evidenced frequent discussion about the duty of candour. Most staff were aware of the duty of candour requirements. However, not all staff across community health care services were fully aware of duty of candour in relation to their roles.

Safeguarding

The trust had clear policies in place relating to safeguarding and whistleblowing procedures. Additional safeguarding guidance was available to staff via the trust's intranet, and a trust run safeguarding helpline was available to staff for additional advice.

Training requirements were set out in line with the specific role undertaken by staff. We found that almost all staff had received their mandatory safeguarding training and knew about the relevant trust-wide policies relating to safeguarding. In some services we found that safeguarding supervision provided opportunities to discuss any individual cases. Most staff were able to describe situations that would constitute abuse and could demonstrate how to report concerns.

A governance process was in place that looked at safeguarding issues at both a trust and at directorate levels on a regular basis.

Assessing and monitoring safety and risk

The trust had an assurance framework and risk register in place. The risk register identified the responsible owner and the timescales for completion of identified actions. Board meeting and quality assurance committee minutes confirmed that corporate and any high level or emerging risks are discussed on an ongoing basis. Risk registers were also in place at service and directorate level. These were monitored through the directorate assurance groups.

We looked at the quality of individual risk assessments across all the services we inspected. In community healthcare inpatient services these were in place and addressed people's risks.

However, we were concerned that five patients under the care of the community child and adolescent mental health team did not have risk assessments. At the secure services we found that some patients were being managed through the use of risk assessments undertaken on previous wards. Other patients within this service did not have clear risk management plans. We also found that within some mental health and learning disability services risk assessments were not always being updated for people following incidents of concern or changes to an individual's needs. Risk assessments had not always been undertaken prior to leave being commenced.

Risk assessments were completed across all community health care services. For example in end of life care at Loughborough hospital we were shown the variety of risk assessments in place for patients in the ward. These included moving and handling, skin integrity, nutrition, falls, and bed rails. These risk assessments were used as the basis for planning care for people and ensuring that people were safe. The unscheduled care team for community services for adults told us they could provide an initial risk assessment via a home visit within two hours of referral.

The trust has an observation policy in place which was updated in line with recommendations made following a series of inpatient deaths in 2012. Generally staff were aware of the procedures for observing patients. Ward managers indicated that they were able to request additional staff to undertake observations. However, both staff and patients told us that increased observation levels could impact on activities and leave.

Safe and clean environments and equipment

The trust undertakes an annual programme of environmental health and safety checks.

Ligature risk assessments are reviewed as part of this programme. The trust told us that all wards had been reviewed in the previous 12 months and that all keys risks had been addressed.

However, we were concerned that ligature risks at some acute wards at the Bradgate Unit, the secure service at the

Inadequate

Are services safe?

Herschel Prins unit and the Agnes Unit had been highlighted through the risk assessments but were not being adequately addressed. At the Belvoir PICU some redevelopment work was being undertaken to address ligature risks. However, we found additional risks that were not being addressed by the building programme. This raises concerns about the trust's ability to risk assess in a proactive rather than reactive manner.

We found that lines of sight were not clear at some acute and secure wards meaning staff could not always observe patients. We were particularly concerned to find areas of some acute and secure wards that could not easily be observed where there was a presence of potential ligature points.

On four acute wards and the PICU there were not clear arrangements for ensuring that there was single sex accommodation in adherence to guidance from the Department of Health and the MHA Code of Practice, to protect the safety of patients.

Within the learning disability service space was limited within the communal areas at the Gillivers and Rubicon Close due to mobility and healthcare equipment. This meant that the environment could be unsafe. There were also unsafe areas in the lounge in Rubicon Close for patients who had epilepsy.

The health-based place of safety at the Bradgate unit did not meet the guidance of the Royal College of Psychiatrists. Furniture was light and portable and could be used as a weapon. Access to the two small rooms was through one door which meant that it could be difficult to exit the room quickly if needed.

The hospitals we visited within community inpatient services were not purpose built. Some hospitals had spread out wards and patients were not easily visible. This meant there could be an increased risk of patients falling, especially during the night when staffing levels were reduced.

Fire procedures and equipment were in place at most services. Most staff had received fire safety training. However, in the community child and adolescent service based at Loughborough Hospital we had some concerns about the frequency of fire drills and systems for recording when people were in the building. Only 63% of staff had updated fire safety training and they had not received training to use of the evacuation chair for people with mobility difficulties. Fire tests had not been recorded at the child and adolescent learning disability service at Rothesay.

Most units that we visited had a clinic room available and were equipped for the physical examination of patients. All clinic rooms we visited appeared clean. However, we were concerned that the clinic room on Phoenix ward at the Herschel Prins unit had severe drainage problems with sewage flowing into the room from the sink on a couple of occasions. The room was cleaned and signed off as fit to use by the health and safety team and the infection control nurse. The trusts estate contractor was coming to survey pipes in the grounds that were said to be the source of the problem. However, this had taken longer than should be expected.

Not all clinic rooms in community adult mental health team bases (where medicines were stored) had hand washing facilities which could increase the risk of infection or cross contamination.

Most inpatient services were found to have hand-washing facilities readily available and we observed staff adhering to the trust's 'bare below the elbow' policy where appropriate. Hand hygiene audits undertaken between October and December 2014 showed that all staff demonstrated good hand hygiene.

In community services we observed staff following best practice relating to hand hygiene and using personal protective equipment (PPE) appropriately. We were told by numerous staff that there were plentiful supplies of PPE at all times.

Regular trust-wide cleanliness audits were undertaken. Most services were clean and well maintained. Patients were mainly happy with the standards of cleanliness. However, we found that the seclusion room at Watermead ward was not clean. Staff told us that that the cleaning service was usually good for general cleaning but there could be difficulties in ensuring a deep clean where required.

In community inpatient services we found the cleaning contract with the service provider was inflexible at the Evington Centre. There were no cleaners on the ward after 4 pm so if patients were discharged and new patients arrived, nurses did the cleaning. Staff across all community health

care services told us the cleaning contract with the external provider did not always repair or maintain a clean environment as quickly as staff wished. Staff completed incident forms to expedite the completion of these tasks.

Most inpatient areas were well maintained and free from clutter. However, staff at a number of services told us that there could be significant delays in repairs being carried out. On three wards in the acute service we found bath/ shower rooms out of order. Staff had not been aware of all of these issues. At Herschel Prins unit a patient had a hole in their bathroom wall which prevented them using their shower. This hole had been there for two months and had not been fixed.

Inpatient services had systems in place to ensure equipment was serviced and electrically tested. Equipment was labelled with testing dates which were current. Staff told us about the procedure in place to clean equipment between patients.

Not all community mental health team bases had emergency alarms where required. We heard about two incidents were staff had been unable to raise the alarm in an emergency situation. We also heard there could be delays in alarms being repaired where required. In acute services we did not see call bells throughout any of the wards to enable patients to request assistance when required. We were particularly concerned that some bathrooms did not have call bells.

Emergency resuscitation equipment was not regularly checked in some community services. At Belvoir PICU the resuscitation trolley was clean and checked on a daily basis but was not sealed and so could be tampered with.

Most staff could describe how they would use the emergency equipment and what the local procedures were for calling for assistance in medical emergencies. However, levels of mandatory training in life support were not good across the trust. The trust provided training information ahead of the inspection. This stated that 73% of relevant staff had received immediate life support and 78% of relevant staff had received adult and paediatric basic life support. We were particularly concerned that only 47% of staff at the child and adolescent inpatient service at Oakham House and 65% of staff in acute services had received training in intermediate life support training.

Community inpatients staff had been trained in intermediate life support, and informed us that if a patient deteriorated or had a cardiac arrest at the community hospital, they would start resuscitation and call the emergency services through 999.

Potential risks

Systems were in place to maintain staff safety in the community. The trust had lone working policies and arrangements and most staff in community teams told us that they felt safe in the delivery of their role. For example the community end of life care service had a “buddy system” where they check in with their buddy at the end of their shift. If staff were worried about a particular visit they will call their buddy before and after the visit so their whereabouts were known.

The trust had necessary emergency and service continuity plans in place and most staff we spoke with were aware of the trust’s emergency and contingency procedures. Staff told us that they knew what to do in an emergency within their specific service. For example community health care services had policies in place to deal with expected risks, such as deep snow or flooding, which were known to all staff.

Restrictive practice, seclusion and restraint

The trust has an executive lead for security management. Policies and procedures were in place covering the management of aggression, physical intervention and seclusion. The trust was also in the process of forming a policy on the use of mechanical restraint.

We reviewed existing policies regarding management of aggression and physical intervention. These did not reference the safe management of patients in a prone position or address specialist needs of children or people with a learning disability, autism or a physical condition in line with guidance.

A briefing had been submitted to the trust’s patient safety committee in January 2015 outlining the trust’s response to the Department of Health’s ‘Positive and Proactive Care: reducing the need for restrictive interventions’. A working group had been set up to look at restrictive practice. However, the trust was yet to comply with all requirements of the Department of Health's guidance by the target date

Inadequate

Are services safe?

of September 2014 as it was yet to formalise a reduction strategy or decide on future training options. The trust acknowledged in the briefing that they were behind the timescales set for immediate improvement in this policy.

The use of restraint and seclusion were defined as reportable incidents at the trust and arrangements were in place to monitor such incidents. Incidents were recorded on a database and would be discussed and monitored at the violence reduction group and patient safety meetings.

Prior to the visit we asked the trust for restraint and seclusion figures. Restraint was used 327 occasions in the six months to January 2015. Of these face down (prone) restraint was used on 38 occasions. This equated to almost 12% of all restraints. At the PICU there had been 47 incidents of restraint. Of these prone restraint was used on 8 occasions equating to 17%. Seclusion was used on 144 occasions. The majority of seclusion episodes were used at acute and PICU services. However, other services such as the secure and forensic services had used this practice on a limited basis. The trust stated that there had been no use of long term segregation.

We reviewed seclusion practice across the trust and we had a number of concerns about restrictive practice and seclusion. These include:

- In the child and adolescent service we found a patient was being nursed in a low stimulus area on constant observations. The doors were locked and the patient was prevented from leaving. However, the seclusion safeguards, such as regular reviews, were not taking place.
- In the acute service we found a 17 year old patient being nursed in seclusion as there was no appropriate service available within an open environment.
- Overall seclusion paperwork was not fully completed in accordance with the Mental Health Act Code of Practice. This was particularly of concern in the acute services.
- In the acute service we reviewed the records of a patient who was being nursed in seclusion. A contemporaneous record was documented however the records lacked any details as to the amount of food and fluid that the patient had taken.
- In the acute service the seclusion rooms did not have intercoms. Therefore patients needed to communicate with staff through a thick wooden door. There were ligature risks within the area. There was no deep clean support available for the wards following seclusion of a patient.
- In the secure service the layout of the seclusion rooms meant that staff could not observe patients at all times to ensure they are safe. Staff had to enter the seclusion room to open the toilet for patients to use. The bed in the seclusion room on Phoenix ward was too high and had been used to climb up to windows and to block the viewing panel.

We observed a number of examples of staff effectively managing patient's aggressive behaviour with an emphasis on de-escalation techniques. Generally we found that staff did not restrict patients' freedom and that informal patients understood their status and knew how to, and were assisted, to leave the wards. However, at Herschel Prins unit the level of security applied to patients and visitors was higher than might be expected for a low secure unit. For example, all patients returning from either escorted or unescorted leave are subjected to a search before entering the wards. In the acute services there were some blanket restrictions. For example lockers were managed by staff and access to the garden was only permitted after midnight, on a one patient basis with an escorting member of staff. At the PICU smoking was only permitted in the garden at designated times.

Safe staffing

In 2014 the trust reviewed and set staffing levels for all teams. Since April 2014 the trust has implemented an online staffing record and has published both the planned and actual staffing levels on their website.

The trust acknowledged challenges regarding recruitment and retention and maintaining safe staffing levels and told us that they are working hard to address this issue. We saw positive information about recruitment initiatives and some teams were improving.

Figures provided indicated that during February 2015 there had been a number of times when actual staffing fell below the planned level. The trust confirmed that they had a vacancy rate of over 7% and that staff turnover stood at over 11 % in February 2015. During February 2015 over 27%

of shifts within inpatient services were covered by agency or bank staff. Acute services had particularly high use of agency or bank staff which ranged between 32 and 62% per ward.

There were not any specific dependency tools used to evaluate the number of staff required to ensure the service was safely staffed at a number of services including the end of life care team, community children, young people and families' services, secure and acute services. The trust confirmed that inpatient services' staffing levels had been set on an 8:1 patient to qualified nurse ratio. We received other documentation that stated that staffing levels had been set in line with actual budget. The trust had also set a target 60:40 split between qualified and unqualified ward staff. At the time of our inspection the trust was not meeting this target but was utilising bank and agency staff to meet this standard. They explained that depending on acuity levels unqualified staff levels were sometimes higher.

The trust told us that processes to request additional staff had been streamlined to aid easier requests and to allow improved monitoring of the use of bank and agency staff. Ward and team managers confirmed that processes were in place to request additional staff where required. However, we found that staffing levels were not always sufficient, particularly in child and adolescent teams. This meant that staff were managing very high caseloads and there were some delays in treatment.

At some acute, forensic and learning disability inpatient units we found that staffing was also insufficient. This meant that staff were unable to take breaks, worked additional hours or were unable to complete necessary tasks. This also meant that patients' leave and activities programmes could be affected. In rehabilitation units there was not always a qualified staff member on duty per unit.

At the health based place of safety at Bradgate unit there was not specific staff to manage the service. This meant when it was in use staff were redeployed from acute services.

Staffing levels across community health care services had been risk assessed and action plans put in place because some services were short staffed. For example, the staffing levels at St Luke's Hospital were not safe prior to our inspection. As a result the trust merged two wards into one. This meant that the service provided at St Luke's Hospital was not sustainable.

Medical cover was generally acceptable. However, we were told that out of hours' medical cover could be an issue in community mental health teams, end of life teams, and secure services. Some older people's community teams had limited or no dedicated medical cover.

Medicines management

The trust used an electronic prescribing and medication administration record system for patients which facilitated the safe administration of medicines. Medicines reconciliation by a pharmacist was recorded on the electronic prescribing and medication administration record system.

Medicines, including those requiring cool storage, were not always stored appropriately as records showed that they were not always kept at the correct temperature, and may not be fit for use. We saw controlled drugs were stored and managed appropriately.

The "cold chain" processes to ensure optimal conditions during the transport, storage, and handling of vaccines were outstanding.

Emergency medicines were available for use and there was evidence that these were regularly checked. However, none of the emergency trolleys were sealed and so could be tampered with.

Following a recent never event, the trust has put in place systems to help prevent this happening again and was extending it to other high risk medicines in the interests of protecting patients

We were concerned about arrangements for medication management within the substance misuse service. There was no system to monitor and manage prescriptions within the service. This meant there was a risk that prescriptions could be lost or stolen. Prescriptions were not securely locked away overnight and were stored in an open office. Staff also took prescriptions home overnight to allow easier travel to neighbourhood services the following day. Naloxone medication was being given to people as a take home dose. This was being given without a Patient Group

Inadequate

Are services safe?

Direction (PGD) in place. PGD's are the legal framework that allows medication to be dispensed to people without the need to see a doctor, without compromising a person's safety.

We found that some medication was out of date in the crisis service and there was no clear record of medication being logged in or out.

At the rehabilitation service we found two patients were necessary medical checks had not been undertaken following administration of high dose anti-psychotic medication.

The rapid tranquilisation policy confirmed that the trust defines rapid tranquilisation as only injectable treatments not oral. This means that some patients could receive additional doses of psychotropic oral medication with no automatic physical monitoring.

Safety syringes and needles were not available on the wards in line with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. During the inspection we witnessed staff on older people's ward administer insulin using a pen with no safety needle.

Records and management

The trust operates a number of electronic records systems as well as paper records in some services. The trust acknowledged this issue and data sharing was placed on the corporate risk register. The trust is in the process of rolling out a new system to mental health services, which will be in place later in 2015. Improvements are also being planned for community healthcare services.

Across services we found a large number of issues relating to record keeping and to difficulties in sharing information.

In community health care services specialist palliative care nurses told us that some general practitioners (GPs) do not have access to the same system. This caused issues with data sharing. For example, the trust uses paper forms for "do not attempt to resuscitate" (DNACPR) as some GPs could not access this information from the system.

The last six serious incidents at Evington Centre for community inpatient services identified a common theme around record keeping. As a result, staff had been provided with informal training looking at records, such as those used in patient care, and record keeping had improved as a result. The paperwork used for identifying and recording pain was also changed. Staff told us they would like to change systems because the paperwork was not easily available when the medicines round was done.

In community mental health teams there were different paper and electronic recording systems in place. Different professionals kept separate files. The services will move to a new electronic system in July 2015 which will be the same as other areas in the trust. Until then there is a danger information is not shared or fully available to all staff seeing a person.

