

Leicester
City Council

MEETING OF THE HEALTH AND WELLBEING SCRUTINY COMMISSION

DATE: WEDNESDAY, 7 MARCH 2018

TIME: 5:30 pm

**PLACE: Meeting Room G.01, Ground Floor, City Hall, 115 Charles
Street, Leicester, LE1 1FZ**

Members of the Commission

Councillor Cutkelvin (Chair)

Councillor Fonseca (Vice-Chair)

Councillors Chaplin, Corral, Osman, Sangster and Waddington.

1 unallocated Non-Group place.

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

Standing Invitee (Non-voting)

Representative of Healthwatch Leicester

For Monitoring Officer

Officer contacts:

Julie Harget (Democratic Support Officer):

Tel: 0116 454 6357, e-mail: Julie.harget@leicester.gov.uk

Kalvaran Sandhu (Scrutiny Policy Officer):

Tel: 0116 454 6344, e-mail: Kalvaran.Sandhu@leicester.gov.uk

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

Information for members of the public

Attending meetings and access to information

You have the right to attend formal meetings such as full Council, committee meetings & Scrutiny Commissions and see copies of agendas and minutes. On occasion however, meetings may, for reasons set out in law, need to consider some items in private.

Dates of meetings and copies of public agendas and minutes are available on the Council's website at www.cabinet.leicester.gov.uk, from the Council's Customer Service Centre or by contacting us using the details below.

Making meetings accessible to all

Wheelchair access – Public meeting rooms at the City Hall are accessible to wheelchair users. Wheelchair access to City Hall is from the middle entrance door on Charles Street - press the plate on the right hand side of the door to open the door automatically.

Braille/audio tape/translation - If you require this please contact the Democratic Support Officer (production times will depend upon equipment/facility availability).

Induction loops - There are induction loop facilities in City Hall meeting rooms. Please speak to the Democratic Support Officer using the details below.

Filming and Recording the Meeting - The Council is committed to transparency and supports efforts to record and share reports of proceedings of public meetings through a variety of means, including social media. In accordance with government regulations and the Council's policy, persons and press attending any meeting of the Council open to the public (except Licensing Sub Committees and where the public have been formally excluded) are allowed to record and/or report all or part of that meeting. Details of the Council's policy are available at www.leicester.gov.uk or from Democratic Support.

If you intend to film or make an audio recording of a meeting you are asked to notify the relevant Democratic Support Officer in advance of the meeting to ensure that participants can be notified in advance and consideration given to practicalities such as allocating appropriate space in the public gallery etc.

The aim of the Regulations and of the Council's policy is to encourage public interest and engagement so in recording or reporting on proceedings members of the public are asked:

- ✓ to respect the right of others to view and hear debates without interruption;
- ✓ to ensure that the sound on any device is fully muted and intrusive lighting avoided;
- ✓ where filming, to only focus on those people actively participating in the meeting;
- ✓ 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 Julie Harget, **Democratic Support on (0116) 454 6357** or email julie.harget@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**

USEFUL ACRONYMS RELATING TO HEALTH AND WELLBEING SCRUTINY COMMISSION

Acronym	Meaning
AEDB	Accident and Emergency Delivery Board
CAMHS	Children and Adolescents Mental Health Service
CHD	Coronary Heart Disease
CVD	Cardiovascular Disease
CCG	Clinical Commissioning Group
LCCCG	Leicester City Clinical Commissioning Group
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
DTOC	Delayed Transfers of Care
ED	Emergency Department
EHC	Emergency Hormonal Contraception
ECMO	Extra Corporeal Membrane Oxygenation
EMAS	East Midlands Ambulance Service
GPAU	General Practitioner Assessment Unit
HALO	Hospital Ambulance Liaison Officer
JSNA	Joint Strategic Needs Assessment
PCT	Primary Care Trust
PICU	Paediatric Intensive Care Unit
PHOF	Public Health Outcomes Framework
RSE	Relationship and Sex Education
STP	Sustainability Transformation Plan
UHL	University Hospitals of Leicester
UEC	Urgent and Emergency Care

PUBLIC SESSION

AGENDA

FIRE / EMERGENCY EVACUATION

If the emergency alarm sounds, you must evacuate the building immediately by the nearest available fire exit and proceed to the area outside the Ramada Encore Hotel on Charles Street as directed by Democratic Services staff. Further instructions will then be given.

1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

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

3. MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on 11 January 2018 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>

4. CHAIR'S ANNOUNCEMENTS AND UPDATE ON PROGRESS WITH MATTERS CONSIDERED AT A PREVIOUS MEETING

To receive updates on the matters considered at previous meetings of the Commission.

5. PETITIONS

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

6. 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.

7. THE CARE QUALITY INSPECTION OF THE LEICESTERSHIRE PARTNERSHIP NHS TRUST **Appendix A
(Pages 1 - 62)**

The Chief Executive of the Leicestershire Partnership Trust submits a report that advises of the outcomes following the Care Quality Commission's (CQC) inspection of the Leicestershire Partnership NHS Trust (LPT) undertaken 9 October - 21 November 2017. The Commission is invited to note and comment as it sees fit.

8. UPDATE ON WINTER PLAN 2017/18 **Appendix B
(Pages 63 - 132)**

The Director of Urgent Care Performance, West Leicestershire Clinical Commissioning Group, submits a report that provides an update on winter pressures, the response of the local health and care system to winter pressures and the effectiveness of winter plans. The Commission is asked to note and comment as it sees fit.

9. SUSTAINABILITY AND TRANSFORMATION PLAN

The Commission will receive a verbal update on the Sustainability and Transformation Plan.

10. LIFESTYLE SERVICES REVIEW

The Commission will receive a verbal update on the Lifestyle Services Review.

11. WORK PROGRAMME **Appendix C
(Pages 133 - 138)**

The Scrutiny Policy Officer submits a document that outlines the Health and Wellbeing Scrutiny Commission's Work Programme for 2017/18. The Commission is asked to consider the Programme and make comments and/or amendments as it considers necessary.

12. ANY OTHER URGENT BUSINESS

HEALTH AND WELLBEING SCRUTINY COMMISSION: 7 MARCH 2018

REPORT OF LEICESTERSHIRE PARTNERSHIP NHS TRUST

CARE QUALITY COMMISSION (CQC) INSPECTION 2017

Purpose of report

1. The purpose of this report is to advise the HWB Scrutiny Commission of the outcomes following the Care Quality Commission's (CQC) inspection of Leicestershire Partnership NHS Trust (LPT) undertaken 9th October-21st November 2017 and provide assurance that LPT has responded to the findings with a range of improvement measures which are subject to robust governance and assurance arrangements.

Introduction

- 2.1 The CQC commenced their inspection on 9th October 2017 of five (from a possible 15) Core Services over the period of four days. This was followed by an inspection of the 'well-led' key question at Trust level which commenced on 14th November 2017, lasting three days. In addition, the CQC held a number of Staff Focus Groups to ask staff working in a variety of different roles to share their views on working for LPT. The CQC plan their inspection based on those services rated as 'inadequate' or 'requires improvement'. The CQC did not inspect the other 10 Core Services because their risk based assessment did not indicate that those services required an inspection at the time or they were rated as 'good' in the previous inspection (CQC Comprehensive Inspection, 14-18th November 2016).
- 2.2 The CQC Inspection 2017 resulted in an improved position for LPT where all 'inadequate' ratings were removed; a total of ten rating changes were made to the five Core Services inspected. The Trust has responded to the 19 'must-do' statutory actions with a range of improvement measures submitted to the CQC as a formal action plan. Overall, the Trust was rated as 'requires improvement' for safe, effective, responsive and well-led and 'good' for caring.
- 2.3 The CQC published one Inspection Report and one Evidence Appendices report on 29th January 2018. These reports are available from <http://www.cqc.org.uk/provider/RT5/reports>

Discussion

- 3.1 The CQC inspected five Core Services as follows -
 - I. Community Health Service for Adults
 - II. Mental Health Crisis Services and Health based Place of Safety
 - III. Community Mental Health Services for adults of working age
 - IV. Acute wards for adults of working age and Psychiatric Intensive Care Units
 - V. Specialist Community Mental Health Services for Children and Young People
- 3.2 There are five key questions that the CQC use to rate all healthcare provider services; are services safe, effective, caring, responsive and well-led? The inspection of five Core Services was followed by an inspection of the 'well-led' key question at

Trust level. The well-led inspection considers whether the leadership, management and governance of the organisation assures the delivery of high-quality care for patients, supports learning and innovation and promotes an open and fair culture.