Out of hours staff, who use an electronic records system, did not have access to relevant CAMHS paper records even if a young person was high risk. Staff said there could be delays in receiving this information. This could pose a risk to both staff and the patient.

In the community learning disability teams some records were over more than one database/system which made locating information a problem. There were also inconsistencies in record-keeping for the autism outreach services and some records were missing.

Requires improvement

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary of findings

We rated Leicestershire Partnership NHS Trust as requiring improvement overall for this domain because:

- Care plans and risk assessment were not always in place or updated were people's needs changed in the forensic and substance misuse services. Peoples' involvement in their care plans varied across the services.
- Staff did not always respond to the needs of patients in community inpatient services.
- Not all services used evidence based models of treatment.
- There was limited access to psychological therapy and there were some issues with accessing physical healthcare.
- Not all staff had received an appraisal or mandatory training. Delays in induction training could place some staff and patients at risk.
- Systems were not robust to ensure compliance with the Mental Health Act (MHA) and the guiding principles of the MHA Code of Practice. There were insufficient processes for the scrutiny of MHA documentation. Patients had not always received their rights, and capacity and consent procedures were not always well managed. Leave was not always granted in line with the MHA requirements. Staff did not always recognise and manage people's seclusion within the safeguards set out in the MHA Code of Practice.
- Procedures were not always followed in the application of the Mental Capacity Act. However, there were good levels of training and understanding of the Mental Capacity Act.

However:

- Generally people received care based on a comprehensive assessment of individual need.
- People's needs, including physical health needs, were usually assessed and care and treatment was planned to meet them.
- Overall we saw good multidisciplinary working.

Our findings

Assessment of needs and planning of care

The Care Quality Commission community mental health survey 2014 found that overall the trust was performing about the same as other trusts in the areas of involving people in care planning and care reviews. Almost 8 out of 10 respondents stated that they had been involved in their care plan, while only 6 out of 10 said they had received a review of their care in the last 12 months.

In the majority of mental health services people's care needs and risks were assessed and care plans had been put in place. However, this was not the case at the forensic and learning disability services where we found significant gaps in care plans and risk assessments. In addition, at these services, and acute and substance misuse services, we found that the quality of care plans varied and some lacked sufficient detail to ensure that staff were aware of patients individual needs and risks. Not all services had reviewed care plans following changes to people's needs, and risk assessments had not always been updated. Not all care plans reviewed indicated the involvement of the patient. This was a particular issue within older people's services.

In community healthcare services we found that people were appropriately assessed and that relevant treatment and care plans had been put in place. For example in community inpatients services we found that nutrition and hydration assessments were completed on all appropriate patients. These assessments were detailed and used the nutritional screening tool (NST). We saw that appropriate follow up actions were taken when a risk was identified to ensure patients received sufficient nutrition and fluid to promote their recovery. We looked at food and fluid records and found these were complete, accurate and current.

Requires improvement

Are services effective?

In end of life care, the hospice at home team used the electronic system to record where people prefer to be cared for and if this is achieved. The team have a target of 80% in facilitating people to be cared for in their preferred place, and met this with 92% of patients.

We found staff did not always respond to the needs of patients in community inpatient services. Several patients told us staff did not respond to call bells. This caused acute anxiety for one patient. Another patient told us staff sometimes put the call bell on their weak side, meaning it was difficult for them to use the bell.

The trust used a number of different IT care records systems. Some services did not have access to electronic systems so used paper based systems. Additional services used a combination of computerised and paper copies for the recording of care. This made it difficult to follow information and meant that the trust could not ensure that people's records were accurate, complete and up to date. We were particularly concerned about gaps in records within the learning disability, substance misuse and forensic services. Staff in community inpatients and end of life care services told us electronic systems for recording patient information were not always accessible to all staff throughout these services.

In community services for children, young people and families we found some effective use of technology to communicate with children and their families, for example a texting service and the virtual clinic in a rural secondary school.

Best practice in treatment and care

Most services were using evidence based models of treatment and made reference to National Institute for Health and Care Excellence (NICE) guidelines. Generally people received care based on a comprehensive assessment of individual need and that outcome measures were considered using the Health of the Nation Outcome Score (HoNOS) or other relevant measures.

We saw evidence that NICE guidance, such as the clinical guidance on the prevention and management of pressure ulcers, was followed in community services for adults and inpatients. However, within the older peoples' mental health services and acute services we found limited awareness of evidence based guidance from NICE. In substance misuse services we found that NICE guidance was not followed in relation to physical health checks.

Community services for adults were proactive in monitoring the quality of outcomes for patients and using the information to drive improvements. The service showed that it routinely monitored patient outcomes and could demonstrate that some of the trust services provided better patient outcomes than other similar or alternative services. The hand clinic was a good example of this. However, in older peoples' community teams we found that there was no use of outcome measures.

In 2014 the trust participated in the National Audit of Psychological Therapies. This indicated that the trust had not considered whether psychological therapies were delivered in line with NICE guidance or had looked at outcomes from the therapy. Within mental health services we found a shortage of psychology staff meaning that not all services were able to offer psychological therapies in line with NICE guidance. The IAPT service was not meeting the key performance indicators (KPIs) set by commissioners in relation to 'access targets'. There was a long wait for psychotherapy (about 24 months) this impacted on community staff who continued to see the person until transferred.

The trust told us that improving the physical healthcare of those with mental health issues or a learning disability was a key priority. Across mental health services most patients' physical health care needs were assessed and most care plans viewed included reference to physical health needs. However, we found that within a number of inpatient services access to GPs was an issue which meant that physical healthcare treatment was not always readily available. We also found some specific examples of concern within substance misuse and rehabilitation services where necessary physical health checks were not undertaken in line with prescribed medication.

The trust had participated in some but not all applicable Royal College of Psychiatrists' quality improvement programmes. The ECT suite at the Bradgate unit held accreditation at the excellent service level. The Agnes unit learning disability service had held accreditation since 2012 but was awaiting confirmation of reaccreditation at the time of our visit. The trust told us that some actions had been required to meet this standard but they had been completed.

The trust has a research strategy and had participated in a wide range of clinical research. The trust also undertook a wide range of clinical effectiveness and quality audits.

Requires improvement

Are services effective?

These included safeguarding practice, medicines management, prescribing, compliance with NICE guidance, medical devices, suicide prevention, clinical outcomes, physical healthcare, care planning, record keeping, pressure ulcer management, consent and capacity, Mental Health Act administration and patient satisfaction.

During 2014 the trust also participated in two national clinical audits: the National audit of psychological therapies (NAPT) and the National audit of schizophrenia (NAS).

The trust had undertaken a trust-wide audit using the Green Light Toolkit in 2009. This audit aims to assess whether services are appropriate for people with a learning disability. The trust told us that this had not been re-audited since but would be looked at through the service development improvement plan which was commenced in January 2015.

Skilled staff to deliver care

In the 2014 NHS Staff Survey, the trust scored better than average for staff receiving relevant training and development and for receiving an appraisal. However, the quality of appraisal was indicated to require improvement with just 41% staff saying it was well structured. The trust was also ranked below average in relation to support from immediate managers. Overall the trust had improved its position across relevant indicators against the 2013 survey results.

Staff told us that supervision was usually available and used to manage performance issues and development. However, a number of staff, particularly those within CAMHS services, told us that a lack of staffing and service pressures meant that they did not always receive supervision and therefore had little feedback on their performance.

The staff survey had found that the percentage of staff suffering work-related stress in the last 12 months had been worse than average and the trust was within the worst 20% of trusts for staff feeling pressure to attend work when feeling unwell. Sickness absence rates had fallen slightly since the staff survey was completed but remained slightly above target at 4.9% in February 2015.

The trust had collected information regarding staff undertaking induction training within the first 3 weeks within their new role. At December 2014 the trust had not met its target with only 86% of new starters undertaking the training within time. At rehabilitation services we were concerned to find staff who were unable to access their induction training for up to four months after their start date. This was of particular concern in respect of management of aggression training. However, we were also told of very good practice for induction at Loughborough Hospital were newly qualified nurses complete induction training for a year. During this year nurses completed training in various competencies including administering intravenous medications, venepuncture, cannulation, syringe driver and catheterisation training.

The trust supplied details of their set mandatory training requirements and uptake. At March 2015 this indicated that 92.7% of staff were compliant with core mandatory training. However, this also stated that not all staff were in date with fire safety, information governance or other mandatory training. We were concerned that only 73% of relevant staff had received immediate life support training, only 68% of staff had received training in strategies for crisis intervention and prevention (SCIP), only 78% of staff had undertaken management of aggression training and only 81% of staff had received medicines management training.

We were concerned that in end of life care services advanced nursing practitioners had no mandatory training in end of life care, pain management, or other areas relating to this service. Staff within acute, rehabilitation and CAMHS had not all received required life support training. In addition we found poor compliance with mandatory training in information governance, moving and handling, and fire safety within CAMHS services.

Staff told us that they usually do have access to mandatory training but there was minimal resource to access specialist training to meet the needs of their client group. Issues of travel and time were stated as barriers to accessing some training. In a training analysis undertaken in January 2015 staff had stated their difficulty in accessing training was due to the pressures of their clinical work increasing alongside a reduction in experienced staff in the teams.

The trust had undertaken a number of initiatives to improve staff engagement and support. The 'listening to and engaging our staff' programme included a leading together initiative for all managers, listening in to action (LiA) which involved staff in service improvement initiatives, 'ask the boss', board and directors' service visits, staff equality champions and staff support groups.

Requires improvement

Are services effective?

The trust uses the Friends and Family Test on a quarterly basis to consider staff's views. At March 2015 this indicated that there had been a slight increase in staffs' level of satisfaction.

The trust confirmed that they were working hard to improve access to training and annual appraisal. From December 2014 incremental pay had been linked to completion of an appraisal. This trust had also implemented on-line training and records systems to improve access to training and data quality.

Multi-disciplinary and inter-agency team work

We found a strong commitment to multi-disciplinary team working across all services. On the wards we visited we usually saw good multidisciplinary working, including ward meetings and regular multi-disciplinary meetings to discuss patient care and treatment.

At most mental health units we saw input from occupational therapists, psychologists and pharmacy. However, in a number of mental health and learning disability services we were told that there was limited access to psychology and occupational therapy.

Community inpatients held ward round meetings which took place each week day and each patient was discussed. We saw documentary evidence of a multi-disciplinary approach to discharge planning. In community services for adults the older persons unit (OPU) provided an excellent example of multi-disciplinary working that resulted in admission avoidance for many elderly people.

Medical cover was a matter of concern in a number of areas. Non-medical prescribers in the substance misuse service were not in receipt of medical supervision to monitor and develop their prescribing practice. The staff in the end of life care services had limited support from doctors who had a specialism in palliative care. At Loughborough hospital there were plans to fully remove medical input in to this service. We observed a very slow response from the on call doctors while inspecting the forensic service. At community mental health teams the use of locums led to inconsistency in the service meaning people were not seen by the same doctor. In CAMHS services a doctor was not always on site so staff would use the on call service out of hours meaning the doctor may not have CAMHS experience.

At most wards there were effective handovers with the ward team at the beginning of each shift. These helped to ensure that people's care and treatment was co-ordinated and the expected outcomes were achieved.

Physiotherapists and occupational therapists in community services for children, young people and families met and discussed issues raised by cases. Team meetings every other month enabled working through case studies and learning from when things had not gone well. Information about new research or developments was shared.

We saw that community teams usually attended discharge planning meetings making the process of leaving the wards more effective. Generally we saw that the community teams worked well with inpatient teams to meet people's needs.

Adherence to the MHA and MHA Code of Practice

Reporting to the quality assurance committee the mental health act assurance group (MHAAG) has overall responsibility for the application of the Mental Health Act (MHA) and the Mental Capacity Act (MCA). An annual report was presented to the board, to inform the executive of performance and required actions across this area. This group also carried out the role of the 'hospital managers' as required by the MHA.

We attended a meeting with the hospital managers and were informed that the hospital managers receive a rigorous induction with training on the MHA and MCA and an induction shadowing other hospital managers.

The MHAAG provides a forum for reviewing and ensuring compliance with the legal and statutory requirements of the MHA. It performed a number of key functions, including:

- monitoring all aspects of MHA performance,
- receiving MHA reviewer reports,
- monitoring actions and responses,
- escalating any outstanding issues and raising issues of concern for resolution to the quality assurance committee and (QAC).

There was some confusion regarding whether MHA training was mandatory at the trust. The quality assurance committee (QAC) agreed MHA training was mandatory in April 2014 and a module was planned to begin in September 2014. We found varying levels of understanding across the trust and different services were unclear

regarding whether this training was mandatory. For example, we noted that staff in the crisis service were trained and knowledgeable but staff in acute services had no specific training.

We visited wards at the trust where detained patients were being treated and reviewed the records of people subject to community treatment. We also looked at procedures for the assessment of people under the MHA. In addition we reviewed a random sample of 20 sets of files within the MHA administration office, covering a variety of sections of the MHA, across several locations for detention. There was not a clear process for scrutinising and checking the receipt of documentation. MHA administrators had recently started a new system in order to scrutinise documentation but not all of the documents we looked at had been scrutinised and, whilst the majority of documents were in place and accurate we identified concerns.

There were some examples of MHA documents missing from files. In the rehabilitation and acute services there were incomplete sets of MHA documents on files and some renewal papers were not available. Reports carried out by the approved mental health professional (AMHP) were not always available in the ward files or the MHA administration files. We could find no record of action taken to obtain the reports.

Patients were usually provided with information about their legal status and rights under section 132, at the time of their detention or soon afterwards. At the forensic and learning disability services we found some exceptions to this. The forms used to record the information were brief and we saw many examples where they were incomplete. For example, patients' understanding of their rights was not always recorded. In four of the core services, where detained patients were being treated, patients' understanding of their rights was not reassessed. We also found that, irrespective of their understanding, patients were not reminded of their rights on a regular basis. A patient on one of the secure wards had only had their rights explained once in twelve months. Files at the MHA office did not routinely include details about whether a person had been provided with their rights under the MHA.

Most of the wards displayed posters about the independent mental health advocate (IMHA) service. However, across all services there were examples where patients had not been informed of, or did not understand, their right to access an IMHA. The exception was the older person's service, where patients were automatically referred to an IMHA if they were unable to understand their rights.

Assessment and recording of patients' capacity to consent at the start of their treatment varied across the core services. There were limited records of discussions between patients and their responsible clinicians (RC) to show patients' understanding of their prescribed medicines and their consent or refusal to take it.

On some of the wards we found treatment was not being given in line with the MHA Code of Practice. On two wards we found T2 certificates, to evidence patients' consent to taking their medication, were not signed by the current RC. On two wards not all prescribed medicines were included on the T2 certificate, which meant patients were being given medication they had not consented to. Similarly, we found examples of medication being given which had not been approved by a second opinion appointed doctor (SOAD) if the patient lacked capacity, or refused to consent to taking medication.

The system for recording section 17 leave did not adhere to the MHA Code of Practice in any of the core services. There were a number of incomplete leave forms. There was a lack of records to show patients were provided with copies of the forms. Several of the wards did not record risk assessments prior to patients going on leave. The outcome of the leave, including the patient's view, was not always recorded in the clinical notes. On one of the wards the leave authorisation was not signed by the patient's current responsible clinician. In the rehabilitation service we saw some leave forms were completed up to twelve months in advance, which meant leave was not being reviewed regularly.

Seclusion was practiced at a number of the services we visited. Generally seclusion paperwork was not fully completed in accordance within the Mental Health Act Code of Practice. We looked at the process of seclusion, including a review of the environment and paperwork in the acute service. We found overall that the record keeping and scrutiny was poor. We found seclusion practices did not always follow the Code of Practice or trust policy. For example, on one ward we found a patient was being nursed in a low stimulus area on constant observations. The doors were locked and the patient was prevented from

leaving. The seclusion safeguards, such as regular reviews, were not taking place. We found good practice with regard to seclusion on the wards for people with learning disabilities and autism.

Good practice in applying the MCA

The trust has a policy in place on the application of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS). Reporting to the quality assurance committee the mental health act assurance group (MHAAG) has overall responsibility for the application of the Mental Capacity Act (MCA). An annual report is presented to the board, to inform the executive of performance and required actions across this area.

The trust told us that training rates for staff in the Mental Capacity Act were good with just over 90% of staff trained at the end of December 2014. Staff confirmed that they had received this training and updates were provided as part of ongoing safeguarding training. Generally most staff had an awareness of the Mental Capacity Act and the Deprivation of Liberty Safeguards. Deprivation of Liberty safeguards applications had usually been made when required. However, records were inconsistent in recording these and staff where not always aware of when an authorisation was in place. At a number of mental health services, particularly learning disability, forensic and older people's services mental capacity assessments and best interest decisions had not always been carried out where applicable

In community healthcare services staff had a clear understanding of their responsibilities in relation to the Mental Capacity Act. They were able to differentiate between ensuring decisions were made in the best interests of people who lacked capacity for a particular decision and the right of a person with capacity to make an unwise decision.

In end of life care services we looked at "do not resuscitate cardio pulmonary resuscitation" (DNACPR) forms in use in the trust. We saw that the trust was proactive in arranging these forms to be completed early in a patient's care. We reviewed five forms and saw all of these had been completed fully. , we noticed that the form the trust used did not have an area for staff to document that a multidisciplinary discussion had taken place. This meant that it was not clear which professionals contributed to the discussion around DNACPR for the patients.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary of findings

We rated Leicestershire Partnership NHS Trust as good overall for this domain because:

- Staff showed us that they wanted to provide high quality care, despite the challenges of staffing levels and some poor ward environments. We observed some very positive examples of staff providing emotional support to people.
- Most people we spoke with told us they were involved in decisions about their care and treatment and that they and their relatives received the support that they needed. We saw some very good examples of care plans being person centred however, not all care plans indicated the involvement of the service user.
- We heard that patients were well supported during admission to wards and found a range of information available for service users regarding their care and treatment.
- The trust has a user engagement strategy which set out the trust's commitment to working in partnership with service users. The trust told us about a number of initiatives to engage more effectively with users and carers.
- Results from the friends and family test indicated a good level of satisfaction with the service.
- Advocacy services were available and promoted.

However:

- Arrangements for visits from families were not always appropriate, particularly in respect of children visiting mental health units.

Our findings

Kindness, dignity, respect and support

Assessments undertaken under the Patient-Led Assessment of the Care Environment (PLACE) reviews in 2014 identified that the trust scored worse than average at 82% for the privacy, dignity and well-being element of the assessment against an England average of 89%. Particular services of concern were Loughborough, Coalville, Feilding Palmer and Ashby community hospitals, and mental health units at Oakham House, the Willows and Mill Lodge. Stewart House rehabilitation unit scored just 53% for this assessment.

We saw that staff were kind, caring and responsive to people and were skilled in the delivery of care. We observed many instances of staff treating patients with respect and communicating effectively with them. Staff showed us that they wanted to provide high quality care. We observed some positive examples of staff providing emotional support to people. However, we observed two occasions in community inpatient services at Feilding Palmer Community and Coalville Community Hospitals where patients' dignity was not always preserved during their treatment.

Generally people told us that staff were kind and supportive, and that they were treated with respect. People we spoke with were mainly positive about the staff and felt they made a positive impact on their care.

Generally staff were knowledgeable about the history, possible risks and support needs of the people they cared for.

We were told that staff respected people's personal, cultural and religious needs. We saw some very good examples of this. For example, the end of life care services team who attend to care for people in their own home, often remove shoes before entering and follow cultural wishes such as wearing head scarves to cover their hair when attending patients.

The involvement of people in the care they receive

At most inpatient services we found welcome packs that included detailed information about the ward and a range of information leaflets about the service. This was not the case at the mental health inpatient wards for children and adolescents. Staff explained this was due to the impending move of the service. Most patients we spoke with told us

that they were given good information when they were admitted to the wards. Some patients at the rehabilitation service told us that they had not received any information at admission.

Community services for adults reported good patient involvement in their care. For example, patients that we spoke with were very positive about the musculoskeletal (MSK) service they received and reported being very involved and well informed about their treatment plan.

Community services for children, young people and families provided support for young people to manage their own treatment and had achieved positive results, such as improving their self-esteem so that they started attending school or college.

Community services for adults' podiatry service was pro-active in promoting self-care and had recently developed protocols for the risk assessment and self-management of warts using silver nitrate sticks. The podiatry service also encouraged people to self-treat using over the counter remedies where it was felt appropriate following assessment.

Within a number of mental health inpatient and community services, substance misuse services, learning disability and community inpatient wards people told us they were usually informed about their care and treatment. However we found that not all care plans and records demonstrated the person's involvement. In addition, within community mental health teams for older people we found that there was not an opportunity for patients to attend care planning meetings. In child and adolescent services we found that care plans were not written in an age appropriate format to be accessible to the patients.

Patients within mental health and learning disability services had access to advocacy including an independent mental health advocate (IMHA) and there was information on the notice boards at most wards on how to access this service. Arrangements were also in place to access independent mental capacity advocates (IMCA) and we saw examples of where this was actively promoted.

Within community healthcare we observed that where a patient was unable to be actively involved in the planning of their care, or where they wanted additional support, staff involved family members with the patients' consent.

In community inpatients we received mixed feedback regarding family involvement but received positive feedback from one family who described the changes staff at Melton Mowbray Community Hospital made to accommodate their preferences for the care of their relative.

Generally within mental health and learning disability services we found some good examples of involving patient's families and carers where appropriate. However, within the short breaks learning disability service we found some examples of staff sharing information with families without the expressed consent of the person.

We found some issues within mental health services in relation to families visiting their loved ones. In forensic services all visits were closely observed, which patients were very unhappy about. At the acute wards there was a specific area for visits involving children. However, this was not available to patients who were admitted to the PICU. Also within acute services there was limited space on wards for visits not involving children.

The trust has a service user and carer involvement strategy which sets out the trust's commitment to working in partnership with service users and carers. This is underpinned by the 'changing your experience for the better programme' which included initiatives to engage more effectively with users and carers. This work is overseen by a trust wide user and carer reference group. Work has included development of a dedicated patient experience team and divisional patient experience committees, public engagement events regarding service reconfiguration, promotion of advocacy and advance statements, increased partnerships with voluntary and community groups and service user involvement in training, recruitment and audit. Other initiatives developed included the use of the 'triangle of care' toolkit which provides an accredited framework to develop carer involvement within local services.

Prior to the inspection we spoke with a large number of user groups, community support organisations and advocacy services. Generally we heard of positive relationships with the trust and of opportunities to be involved in providing feedback on how services are run or planned.

Most inpatient services had community meetings or forums to engage patients in the planning of the service and to

Good

Are services caring?

capture feedback. Patients told us they felt able to raise concerns in the community meetings and that they usually felt listened to. We saw that there was information available throughout the trust and via its website about how to provide feedback on the specific services received by people.

The trust had been a pilot site for the Friends and Families Test (FFT) in 2013 and had fully implemented this across the trust in April 2014. In the 12 months prior to our visit there had been almost 6000 responses to this survey. At March 2015 the results indicated that 96% of respondents were likely or extremely likely to recommend the trust services.

Requires improvement

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary of findings

We rated Leicestershire Partnership NHS Trust as requiring improvement overall for this domain because:

- The trust was not meeting all of its targets in respect of the delivery of community services. Some teams had significant waiting lists.
- We were told that there was a shortage of beds in acute, PICU and CAMHS services.
- Out of area placements were high for acute services and the PICU was unavailable to female patients as it did not meet the guidance on mixed sex accommodation.
- A lack of available beds meant that people may have been discharged early or managed within an inappropriate service. However, staff worked well with other services to make arrangements to transfer or discharge patients.
- We were also concerned about the operation of the referral line for the crisis service. Performance information had also not been available this service.
- We found that the environment in a number of units did not reflect good practice guidance and had an impact on people's dignity or treatment.
- Within three acute wards and the PICU there were no female only lounges as required by the Mental Health Act Code of Practice and Department of Health guidance.

However:

- We found a range of information available for service users regarding their care and treatment and many of the leaflets were available in other languages.
- A process in place to address peoples' complaints. However, improvement is required to ensure all complaints are captured at trust level and learned from.
- Most units that we visited had access to grounds or outside spaces and generally had environments that promoted recovery and activities.
- Interpreters were available and we observed some very good examples of staff meeting the cultural needs of their patients.

Our findings

Access, discharge and bed management

The trust was asked for information ahead of our inspection regarding the days from initial assessment to onset of treatment but could not supply this as they did not currently collect this information. The trust has met just 65% of its targets for the average number of days from referral to initial treatment. Particular areas of concern were highlighted as ADHD services, community mental health teams, domiciliary therapy, dietetics, continence services, older people's mental health services and memory clinics, and psychological therapies. At March 2015 the trust had almost met its target for percentage of patients on CPA followed up within 7 days of discharge at 94.7%.

The trust monitors both bed occupancy rates and delayed transfers of care. At the time of the inspection the number of delayed transfers of care was 8.7% against a target of 5.9% for mental health services and at 1.06% against a target of 2.12% for community inpatient care. At March 2015 bed occupancy rates at the trust stood at 89.5% across all mental health services and 94.0% for community inpatient services which is above the England average. We also analysed the data for bed occupancy this was at 99% occupancy for adult mental health and learning disability services. The trust told us that the average length of stay for mental health wards was 53 days.

Throughout this inspection we were consistently told there was a shortage of beds for acute mental health and psychiatric intensive care. We observed during the inspection that there was often a problem finding beds for patients who needed an admission. We were shown supporting data which gave the bed occupancy on the wards as very often above 100% capacity. Community and crisis team members told us that they spent a lot of time trying to find appropriate inpatient beds for people. It was

frequently necessary to admit other patients into the beds of patients who were on short term leave. We observed that one patient had returned from leave on Bosworth ward. A bed was not immediately available for this patient, so they had been asked to wait in the lounge until a bed became available. We also observed a 17 year old female patient being nursed in a seclusion room on an adult ward due to no appropriate bed.

Staff told us there could be delays if patients needed to be transferred to more appropriate care facilities, such as a psychiatric intensive care unit (PICU) as there were no beds available there.

We found that there were waiting times for rehabilitation and child and adolescent inpatient services. We were particularly concerned that there is currently no PICU available to female patients as the single PICU is designed in a way that cannot accommodate patients of both genders. This meant the trust either breaching single sex accommodation guidance or placing female patients out of area.

The trust had a bed management system for mental health services. During the day a bed management team co-ordinated admissions whereas at night this responsibility fell to the night co-ordinator. During our unannounced visit, the night co-ordinator explained that a patient who did not need a substance misuse service was being admitted to a detoxification bed usually for patients with substance misuse problems. There was no other bed available within the trust. The alternative was to find a bed out of area.

The trust told us that they are trying to reduce the out of area admissions. Staff and patients also reported concerns about the high level of out of area admissions. This also usually meant that patients were subsequently transferred or repatriated, which was sometimes disruptive to the continuity of their care. At the time of our inspection there were 19 patients in out of area acute beds (that is, beds which are not within the trust's catchment area). Of these patients, we noted that one patient had been out of area for 144 days, although the overall average was 38 days.

We observed that at all inpatient services' staff worked with other services to make arrangements to transfer or discharge patients. However, staff told us that bed availability in the acute, intensive care unit and CAMHS services meant that there had been delays on occasion in transferring a patient. We found that generally there was evidence of different groups working together effectively to ensure that patients' needs continued to be met when they moved between services.

The mental health ward teams told us that they worked closely with both crisis services and community teams to ensure continuity of care when patients were discharged from hospital. At most wards we found that arrangements for discharge were discussed and planned with the care co-ordinators and other involved care providers and many people told us that they were fully involved in their discharge planning.

In community inpatient services we found that home assessments were completed with the patient and carers by a member of the multidisciplinary team before discharge. This ensured equipment or further community support was provided once the patient was discharged home. The end of life care services and MacMillan nurses told us they worked closely with other members of the multidisciplinary team, for example GPs and district nurses, in order to ensure patients received timely access to and discharge from services. We were told about the rapid discharge system that could enable the discharge of a patient within four hours by arranging relevant care packages at their home and equipment.

The trust had developed a new model for the crisis service which was in the third week of operation at the time of this inspection. Target times and clear criteria had been set but the trust had not yet been able to measure performance. It therefore was not possible to measure the speed of the crisis service's response to referrals and whether they were meeting their targets. Information available following the inspection indicated that the service had met the 24 hour target but had not met the targets for 2 hour, 4 hour and 72 hour assessments. We were concerned about the crisis referral line which was staffed by untrained administrators rather than clinicians. We also heard of delays in response to this line and found that there was no way of gauging unanswered calls. We found that people were mainly positive about the reorganisation of the service

Across community mental health, learning disability and physical healthcare teams we heard about a number of unacceptable waiting times. These included community

teams for paediatrics and child and adolescent mental health, older peoples' teams, learning disability teams, adult ADHD teams, liaison services, substance misuse services and psychology services.

The service environment optimises recovery, comfort and dignity

Since 2013 'Patient-Led Assessments of the Care Environment' (PLACE) visits had taken place to a number of inpatient services. This is a self-assessment process undertaken by teams including service users and representatives of Healthwatch. The results indicated that the trust overall scored above average for the standard of cleanliness, but below average for food, facilities, and privacy, dignity and wellbeing.

Facilities were rated low in a number of services. The national average score was 92.5%. The trust only met or bettered this score for four of the 17 inpatient services reviewed.

Scores for privacy, dignity and wellbeing were also rated very low in a number of services. The national average score was 89.6%. Only three of the 17 services reviewed met this score. Of these, Mill Lodge, Oakham House and Stewart House scored less than 65%.

We noted some units required updating and staff at a number of services told us that there could be significant delays in repairs being carried out. On three wards in the acute service and one ward in the older peoples' mental health service we found bath/shower rooms out of order. Within older peoples mental health wards we found that Coleman ward was not dementia friendly. At the forensic service we had some concerns about space for people to meet visitors. Not all facilities had a space for children to visit. We found limited space within the learning disability short breaks services for activities and for people with physical health needs to manoeuvre. Generally we found that inpatient services were clean and had environments that promoted recovery. Most had room for activities, space for quiet and a place to meet visitors

On a number of units we found arrangements that did not promote people's dignity.

We were very concerned about sleeping arrangements within the acute services at the Bradgate Unit which was predominantly dormitory style, with up to four patients sleeping in one dormitory. Curtains were provided between the beds but this did not provide the privacy required. Male and female dormitories were adjacent or opposite each other. During our visit we noted dormitory doors open and we were able to observe patients within. Bathroom facilities were allocated as single gender but due to repairs and there location we noted members of the opposite gender using the facilities.

Within three acute wards and the PICU there were no female only lounges as required by the Mental Health Act Code of Practice and Department of Health guidance.

Most units that we visited had a clinic room available and were equipped for the physical examination of patients.

We found that most services had access to grounds or outside spaces, but most garden areas did not have a shelter for use in inclement weather.

Most inpatient services had lockable storage available to patients. Whilst patients had access to a lockable storage space at the acute wards, they did not have the keys for the storage and had to approach a member of staff. In longer stay services we found that people were able to personalise their bedroom space.

Wards we visited had a telephone available for patient use. However, within acute, PICU and forensic services these were not sited in a private area and patients complained about their calls being overheard. At Thornton ward the payphone was out of order and patients told us this was a frequent issue.

Most patients were happy with the choice and quality of food available to them. However, some patients at the forensic service, older peoples' services at the Bennion Centre and in the learning disability service were unhappy with the choice available and the repetitiveness of the menu. Most wards had facilities for drinks and snacks outside of meal times. In the majority of cases these were open to patients as appropriate. At the forensic service patients did not have access to a fridge meaning milk and other perishables were not adequately stored.

Meeting the needs of all people who use the service

Inpatient and community services were provided from facilities that were equipped for disability access.

We found a range of information available for service users regarding their care and treatment both within services and via the trust website. Many of the leaflets viewed were

available in other languages and formats. However, we found that in the end of life service care plans and information was not available in an appropriate format for people with dementia or a learning disability. We found limited information available to people within the crisis services.

In community services for adults staff used a 'getting to know me' booklet which identified person centred information around the person's preferred routines and information that was important to patients living with dementia. However, this information had not been consistently filled out within the records we reviewed at Feilding Palmer Hospital. Community services for adult heart failure patients could access advice via an email helpline with a guaranteed response within 72 hours.

Staff told us that interpreters were available via a central request line and were used to assist in assessing patients' needs and explaining their care and treatment. We observed some very good examples of staff conversing with patients in their own language were English was not the patients first language. In community services we heard about some good practice were staff had asked patients about their preferences were interpretation was required. This meant a patient could choose between an independent translator or family support for their translation needs.

At most inpatient services we saw that multi-faith rooms were available for patients to use and that spiritual care and chaplaincy was provided when requested. We saw there was a range of choices provided in the menu that catered for patients dietary, religious and cultural needs.

End of life care palliative care nurses told us they aimed to find out patients' wishes and religious beliefs early in their care so they can document this and ensure their wishes can be carried out. Staff told us that they have been able to assist a family in the early release of a body so that burial times were adhered to.

Listening to and learning from concerns and complaints

The trust provided details of all complaints received during 2014. There had been 322 formal complaints. The largest number of these related to nursing and health visiting. The analysis of this highlighted key themes as clinical treatment, staff attitudes, delays to appointments, admission and discharge, and communication. The trust informed us that during the period 53% of complaints had been upheld. During the period 3 complaints had been referred to the Parliamentary and Health Service Ombudsman (PHSO) as the complainant remained unhappy with the outcome. These had not been upheld by the PHSO. The trust also provided information about the complaint issues and the actions they had taken as a result of the findings. We reviewed this information and saw some good examples of learning from complaints.