- 3.3 The CQC Inspection 2017 resulted in an improved position for LPT where all 'inadequate' ratings were removed; a total of ten rating changes were made to the five Core Services inspected.

Significant achievements include –

- Community Health Services for Adults improved their overall rating from 'requires improvement' to 'good'
- Specialist Community Mental Health Services for Children and Young People had three 'inadequate' ratings removed and their overall rating improved to 'requires improvement'

- 3.4 Table 1 below presents the CQC inspection 2017 ratings and the improved position by key question (indicated by directional arrows) since the 2016 CQC Comprehensive inspection.

Table 1. CQC Inspection 2017 ratings

Ratings for Community Health Core Services inspected (one)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good ↔ Oct 2017	Good ↔ Oct 2017	Good ↔ Oct 2017	Good ↑ Oct 2017	Requires improvement ↔ Oct 2017	Good ↑ Oct 2017

Ratings for Mental Health Core Services inspected (four)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement ↔ Oct 2017	Good ↑ Oct 2017	Good ↔ Oct 2017	Requires improvement ↑ Oct 2017	Requires improvement ↔ Oct 2017	Requires improvement ↔ Oct 2017
Community-based mental health services for adults of working age	Requires improvement ↔ Nov 2017	Requires improvement ↔ Nov 2017	Good ↑ Nov 2017	Requires improvement ↔ Nov 2017	Good ↑ Nov 2017	Requires improvement ↔ Nov 2017
Mental health crisis services and health-based places of safety	Requires improvement ↔ Oct 2017	Good ↑ Oct 2017	Good ↔ Oct 2017	Requires improvement ↔ Oct 2017	Requires improvement ↔ Oct 2017	Requires improvement ↔ Oct 2017
Specialist community mental health services for children and young people	Requires improvement ↑ Oct 2017	Requires improvement ↔ Oct 2017	Good ↔ Oct 2017	Requires improvement ↑ Oct 2017	Requires improvement ↔ Oct 2017	Requires improvement ↑ Oct 2017

- 3.5 In the inspection report the CQC highlighted areas of demonstrable improvement including -

- The Trust had addressed the issues identified in the previous inspection at the Health Based Place of Safety and introduced an all-age facility.

- The Trust has strengthened the monitoring of patients waiting to be seen in specialist community mental health services for children and young people.
- Staff are 'kind, caring and respectful towards patients', and that 'most patients spoke positively about their care'.
- The process for monitoring patients on the waiting list in specialist community mental health services for children and young people had been strengthened.
- Care planning had improved, particularly in the crisis service.
- There was an effective incident reporting process which investigated and identified lessons from incidents which were shared in most teams.
- There is 'effective multi-disciplinary working' between staff teams.
- Patients and carers knew how to complain and complaints were investigated and lessons identified.
- Staff were kind, caring and respectful towards patients. Most patients spoke positively about their care and said they were involved. Patients had access to advocacy and there were robust governance arrangements in place for use of the Mental Health Act.
- Staff kept risk assessments up to date and carried out comprehensive assessments which were holistic and recovery focused. Across the teams, we found up to date ligature audits in place.

3.6 The CQC highlighted areas for improvement including -

- Some maintenance and sound proofing issues in some environments.
- Issues with staffing levels in some community teams, however the CQC noted that 'the Trust tried to book regular bank and agency staff to provide continuity of care'. [We are not alone in the current national recruitment shortage for nursing staff and have recently strengthened our recruitment and retention strategy].
- Some medicines management issues.
- High caseloads in community teams, although it was recognised that this is high on the Trust's risk register and plans are in place to manage this.
- Some care plans did not record patient involvement adequately, however the CQC noted that 'most patients spoke positively about their care and said they were involved'.
- Not all staff record their clinical supervision.
- There are two and four bedroom dormitories in mental health wards which are not ideal [however we require significant investment to change these environments].
- Some data quality issues were identified, however the CQC noted that 'the Trust was aware of the issues in relation to waits and data quality and was working towards addressing them'.

3.7 The Trust submitted its response to the 19 statutory 'must-do' actions with a range of improvement measures collated as a formal action plan. Table 2 below provides a summary of the actions the Trust is taking to address the findings.

3.8 Table 2: LPT over arching actions to the 19 ‘must-do’ requirements

Core Service	No. of actions required	Core Service action
Community Health Service for adults	2	Identify a set of outcome measures for community nursing services. Build on the Co-ordinated Community Health Services model to enable caseload management including implementation of Auto-planner to ensure right nurse, right skills, right time.
Acute Wards for adults of working age and psychiatric intensive care units	4	Ensure that 85% of staff record clinical supervision on the Trust’s ULearn system. Implement Standard Operating Procedures to support safe management of medicines. Further mitigate risks associated with blind spots. Sustain cleanliness of the ward environment and monitor performance of estate repairs.
Community based mental health services for adults of working age	6	Ensure sufficient staffing to meet the demand on the service and ensure staff caseloads are managed safely using the caseload complexity tool. Implement Standard Operating Procedures to support safe management of medicines. Review community staff bases to ensure the safety of staff and service users. Ensure up to date care plans, risk assessments and physical health assessments. Ensure that patients are reminded of their rights. Roll out of caseload complexity tool.
Mental health crisis services and health-based places of safety	3	Review interview rooms to ensure safe working environments for staff and patients supported by refurbishment bid. Review of performance monitoring systems and processes including recording of data and referral times.
Specialist community mental health services for children and young people	4	Embed care planning templates across all teams. Develop a framework for the safe management of individual clinical caseloads. Undertake environmental risk assessments across all sites to ensure they meet the needs of service users. Improvement programme to optimise capacity and improve patient flow.

3.9 The CQC rated the Trust ‘requires improvement’ at Trust level following its inspection of the ‘well-led’ key question. The well-led inspection considers whether the leadership, management and governance of the organisation assures the delivery of high-quality care for patients, supports learning and innovation and promotes an open and fair culture. The CQC found that the Trust had a clear vision and values that were displayed in all services and staff knew about them; staff said that they felt supported by managers and knew who their senior managers were; the Trust was aware of issues relating to waits and data quality, and was working to address them but remained of concern. In addition the quality of some data was poor which the Trust was working towards improving.

- 3.10 There were zero statutory 'must-do' actions in response to the 'well-led' inspection at Trust level.

Governance and assurance arrangements

- 4.1 The Trust prepared a robust response to the 19 statutory 'must-do' actions using a range of improvement measures submitted to the CQC as a formal action plan. The Trusts Quality Assurance Committee (QAC) will maintain oversight for delivery of the 19 agreed actions.
- 4.2 In November 2017, the QAC reviewed its existing governance and assurance arrangements for overseeing delivery of the CQC action plan. Every action will be allocated to a Senior Responsible Owner (SRO) who will maintain overall accountability for delivery and regularly report on progress against the agreed action. Progress against every action will be presented to a relevant committee/group in line with their Terms of Reference and these groups will provide QAC with an assurance opinion. This approach ensures ownership of improvement actions deeper into services, whilst embedding the role of assurance into the work programmes for corporate governance groups and committees. The QAC will receive a monthly progress report to inform the Trust Board.
- 4.3 The CQC will review delivery of the agreed actions with the Trust on a quarterly basis through the Provider Engagement meetings.
- 4.4 Commissioners and NHS Improvement (NHSI) continue to be closely engaged with the Trust through regular reporting via the commissioner's monthly Clinical Quality Review Group (CQRG) and NHSI bi-monthly Provider Review Meetings (PRMs).