The trust provided details of their formal complaints process. This set out arrangements for response, investigation and ensuring lessons are learned and shared. All formal complaints are reviewed by the divisional director responsible for the service and responses are signed by the chief executive. Complaints information was discussed at local governance meetings and is reviewed by the quality assurance committee. The board receive the report from the quality assurance committee which includes details of complaints received and any relevant actions.

Ongoing training regarding the complaints process is not currently available. This had been recognised as an area for development by the trust. Staff told us they that were aware of complaints raised in the service and usually heard of the outcome and any learning this raised. Staff were generally aware of the complaints process and received information about the complaints process as part of induction training.

At the inpatient services most patients told us that they were given information about how to complain about the service. This was usually contained within the ward information and included information about how to contact the patients advice and liaison service (PALS). Information about the complaints process was usually displayed at the wards. Most patients knew how to complain and felt they would be listened to.

In some but not all community teams we found that complaints information was displayed and that additional information was available. Most community patients knew how to complain.

Complaints information was also looked at some of the services we visited. Reports usually detailed the nature of complaints and a summary of actions taken in response.

Requires improvement

Are services responsive to people's needs?

Generally complaints had been appropriately investigated and included recommendations for learning. At some units we saw actions that had occurred as the result of complaints.

The trust told us that they are actively trying to manage complaints on an informal basis. In a number of community and inpatient services verbal complaints were managed at service level and the findings were usually acted upon. However, we found a number of services including CAMHS, substance misuse services, forensic and end of life services were these were not logged or notified to the trust complaints team. This meant some issues may not be tracked and resolved by the trust as there was no auditing system in place for verbal complaints. This also may mean that the trust does not have a clear understanding of themes emerging from complaints.

Requires improvement

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary of findings

We rated Leicestershire Partnership NHS Trust as requiring improvement overall for this domain because:

- We reviewed the risk registers for the trust and directorates and noted that while some of the concerns we found had been highlighted others had not been flagged.
- The trust had not met all its strategic objectives.
- The trust had failed to ensure all required improvements were made and sustained at the acute services at the Bradgate Unit following compliance actions made in 2013.
- We were concerned that the trust had not always delivered safe and quality care despite a well organised governance structure and quality system. Our findings indicate that that there is room for improvement to ensure that lessons are learned from quality and safety information and that actions are embedded in to practice.

However:

- The trust board had developed a vision statement and values for the trust and most staff were aware of this.
- The trust had undertaken positive engagement action with service users and carers.

Our findings

Vision, values and strategy

While the board and senior management had a vision with strategic objectives in place, staff did not feel fully engaged in the improvement agenda of the trust.

The trust board had developed a vision statement and values for the trust in 2013. The vision was stated as: 'To improve the health and wellbeing of the people of Leicester, Leicestershire and Rutland by providing high quality, integrated physical and mental health care pathways'. The trust values were confirmed as: respect, compassion, trust and integrity.

The trust gave us a copy of their quality strategy for 2013 to 2016. This included the overarching trust objectives. These were: 'to deliver safe, effective, patient-centred care in the top 20% of our peers; to partner with others to deliver the right care in the right place at the right time; staff will be proud to work here, and we will attract and retain the best people; and ensure sustainability'. The strategy also sets out more detailed objectives to meet this plan, as well as arrangements to monitor progress.

Additional annual objectives were also set out in the annual quality account. For 2014/15 the objectives included better physical health care for older people, the 'changing your experience for the better' programme, a review of acute mental health bed usage, initiatives to improve transitions for young people and improved crisis care. The integrated business plan underpins the quality strategy and quality account objectives and sets out the trust's financial plans for 2013 to 2016.

The trust board, executive team and quality assurance committee review performance against the strategy on a monthly basis via a business performance report and dashboard approach known as the 'Integrated quality and performance report' (IQPR). Performance against annual objectives is also published within the quality account.

The trust board members we spoke with were clear about the vision and strategy and were able to articulate their specific areas for improvement. Senior management were aware of the strengths and improvement needs of the trust and the specific objectives of their own service areas.

We were told that the vision and strategy were developed following detailed engagement with service users, staff and commissioners. Across all directorates we found an inconsistent level of staff knowledge and awareness of the trust's vision and strategy. Some staff confirmed that they had received a copy of the vision and values on a wallet sized card. Some staff told us that they had received further

information about the vision and strategy as part of a self-evaluation package given to teams in advance of our inspection. Other staff had a clearer understanding of the vision, values and strategy. Staff demonstrated that they usually had a better understanding of directorate and service level objectives than of the trust wide objectives.

Good governance

We found that while performance improvement tools and governance structures were in place these had not always brought about improvement to practices. Our findings indicate that that there is room for improvement to ensure that lessons are learned from quality and safety information and actions are imbedded in to practice.

The trust has a board of directors who are accountable for the delivery of services and seek assurance through its governance structure for the quality and safety of the trust. Reporting to this are committees for quality assurance, workforce and organisational development, finance and performance, and audit and assurance. The trust manages all quality governance through the quality assurance committee. Reporting to this are sub-committees for clinical effectiveness, patient safety, safeguarding, health and safety, infection control, patient and carer experience, medicines management and medical devices. These committees had terms of reference, defined membership and decision making powers.

The trust operates an enterprise risk management risk escalation methodology compliant with ISO 31000. This is described within both the trusts board assurance and escalation framework document and the risk management strategy.The trust had an integrated board assurance framework and risk register which is reviewed monthly by the board. Risk registers were also in place held at different levels of the organisation which were reviewed at directorate meetings. We saw that there was a clear disconnect between the risks identified at grass roots level and those recognized by board.

The integrated quality and performance report (IQPR) acts as a performance report against key indicators and an early warning system for identifying risks to the quality of services. This includes measures of organisational delivery, workforce effectiveness and quality and safety. These include: complaints, serious incidents, access and waiting time targets, delayed transfers of care, bed occupancy, average length of stay, as well as staffing measures such as vacancies, sickness, turnover and training rates.

A Mental Health Act assurance group had overall responsibility for the application of the Mental Health Act and the Mental Capacity Act. We met with the hospital managers and found that they provided a regular annual report to the board, to inform of performance in this area. The board also received further information and assurance regarding the Mental Health Act through the board committee structure. There are a large number of concerns about the application of the Mental Health Act and there was a disconnect between board level awareness of these and practices at ground level. We reviewed the annual Mental Health Act report and MHA assurance group minutes and noted that a number of these issues had been raised by the hospital managers since April 2014 and were still outstanding. These included mandatory MHA training for staff, a more robust audit process and better organisation of legal documentation.

The trust publishes a leaflet, 'Clinical Governance: What does it mean for us all in our trust?' This leaflet makes explicit the reasons that sound governance systems are important and the responsibilities of individual staff members. Staff demonstrated they were aware of their responsibilities in relation to governance. Most staff told us that they were aware of the governance structure and had access to performance information and meeting minutes. Most staff told us they would escalate risks they were aware of.

Team managers confirmed that they were involved in governance groups and that they were able to raise issues through the risk register and operational groups. We reviewed the risk registers for the trust and directorates and noted that while some of the concerns we found had been highlighted others, such as ligature and environmental issues, mixed gender accommodation, medication management and clinical risk management, had not been flagged. This shows a poor grasp by the board of these serious failings.

We found a large number of practices and resources that required improvement. Issues of concern included poor

Requires improvement

Are services well-led?

environments and ligature risks, single sex accommodation issues, under compliance of mandatory training, supervision and appraisal, demand for beds, staffing issues, restrictive practices and medicines management.

In July 2013 we had inspected the Bradgate mental health unit. We were concerned about the care and welfare of patients and co-operation with other providers and issued warning notices. We returned in November 2013 and found some improvement. At this inspection we found that some issues of care and welfare such as care planning and seclusion practice had not been fully met or sustained. This is a serious breach and shows a disconnect with board understanding of the performance of the trust.

We reviewed the performance reports for the previous year's objectives. We noted that while some progress had been made some objectives had not been fully met or sustained such as improvements to record keeping, clinical supervision and physical healthcare for mental health inpatient services. Objectives for 2014/15 had included improvements to bed management and care planning in acute services. We found these remained issues in the acute services.

We were concerned that despite a well organised governance structure and quality system the trust did not always deliver safe and good quality care. Improvement is necessary to ensure that lessons are learned from quality and safety information and are embedded in to practice.

Leadership and culture

Morale was found to be poor in some areas and some staff told us that they did not feel engaged by the trust although managers and leaders were visible. Staff in the CAMHs services, forensic services and older peoples' teams stated that morale was poor and that they did not feel engaged by the trust. The board was not always sighted on these issues.

In the 2014 NHS Staff Survey, the trust was ranked about average overall. The trust was below average in relation to 13 measures including support from immediate managers, feeling valued, job satisfaction and being able to contribute to development. Overall the trust had slightly improved its position across relevant indicators against the 2013 survey results. The staff survey had found that the percentage of staff suffering work-related stress in the last 12 months had been worse than average and the trust was within the worst 20% of trusts for staff feeling pressure to attend work when feeling unwell.

We looked at data available about staffing. The trust confirmed that they had a vacancy rate of over 7% and that staff turnover stood at over 11 % in February 2015. During February 2015 over 27% of shifts within inpatient services were covered by agency or bank staff. Acute services had particularly high use of agency or bank staff which ranged between 32 and 62% per ward. Sickness absence rates had fallen slightly since the staff survey was completed and remained slightly above target at 4.9% in February 2015.

The trust told that they had undertaken a range of initiatives to engage staff. The 'listening to and engaging our staff' programme included a leading together initiative for all managers, listening in to action (LiA) which involved staff in service improvement initiatives, 'ask the boss', board and directors' service visits, staff equality champions and staff support groups.

The trust uses the Friends and Family Test on a quarterly basis to consider staff's views. At March 2015 this indicated that there had been a slight increase in staffs' level of satisfaction. We found that staff were very committed to ensuring that they provided a good and effective service for people who used the services. Most, but not all, staff felt able to influence change within the organisation. However, staff in the end of life service and the CAMHs services told us that they did not know the long term plans from the trust and could not influence change.

Most staff told us they knew their immediate management team well and most felt they had a good working relationship with them. Most staff were aware of, and felt supported by, the trust's directorate management structures. Most staff were aware of who the senior management team were at the trust. Some staff stated that they had met with or seen senior managers at their service and felt supported by this.

Staff were aware of their role in monitoring concerns and assessing risks. They knew how to report concerns to their line manager and most felt they would be supported if they did. We found some good examples of staff feeling that learning from past incidents was informing planning of services or service provision. However, a small number of

Requires improvement

Are services well-led?

staff in children, young people and families services told us they had not been supported by their managers and they felt unable to raise concerns, or if they did raise concerns these would not be appropriately dealt with.

Some staff at a Black and Minority Ethnic staff focus group from across the trust told us they did not always feel supported or engaged as trust staff members.

In 2014 a CQC regulation was introduced requiring NHS trusts to be open and transparent with people who use services and other 'relevant persons' in relation to care and treatment and particularly when things go wrong. The trust had undertaken an audit to understand any improvements required to meet this duty of candour. Following this a number of actions were undertaken including duty of candour considerations being incorporated into the serious investigation framework and report and complaints process. Minutes of directorate and locality governance groups evidenced frequent discussion about the duty of candour. Whilst most staff were aware of the duty of candour requirements not all staff across community health care services were fully aware of duty of candour in relation to their roles.

Engagement with the public and with people who use services

The trust has a user engagement and carers' strategy that sets out the trust's commitment to working in partnership with service users and carers. Underpinning this is an improvement programme called 'changing your experience for the better'. Through this they had undertaken a number of initiatives to engage more effectively with users and carers. These included the development of patients' experience workers, ensuring that all divisional patient safety and experience groups had involvement plans, involving service users in recruitment, training and service planning, promotion of advocacy and advance statements, and increased partnerships with voluntary and community groups. Other initiatives developed included the use of the 'triangle of care' toolkit which provides an accredited framework to develop carer involvement within local services.

The trust had been a pilot site for the Friends and Families Test (FFT) in 2013 and had fully implemented this across the trust in April 2014. In the 12 months prior to our visit there had been almost 6000 responses to this survey. At March 2015 the results indicated that 96% of respondents were likely or extremely likely to recommend the trust services.

Since 2013 'Patient-Led Assessments of the Care Environment' (PLACE) visits had taken place to a number of inpatient services. This is a self-assessment process undertaken by teams including service users and representatives of Healthwatch.

Most inpatient services had community meetings or forums to engage patients in the planning of the service and to capture feedback. Patients told us they felt able to raise concerns in the community meetings and that they usually felt listened to. Patients and their families or carers were engaged by staff in community health care groups using a variety of methods. We saw that there was information available throughout the trust and via its website about how to provide feedback on the specific services received by people.

Many patients told us that they felt listened to and their requests were usually acted upon.

Not all care plans reviewed in mental health services indicated involvement of the patient. Not all patients were aware of the content of their care plans. In addition, within community mental health teams for older people we found that there was not an opportunity for patients to attend care planning meetings. In child and adolescent services we found that care plans were not written in an age appropriate format to be accessible to the patients. We also found significant issues in relation to patients being treated without clear consent. In community healthcare services patients stated that they were usually involved in their care

Prior to the inspection we spoke with a large number of user groups, community support organisations and advocacy services. Generally we heard of positive relationships with the trust and of opportunities to be involved in providing feedback on how services are run or planned.

Quality improvement, innovation and sustainability

The trust had participated in some but not all mechanisms for quality improvement.

The trust participated in some accreditation schemes and service networks open to them. The ECT services at the

Requires improvement

Are services well-led?

Bradgate Unit were accredited with ECTAS (Royal College of Psychiatrist's accreditation for ECT). The Agnes Unit learning disability service had held accreditation since 2012 but was awaiting confirmation of reaccreditation at the time of our visit. The trust told us that some actions had been required to meet this standard but they had been completed. However, the trust had not participated in all relevant accreditation schemes, for example the acute service was not accredited by the AIMS (Royal College of Psychiatrist's accreditation for inpatient services) programme and the forensic services was not part of the quality network for forensic services.

The trust has a research strategy and had participated in a wide range of clinical research.

The trust also undertook a wide range of clinical effectiveness and quality audits. These included safeguarding practice, medicines management, prescribing, compliance with NICE guidance, medical devices, suicide prevention, clinical outcomes, physical healthcare, care planning, record keeping, pressure ulcer management, consent and capacity, Mental Health Act administration and patient satisfaction.

During 2014 the trust also participated in two national clinical audits: the National audit of psychological therapies (NAPT) and the National audit of schizophrenia (NAS). The National Audit of Psychological Therapies indicated that the trust had not considered whether psychological therapies were delivered in line with NICE guidance or had looked at outcomes from the therapy. The trust had participated in the National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH) in 2012.

Community services for adults had initiated innovative practice. This speech and language therapy team (SALT) had initiated a pilot where they worked with the dieticians and staff from local care homes to identify training needs. The team then provided the training for the care homes and improved the care patients received. The team had been awarded a Leicestershire Partnership Trust excellence award for this project.

The trust heart failure team had started an initiative to 'grow their own' nurse specialists. There were three Band 6 nurses on a three month induction. A competency framework was being put in place to support these nurses in developing the necessary skills for their specialist roles.

In end of life care services at St Luke's Hospital, a project called 'sisters act' had been implemented which encouraged staff to give feedback about the service and encouraged them to think about how it could be improved. This had been rewarded by an award from the trust.

A new model of service delivery for the crisis service had been introduced and was in its third week of operation at the time of the inspection. Staff and stakeholders had been involved in the development of the model. We found that a dashboard of key performance indicators was being developed but there was no reliable performance data, other than the number of referrals, to gauge the performance of the service. We were told by managers that the trust had agreed to suspend the interim dashboard, as the data was not reliable, until there was the ability for the electronic system to populate the dashboard in April 2015.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The provider did not protect patients against the risks associated with the unsafe management of medicines.** • Arrangements for medication management within the substance misuse service were not robust. • Some medication was out of date In the crisis service. • At the rehabilitation service we found two patients were necessary medical checks had not been undertaken following administration of high dose anti-psychotic medication. • The rapid tranquilisation policy did not cover oral treatment. • Fridge temperatures in the acute service were not monitored meaning medicines may not be safe. • The trust had not implemented the requirements of the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises

This section is primarily information for the provider

Requirement notices

The provider had not ensured that patients were protected from the risks associated with unsafe or unsuitable premises by means of suitable design and layout.

• Not all wards at the acute service at the Bradgate unit, and the PICU complied with guidance on same sex accommodation.

• Some wards at the acute and forensic services, and the PICU had potential ligature points that had not been fully managed or mitigated.

• Observation was not clear within some of the acute and forensic wards.

• Not all seclusion facilities had safe and appropriate environments.

• Repairs had not always been completed in a timely way.

• Sluice doors were not always kept locked to prevent patients and visitors having potential access to harmful products.

• The health-based place of safety at the Bradgate unit did not meet guidance: furniture was light and portable and access arrangements were unsafe.

This was in breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulations 10 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment

The provider did not make suitable arrangements to protect patients and staff from the risk of harm during an emergency by providing and maintaining necessary equipment.

• Not all community and inpatient service had a means to raise an alarm in an emergency.

This section is primarily information for the provider

Requirement notices

• Not all emergency equipment was checked on a regular basis.

This was in breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

The trust did not take appropriate steps to ensure there were sufficient numbers of staff.

• Not all community and inpatient services had sufficient staffing to safely meet patient need.

• Not all services had access to specialist medical support in a timely way.

This was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

People were not being protected against the risks of receiving care or treatment that is inappropriate or unsafe.

• A lack of availability of beds meant that people did not always receive the right care at the right time and sometimes people were moved, discharged early or managed within an inappropriate service.

This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People were not being protected against the risks of receiving care or treatment that is inappropriate or unsafe. • Not all seclusion facilities met the guidance of the Mental Health Act Code of practice. • Not all seclusion was recognised and managed within the required safeguards. • The trust was yet to fully implement guidance from the Department of Health regarding restrictive practice. This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People were not being protected against the risks of receiving care or treatment that is inappropriate or unsafe. • Not all patients within the forensic and substance misuse services had a risk assessment in place. • Not all risk assessments and care plans were updated consistently in line with changes to patients' needs or risks. • Peoples' involvement in their care plans varied across the services. This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulations 9 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People were not being protected against the risks of receiving care or treatment that is inappropriate or unsafe by means of planning and delivering care to meet individual service user's needs. • There was limited and delayed access to psychological therapy. This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulations 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The trust did not make appropriate arrangements to ensure the consent to care and treatment of all services users. • Not all patients had recorded assessments of capacity. • Procedures required under the Mental Capacity Act were not always followed. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The trust did not ensure that services users were protected against the risks of unsafe or inappropriate care and treatment due to a lack of accurate records being made and held securely.

This section is primarily information for the provider

Requirement notices

• Procedures were not always followed for detention under the Mental Health Act and records relating to patient's detention were not always in order.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

People were not being protected against the risks of receiving care or treatment that is inappropriate or unsafe by means of planning and delivering care in a way that ensures the welfare and safety of the patient.

• Arrangements for patients taking section 17 leave were not clear and in line with the Mental Health Act.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

People were not being protected against the risks of receiving care or treatment that is inappropriate or unsafe by means of planning and delivering care in line with Mental health Act Code of practice.

• Not all patients who were detained under the Mental Health Act had information on how to contact the CQC.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The trust had not made suitable arrangements to ensure that staff were appropriately supported in relation to their responsibilities, including receiving appropriate training, professional development, supervision and appraisal. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The trust did not ensure that services users were protected against the risks of unsafe or inappropriate care and treatment through availability of accurate information and documents in relation to the care and treatment provided. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The trust did not protect people, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the trust to identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity.

This section is primarily information for the provider

Requirement notices

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Appendix E

Scrutiny

Leicester City Council

Scrutiny Task Group Report

Equality Impact Assessments (EIAs) and Lesbian, Gay, Bisexual & Trans (LGBT) Issues

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A Report of the Overview Select Committee

March 2015

Leicester City Council

Contents

1 Introduction

1.1 Acknowledgements

1.1.1. As Chair of the Task Group I would like to thank everyone who came to the meetings - with such positive and creative suggestions that some have already been taken on board. It has helped improve the council's links with the communities by involving the LGBT Centre.

1.1.2. I would especially like to thank the Equalities team, Miranda Cannon and the Scrutiny team for the efficient and focussed work on this one aspect of EIAs. This is an important piece of work and their contributions are highly valued.

1.2 Background

1.2.1. Following a meeting with the Lesbian, Gay, Bisexual and Trans (LGBT) Centre, Members raised concerns at Overview Select Committee (OSC) about how the Council considers issues impacting on LGBT communities, and that equality impact assessments (EIAs) rarely commented on impacts for the sexual orientation and gender reassignment protected characteristics.

1.2.2. It was therefore resolved at the OSC meeting on 16th October to set up a task group to review EIAs and in particular those relating to the LGBT community. Also, whether improvements could be made to ensure greater consideration of LGBT issues in future.

1.2.3. The LGBT Centre stated that whilst there is still a need for improvements in the Council, other organisations, particularly the city Clinical Commissioning Group (CCG) were even further behind. They also raised the issue of their need for a sustainable funding stream in order to continue providing the wide range of services for LGBT people.

1.3 Recommendations

The Assistant Mayor for Community Involvement, Partnerships and Equalities and the Executive are asked to consider and respond to the following recommendations:

1.3.1. A methodology is developed for capturing demographics of the LGBT population in Leicester.

1.3.2. A mandatory equalities awareness e-learning module is rolled out to all staff and monitored to ensure it is completed.

1.3.3. A robust training plan for LGBT awareness is put together for frontline staff in key departments starting with Children's Services, Sports and Leisure Services, Adult Social Care and Housing.

1.3.4. The Equalities Team works with the LGBT Centre to provide information in the Members Induction pack that is specific to LGBT issues and makes clear that L, G, B and T are separate communities with different needs.

1.3.5. The Equalities Team should sign off of all EIAs to show they have been involved and consulted throughout the process and are monitoring progress.

1.3.6. Recognising L, G, B and T are separate communities, the council should consult with members of the communities (through resources like the LGBT Centre) on how consideration of the different needs can be made more explicit on EIAs for example by separating out lesbian, gay, bisexual and trans needs.

1.3.7. An Equalities Champions Scheme for all service areas should be established to support the work of the Equalities Team.

1.3.8. Signposting and involving organisations such as the LGBT Centre needs to be embedded as normal practice during EIA and consultation processes where appropriate, and this should be led by the Equalities and Research and Intelligence Teams.

1.3.9. A Service Level Agreement (SLA) is formed with the Centre to agree how they can strengthen links with the Council and embed good practice in Council work.

The Deputy City Mayor and the Health and Wellbeing Board are asked to consider and respond to the following recommendation:

1.3.10. Encourage all health partners to consider the needs of LGBT communities in everyday practice and when making service changes and/or procuring and commissioning services.

Overview Select Committee is asked to consider the following recommendations:

1.3.11. An action plan is requested and compiled with outcomes to all the recommendations from this report and for it to be reported back to the commission.

1.3.12. To request information to understand how we can work within procurement cost thresholds to ensure a fair opportunity for local providers and how tendering exercises are advertised and promoted to local providers.

Overview Select Committee is asked to request the following from other scrutiny commissions:

1.3.13. The Housing scrutiny commission is recommended to establish if there is an adequate policy in place to support LGBT people should they be made homeless because of their sexual orientation and/or gender identity.

1.3.14. The Health and Wellbeing scrutiny commission should determine if the needs of LGBT people are being adequately considered and responded to, particularly in relation to sexual and mental health.

1.3.15. The Adult Social Care scrutiny commission considers when the needs of LGBT people are being adequately considered when providing domiciliary care and also when older people are placed in residential care.

1.3.16. The Children, Young People and Schools scrutiny commission looks at the work done in schools to combat homophobic bullying and support for LGBT pupils in greater detail and identify any future improvements needed.

The task group would also like to acknowledge and raise awareness of the following:

1.3.17. Good practice undertaken by the staff in the Council's Customer Service Centre when handling issues and signposting and also the rollout of LGBT awareness training by Sport Services.

1.3.18. At the recommendation of members of the task group the EIA template has been amended to include two additional questions; the author is asked to summarise why the protected characteristics they have commented on are relevant to the proposal, and why those they've not commented on aren't.

2 Current situation in Leicester

2.1 Scope

2.1.1. The remit of the task group was to consider the following:

- What does the Council currently do?
- What works well?
- What areas of the Council do it particularly well or are in need of improvement?
- What are the barriers?
- What could be done better?

2.1.2. The Council currently undertakes the following to continue to drive forward equalities, particularly in relation to LGBT communities:

- Encourage training for staff across all services but targeting where there is most need.
- Senior management consider training as a mandate where appropriate.
- The corporate induction is being revamped with equalities included as part of it.
- Considering how managers deal with issues such as staff undergoing gender reassignment and offering them appropriate support.
- Supporting the Council's LGBT employee group.
- Continue to encourage staff to disclose their own sexuality in order to monitor and act upon issues effectively.
- Continue to participate in the Stonewall Workplace Equality Index to improve the Council's performance to tackle discrimination and create an inclusive workplace for your lesbian, gay and bisexual employees.
- Liaising with local partners to continue to gather good practice ideas.

2.1.3. The task group found that a panel of external people are brought together on a regular basis to review EIAs, for example this was done in November/December to look at initial spending review EIAs. As a result, the feedback has helped to continually review and improve the EIA template. A new, simpler template is being piloted and people are finding the current simplified template easier to use. The template is also regularly reviewed in light of legal judgements and good practice cited in consideration of protected characteristics.

2.2 Demographics

2.2.1. The census does not ask for a person's sexual orientation and therefore there is no accurate data on the numbers of people that are lesbian, gay or bisexual (LGB). Also, some people are not comfortable about disclosing their sexuality.

2.2.2. Statistics on the Trans communities are even scarcer and there appear to be no reliable figures available on the size of the Trans population in the UK, nor any data on how many people request or receive gender reassignment services.

2.2.3. The latest major survey that asked for people's sexual orientation was the Integrated Housing Survey in 2012. The tables below show the results from 169,239 respondents of which 1.5% of people identified themselves as LGB.

Sexual Orientation by Gender[1]

	Heterosexual / Straight	Gay / Lesbian	Bisexual	Other	Don't know / Refusal	No response
Men	93.2%	1.5%	0.3%	0.3%	3.5%	1.2%
Women	93.7%	0.7%	0.5%	0.3%	3.8%	1%
Total	93.5%	**1.1%**	**0.4%**	0.3%	3.6%	1.1%

Sexual Orientation by Region[1]

	Heterosexual/ Straight	Gay/ Lesbian/ Bisexual	Other	Don't know/ Refusal	No response
North East	95.1	1.7	0.1	2	1.1
North West	94.1	1.6	0.3	2.9	1.1
Yorkshire and The Humber	94.2	1.3	0.3	3.1	1
East Midlands	94.1	**1.3**	0.3	3.3	1
West Midlands	93.5	1.2	0.3	3.9	1.2
East of England	93.4	1	0.1	4.6	0.9
London	89.9	2.5	0.4	5.8	1.4
South East	94.1	1.5	0.3	3.2	0.9
South West	92.8	1.4	0.2	4.4	1.2
Wales	94.3	1.3	0.4	2.8	1.3
Scotland	94.9	1.4	0.3	2.3	1.1
Northern Ireland	94.8	1.1	0.3	2.9	0.9

2.2.4. Stonewall believe the true figures are greater than this though and believe it to be around 5 – 7% of the population. With Leicester's population being at approximately 330,000 this would mean estimates of around 16,500 – 23,100 in the city based on Stonewall's estimation[2].

2.2.5. If we use 1.5% as the estimated percentage of population from the Integrated Housing Survey then the figure for the city would be 4,950 people. With such variations in the levels it concurs that it is difficult to get an accurate understanding of the numbers and more robust data capturing is required.

2.2.6. **The task group recommends that a methodology is developed for capturing demographics of the LGBT population in Leicester.**

[1] Integrated Household Survey 2011/12 - http://www.ons.gov.uk/ons/dcp171778_280451.pdf
[2] Stonewall - http://www.stonewall.org.uk/at_home/sexual_orientation_faqs/2694.asp

3 Findings

3.1 Issues facing LGBT communities

3.1.1. There are no specific reports/studies that list a set of issues facing LGBT communities, but there are themes that highlight some key areas that also emerged during discussions of the task group. These are described in this section of the report.

3.1.2. Lack of understanding of needs

As mentioned earlier in the report we don't have a clear understanding of the demography of LGBT communities and this often means there isn't enough emphasis placed on their needs. Also, the needs of LGBT people are lumped together however there are differences in the needs of gay men to those of lesbian women and also of bisexual people. There is an even greater discrepancy of needs when considering trans people.

The LGBT Centre reaffirmed this as they said there was a concern that some EIAs carried out by the Council suggest there is not a need, but there are obvious needs which are missed or ignored. Also some forms capturing data often don't ask for sexual orientation which means that the needs of LGBT people can often be ignored.

3.1.3. Discrimination

LGBT people still face persecution due to their sexual orientation or gender identity. Whether it is homophobic bullying at schools or discrimination at work or in everyday life there is still a lot of work to be done to address this to ensure that LGBT people are treated equally. This abuse can be verbal and/or physical and can be direct or indirect.

Examples of indirect cases of this raised by the LGBT Centre are Gay men are getting asked if they had a wife or a girlfriend, when receiving care the questions they are asked are often pre-empted with "this is embarrassing but…" or "it's a difficult question but…" and staff making heterosexual assumptions when addressing LGBT issues/needs.

Direct abuse can include hate crimes such as verbal abuse and name calling to more extreme cases of rape and physical violence all due to the person's sexual orientation (or perceived sexual orientation) or gender identity.

3.1.4. Issues facing LGBT Youth

Research into LGBT communities suggests that homelessness amongst LGBT young people[3] is a concern with kids being kicked out of their families and homes because of their sexual orientation and/or gender identity with some also suffering abuse from their families.

The Housing scrutiny commission is recommended to consider if there is an adequate policy in place to support LGBT people should they be made homeless because of their sexual orientation and/or gender identity.

As previously mentioned, homophobic bullying is also an issue particularly at school and on social networking sites. Also, young people face confusion around their identity and have difficulties coming out with little or no support. With all these issues to contend with these experiences often leave young people particularly vulnerable to mental and physical health issues and suicidal tendencies.

The task group recommends that the Children, Young People and Schools scrutiny commission look at the work done in schools to combat homophobic bullying and support for LGBT pupils in greater detail.

3.1.5. Issues facing Black and minority ethnic (BME) LGBT people

BME young people who are LGBT in particular are facing real difficulty with acceptance from their family. The LGBT Centre works with the Albert Kennedy Trust in these cases.

Generally many of the issues facing the general LGBT population are even worse for those that are of a BME background.

3.1.6. Health concerns

Sexual health, social care and mental health are all areas of healthcare that hold specific concerns for LGBT people and disparity in its delivery in comparison to that for heterosexual people.

The LGBT Centre stated that there is still a need to increase sexual health awareness, with the number of LGBT people diagnosed with HIV rising, particularly amongst those from emerging communities.

[3] Albert Kennedy Trust: LGBT Youth Homelessness: A UK National Scoping of Cause, Prevalnece, Response and Outcome (2014) - http://akt.org.uk/webtop/modules/_repository/documents/AlbertKennedy_ResearchReport_FINALInteractive.pdf
'Hidden in Plain Sight' : Homelessness Amongst Lesbian and Gay Youth (2001) - http://www.natcen.ac.uk/media/23798/hidden-plain-sight-homelessness.pdf

As mentioned, in relation to young people there can be serious concerns around the mental health of LGBT people after years of being mistreated and or discriminated against. This can also have a connection to substance misuse and suicide.

The LGBT Centre also highlighted health inequalities from GPs being particularly poor, with people feeling quite embarrassed or fearful after visiting their GP. Also an example was given of a lesbian woman whose long-term partner was in hospital and died from cancer and it was only when she rang to see if she was ok that she was told and was offered very little support.

The task group recommends that the Health and Wellbeing board encourages all health partners to consider the needs of LGBT communities in every day practice and when making service changes and/or procuring and commissioning services.

It is also recommended that the Health and Wellbeing scrutiny commission considers if the needs of LGBT people are being adequately considered and responded to, particularly in relation to sexual and mental health.

There are also reports which highlight concerns facing older LGBT people when accessing social care with some older people concerned about facing discrimination and/or care workers not understanding their specific needs.

It is recommended that the Adult Social Care scrutiny commission considers if the needs of LGBT people are adequately considered when providing domiciliary care and also when older people are placed in residential care settings.

In an area of good practice the LGBT Centre has supported NHS England to compile a Trans Care Pathway for health practitioners to use when dealing with Trans people.

3.1.7. Issues facing Trans people

The task group heard that Trans people are consistently abused, discriminated against, harassed, and assaulted. Self-harm and attempting suicide is also more prominent. Also, it is often the case that the “T” gets excluded from LGBT initiatives and campaigns.

Issues in the early stages of people going through gender dysphoria were highlighted by the LGBT Centre, particularly around the use of changing rooms with Trans people being challenged ,often disrespectfully. This had been identified in sport services at a Council leisure centre and since then training to raise awareness has been rolled out and mandated to all leisure centre staff.

3.1.8. Domestic abuse

Violence and abuse at home at the hands of family or a partner is also something that can be prevalent within LGBT communities. Quite often the support is not geared at adequately supporting LGBT people and their specific needs.

3.1.9. Issues facing LGBT Asylum Seekers

The deportation and detention process for migrants is particularly pernicious for LGBT people, who are often the subject of harassment and abuse.

Many gay asylum seekers feel a lot of shame about their sexual orientation and are from countries where they could face serious harm if they were open about being gay. In some cases it might even be illegal for them to be gay in their home country.