Additional matters

- 5.1 **Estate investment.** LPT is progressing plans to establish a purpose built 15-bed in-patient unit to provide Specialist Child and Adolescent Mental Health Services (CAMHS) in Leicester. This will involve the relocation of the CAMHS 10-bed inpatient service currently provided at Coalville Community Hospital, to the Glenfield site. In July 2017, NHS England announced that the Leicester, Leicestershire and Rutland Sustainability and Transformation Programme had Category 2 (Advanced) status, which is a pre-condition for capital funding. NHS England also announced that the Trust's CAMHS in-patient capital bid had been successful. In August 2017, NHS Improvement confirmed the £8.0 million capital allocation to LPT and the terms and conditions that will apply. These conditions include their approval of the Full Business Case, a value for money assessment and commitment to post-project evaluation. This new unit at the Glenfield Hospital site will introduce for the first time in the local area, the provision of specialist in-patient Eating Disorder services for young people. Mobilisation has commenced and LPT is investing £807,000 at risk to get the project to full business case. The indicative timeline for this work is:
- Finalisation of mental health and eating disorder service model – stress testing underway
 - Building design, planning permission and contract agreed with Interserve – August 2018
 - Full business case approval – October 2018

- Construction and commissioning – February 2020
- Service relocation – March 2020

5.2 **Information on agency staffing.** LPT has a Centralised Team (CSS) responsible for deploying temporary staff. Temporary staff includes a bank workforce of 1420 bank only staff and 1682 substantive staff who have additional bank contracts. The bank workforce includes Registered Nurses (RN), Healthcare Assistants (HCA), Allied Health Professionals and administrators. Where we are unable to fill a vacant shift with a bank worker we will try to fill the shift with an agency worker via our mastervend agency contracts. Around 50% of all agency use is Registered Nurses, 30% administrators, 16% Healthcare Assistants and 10% other. The administration agency use includes hosted services who deliver services to other NHS Trusts and organisations. LPT workforce is currently comprised of 70% substantive staff, 25% bank workers and 5% agency workers. LPT are actively reducing the use of agency and since April 2017, there has been a 7% decrease in the number of agency shifts filled. Many of bank workers work in the same area consistently. For example 65% of bank nurses who work in Community Hospitals and 48% of bank nurses who work at the Bradgate Mental Health Unit work on the same ward consistently.

Table 3 below outlines those services using temporary staff and the actions being taken.

Table 3: Service use of temporary staff.

Service	Explanatory
AMH.LD - Bradgate Unit Wards	Historically a challenging area to recruit to but generally a very good supply of bank HCAs. Significant RN vacancies across the unit. RRP (payment of professional registration) in place for substantive registered nurses from January 2018.
AMH.LD - Herschel Prins Centre	Griffin Ward (PICU) re-opened on 30th November and original staff have been redeployed back from their various Bradgate Wards, resulting in higher agency since November 2017. Enhanced rates for HCL agency block bookings ended on 30th January. RRP (payment of professional registration) in place for substantive registered nurses from 12th January 2018. The service is reviewing staffing levels and may require further incentives to encourage bank and agency staff to work in this area.
AMH.LD - HMP Leicester	HMP Leicester is due to transfer to a new provider in March 2018. In the interim there is little or no substantive recruitment and existing substantive staff will be subject to TUPE. Agency and bank workers have been sourced to staff the service until LPTs contract ends. LPT have authorised paying above price caps and block book for agency workers in this service to ensure we can retain them through to the end of March 2018. Substantive and bank staff also have RRP in place (£1562 per annum for registered staff, £952 per annum for unregistered staff. Pro-rated if part time). Stability is particularly important in prison services as the security clearance process takes a significant length of time.

AMH.LD - Mill Lodge	This service moved from Kegworth to Narborough in 2017 which contributed to the number of vacancies in this service. CSS has dedicated some resource to finding bank workers to work in this service including offering training sessions and pay incentives.
CHS - CHS Hospitals	In January, 60% of framework agency use was on community hospital wards. RRP scheme for substantive Band 5 and 6 nurses has been agreed for St Luke's and Feilding Palmer Hospitals (£2000 over 3 years). Peripatetic Nurse posts are in a recruitment process. Pharmacy Technicians role should help reduces demand for agency nurses.
CHS - CHS Community (district nursing / planned care / evening service)	In response to staffing vacancy levels within the city community nursing services we have authorised the use of agency nurses above price cap until 29 th April 2018. We have worked closely with our mastervend provider to block book nurses to prevent use of off-framework agencies. This service is part-way through a transformation programme and it is anticipated this will significantly reduce reliance on agency staff.
FYPC - CAMHS	There have been additional staffing requirements in CAMHS due to additional commissioned service and requirements to reduce waiting times.
Psychiatry (Adult, Child and Older People) - Medical Locums	Within AMH.LD, successful recruitment has been undertaken, but there have been some sickness requiring the use of medical locum. In line with most other similar organisations the recruitment of child Psychiatrists remains very difficult. Two medical locums are currently contracted whilst permanent recruitment takes place. It is important to note however that three cycles of recruitment have failed for these posts with the Trust now engaging with partners to recruit from abroad.

The bank workforces is integral to the delivery of safe, high quality care and are highly valued as flexible, responsive, well trained colleagues who understand LPT policies and procedures. The Trust shall continue to grow the bank workforce not only to help reduce the volume of agency workers in the Trust but also to improve our ability to respond to the needs of patients with the right workforce at the right time in the right place.

Conclusions

- 6.1 This report advises the HWB Scrutiny Commission about the demonstrable improved outcomes following the CQC Inspection 2017 and provides assurance that the Trust has responded to the findings. It is anticipated that in response to the CQCs revised approach to inspection, the Trust will be inspected again in 2018, alongside a 'well-led' review at Trust level.

Background papers

- 7.1 A full copy of the published CQC Inspection reports is available for download from: <http://www.cqc.org.uk/provider/RT5/reports>

Leicestershire Partnership NHS Trust

Inspection report

Bridge Park Plaza, Bridge Park Road
Thurmaston
Leicester
Leicestershire
LE4 8PQ
Tel: 01162252525
www.leicspart.nhs.uk

Date of inspection visit: 9 Oct to 21 Nov 2017
Date of publication: 23/01/2018

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

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

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix: www.cqc.org.uk/provider/RT5/reports.

Ratings

Overall rating for this trust

Requires improvement 

Are services safe?

Requires improvement 

Are services effective?

Requires improvement 

Are services caring?

Good 

Are services responsive?

Requires improvement 

Are services well-led?

Requires improvement 

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

Summary of findings

Background to the trust

The trust was created in 2002 to provide mental health, learning disability and substance misuse services. In April 2011 the trust merged with Leicester City and Leicestershire County and Rutland Community Health Services as a result of the national transforming community services agenda. This has enabled joined up mental health and physical health care pathways to advance health and wellbeing for the people and communities of Leicester, Leicestershire and Rutland. The trust no longer provides substance misuse services. The trust has 16 active locations registered with CQC.

We inspected community health services for adults, acute wards for adults of working age and psychiatric intensive care unit, community based mental health services for adults of working age, mental health crisis services and health based place of safety and specialist community mental health services for children and young people.

The trust has 628 inpatient beds across 39 wards, 10 of which are children's mental health beds. The trust also has 73 outpatient clinics a week and 436 community clinics a week.

The trust serves a population of approximately one million people across Leicester, Leicestershire and Rutland, has a budget in excess of £250 million and employs over 5,500 staff in a wide variety of roles. The trust obtained a £1.6m surplus year ending March 2017.

Services are commissioned through local clinical commissioning groups and specialised commissioning within NHS England.

CQC undertook a comprehensive inspection of the trust in March 2015 with the inspection report published 10 July 2015. The overall rating was requires improvement. The trust was rated inadequate for safe, requires improvement for effective, responsive and well led, and good for caring.

The last comprehensive inspection was 14 to 18 November 2016. Reports were published 2 February 2017. The overall rating was requires Improvement. The service was rated as requires Improvement for safe, effective, and well led, inadequate for responsive and good for caring.

The areas of non-compliance were:

Regulation 10 HSCA Regulated Activities Regulations 2014 Dignity and respect.

- The trust had not ensured the privacy and dignity of patients was protected at all times.
- Shower rooms on one ward did not have shower curtains for the privacy and dignity of patients.
- The trust admitted males to female areas. The trust must ensure that it complies with Department of Health guidance in relation to mixed sex accommodation.

Regulation 12 HSCA Regulated Activities Regulations 2014 Safe care and treatment.

- The trust had not completed work to remove ligature risks on acute wards. The trust must ensure that ligature risks are removed, as far as is practical to ensure a safe environment for patient care.
- Wards continued to have ligature risks, including door handles, soap and towel dispensers and window closers.
- The trust had hydraulic beds in use. These beds posed a risk of ligature and barricade for patients.
- Wards had areas where staff could not easily observe patients.
- One ward had nurse call alarms that were not in working order.
- Staff were not always recording room and fridge temperatures in clinical rooms. The trust must consistently maintain medication at correct temperatures in all areas.