Officials working on asylum cases focus a lot on sexual activity thinking this is proof that someone is really gay, expecting them to answer very detailed questions about their sex lives which they may feel uncomfortable or unsafe in answering due to a lack of trust in people from the persecution they will have faced in their home country.[4]

As such the process itself to seek asylum can be distressing and then on top of this they face the issue of adjusting to a new country and coming to terms with their sexuality or gender identity.

3.2 Equality Impact Assessments (EIAs)

3.2.1. Following the introduction of the Public Sector Equality Duty (PSED) as part of the Equality Act 2010, the protected characteristics have now been extended to also include:

- Age
- Gender reassignment
- Pregnancy/maternity
- Religion/belief
- Sexual orientation
- And for specific instances, marriage and civil partnerships

3.2.2. Whilst there is no longer a statutory requirement to complete an EIA the Council still ensures they are completed. The aim of the public sector equality duty is to:

- Eliminate unlawful discrimination, harassment and victimisation

[4] Stonewall - http://www.youngstonewall.org.uk/know_your_rights/immigration_and_asylum/challenges_facing_gay_asylum_seekers/default.aspx

- Advance equality of opportunity between different groups
- Foster good relations between different groups

3.2.3. An EIA sets out the anticipated impact a proposed action will potentially have on service users (or staff) – existing or anticipated in future – and how any negative impacts can be mitigated. Equalities considerations have to take place throughout the whole process from start to finish. The PSED is an ongoing duty and should be revisited to ensure that initial assumptions are as originally thought.

3.2.4. The main ground for legal challenge from an equality perspective is on the basis of the PSED not being met. The PSED is concerned with process rather than substance: the Council is required to have due regard to the need to achieve the various statutory objectives, not to actually achieve the statutory objectives.

3.2.5. The only legal challenge considered by the Court since the implementation of the Equality Act 2010 has been the recent one regarding the decision making process for the closure of Herrick Lodge, an Elderly Persons Home. The Council was able to successfully demonstrate that it had adequately addressed the main points of contention raised by the claimant.

3.2.6. Judges in some legal challenges on grounds of not meeting the PSED have stated that consideration of every protected characteristic is not required, reiterating that this is the case only where the protected characteristic is relevant to the matter at hand. However, it has been highlighted that there are occasions when gender reassignment or sexual orientation are not considered properly, particularly in EIAs, and it states there are no implications when there are. As such it is important to ensure the correct characteristics are identified and considered.

3.2.7. **Since the first meeting of the task group, at the recommendation of members of the group the EIA template has been amended to include additional questions; the author is asked to summarise why the protected characteristics they have commented on are relevant to the proposal and why those they've not commented on are not relevant.**

3.2.8. As stated earlier it is also important that LGBT communities are not considered as one group and the separate issues for each of those communities are considered in the same way we would separate issues affecting men and women for example. **The task group recommends that recognising L,G,B and T are separate communities the council consults with members of the communities (through resources like the LGBT Centre) on how consideration of the different needs can be made more explicit on EIAs for example by separating out lesbian, gay, bisexual and trans needs.**

3.3 Procurement and commissioning

3.3.1. The task group set out to establish if the Council's procurement and commissioning processes adequately considered equalities issues and gave fair opportunities for local groups with expert knowledge. There was also a need to understand if organisations successful in gaining a contract understood their role in ensuring they addressed inequalities when delivering services.

3.3.2. The procurement team has produced guidance on incorporating equalities into the procurement process in conjunction with the equalities team for procurement officers to check that service areas have considered relevant equalities implications and have completed an EIA where necessary.

3.3.3. The Council cannot breach procurement rules and prevent national organisations from applying for contracts in the city, particularly for higher cost threshold tenders. Although they can weight tender evaluations in relation to questions around local knowledge and understanding. . **However, there is a need to greater understand how we can work within the thresholds and how they are advertised and promoted to local providers and the task group recommends this is looked at in greater detail.**

3.3.4. Procurement are working with the equalities and commissioning teams to develop and deliver a workshop for the local voluntary sector in June/July on how the PSED impacts upon them when the Council procures services from them.

3.4 Equalities training and support

3.4.1. There is currently no training plan for Council staff that specifically relates to LGBT issues or equalities more generally. When training is offered, take up has usually been very low. There is a segment for equalities in the Corporate Induction for staff and there is an e-learning course available but this is not mandatory. There is no refresher training offered.

3.4.2. As one of the partners of the LGBT Centre, the Council is entitled to three full day training sessions or six half day training sessions but these are yet to be utilised.

3.4.3. An example of good practice was when Sport Services commissioned LGBT awareness training in response to complaints about poor customer care for LGBT leisure centre users to which 128 staff attended. This was however reactive and it's unclear as to whether this will continue to be rolled out to new staff.

3.4.4. **The task group recommends that a mandatory equalities awareness e-learning module is rolled out to all staff and monitored to ensure it's completed and that a robust training plan for LGBT awareness is put together for frontline staff in key departments starting with Children's**

Services, Sports and Leisure Services, Adult Social Care and Housing.

3.4.5. An equalities session is included in the Members Induction and they will also receive a pack to make them aware of equalities issues. **It is recommended that the Equalities Team works with the LGBT Centre to put information in the Members pack that is specific to LGBT issues and makes clear that L, G, B and T are separate communities with different needs.**

3.4.6. There is an annual EIA session as part of the annual budget process, jointly delivered by the equalities team with Mark Noble. This is open to all officers and tends to involve Heads of Service/service managers who are responsible for development of budget proposals. There is no specific session more generally for all EIAs.

3.4.7. An initial discussion by an equality officer with the lead service officer tasked with completing an EIA is found to be the best method of support with the equalities team able to discuss what needs to be considered within an EIA and also any follow up questions which can help quality assure the process.

3.4.8. There is currently no requirement for the officer completing the EIA to consult the Equalities Team, which means that they cannot always support officers through the process ensuring all protected characteristics have been checked appropriately. **The task group recommends that the Equalities Team should have a section in the sign off of EIAs to say they have checked through it and been consulted with throughout to ensure they are involved in all EIA processes and that they monitor progress of them.**

3.4.9. The task group also recognised that specialist organisations are often not utilised effectively in completing EIAs or consulted effectively when proposing changes to services. **It is therefore recommended that signposting and involving organisations such as the LGBT Centre needs to be embedded as normal practice during EIA and consultation processes where appropriate and this should be led by the Equalities and Research and Intelligence Teams.**

3.4.10. There are 3.6 FTE in the Equalities Team comprising of one Corporate Equalities Lead and two full-time and one part-time Equalities Officers. Whilst the team is there to advise, support and deliver on equalities work, it is the responsibility of the whole Council to ensure equalities is embedded in their everyday practice. It was heard that other sections are using 'Champions' to support teams to help delivery and awareness of their work **and the task group recommends that Equalities Champions for all service areas are considered to support the work of the Equalities Team.**

3.5 Reporting concerns

3.5.1. Members of the public who may wish to report LGBT issues relating to poor customer care/access to service issues report these through the Council's complaints procedure. The first point of contact is Customer Services, either online, by telephone or in person. Complaints are forwarded to the Corporate Equalities Team when a more specialist answer is required - for example, what is required by the law in responding to a certain situation?

3.5.2. For those wishing to report personal hate incidents it is reported through the Council's community safety reporting mechanism. They will liaise with the Police and other partners where appropriate.

3.5.3. Both reporting systems have designated reporting centres across the city. Staff are trained on how to handle incidents. Trends are tracked through the respective monitoring routes. Victims or those reporting incidents requiring support are signposted to Victim Support.

3.5.4. **The Council's Customer Service Centre was cited as an area of good practice with staff handling issues appropriately and signposting as appropriate. The LGBT Centre said they had done a mystery shop of them on three occasions and they were all successful.**

3.6 Leicester LGBT Centre

3.6.1. Established 1997 as a PLC and obtained charitable status in May 2011 and is set up to support LGBT people, groups and communities in Leicester, Leicestershire and Rutland.

3.6.2. **Mission**

- Recognises that LGBT people face discrimination
- This affects opportunities, to be involved, included and valued
- Centre exists to provide safe social and support space, deliver high quality professional services, responsive to local need

Aims

- Provide safe accessible and appropriate services,
- Venue and support to combat social isolation, exclusion and discrimination
- Promote a positive environment that empowers LGBT
- Educate those who aren't LGBT

Services

- Provide information in a range of formats on a wide range of subject that affect LGBT people's lives
- Signposting and referrals to other services

3.6.3. There is a lot of work done by the Centre which saves on costs/impacts to other services which is overlooked; the true costs of the services they provide are a lot more than the funding they receive. In particular, these savings are to health services, yet there has never been any funding received from health providers. The uncertainty of funding, impacts on the work the centre does and the people it supports and a sustainable funding approach needs to be sought.

3.6.4. At the end of 2014, the Council provided a grant of £28,000 to the LGBT Centre from the VCS urgent support fund in recognition of the importance of the work the centre does and the financial challenges it faces. This follows a similar grant in the previous year. It is recognised that this is only a short-term solution to the financial sustainability of the service, and there is a continuing dialogue with the centre to support them in achieving a sustainable position.

3.6.5. There are only four other areas that have a dedicated LGBT centre/service, and the Centre has local knowledge, frontline service delivery experience and is considered a centre of excellence that should be utilised to improve services in the city.

3.6.6. The centre are about to change their name from the LGBT Centre to 'The Centre' to help people understand that they support a range of different communities.

3.6.7. Whilst it is important for the Council to ensure it works closely with the Centre and other local organisations it is equally important that this is a two way process and that the centre also engage when Council services approach them.

3.6.8. **The task group recommends that a Service Level Agreement (SLA) is formed with the Centre to agree how they can strengthen links with the Council and embed good practice in Council work.**

3.7 Stonewall

3.7.1. Since 2005, more than 800 major employers have taken part in Stonewall's Workplace Equality Index (WEI), using the criteria as a model for good practice. Submissions to the Index are assessed against questions across ten areas of good practice:

- Section 1: Employee Policy - determines whether the organisation has policies in place that guarantee the equal treatment of LGB employees.

- Section 2: Training - assesses the content and reach of the organisation's sexual orientation diversity training.

- Section 3: Staff Network Group - looks at the facilities made available for LGB staff to network, consult and feedback to the organisation.

- Section 4: All staff engagement - establishes how the organisation engages with all staff to raise awareness on LGB issues.

- Section 5: Career development - examines the career development opportunities the organisation makes available to LGB staff.

- Section 6: Line managers - examines how line managers promote diversity within their teams.

- Section 7: Monitoring - examines how the organisation monitors sexual orientation and what has been done with the data collected.

- Section 8: Procurement - examines how the organisation engages with existing and potential suppliers.

- Section 9: Community engagement - examines how the organisation engages with wider LGB community.

- Section 10: Additional work and optional sections - examines additional work the organisation has done that has not been captured elsewhere.

3.7.2. The Council's ranking is gradually improving after ranking 244 out of 376 in the first year in 2013 and 186 out of 369 in 2014.

3.7.3. Prior to joining Stonewall, the equalities team had a limited involvement with the Council's employee groups as the work was not prioritised. Since joining the main benefit has been sharing and learning from good practice of other local partners who are also in the WEI: County Council, NHS LPT, DMU, Leicestershire Police and Leicestershire Fire Service. This allows a coordinated response to LGBT events, enhancing the profile of LGBT equality and awareness through the local media. Engagement with Stonewall has helped to make positive changes within the Council, which has been good for staff and for our reputation, making us think about and improve the way we engage with our staff and service users.

3.7.4. The Council is also signed up to the Education Champions Programme where Stonewall works with local authorities to determine ways to address homophobic bullying in schools. The purpose is to promote a safer and inclusive learning environment for all young people. Stonewall's resources and support have helped schools focus on homophobic bullying as part of curriculum based activities and whole school approaches.

3.7.5. Whilst it is recognised that these resources from Stonewall have been helpful it is clear that they haven't solved the issue of homophobic bullying or ensured the protection of LGBT pupils in schools. The task group heard of cases of poor support from head teachers for LGBT students. As

mentioned earlier in the report it is recommended that the Children, Young People and Schools scrutiny commission look at this in greater detail.

3.8 Trade

3.8.1. Trade Sexual Health is a health charity working with the LGBT communities in Leicester, Leicestershire and Rutland. They offer a range of free and confidential support and advice services around sexual health and HIV information; one-to-one emotional and practical support; support in 'coming out', sexuality and relationships; rapid HIV testing; community based men's sexual health clinics; safer-sex packs for men and women; and a fully qualified counselling service.

3.8.2. Due to the short period in which the task group had complete this piece of work there wasn't enough time to engage with Trade, but does recommend that any further work within this area, particularly around sexual health should include engaging with Trade.

4 Summary

4.1 Conclusions

4.1.1. The Council has a number of areas where it has worked to ensure the needs of LGBT communities and its staff for example by signing up to Stonewall's Workplace Equality Index. There has also been evolving process surrounding EIA's in ensuring that they are revamped in line with policy changes, legal challenges and other lessons learnt.

4.1.2. There are some areas of good practice with the way that the Customer Service Centre responds to specific LGBT queries and the specific LGBT Awareness training for staff in Sports Services.

4.1.3. However a lot of work still appears to be ad hoc and disjointed with the feeling that equalities is still considered an 'add on' to work rather than embedded in everyday practice. The work around EIA's is improving this but there is still some work to ensure that specific issues around sexual orientation and gender reassignment are appropriately considered as protected characteristics.

4.1.4. There have been a number of recommendations made in this report which support the need for **an action plan to join up work done around equalities more generally and those that are specific to LGBT issues.**

4.1.5. The need for partnership working has been highlighted during the work of the task group and in particular utilising local expertise. With the LGBT communities facing such complex issues it is important that the services provided for them are fit for purpose and accurately address the issues that they face.

5 Summary of Appendices

Appendix A – EIA Template

6 Report Author

Councillor Lucy Chaplin
Chair, Adult Social Care Scrutiny Commission and
Chair, EIA/LGBT Issues Task Group

APPENDIX A

Equality Impact Assessment (EIA) Template: Service Reviews/Service Changes

Title of spending review/service change/proposal	
Name of division/service	
Name of lead officer completing this assessment	
Date EIA assessment completed	
Decision maker	e.g. City Mayor/Assistant Mayor/Director
Date decision taken	

Please ensure the following:

(a) That the document is understandable to a reader who has not read any other documents, and explains (on its own) how the Public Sector Equality Duty is met. This does not need to be lengthy, but must be complete.

(b) That available support information and data is identified and where it can be found. Also be clear about highlighting gaps in existing data or evidence that you hold, and how you have sought to address these knowledge gaps.

(c) That the equality impacts are capable of aggregation with those of other EIAs to identify the cumulative impact of all service changes made by the council on different groups of people.

1. Setting the context Describe the proposal, the reasons it is being made, and the intended change or outcome.

2. Equality implications/obligations Which aims of the Public Sector Equality Duty (PSED) are likely be relevant to the proposal? In this question, consider both the current service and the proposed changes.	
	Is this a relevant consideration? What issues could arise?
Eliminate unlawful discrimination, harassment and victimisation How does the proposal/service ensure that there is no barrier or disproportionate impact for anyone with a particular protected characteristic	
Advance equality of opportunity between different groups How does the proposal/service ensure that its intended outcomes promote equality of opportunity for users? Identify inequalities faced by those with specific protected characteristic(s).	
Foster good relations between different groups Does the service contribute to good relations or to broader community cohesion objectives? How does it achieve this aim?	

3. Who is affected? Outline who could be affected, and how they could be affected by the proposal/service change. Include current service users and those who could benefit from but do not currently access the service.
4. Information used to inform the equality impact assessment What **data, research, or trend analysis** have you used? Describe how you have got your information and what it tells you. Are there any gaps or limitations in the information you currently hold, and how you have sought to address this, e.g. proxy data, national trends, etc.
5. Consultation What **consultation** have you undertaken about the proposal with current service users, potential users and other stakeholders? What did they say about: ▪ What is important to them regarding the current service? ▪ How does (or could) the service meet their needs? ▪ How will they be affected by the proposal? What potential impacts did they identify because of their protected characteristic(s)? ▪ Did they identify any potential barriers they may face in accessing services/other opportunities that meet their needs?