Summary of findings

- Staff had not ensured that out of date medication was disposed of appropriately.

Regulation 15 HSCA Regulated Activities Regulations 2014 Premises and equipment.

- The trust had not ensured that all equipment within the patient area was free from damage and suitable for use.
- One ward had a damaged shower fitting and toilet roll holder that posed a risk to patient safety.

Regulation 18 HSCA Regulated Activities Regulations 2014 Staffing.

- The trust did not deploy sufficient numbers of suitably qualified, competent, skilled and experienced persons.
- The trust had not ensured there were sufficient registered nurses for safe care and treatment.
- The trust had not ensured all staff were in receipt of regular supervision. The trust could not be sure staff were appropriately supported for their role.
- The trust had not ensured that patients could access psychological input, in accordance with National Institute for Health and Care Excellence guidelines.
- The trust had not ensured all staff were up to date with mandatory training requirements. The trust reported low levels of compliance with immediate life support training. The trust was required to address this following the CQC inspection in 2015.

Overall summary

Our rating of this trust stayed the same . We rated it as Requires improvement   

What this trust does

Leicestershire Partnership NHS Trust provides mental health and community health services across 16 locations throughout Leicester, Leicestershire and Rutland. The trust delivers the following mental health services:

- Acute wards for adults of working age and psychiatric intensive care units
- Child and adolescent mental health wards
- Community mental health services for people with learning disabilities or autism
- Community-based mental health services for adults of working age
- Community-based mental health services for older people
- Forensic inpatient/secure wards
- Long stay/rehabilitation mental health wards for working age adults
- Mental health crisis services and health-based places of safety
- Specialist community mental health services for children and young people
- Wards for older people with mental health problems
- Wards for people with learning disabilities or autism

In addition, the trust provides the following community health services:

- Community health services inpatient services

Summary of findings

- Community health services for adults
- Community health services for children, young people and families
- Community health services for end of life care

The trust serves a population of approximately one million people across Leicester, Leicestershire and Rutland, has a budget in excess of £250 million and employs over 5,500 staff in a wide variety of roles.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We inspected five complete services which we previously rated as inadequate or requires improvement or which we risk assessed as requiring an inspection this time. These were:

- Acute wards for adults of working age and psychiatric intensive care units
- Community-based mental health services for adults of working age
- Mental health crisis services and health-based places of safety
- Specialist community mental health services for children and young people
- Community Health services for adults.

We did not inspect the other 10 core services during this inspection because the risk based assessment did not indicate these services required an inspection this time or they were rated as good in previous inspection.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question at the trust level. Our findings are in the section headed Is this organisation well-led?

What we found

Overall trust

Our rating of the trust stayed the same. We rated it as requires improvement because:

- We rated safe, effective, responsive and well led as requires improvement and caring as good. We rated the four mental health core services as requires improvement and community health services for adults as good. In rating the trust, we took into account the previous ratings of the core services we did not inspect on this occasion.

Summary of findings

- We rated the trust as requires improvement for well led.
- The environment in some services was poor, not well maintained and not kept clean. The acute mental health wards had broken facilities which had not been repaired in a timely manner and we found dirt in some areas on one ward. The environment in specialist community mental health services for children and young people, and community based mental health services for adults of working age was not suitable, did not promote safe practice and was not well maintained. The environment in the crisis service did not ensure confidentiality as rooms were not sound proofed and conversations could be heard outside the room.
- Staffing levels did not meet requirement in some community teams. There was a high vacancy rate of 12.9% for band 5 and 6 nurses in community based mental health services for adults of working age, 18.9% for band 5 and 6 nurses in crisis service and 17.3% across community health services for adults.
- Patients were not always safeguarded. Patients waiting for their appointment in community based mental health services for adults of working age had access to a room unsupervised which held items which could cause harm. Patients waiting for their appointment in the specialist community mental health services for children and young people used a shared waiting room with the learning disabilities adults' services. This could pose a risk as patients were unsupervised in this area.
- We identified medicines management issues, including out of date medication in the acute mental health wards and fridge temperatures were not monitored in community based mental health services for adults. The policy for rapid tranquillisation was not in line with national guidance.
- Staff held high caseloads in community based mental health services for adults of working age, an issue which had been recognised by the trust and placed on the risk register. Waiting times and lists remained of concern, and this had been identified in the previous inspection. There were a high number of patients on the waiting list for treatment in the specialist community mental health services for children and young people. The waiting times in community based mental health services for adults of working age were long and breached targets. A high number of outpatient appointments were cancelled. The psychiatric outpatients was responsible for 2094 of the breaches, with city east reporting the highest of these breaches at 429.2
- Not all patient records showed a full assessment of need, including physical health needs or up to date care plans. Care plans were not always holistic and person centred.
- Staff were not always recording their supervision on the electronic system so we could not be assured they were receiving it regularly.
- The acute mental health wards had two and four bedded dormitories which did not promote privacy and dignity. Patients returning from leave from the acute mental health wards were not assured of returning to their original ward. This reduced continuity of care.
- The governance processes had not picked up the issues around repairs, medicines and cleanliness.
- The quality of some of the data was poor. Staff could not rely on performance reports being accurate. Some local managers were keeping their own records to ensure performance was monitored.

However:

- The trust had addressed the issues regarding the health based place of safety identified in the previous inspection.
- The process for monitoring patients on the waiting list in specialist community mental health services for children and young people had been strengthened since the last inspection.
- Care planning had improved in the crisis service.

Summary of findings

- There was an effective incident reporting process which investigated and identified lessons from incidents which were shared in most teams.
- Patients and carers knew how to complain and complaints were investigated and lessons identified.
- Staff were kind, caring and respectful towards patients. Most patients spoke positively about their care and said they were involved. Patients had access to advocacy.

Are services safe?

Our rating of safe stayed the same. We took into account the current ratings of services not inspected this time. We rated it as requires improvement because:

- The environment in some services was poor, not well maintained and not kept clean. The acute mental health wards had broken facilities which had not been repaired in a timely manner and we found dirt in some areas on one ward. The environment in some community teams was not suitable, did not promote safe practice and was not well maintained.
- Staffing levels did not meet requirement in some community teams. There was a high vacancy rate of 12.9% for nurses in community based mental health services for adults of working age, 18.9% in crisis service and 17.3% in community health services for adults, resulting in high caseloads and cancelled appointments.
- Patients were not always safeguarded. Patients waiting for their appointment in one community mental health base had access to a room unsupervised which held items which could cause harm. Patients waiting for their appointment in the specialist community mental health services for children and young people used a shared waiting room with the learning disabilities adults' services. This could pose a risk as patients were unsupervised in this area.
- We identified medicines management issues including out of date medication in the acute mental health wards and fridge temperatures were not monitored in community based mental health services for adults. The policy for rapid tranquillisation was not in line with national guidance.

However:

- The health based place of safety met requirements. Most services completed timely risk assessments and updated them regularly. The trust had improved the monitoring of young people waiting for treatment.
- The trust tried to book regular bank and agency staff to provide continuity of care.
- Staff were aware of the Duty of candour and reported incidents using the electronic system. Incidents were investigated and actions identified.

Are services effective?

Our rating of effective stayed the same. We took into account the current ratings of services not inspected this time. We rated it as requires improvement because:

- There were data quality issues. The reports for community health services for adults were not accurate as they didn't capture all visits. Performance reports were not an accurate reflection of work completed because the system did not allow corrections to be made.
- Not all patient records showed a full assessment of need, including physical health needs or up to date care plans. Care plans were not always holistic and person centred.
- Staff were not always recording their supervision on the electronic system, although some managers were keeping local records.

However:

Summary of findings

- There was effective multidisciplinary working across all services.
- The trust provided specific training for staff.
- The trust had a comprehensive audit programme.

Are services caring?

Our rating of caring stayed the same. We took into account the current ratings of services not inspected this time. We rated it as good because:

- Staff were kind, caring and respectful towards patients.
- Most patients spoke positively about their care and said they were involved.
- Patients had access to advocacy.

However:

- The involvement of patients and carers in care was not always documented.

Are services responsive?

Our rating of responsive stayed the same. We took into account the current ratings of services not inspected this time. We rated it as requires improvement because:

- There were 323 patients on the waiting list for assessment in the specialist community mental health services for children and young people. There were 622 waiting for individual interventions or second opinions within the services, for example waiting for family therapy, primary mental health, eating disorder services and learning disabilities. Of these 569 were waiting for specific treatment within the community teams.
- The waiting times in community based mental health services for adults of working age were long and breached targets. A high number of outpatient appointments were cancelled.
- The environment in the specialist community mental health services for children and young people did not ensure confidentiality as rooms were not sound proofed and conversations could be heard outside the room.
- Three of the acute mental health wards had two and four bedded dormitories which did not promote privacy and dignity.
- Patients returning from leave from the acute mental health wards were not assured of returning to their original ward. This reduced continuity of care.
- The crisis service was not meeting its targets for seeing patients referred to them.

However:

- The process for monitoring young people on the waiting list had been strengthened since the last inspection. The service met the target for seeing referrals within 13 weeks of referral. There were no patients waiting for more than a year which was an improvement since the last inspection.
- Patients and carers knew how to complain and the trust investigated complaints and identified actions.

Are services well-led?

Our rating of well-led stayed the same. We took into account the current ratings of services not inspected this time. We rated it as requires improvement because:

Summary of findings

- The governance processes in place had not picked up the issues around waits for repairs, medicines management and cleanliness.
- Waiting times and lists remained of concern, and this had been identified in the previous inspection.
- The quality of some of the data was poor. Staff could not rely on performance reports being accurate. Some local managers were keeping their own records to ensure performance was monitored. The trust acknowledged this and was working towards improving the data quality.

However:

- The trust had a clear vision and values which were displayed in all services and staff were able to tell us about them.
- Staff told us they felt supported by the managers and knew who senior managers were.
- The trust was aware of the issues in relation to waits and data quality and was working towards addressing them.

Community health services

Our overall rating of community health services stayed the same. We took into account the current ratings of services not inspected this time. We rated service as good because:

- We rated safe, effective, caring, and responsive as good, and well led as requires improvement.
- We rated all four of the core services as good.

Community health service for adults

Our overall rating of community health service for adults improved. We rated services as good because:

- We rated safe, effective, caring and responsive as good and well led as requires improvement
- Patients were protected from avoidable harm and abuse, systems were in place to investigate incidents and concerns and staff received suitable training in safety systems. Risk assessments were completed and care plans implemented to keep patients safe and promote wellbeing. The service had plans in place to manage service disruption and major incidents.
- The service used evidence based, best practice guidance throughout its policies and procedures and ways of working. Clinical audit was taking place and learning was shared across the service. Staff were suitably trained with the relevant knowledge and skills to carry out their work, had regular appraisals and had access to the information they needed to perform their duties. Multidisciplinary team work both internal and external to the service was effective and patients were supported to make informed decisions about their care.
- Patients were supported, treated with dignity and respect and involved as partners in their care. They told us that staff were kind and caring.
- Services and care were planned with the local population in mind and to address the individual needs of patients. Facilities had been adapted to improve access and systems were in place to support the most vulnerable. Patients knew how to make a complaint or raise a concern and complaints were taken seriously.
- A new leadership structure had been introduced since the last inspection and had not yet fully embedded in the service. Leaders were motivated and developing their skills to address the current challenges to the service. Staff support systems were in place and there was a drive to engage with staff. Governance structures were in place and risks registers were reviewed regularly.

However:

Summary of findings

- The service still had challenges in recruiting sufficient staff which meant that the service, in particular community nursing, was understaffed at times impacting on staff satisfaction and compromising patient care.
- Staff did not always have time to attend clinical supervision sessions and patient information systems were inconsistently utilised and did not always enable effective working.
- Patient outcomes were not routinely collected so the quality of the clinical care being delivered could not be measured or benchmarked.
- There were long waiting times from initial referral to being seen in some clinics and services although these had improved in some areas since the last inspection.
- The community nursing service could not measure its performance in relation to response times for unplanned care.
- The leadership, governance and culture did not always support the delivery of high quality person centred care.
- Staff satisfaction varied greatly across the service with some staff feeling devalued.

Mental health services

Our overall rating of mental health services stayed the same. We took into account the current ratings of services not inspected this time. We rated services as requires improvement because:

- We rated safe, effective, responsive and well led as requires improvement, and caring as good.
- We rated four of the 11 core services as good and seven as requires improvement.
- The quality and safety of the environment was poor in some of the areas we visited. The trust did not ensure repairs were completed in a timely manner. Wards had two and four bedded rooms which did not promote privacy and dignity. There were issues with medicines management. Patients were not always safeguarded when waiting for the appointments in clinics.
- Staff held high caseloads in community based mental health services for working age adults and a high number of appointments were cancelled. There were high numbers waiting for treatment in specialist community mental health services for children and young people.
- Data quality remained an issue which resulted in inaccurate reports and managers keeping local records to ensure correct monitoring. Staff were not always able to keep their electronic supervision records up to date and kept local records.

However:

- The trust had addressed the issues identified in the previous inspection in relation to the health based place of safety.
- The trust was using regular bank and agency nurses where possible to maintain continuity of care.
- Care planning had improved in crisis services.
- The trust had strengthened the monitoring of patients waiting to be seen in specialist community mental health services for children and young people

Acute wards for adults of working age and psychiatric intensive care units

We rated services as requires improvement because:

- We rated safe, responsive and well led as requires improvement and effective and caring as good.

Summary of findings

- There were issues with the environment at the Bradgate unit. The older wards had blind spots which had not been completely mitigated. Repairs were not carried out in a timely manner and we found two areas on one ward which had gathered dust and this had not been picked up by the cleaning staff.
- Vacancy rates were high with the highest being on Ashby ward at 50%.
- We found out of date medications in the clinic rooms on several wards. The processes for checking had not picked these up.
- Bed occupancy meant that patients returning from leave may not return to their original ward, meaning a lack of continuity of care.
- The older wards still had dormitories of two and four beds, which reduced the ability to maintain privacy and dignity for patients.
- Staff were not always recording their supervision on the electronic system.

However:

- The wards tried to book regular bank and agency staff so they knew the ward and patients, to provide continuity of care.
- Staff kept risk assessments up to date and carried out comprehensive assessments which were holistic and recovery focused.
- Staff were kind, compassionate and respectful towards patients.

Community-based mental health services for adults of working age

We rated services as requires improvement because:

- We rated safe, effective and responsive as requires improvement, and caring and well led as good.
- The vacancy rate was 12.9% for band 5 and 6 nurses. Staff held high caseloads and there were breaches of waiting times. This issue was on the risk register.
- In one of the waiting areas patients were able to access a room unsupervised which contained items which could cause harm.
- Staff did not review care plans regularly, we found 45% were not up to date. Staff did not always carry out physical health assessments, 52% did not have an assessment.

However:

- Staff treated patients with respect and maintained dignity.
- Staff felt supported by their managers and received regular supervision and annual appraisals.
- There was effective multidisciplinary working. Staff monitored those patients on the waiting list regarding risk levels.
- Staff had been given lone worker safety devices to ensure their safety.

Mental health crisis services and health-based places of safety

We rated services as requires improvement because:

- We rated responsive and well led as requires improvement, and safe, effective and caring as good.
- Interview rooms were unsafe. They did not have alarms or vision panels in the door. They contained items which could pose a danger to staff and patients.

Summary of findings

- Staffing levels were below the expected level. The vacancy rate for the service was 12.9% and for band 5 and 6 nurses was 18.9%.
- The quality of the data produced was poor and staff needed to correct the data when reports were produced.
- The service was not meeting its performance targets.

However:

- The trust had addressed the issues previously identified with the health based place of safety.
- Care plans were up to date and holistic.
- There was effective communication between the service and other healthcare professionals.
- Staff received regular managerial and group supervision.