6. Potential equality Impact			
Based on your understanding of the service area, any specific evidence you may have on service users and potential service users, and the findings of any consultation you have undertaken, use the table below to explain which individuals or community groups are likely to be affected by the proposal because of their protected characteristic(s). Describe what the impact is likely to be, how significant that impact is for individual or group well-being, and what mitigating actions can be taken to reduce or remove negative impacts. Looking at potential impacts from a different perspective, this section also asks you to consider whether any other particular groups, especially vulnerable groups, are likely to be affected by the proposal. List the relevant that may be affected, along with their likely impact, potential risks and mitigating actions that would reduce or remove any negative impacts. These groups do not have to be defined by their protected characteristic(s).			
Protected characteristics	**Impact of proposal:** Describe the likely impact of the proposal on people because of their protected characteristic and how they may be affected. Why is this protected characteristic relevant to the proposal? How does the protected characteristic determine/shape the potential impact of the proposal?	**Risk of negative impact:** How likely is it that people with this protected characteristic will be negatively affected? How great will that impact be on their well-being? What will determine who will be negatively affected?	**Mitigating actions:** For negative impacts, what mitigating actions can be taken to reduce or remove this impact? These should be included in the action plan at the end of this EIA.
Age			
Disability			
Gender Reassignment			

Marriage and Civil Partnership			
Pregnancy and Maternity			
Race			
Religion or Belief			
Sex			
Sexual Orientation			
Summarise why the protected characteristics you have commented on, are relevant to the proposal? **Summarise why the protected characteristics you have not commented on, are not relevant to the proposal?**			

Other groups	**Impact of proposal:** Describe the likely impact of the proposal on children in poverty or any other people who we consider to be vulnerable. List any vulnerable groups likely to be affected. Will their needs continue to be met? What issues will affect their take up of services/other opportunities that meet their needs/address inequalities they face?	**Risk of negative impact:** How likely is it that this group of people will be negatively affected? How great will that impact be on their well-being? What will determine who will be negatively affected?	**Mitigating actions:** For negative impacts, what mitigating actions can be taken to reduce or remove this impact for this vulnerable group of people? These should be included in the action plan at the end of this EIA.
Children in poverty			
Other vulnerable groups			
Other types of groups (ie. mobile phone users)			

7. Monitoring Impact

You will need to ensure that monitoring systems are established to check for impact on the protected characteristics and human rights after the decision has been implemented. Describe the systems which are set up to:

- monitor impact (positive and negative, intended and unintended) for different groups
- monitor barriers for different groups
- enable open feedback and suggestions from different communities
- ensure that the EIA action plan (below) is delivered.

8. EIA action plan

Please list all the equality objectives, actions and targets that result from this Assessment (continue on separate sheets as necessary). These now need to be included in the relevant service plan for mainstreaming and performance management purposes.

Equality Outcome	Action	Officer Responsible	Completion date

Sign off for EIA by.....

Review of EIA by internal critical friends.....and their comments.

Amendment of EIA in light of critical comments.....

Appendix F

Health and Wellbeing Scrutiny Commission Briefing

Temporary relocation of the Wet Day Centre (Anchor Centre)

Lead directors: Tracie Rees/ Ruth Tennant

City Mayor

Ward(s) affected: Castle

Report author: Julie O'Boyle Consultant in Public Health

Kate Gallopi Head of Commissioning Adult Social Care

Author contact details: Julie.oboyle@leicester.gov.uk

1.0 Purpose of Briefing

To provide the Health and Wellbeing Scrutiny Commission with an update on the plans to temporarily relocate the wet day centre from Dover Street.

2.0 Background

The Anchor Centre is a wet day centre for entrenched drinkers in the City providing services for people with alcohol and drug problems such as primary health care, housing & benefits advice, day time activities and general support.

Many of the clients accessing the centre can be described as street drinkers. In the context of this report, a street drinker is someone who drinks heavily in public places and appears, in the short term, to be unable or unwilling to stop or control their drinking. Street drinkers often have a long history of alcohol misuse, and frequently drink in groups.

The activities of some street drinkers and in some cases just their presence can adversely affect other members of the public, causing noise, litter and general nuisance. Street drinkers usually have multiple vulnerabilities including drug use, mental health issues, physical health problems and homelessness. Street drinkers are at risk of arrest for public drunkenness, shoplifting, begging and other public order offences as well as being at increased risk of being the victim of assault.

People who have severe alcohol dependence need to drink alcohol every day; sudden abstinence without medical support has serious health implications and can be fatal. Traditional treatment services require clients to be abstinent whilst on the premises; this is not always appropriate for this group who either fail to engage or are effectively excluded from mainstream services.

The service at the Anchor Centre is provided by Inclusion Healthcare, via an external contract, which is due to expire on 30th June 2016.

The service uses a harm reduction approach to encourage individual clients to achieve specific goals related to their alcohol consumption. Evidence shows that for this particular client group this approach is effective in terms of reduced societal costs, reduced utilisation of public services and decreased alcohol consumption. It also has the advantage of taking street drinkers away from public places where they are perceived by the public to be problematic.

Other cities that do not have a wet day facility rely mainly on enforcement, which has

shown to be of limited impact. Formal enforcement on its own has been shown to have unintended consequences, for example just moving people from one place to other; it has also been demonstrated that the threat of confiscation can lead to street users drinking more quickly for fear of it being removed and if their alcohol is removed, turning to shop lifting or aggressive begging to replace the money and the drink.

Leicester has increased its ability to deliver enforcement through the roll out of a city wide public spaces protection order (PSPO) to tackle street drinking. This came into force on the 5th January 2015. A new approach to managing persistent street drinkers based on the Integrated offender management model of shared responsibility has also been implemented. This approach has delivered significant reductions in the numbers of visible street drinkers and the number of complaints received about street drinkers. The Anchor centre is an essential and integral part of this model.

3.0 Current Accommodation

The service is currently located in Dover Street in a council owned property. The building is in a poor state of repair, with associated risks to service users and staff.

Surveys undertaken by Property Services show that significant expenditure would be required to bring the current accommodation up to a minimum standard to support the operational delivery of the service and it has previously been agreed that this is not cost-effective.

The service provider, Inclusion Health, has raised ongoing concerns about the difficulties of providing the service from Dover Street, as they are not able to provide key facilities such life skills training, which are specified in the contractual arrangements. Inclusion Health have registered their concerns with the City Council and have stated they may terminate their contract if the service is not located to more suitable premises.

We are now in a position where we need to relocate the service on a short term basis until the end of the current contract. The long term future of service provision for this complex and vulnerable client group is subject to a separate review.

4.0 Review of property

Property services have conducted a number of exercises to identify suitable alternative accommodation for the service including a review of council owned properties and private sector properties. Early reviews included the option of relocating the centre to 96 New Walk.

A more recent review has highlighted some potential properties not previously available which are currently being considered.

A number of criteria have been used to judge whether a property is suitable as a short term solution. These include;

- Appropriate planning permission
- Health and safety considerations – including;
  vicinity of major roads,

number/condition of stairs

- Location – within easy access to other services, preferably not a shared building
- Outdoor space – to obviate the need for clients to leave the premise to smoke
- Indoor space – sufficient facility to accommodate group work, healthcare space, private interview room, sufficient toilet facilities, kitchen space, preferably shower/bathing facilities
- Cost including the extent and cost of any refurbishment

Many of the properties scoped have been rejected for health and safety reasons including steep enclosed stairways, small rooms, limited access and limited toileting facilities.

The substance misuse lead commissioner is working with property services to review those properties identified as being potentially suitable.

5.0 Conclusion

The poor state of repair of the current premises means that an immediate relocation of the service is required. At the current time a number of premises are being reviewed to identify if they are a suitable.

The long term future provision of services for this complex and vulnerable client group is the subject of a separate review, due to report in October.

Details of Scrutiny

Appendix G

Health and Wellbeing Scrutiny Commission Briefing

Substance Misuse Services Re-Procurement

Lead director: Tracie Rees

City Mayor

Ward(s) affected: All

Report author: Julie O'Boyle Consultant in Public Health

Kate Gallopi Head of Commissioning Adult Social Care

Author contact details: Julie.oboyle@leicester.gov.uk

1.0 Purpose of Briefing

To provide the Health and Wellbeing Scrutiny Commission with an update on the plans to re-procure substance misuse services for the city.

2.0 Background

Existing contracts for substance misuse services in the City are due to expire in June 2016.

In accordance with best practice a review of the existing services has been undertaken.

The current services, by virtue of the fact that they are separate, provide the opportunity for attrition at the boundaries of services. This means that there is the potential for service users at these transition points to unintentionally leave services thus jeopardising their recovery journey.

There are currently separate community based services for Leicester City residents and Leicestershire and Rutland County residents. Service users have told us that they would welcome the opportunity to access services at a location away from their place of residence perhaps for convenience to fit in with their work schedule or for reasons of anonymity; under the current service structure this is not possible.

A recommendation was made to executive leads that we work with partners in the county to investigate the feasibility of a jointly commissioned single integrated LLR wide substance misuse service.

Consultation with key stakeholders was undertaken between November and December 2014. This exercise demonstrated support for a single integrated substance misuse service across LLR.

County partners conducted their own engagement and have confirmed their commitment to jointly commission an LLR service that provides equity for service users across the sub-region. This secures the partnership to support the preferred option for the future of substance misuse services.

A second stage consultation exercise is currently underway across Leicester Leicestershire and Rutland. This exercise closes on 16th August 2015. The

consultation can be accessed here
https://consultations.leicester.gov.uk/corporate-resources-and-support/subsance2015/consult_view

Details of the consultation have been shared with a LLR wide stakeholder list-that has included Police, Probation, Local medical and Pharmaceutical councils, as well as local voluntary sector/community groups that have identified they work with people with drug/alcohol problems. The consultation has also been promoted via FACE e-mail and Interface in the City. A copy of the consultation document is provided as an appendix to this document.

Soft market testing to gauge interest and opinions of provider organisations in the new model is also underway.

3.0 The Model

The proposed model is a jointly commissioned, single service for substance misuse across LLR. Fortuitously the County contracts cease at the same time as the City contracts, enabling alignment of timescales for re-procurement. An integrated LLR model provides equity in service provision for residents across Leicester, Leicestershire and Rutland.

In addition to providing an effective service model, this joint approach provides the optimum opportunity for delivering efficiencies, as the 4 existing separate services totalling £10m will be re-procured into one service. Previous service consolidation exercises have resulted in 8 -10% efficiency savings with no impact on front line service delivery and therefore this option has the potential to deliver up to £1m savings through efficiencies and reduced duplication. Any savings realised through the re-procurement will contribute to the Council's savings/efficiency programme.

This jointly commissioned option is supported by Leicestershire and Rutland County Councils Public Health Departments, who have secured political sign off for this model; and the Office of the Police and Crime Commissioner (OPCC), who contributes £0.5m to the budget.

Advantages

1. Service continuity and consistency
2. Eliminating unnecessary duplication across services
3. Equity in access to services regardless of whether users live in the city or the counties.
4. Supports service user anonymity; users could access services not in immediate area of residence, but equally will be able to access services close to home.
5. Seamless service provision that will support the movement of service users in their journey within the pathway, and lead to reduced attrition rates i.e. reduce the likelihood of service users dropping out of treatment as they navigate their way through the treatment journey.
6. Improved accountability that will support improved performance of contracts.
7. Delivery of efficiencies, increased value for money.
8. Ability of provider to redistribute resources across the system.

Risks / Disadvantages

City specifics regarding need could be at risk. This would be managed through;

1. Separate City and County service specifications and reinforced through contractual monitoring. Clear partnership agreements would be drawn up to support the joint commissioning arrangements.
2. TUPE risk. Procurement of a large contract of this nature does come with TUPE implications that could be a potential barrier for procurement. It is recommended that start-up costs are offered to potential providers to cover any immediate TUPE costs and to stimulate the response of the market by encouraging providers to tender for the contract. There are some non-recurrent funds within the budget that could be set aside for this purpose.

4.0 Conclusion

Lead executive members have been briefed on the proposed model which is supported by key stakeholders and service users. To meet the timescales for procurement an invitation to tender will be issued on 5th October 2015.

Details of Scrutiny

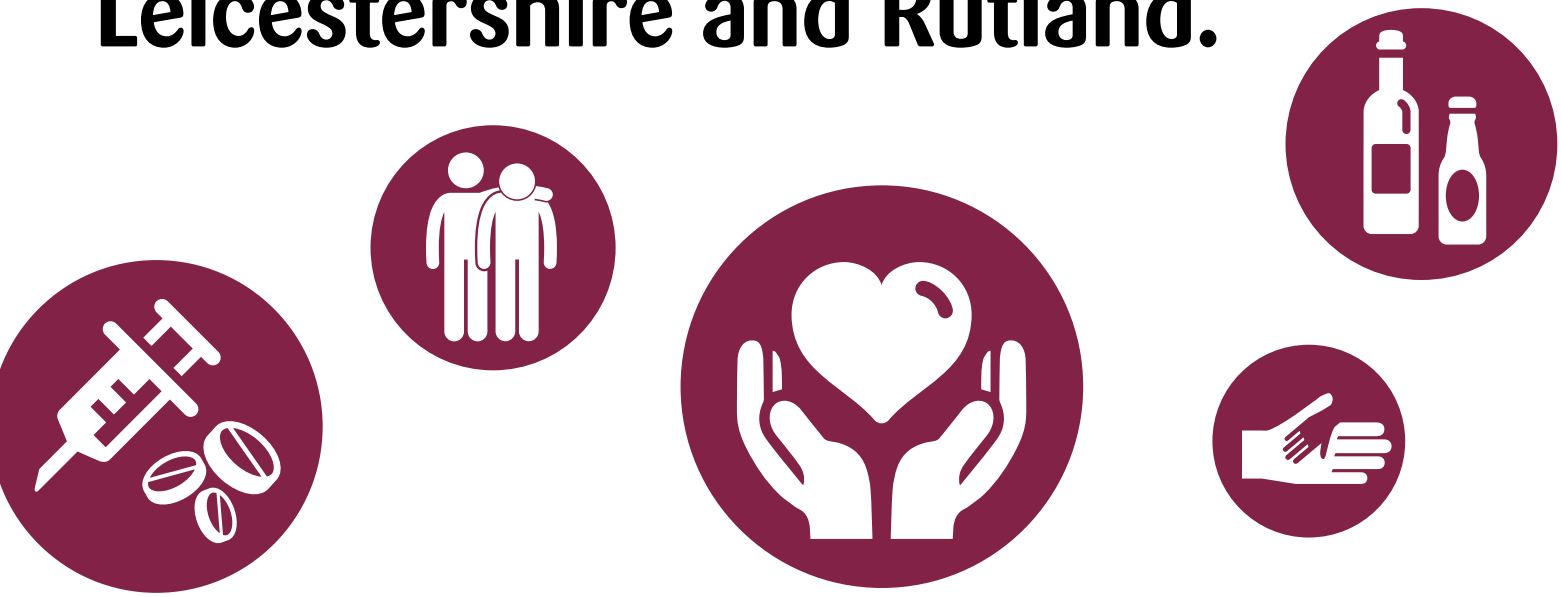
Appendix G1

Leicestershire County Council

Rutland County Council

Leicester City Council

Have your say on proposed changes to the substance misuse support services in Leicester, Leicestershire and Rutland.



Tell us how this might affect you - Leicestershire County Council:
www.leics.gov.uk/haveyoursay/substancemisuse

Leicester City Council: **http://consultations.leicester.gov.uk**

Rutland County Council:
www.rutland.gov.uk/substancemisuse

For general enquiries or comments about this consultation phone **0116 305 0705** or email **phbookings@leics.gov.uk**

Public consultation: Submit your views by midnight 16 August 2015

Why change?

Currently, Leicester, Leicestershire and Rutland councils each commission their own substance misuse support services. Current provision comes to an end in June 2016 which has provided an opportunity to review our services and look at how we can work together and share resources. This will help us to provide more integrated services and make it easier for people to access the support they need.

During 2014-2015 as individual councils we undertook initial consultation and reviewed a number of our substance misuse services. The feedback and results from this initial work helped to shape our current proposals.

Leicester, Leicestershire, and Rutland councils and the Office of the Police and Crime Commissioner are now proposing to put in place one substance misuse service which would cover Leicester, Leicestershire and Rutland from July 2016.

We are now in a position to progress together and jointly develop more detailed plans about future substance misuse services.

Over the next few weeks you will have the opportunity to tell us what you think of the proposal for one substance misuse service. Your feedback will help to further shape the model of delivery.

We are consulting the public on this proposal from 13 July 2015 until midnight on 16 August 2015.

Your views are important to us so that we can better understand how the proposals could affect you and how we can make these changes work best for you.

What is the current service?

Across Leicester, Leicestershire and Rutland, we currently have a number of specialist substance misuse services which vary in size and geographic area; six of the services are identified below:

1. Leicester, Leicestershire and Rutland wide criminal justice services
2. Leicester city only - adults
3. Leicester city only - young people - criminal justice and non-criminal justice
4. Leicestershire and Rutland combined adults and young people
5. Leicestershire only - young people in criminal justice services
6. Leicester, Leicestershire and Rutland hospital-based alcohol liaison service

Our proposals in detail – the new model

The new service would combine the six specialist services listed above into one single service which serves Leicester, Leicestershire and Rutland. This will make it easier to access support across the three authorities and reduce areas of duplication and running costs.

The service model would include a focus on:

- supporting individuals into recovery
- providing support services including treatment and harm reduction programmes
- providing services appropriate to the age of the user
- services that would be available at locations across Leicester, Leicestershire and Rutland to ensure they are accessible to all
- referrals from the criminal justice system for both young people and adults (for example on arrest, at court and through community sentences)
- joined-up working with health, social care, criminal justice services and those that support vulnerable individuals and families.