Specialist community mental health services for children and young people

We rated services as requires improvement because:

- We rated responsive, effective and well led as requires improvement and safe and caring as good.
- There were still a high number on a waiting list for treatment. Data provided showed 945 patients on the waiting list for treatment, this included waiting for services outside of this core service such as family therapy, young people's team, primary mental health, eating disorders, home treatment, and learning disability services. The inspection that took place in November 2016, found 647 children waiting for a specific treatment within community out-patient teams following their initial access assessment and whilst this had reduced to 569 children, it was still a high number waiting. Some patients said the long waiting times had made them feel more anxious. Some patients, parents and carers felt there was poor communication between agencies, autism outreach, schools, and children and adolescent mental health services.
- We found issues with the environment. Not all sites where community child and adolescent mental health services were delivered were well designed, visibly clean, well maintained and met the needs of the patient. At Loughborough county team, there were no alarms fitted or personal alarms available; staff would call out if they needed assistance. At Valentine Centre county and Westcotes House city there were no alarms in treatment rooms although, staff held personal alarms. At Westcotes House the soundproofing between the corridors and interview rooms was poor. We could hear conversations between patients and staff. The environment was not visibly clean. The family therapy interview rooms did not have vision panels to keep patients safe.
- We found out of date equipment at the Valentine Centre in the video family therapy room. We found some issues at Valentine Centre and Westcotes House clinic rooms where the service did not have all the equipment to carry out physical health observations. The crisis service waiting area was shared with the adult learning disability community team. This was a safeguarding risk for children and young people waiting for their appointments.
- Record keeping was poor in some areas. Not all patients had a care plan and risk assessment. At Loughborough capacity and competence was not always recorded and managed well. Teams at a local level had not changed to the new systems. New care plan templates were set up but not consistently used. Care plans were not written in a holistic and personalised manner; and not focused on outcomes strengths, or age appropriate. Staff told us 924 care plans had been completed, we found 179 patients still did not have care plans in place.
- Some staff had large caseloads of up to 40. Staff told us managers reviewed caseloads with staff during management supervision. Not all staff had manageable caseloads to be able to respond to patient needs.

However:

Summary of findings

- The rating had improved from the November 2016 inadequate rating. Managers had introduced a specialist child and adolescent mental health traffic light system, a red, amber and green rating tool for managing risk. In addition to this, risk assessments were comprehensive and reviewed as per the trust policy, six monthly or after risk incidents. Staff reviewed young people's risk at every appointment and recorded this in the case notes. Managers had introduced a duty clinician to manage caseload sizes and reduce patients' risks. The service was meeting the target for initial assessment within 13 weeks of referral with a compliance of 99%. However, 323 were waiting for their first appointment through the access team, to complete a core mental health assessment. There were no children who had waited more than a year for treatment.
- The clinic rooms across sites had all the equipment calibrated. Therefore, staff could ensure accurate measures of blood pressure were being recorded. Across the teams, we found up to date ligature audits in place. At the Valentine Centre improvements had been made to the storage of cleaning materials.
- Since the last inspection the service now had a Section 136 suite that met the standards set out in the Royal College Standards. The 136 suite is a place of safety for those who have been detained under Section 136 of the Mental Health Act. A children's adolescent mental health crisis service had been developed and commenced in April 2017.
- We observed clinicians working with young people were skilled and very positive. There was regular and effective multidisciplinary working. Staff provided psychological therapies as recommended by NICE such as group work and cognitive behavioural therapy. Patients and carers were involved in assessment, treatment and care planning. There were clear treatment pathways.

Ratings tables

The ratings tables in our full report show the ratings overall and for each key question, for each service, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account, for example, the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Areas for improvement

We found areas for improvement including six breaches of legal requirements that the trust must put right. We found 23 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information see the Areas for improvement section later in this report.

Action we have taken

We issued six requirement notices to the trust. That meant the trust had to send us a report saying what action it would take to meet these requirements.

Our action related to breaches of six legal requirements at a trust wide level and in the five core services.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

What happens next

We will make sure that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Summary of findings

Areas for improvement

Action the trust **MUST** take to improve:

Action a trust **MUST** take is necessary to comply with its legal obligations. Action a trust **SHOULD** take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

We told the trust it must take action to bring services into line with six legal requirements. This action related to the five services.

Community health services

Community health services for adults

- The trust must improve its performance in collecting information about patient outcomes in order to assure itself of the quality of the services being delivered.
- The trust must ensure that staff are able to complete their workload within their working hours.

Mental health services

Acute wards for adults of a working age and psychiatric intensive care units

- The trust must ensure that staff record their supervision in line with trust policy.
- The trust must ensure the proper and safe management of medicines.
- The trust must ensure that blind spots are managed fully to enable staff to observe patients.
- The trust must ensure that wards are clean and that equipment and facilities are maintained in a timely way.

Community based mental health services for adults of working age

- The trust must ensure that there is sufficient staffing to meet the demands of the service and caseloads of individual staff members are managed safely.
- The trust must ensure the proper and safe management of medicines and medical equipment.
- The trust must ensure they mitigate against identified environmental risks to keep patients and staff safe.
- The trust must ensure that all patients have an up to date care plan, risk assessment and physical health assessment.
- The trust must ensure that patients subject to Mental Health Act community treatment orders have their rights explained to them at regular intervals and that this is documented.
- The trust must ensure work continues to reduce caseloads in community teams.

Mental health crisis services and health-based places of safety

- The trust must ensure interview rooms in the crisis team are safe and fit for purpose.
- The trust must ensure systems support reliable recording of data in order to have oversight of key performance indicators and safeguarding referrals
- The trust must ensure teams are able to meet targets for referral to assessment and treatment within the crisis, mental health triage, and psychiatric liaison teams.

Summary of findings

Specialist community mental health services for children and young people

- The trust must ensure care plans are personalised and holistic, and patients are involved in care planning.
- The trust must ensure that caseloads of individual staff are manageable.
- The trust must ensure sites where services for children and young people are delivered are safe, clean, and meet the needs of the patients.
- The trust must ensure work continues to reduce the number waiting for assessment and work to reduce those waiting for treatment within the service.

Action the trust **SHOULD** take to improve:

We told the trust it should take action either to comply with a minor breach that did not justify regulatory action, to avoid breaching a legal requirement in future or to improve services. These 23 actions related to the whole trust and the five core services.

Community health services

Community health services for adults

- The trust should promote the lone working policy and carry out audits to check if staff understand and are following the policy. This is required as part of regulation 12 but we considered that it would be disproportionate for that one finding to result in a judgement of a breach of the regulation overall in this service.
- The trust should ensure that all bank and agency staff have the appropriate skills to care for patients. This is required as part of regulation 18 but we considered that it would be disproportionate for that one finding to result in a judgement of a breach of the regulation overall at the service.
- The trust should review their policies for record keeping in the patient's home to ensure there is consistency across the patch. This is required as part of regulation 17 but we considered that it would be disproportionate for that one finding to result in a judgement of a breach of the regulation overall at the service.

The provider is not currently doing the following, that we have identified as an area for improvement but which does not link directly to a regulation.

- The trust should continue its work to ensure daily caseload levels for community nursing staff are manageable and staff are able to access clinical supervision and meetings relevant to their role.
- The trust should review the information captured on the community nurse daily reports to ensure it captures all planned, unplanned and cancelled visits. The trust should produce validated data on response times for unplanned care and share this information widely.
- The trust should review the use of the tough books and ensure they are being used consistently across the patch and that patient records are completed in a timely manner.
- The trust should ensure patients know the name of the community staff member who is responsible for their care.
- The trust should review the waiting times at some clinics and identify ways to reduce lengthy waits to improve the patient experience.
- The trust should work towards improving perceptions between staff working in the city and staff working in the county. The trust should ensure managers engage with staff in the areas that have not been directly involved in the transformation programme.

Summary of findings

- The trust should expedite the developments in the electronic record system in order that it can produce meaningful data on response times for unplanned care.

Mental health services

Acute wards for adults of a working age and psychiatric intensive care units

- The trust should ensure that wards are clean and maintenance issues are dealt with in a timely way. This is required as part of regulation 12 but we considered that it would be disproportionate for that one finding to result in a judgement of a breach of the regulation overall at the service.

The provider is not currently doing the following that we have identified as an area for improvement but which does not link directly to a regulation.

- The trust should ensure that patients have access to a bed on their admitting ward when returning from leave.
- The trust should consider working towards providing single rooms for patients and removing two and four bedded dormitories.
- The trust should consider how to follow best practice in the implementation of the smoke free policy.

Community based mental health services for adults of working age

These are required as part of regulations 9 and 17 but we considered that it would be disproportionate for one finding to result in a judgement of a breach of the regulation overall at the service.

- The trust should ensure that patients' views are included in care plans.
- The trust should ensure that the electronic patient record system is fit for purpose.
- The trust should review the level of required social work input across the teams.
- The trust should ensure that performance data provided to managers is accurate.
- The trust should review how patients and carers could be further engaged in service developments.

Mental health crisis services and health-based places of safety

- The trust should ensure that shifts are covered with the required numbers of appropriately trained and skilled staff. This is required as part of regulation 18 but we considered that it would be disproportionate for that one finding to result in a judgement of a breach of the regulation overall at the service.
- The trust should ensure all staff are in receipt of appraisals in line with their policy. This is required as part of regulation 18 but we considered that it would be disproportionate for that one finding to result in a judgement of a breach of the regulation overall at the service.

Specialist community mental health services for children and young people

- The trust should ensure that interview rooms are fitted with alarms and staff have access to personal alarms. This is required as part of regulation 12 but we considered that it would be disproportionate for that one finding to result in a judgement of a breach of the regulation overall at the service.
- The trust should ensure patients' mental capacity assessments are recorded. This is required as part of regulation 17 but we considered that it would be disproportionate for that one finding to result in a judgement of a breach of the regulation overall at the service.

Summary of findings

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

We rated well-led at the trust as requires improvement because:

- Whilst we acknowledge improvements had been made in terms of processes and structures. This assessment focused on well-led at trust level, and drew on our wider knowledge of quality in the trust at all levels. We rated well led as requires improvement for four of the five core services. The overall rating for specialist community mental health services for children and young people and for community health services for adults improved and eight of the 25 key questions, across the five core services we inspected had improved.
- We identified that improvements were required in relation to the environment in acute wards for adults of working age, community based services mental health services for working age adults, and in specialist community mental health services for children and young people. Whilst governance processes had identified some of the issues we found in relation to cleanliness, maintenance, medicines management, and record keeping, these had not been resolved.
- Waiting times remained high in community based services mental health services for working age adults, and in specialist community mental health services for children and young people.
- Staff across the trust were not always clear or fully informed of the trust's development plans. In order to address this, the trust had shared information via email, newsletters and bulletins. However, there were teams in which staff felt unsure of the trust's plans.
- Data quality remained an issue despite the ongoing work to cleanse data and improve systems. Some local managers kept their own records to ensure local monitoring was in place.
- There was limited reporting to board on physical healthcare provision within mental health services.

However:

- The trust had an experienced leadership team with the skills, abilities, and commitment to provide high-quality services. They recognised the training needs of managers at all levels, including themselves, and worked to provide development opportunities for the future of the organisation.
- The board and senior leadership team had set a clear vision and values that were at the heart of all the work within the organisation. They worked hard to make sure staff at all levels understood them in relation to their daily roles.
- The trust strategy was directly linked to the vision and values of the trust. The trust involved clinicians, patients and groups from the local community in the development of the strategy and from this had a clear plan to provide high-quality care with financial stability.
- Senior leaders made sure they visited all parts of the trust and fed back to the board to discuss challenges staff and the services faced. The executive team carried out boardwalks, visiting services to speak with patients and staff. The patient voice was heard at the beginning of every board meeting. Staff presented at every board meeting.
- The trust had a clear structure for overseeing performance, quality and risk, with board members represented across the divisions. This gave them greater oversight of issues facing the service and they responded when services needed

Summary of findings

more support. The board reviewed performance reports that included data about the services, which divisional leads could challenge. Work was in progress to cleanse data inaccuracies and reduce caseloads. The trust recognised the risks created by the introduction of new information technology and business systems in the services. This was identified as a significant risk to the efficiency of services, in the absence of sufficient capital funding. Early identification of this risk allowed the trust to prioritise funding to manage this potential future risk to ensure the systems are maintained and able to provide effective care to patients.

- The leadership team worked well with the clinical leads and encouraged divisions to share learning across the trust. Services were encouraged to develop innovative ways of filling vacant roles to address the nursing shortfall where appropriate. The trust was committed to continuously looking at how it could improve services through projects, research and audit.
- The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation. It had developed a more outward facing approach to learn from good performing trusts.
- Board members were sighted on the issues of high caseloads and staffing. The board was supportive of the planned measures to review caseloads, implement auto planning for daily visits in the community nursing services and the review of roles in teams.
- Board members had recognised that they had work to do to improve diversity and equality across the trust and at board level and implemented plans to address.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement →← Jan 2018	Requires improvement →← Jan 2018	Good →← Jan 2018	Requires improvement →← Jan 2018	Requires improvement →← Jan 2018	Requires improvement →← Jan 2018

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

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community	Good ↔ Jan 2018	Requires improvement ↔ Jan 2018	Outstanding ↔ Jan 2018	Good ↔ Jan 2018	Requires improvement ↔ Jan 2018	Good ↔ Jan 2018
Mental health	Requires improvement ↔ Jan 2018	Requires improvement ↔ Jan 2018	Good ↔ Jan 2018	Requires improvement ↔ Jan 2018	Requires improvement ↔ Jan 2018	Requires improvement ↔ Jan 2018
Overall trust	Requires improvement ↔ Jan 2018	Requires improvement ↔ Jan 2018	Good ↔ Jan 2018	Requires improvement ↔ Jan 2018	Requires improvement ↔ Jan 2018	Requires improvement ↔ Jan 2018

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

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good ↔ Jan 2018	Good ↔ Jan 2018	Good ↔ Jan 2018	Good ↑ Jan 2018	Requires improvement ↔ Jan 2018	Good ↑ Jan 2018
Community health services for children and young people	Good Nov 2016	Good Nov 2016	Outstanding Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Community health inpatient services	Requires improvement Nov 2016	Requires improvement Nov 2016	Good Nov 2016	Good Nov 2016	Requires improvement Nov 2016	Requires improvement Nov 2016
Community end of life care	Good Nov 2016	Requires improvement Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Overall*	Good ↔ Jan 2018	Requires improvement ↔ Jan 2018	Outstanding ↔ Jan 2018	Good ↔ Jan 2018	Requires improvement ↔ Jan 2018	Good ↔ Jan 2018

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

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement ➡️ Jan 2018	Good ⬆️ Jan 2018	Good ➡️ Jan 2018	Requires improvement ⬆️ Jan 2018	Requires improvement ➡️ Jan 2018	Requires improvement ➡️ Jan 2018
Long-stay or rehabilitation mental health wards for working age adults	Requires improvement Nov 2016	Requires improvement Nov 2016	Good Nov 2016	Requires improvement Nov 2016	Requires improvement Nov 2016	Requires improvement Nov 2016
Forensic inpatient or secure wards	Good Nov 2016	Requires improvement Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Child and adolescent mental health wards	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Wards for older people with mental health problems	Good Nov 2016	Requires improvement Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Wards for people with a learning disability or autism	Requires improvement Nov 2016	Requires improvement Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Requires improvement Nov 2016
Community-based mental health services for adults of working age	Requires improvement ➡️ Jan 2018	Requires improvement ➡️ Jan 2018	Good ⬆️ Jan 2018	Requires improvement ➡️ Jan 2018	Good ⬆️ Jan 2018	Requires improvement ➡️ Jan 2018
Mental health crisis services and health-based places of safety	Requires improvement ➡️ Nov 2017	Good ⬆️ Nov 2017	Good ➡️ Nov 2017	Requires improvement ➡️ Nov 2017	Requires improvement ➡️ Nov 2017	Requires improvement ➡️ Nov 2017
Specialist community mental health services for children and young people	Requires improvement ⬆️ Jan 2018	Requires improvement ➡️ Jan 2018	Good ➡️ Jan 2018	Requires improvement ⬆️ Jan 2018	Requires improvement ➡️ Jan 2018	Requires improvement ⬆️ Jan 2018
Community-based mental health services for older people	Requires improvement Nov 2016	Requires improvement Nov 2016	Requires improvement Nov 2016	Requires improvement Nov 2016	Requires improvement Nov 2016	Requires improvement Nov 2016
Community mental health services for people with a learning disability or autism	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Overall	Requires improvement ➡️ Jan 2018	Requires improvement ➡️ Jan 2018	Good ➡️ Jan 2018	Requires improvement ➡️ Jan 2018	Requires improvement ➡️ Jan 2018	Requires improvement ➡️ Jan 2018

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

Community health services

Background to community health services

The trust was created in 2002 to provide mental health, learning disability and substance misuse services. In April 2011 the trust merged with Leicester City and Leicestershire County and Rutland Community Health Services as a result of the national transforming community services agenda. This has enabled joined up mental health and physical health care pathways to advance health and wellbeing for the people and communities of Leicester, Leicestershire and Rutland.