How the consultation will work

The consultation begins on 13 July 2015 and will end at midnight on 16 August 2015.

To submit your views please fill out the consultation questionnaire and make sure it reaches us by midnight on 16 August 2015 at the latest. Leicester, Leicestershire and Rutland councils will make the questionnaire available online from 13 July 2015. The questionnaire is available at **www.leics.gov.uk/haveyoursay/substancemisuse**

We will also be holding a series of meetings for those people most affected by the changes including service users and/or their family members, staff and carers. Support will be available as required to ensure that all service users have the opportunity to participate.

Paper copies of the questionnaire are available on request by calling 0116 305 0705.

If you are able to, please complete the questionnaire online as it will save us money.

You can send your completed questionnaire to the following freepost address:

Substance misuse consultation
Leicestershire County Council
Room 300B
Have Your Say
FREEPOST NAT 18685
Leicester
LE3 8XR

If you need help to complete this questionnaire or have any questions about the consultation, please call **0116 305 0705** or email **phbookings@leics.gov.uk**

Your feedback will be used to inform the decisions about these proposals.

This information is also available in Easy Read format

Call **0116 305 0705**
or email
phbookings@leics.gov.uk

What happens next?

Your feedback will be incorporated with the other consultation feedback received. This information will then be presented for discussion with Executive Members at Rutland County Council and Leicester City Council. The Cabinet at Leicestershire County Council will also discuss these findings in September 2015. The results from the consultation will be published on the council websites in due course.

You can view the latest information in a number of ways

Visit us online **www.leics.gov.uk/haveyoursay/substancemisuse**
Our web pages will be kept up-to-date with the latest information and developments.

You'll also be able to access the questionnaire at **www.leics.gov.uk/haveyoursay/substancemisuse**

Send an email to **phbookings@leics.gov.uk** to register for the latest news and updates

Follow us @leicscountyhall for general updates from the council, including the developments on the budget.

Alternatively, you can telephone **0116 305 0705** to ask for information in printed or alternative formats.

જો આપ આ માહિતી આપની ભાષામાં સમજવામાં થોડી મદદ ઇચ્છતાં હો તો 0116 305 0705 નંબર પર ફોન કરશો અને અમે આપને મદદ કરવા વ્યવસ્થા કરીશું.

ਜੇਕਰ ਤੁਹਾਨੂੰ ਇਸ ਜਾਣਕਾਰੀ ਨੂੰ ਸਮਝਣ ਵਿਚ ਕੁਝ ਮਦਦ ਚਾਹੀਦੀ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ 0116 305 0705 ਨੰਬਰ ਤੇ ਫ਼ੋਨ ਕਰੋ ਅਤੇ ਅਸੀਂ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਦਵਾਂਗੇ।

এই তথ্য নিজের ভাষায় বুঝার জন্য আপনার যদি কোন সাহায্যের প্রয়োজন হয়, তবে 0116 305 0705 এই নম্বরে ফোন করলে আমরা উপযুক্ত ব্যক্তির ব্যবস্থা করবো।

اگر آپ کو یہ معلومات سمجھنے میں کچھ مدد درکار ہے تو براہ مہربانی اس نمبر پر کال کریں 0116 305 0705 اور ہم آپ کی مدد کے لئے کسی کا انتظام کر دیں گے۔

假如閣下需要幫助，用你的語言去明白這些資訊，請致電 0116 305 0705，我們會安排有關人員為你提供幫助。

Jeżeli potrzebujesz pomocy w zrozumieniu tej informacji w Twoim języku, zadzwoń pod numer 0116 305 0705, a my Ci dopomożemy.

Have your say on proposed changes to the substance misuse support service

Please note: Your responses to the main part of the survey (Q1 to Q12, including your comments) may be released to the general public in full under the Freedom of Information Act 2000. Any responses to the questions in the 'about you' section of the questionnaire will be held securely and will not be subject to release under Freedom of Information legislation, nor passed on to any third party.

Q1 In what role are you responding to this consultation? Please tick one only

- ☐ Service user
- ☐ Family member/carer of someone experiencing substance misuse
- ☐ Interested member of the public
- ☐ Member of council staff
- ☐ Work for a substance misuse provider
- ☐ Representative of a voluntary sector organisation or charity
- ☐ GP/pharmacist or other healthcare professional
- ☐ Other professional/stakeholder e.g. elected member, council representative, business etc.
- ☐ Other (please specify below)

Other (please specify)

Q2 If you are a representative of a service provider, voluntary organisation/charity, GP/pharmacist or other professional/stakeholder, please provide your details.

Name:

Organisation:

This information may be subject to disclosure under the Freedom of Information Act 2000

Q3 We propose that the new service provides convenient access points within Leicester, Leicestershire and Rutland. Users would be able to get to venues convenient to them wherever they live in Leicester city, Leicestershire or Rutland.

To what extent do you agree or disagree with this proposal? Please tick one only

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
☐	☐	☐	☐	☐	☐

Q4 Why do you say this?

Q5 We propose that the new model will provide substance misuse services for both adults and young people. The services would be tailored to meet individual need in a way that is appropriate for their age, e.g. young people, young adults or older people.

To what extent do you agree or disagree with this proposal? Please tick one only

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
☐	☐	☐	☐	☐	☐

Q6 Why do you say this?

Q7 We would like the new service to provide a service to adults and young people in the criminal justice system (e.g. court ordered treatment) as well as all other users.

To what extent do you agree or disagree with this proposal? Please tick one only

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
☐	☐	☐	☐	☐	☐

Q8 Why do you say this?

Q9 Overall, on balance, to what extent do you agree or disagree with our new model of service? Please tick one only

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
☐	☐	☐	☐	☐	☐

Q10 Why do you say this?

Q11 Do you have any alternative ideas for how we should provide substance misuse support services?

Q12 Do you have any other comments?

Please CONTINUE if you are a service user, family member/carer of someone experiencing substance misuse or an interested member of the public.

Professionals and other stakeholders, thank you, you have now completed the questionnaire.

About you

The councils are committed to ensuring that their services, policies and practices are free from discrimination and prejudice and that they meet the needs of all sections of the community.

To enable us to check that what we are providing is fair and effective, we would be grateful if you would answer the questions below. You are under no obligation to provide the information requested, but it would help us greatly if you did.

Q13 Are you male or female? Please tick one only

- ☐ Male
- ☐ Female

Q14 Do you identify as transgender? For the purposes of this question 'transgender' is defined as an individual who lives, or wants to live, full time in the gender opposite to that they were assigned at birth. Please tick one only

- ☐ Yes
- ☐ No

Q15 What was your age on your last birthday? Please tick one only

- ☐ Under 16
- ☐ 16-24
- ☐ 25-34
- ☐ 35-59
- ☐ 60-74
- ☐ 75+

Q16 Which area do you live? Please tick one only

- ☐ Leicester City
- ☐ Leicestershire County - Blaby District
- ☐ Leicestershire County - Charnwood Borough
- ☐ Leicestershire County - Harborough District
- ☐ Leicestershire County - Hinckley and Bosworth Borough
- ☐ Leicestershire County - Melton Borough
- ☐ Leicestershire County - North West Leicestershire District
- ☐ Leicestershire County - Oadby and Wigston Borough
- ☐ Rutland County
- ☐ Don't know
- ☐ Other (please specify)

Other (please specify)

Q17 What is your full postcode? This will allow us to see how far people travel to use services

Q18 Are you a carer of a person aged 18 or over? Please tick one only

- ☐ Yes
- ☐ No

Q19 Do you have a long-standing illness, disability or infirmity? Please tick one only

- ☐ Yes
- ☐ No

Q20 What is your ethnic group? Please tick one only

- ☐ White - English/Welsh/Scottish/Northern Irish/British
- ☐ White - Irish
- ☐ White - Gypsy or Irish Traveller
- ☐ White - Any other White background
- ☐ Mixed/multiple ethnic groups - White and Black Caribbean
- ☐ Mixed/multiple ethnic groups - White and Black African
- ☐ Mixed/multiple ethnic groups - White and Asian
- ☐ Mixed/multiple ethnic groups - Any other mixed/multiple ethnic background
- ☐ Asian or Asian British - Indian
- ☐ Asian or Asian British - Pakistani
- ☐ Asian or Asian British - Bangladeshi
- ☐ Asian or Asian British - Chinese
- ☐ Asian or Asian British - Any other Asian background
- ☐ Black or Black British - African
- ☐ Black or Black British - Caribbean
- ☐ Black or Black British - Any other Black/African/Caribbean background
- ☐ Other ethnic group - Arab
- ☐ Other ethnic group - Any other ethnic group

Q21 What is your religion? Please tick one only

- ☐ No religion
- ☐ Christian (all denominations)
- ☐ Buddhist
- ☐ Baha'i
- ☐ Hindu
- ☐ Jewish
- ☐ Muslim
- ☐ Sikh
- ☐ Any other religion

Q22 Many people face discrimination because of their sexual orientation and for this reason we have decided to ask this monitoring question. You do not have to answer it, but we would be grateful if you could tick the box next to the category which describes your sexual orientation. Please tick one only

- ☐ Bi-sexual
- ☐ Gay
- ☐ Heterosexual / straight
- ☐ Lesbian
- ☐ Other

Thank you for your assistance. Your views are important to us. This information will then be presented for discussion with Executive Members at Rutland County Council and Leicester City Council. The Cabinet at Leicestershire County Council will also discuss these findings in September 2015. The results from the consultation will be published on the council websites in due course.

Please return to: Substance misuse consultation, Leicestershire County Council, Room 300B, Have Your Say, FREEPOST NAT 18685, Leicester, LE3 8XR

No stamp is required

Data Protection: Personal data supplied on this form will be held on computer and will be used in accordance with the Data Protection Act 1998. The information you provide will be used for statistical analysis, management, planning and the provision of services by the county council and its partners. Leicestershire County Council will not share any information collected from the 'About you' section of this survey with its partners. The information will be held in accordance with the council's records management and retention policy. Information which is not in the 'About you' section of the questionnaire may be subject to disclosure under the Freedom of Information Act 2000.

P0298 JULY 2016 AW02 _ PRINT

Appenddix H

Health and Wellbeing Scrutiny Commission Briefing

Local Health Messages Development

Lead director: Ruth Tennant

Ward(s) affected: All

Report author: Ivan Browne- Consultant in Public Health

Alex Barker- Communication Officer

Author contact details: Ivan.browne@leicester.gov.uk

1.0 Purpose of Briefing

To outline the plans of the Health and Wellbeing Scrutiny Commission to support the development of effective health message communincation for the Leicester population.

2.0 Background

Effective health communication is essential to promote, and ultimately protect, health. It draws on numerous disciplines including mass media, speech communication, health education, marketing, journalism, public relations, psychology, informatics and epidemiology.

Communicating health messages can take many forms and it includes both written and verbal formats. *Healthy People 2010* defines health communication as "*the art and technique of informing, influencing, and motivating individual, institutional, and public audiences about important health issues"*.

With this in mind health messages need to be informative, encouraging, inspiring, relevant, accurate, accessible, understandable and resonate with the intended audience.

Locally, the public health department, in particular, has been involved in the development and dissemination of a number of health messages covering a range of subject matter – (see appendix 1 for key examples). However, it is recognised that whilst we can easily quantify the input allocated to these messages, we cannot always quantify how effective these messages have been or whether we use the most appropriate mechanisms available to reach our target populations. The commission recognises that effective evaluation of health communications activities, both individually and as a whole, is required to help inform and shape future health communication plans.

3.0 The Proposal

The current Health & Wellbeing Scrutiny Commission will seek to support the Local Authority to enhance its delivery of key health messages to the local population as it

recognises that effective health communication is essential to improving the health and wellbeing of the Leicester population. Through the processes of review, confirm and challenge, it is the commissions' intention to consider examples of best practice that could potentially be adopted locally, as well as helping to support local initiatives that aim to convey positive health messages.

The commission seeks to ensure that local health messages encourage individual action by the person, collective change by the community, advocacy and leadership by decision makers and awareness and acknowledgement by the population. The scoping exercise will help in the consideration of a number of questions about local health messages, which may include the following:

- What's out there already that we can learn from?
- Who do we need to reach locally?
- What do we want to say?
- Where do we want to say it?
- How do we want to say it?
- How do we measure how effective the message was?

4.0 Conclusion

This briefing introduces the health messaging development workstream to the Health and Wellbeing Commission agenda.

Details of Scrutiny

Appendix 1

Topic	Rationale	Target Group	Method/s of communication used	When	Any evaluation or feedback carried out following
Cardio vascular disease **(NHS Health Checks)**	To raise awareness of NHS Checks and provide patients with information about what they can expect when they have a check	40-74 year olds who have not had a check within 5 years	Leaflet production, mass media bus campaign	June 2013 Nov 2014	none
Diabetes	To raise awareness of diabetes testing and how to reduce the risk	General public plus high prevalence populations	Diabetes UK roadshow in Humberstone gate plus local charity Silver Star in various locality areas including Evington and Belgrave.	November 2014	Diabetes UK roadshow: 279 people accessed the event and 172 of those were referred to their GP. 108 people were tested by Silver Star with 52 people referred to their GP.
Oral health	National smile month – to raise awareness of good oral health	Families with young children	Events, roadshows, leaflets, mass media bus campaign, public realm posters, schools and adult competitions, free oral health packs, traditional and social media outputs	May/June 2014 May/June 2015	All primary schools children in Leicester received oral health packs and healthy teeth happy smiles literature
Physical activity	To raise awareness of the importance of physical activity and to	General population	Event held at Aylestone leisure centre, leaflet and poster campaign,	July 2013	Over 200 people engaged with free activities and giveaways

	signpost to LCC sports provision		traditional and social media, website.		
Mental health	Raise awareness of the importance of positive mental health and signpost toward support and help and advice	General population	Public realm posters, traditional and social media	March 2015	none
Smoking	Development and production of a film to educate and inform pregnant smokers of the dangers of smoking and support their quit	Pregnant smokers in the city	Screening of the film in all CYPF centres, traditional and social media, link on our website, professional engagement	October 2014	Professional engagement led to film being shared nationally and internationally.
Alcohol	Lead agency on alcohol awareness week	General population, including targeting students	Public events, university focused events held at both universities, traditional and social media,	November 2014/15	Over 500 students at both universities were engaged with targeted alcohol awareness events. regional, and local, media coverage
Healthy weight	Promote the importance of a healthy balanced diet	Targeted families with young children (targeted through children's centres)	Supported cook and eat sessions in children's centres – these were an addition to the existing planned cook and eat session.	April – June 2013	12 families took part in the targeted our healthy city branded cook and eat sessions
Sexual health	Sexual health event held at Leicester	Student population	Student centred advertising, social	November 2014	Over 300 students attended the drop in

	University (Oadby campus)		media, supporting partner agencies events		session
'Our healthy city'	Promote the 'launch' of public health with the local authority as the lead	General public	Live cooking event in Leicester Market	April 2013	Audience for cooking made up of over 300 people. 300 bags of recipe cards and ingredients given away
Healthy children	Lead partner agency for the pilot Smart Start project	Families with young children (specifically those in receipt of NEG funding)	Targeted week of free breakfasts, cook and eat sessions, public events and giveaways, schools competition	March 2014	300 entries into school completion; 500 breakfasts given away during the week; 10 cook and eat sessions delivered; regional and local media coverage
General	General health messaging	General public	General health messages on a variety of themes via social media and public realm advertising, website updates, communication for consultations, materials, events, partnership meetings and engagement at all levels.	ongoing	It has been seen that the public health messages, in general, are more popular than other city council messages through social media

Health and Wellbeing Scrutiny Commission

Work Programme 2015 – 2016

Meeting Date	Topic	Actions Arising	Progress
6 Aug 2015	1) Healthwatch briefing 2) Reduction in Public Health budget and impact on service delivery 3) LPT – CQC Quality Report 4) Scrutiny Review of LGBT communities – Consider issues raised in the review 5) Update on Anchor Centre 6) Substance Misuse Services – re-procurement 7) Communicating Health Messaging		
28 Sep 2015	1) Fosse Arts Update 2) Health and Wellbeing Survey 3) Performance Reporting 4)		
29 Oct 2015			
14 Jan 2016			
10 Mar 2016			
5 May 2016			

Forward Plan Items

Topic	Detail	Proposed Date
Better Care Together	Progress to the plan	
Dementia, Dental Care, Diabetes, GPs, Obesity, Smoking, and substance Misuse	Progress to individual strategies/services	
Health and Wellbeing Board	Protocol between scrutiny and the board and update on work of the board.	
Health and Wellbeing of staff	Monitoring of sick days and support services	
Health Visitors and School Nurses	Understanding of the transfer of services to the Council	
Mental Health Services for Black British Men	Review progress to recommendations made by scrutiny	
Performance Reporting	Regular performance reports to relevant indicators	
Reduction in Public Health budget	Impact on service delivery	