The trust provides the following community health services:

- Community health services inpatient services
- Community health services for adults
- Community health services for children and young people
- Community health services for end of life care

We inspected community health services for adults in October 2017.

Summary of community health services

Good   

Our rating of these services stayed the same. We took into account the current ratings of services not inspected this time. We rated them as good because:

- We rated safe, effective, caring and responsive as good and well led as requires improvement.
- We rated three of the core services as good and one as requires improvement.

Community health services for adults

Good  

Key facts and figures

Leicester Partnership Trust (LPT) provides community health services to over one million people across Leicester City, Leicestershire and Rutland. Just under one third live in Leicester City and approximately four percent live in Rutland.

The community health services for adults, is part of the community health services directorate and provides community nursing services, including specialist respiratory and heart failure nurses, community therapy services including rehabilitation and a falls prevention service. These are provided by teams of occupational therapy and physiotherapists, a county wide podiatry service and speech and language therapy are also available.

Referrals to the service are mainly made through the single point of access, a small contact centre where calls are assessed by a team of specially trained staff.

The majority of patients cared for by community health services for adults are over 65 years of age. Services provide care and support to help patients stay well and prevent future problems, support them to live at home and provide treatment when they are ill to help them recover.

Community health services for adults are delivered from a wide range of locations including trust premises and third party locations delivering services to local communities. In Rutland, health services are delivered in partnership with the local authority where an integrated model of health and social care is being delivered.

Community nursing teams are located throughout the city and county areas with the three main areas being the city, the east and the west. Each area has planned visit teams which provide scheduled care and unscheduled care. The intensive community support teams provide care in 256 virtual beds across the whole LPT area. This team provides up to 10 days (in principal) of intensive community nursing care and rehabilitation often for patients discharged from hospital who are not yet fully independent.

In conjunction with these teams is a Leicester, Leicestershire and Rutland night service unit, this is centrally coordinated from a city location. The team can provide care all night for up to four patients in their own home.

Primary care coordinators employed by the trust are located in local trust hospitals to identify, assess and where appropriate facilitate the timely discharge of patients back into their own home with community support or to a local community hospital.

This service had been previously inspected as part of a comprehensive inspection in November 2016, when we rated the community health service for adults as requires improvement. This inspection was part of a wider trust follow up inspection.

As part of the inspection we visited locations where community nursing teams were based including health centres and community hospitals. We accompanied nurses on visits to patient homes and observed patients attending clinics. We spoke with 13 patients, six relatives and 57 members of staff. We reviewed 10 sets of patient records and listened to four calls made to the single point of access centre.

Summary of this service

Our rating of this service improved. We rated it as good because:

- We rated safe, effective, caring and responsive as good and well led as requires improvement

Community health services for adults

- Patients were protected from avoidable harm and abuse, systems were in place to investigate incidents and concerns and staff received suitable training in safety systems. Risk assessments were completed and care plans implemented to keep patients safe and promote wellbeing. The service had plans in place to manage service disruption and major incidents.
- The service used evidence based, best practice guidance throughout its policies and procedures and ways of working. Clinical audit was taking place and learning was shared across the service. Staff were suitably trained with the relevant knowledge and skills to carry out their work, had regular appraisals and had access to the information they needed to perform their duties. Multidisciplinary team work both internal and external to the service was effective and patients were supported to make informed decisions about their care.
- Patients were supported, treated with dignity and respect and involved as partners in their care. They told us that staff were kind and caring.
- Services and care were planned with the local population in mind and to address the individual needs of patients. Facilities had been adapted to improve access and systems were in place to support the most vulnerable. Patients knew how to make a complaint or raise a concern and complaints were taken seriously.
- A new leadership structure had been introduced since the last inspection and had not yet fully embedded in the service. Leaders were motivated and developing their skills to address the current challenges to the service. Staff support systems were in place and there was a drive to engage with staff. Governance structures were in place and risks registers were reviewed regularly.

However:

- The service still had challenges in recruiting sufficient staff which meant that the service, in particular community nursing, was understaffed at times impacting on staff satisfaction and compromising patient care.
- Staff did not always have time to attend clinical supervision sessions and patient information systems were inconsistently utilised and did not always enable effective working.
- Patient outcomes were not routinely collected so the quality of the clinical care being delivered could not be measured or benchmarked.
- There were long waiting times from initial referral to being seen in some clinics and services although these had improved in some areas since the last inspection.
- The community nursing service could not measure its performance in relation to response times for unplanned care.
- The leadership, governance and culture did not always support the delivery of high quality person centred care.
- Staff satisfaction varied greatly across the service with some staff feeling devalued.

Is the service safe?

Good   

Our rating of safe stayed the same. We rated it as good because:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Incidents were thoroughly investigated and lessons were learnt and communicated widely to support improvement.

Community health services for adults

- Staff had received up to date training on all safety systems. Sufficient priority was given to safeguarding vulnerable adults and children and there was active engagement in local safeguarding procedures and work with other relevant organisations.
- Risks to patients who used services were assessed monitored and managed on a day to day basis including signs of deteriorating health and medical emergencies. Risk assessments were person centred, proportionate and reviewed regularly.
- Plans were in place to respond to emergencies and major incidents. Anticipated changes in demand and disruption were assessed, planned for and managed effectively.

However:

- There were periods of understaffing or inappropriate skill mix which had not been addressed particularly in community nursing services and more noticeably in the city teams.

Is the service effective?

Good   

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

- Patients' care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation. Patients had comprehensive assessments of their needs.
- There was participation in local audits, results were shared with staff and the information was used to improve care and treatment.
- Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. Staff were supported to maintain and further develop their skills and experience.
- Staff were supported through regular appraisals. Processes were in place for managing staff when their performance was poor or variable.
- Patient care was coordinated across different staff, teams and services. Staff worked collaboratively to understand and meet the range and complexity of patients' needs. Patients were discharged at an appropriate time and when all necessary care arrangements were in place.
- Staff could access the information they needed to assess, plan and deliver care to patients in a timely way.
- Patients were supported to make decisions and where appropriate their mental capacity was assessed and recorded. The process of seeking consent from patients was understood by staff.

However:

- The outcomes of patients' care and treatment were not always monitored regularly or robustly. Participation in external audits and benchmarking was limited.
- There were gaps for management and support of clinical supervision. Rates of attendance at clinical supervision sessions were generally poor.
- Systems to manage and share care records and information were cumbersome and uncoordinated. Patients did not always have a copy of the information that was shared about them.

Community health services for adults

Is the service caring?

Good   

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

- Feedback from patients who use the service and those that are close to them was positive about the way staff treated patients.
- Patients understood their care, treatment and condition. Patients and staff worked together to plan care and there was shared decision making about care and treatment.
- Staff responded compassionately when patients needed help and support. Patients' privacy and confidentiality was respected at all times.
- Staff helped patients and those close to them to cope emotionally with their care and treatment. Patients were enabled to manage their own health and care when they could to maintain independence.

Is the service responsive?

Good  

Our rating of responsive improved. We rated it as good because:

- Services were planned and delivered in a way that met the needs of the local population. Care and treatment was coordinated with other services and other providers.
- Facilities and premises were appropriate for the services being delivered and reasonable adjustments were made when patients found it hard to access services.
- Access to care was managed to take account of patients' needs including those with urgent needs.
- It was easy for patients to complain or raise a concern. Complaints and concerns were always taken seriously. Improvements were made to the quality of care as a result of complaints and concerns.

However:

- Some patients were not able to access services for assessment, diagnosis or treatment when they needed to. In some services there were long waiting times, delays or cancellations. Action to address this was not effective.

Is the service well-led?

Requires improvement   

Our rating of well-led stayed the same. We rated it as requires improvement because:

- The service did not have robust processes in place to measure patient outcomes so could not assure itself of the quality of care being delivered
- Staff satisfaction was mixed. Staff did not always feel actively engaged or empowered. There were teams working in silos, management and clinicians did not always work cohesively.

Community health services for adults

- Information to drive service improvement was not robust.

However:

- There was a clear statement of vision and values in place.
- Governance meetings were taking place at team and hub levels and interacted with each other appropriately. Quality received sufficient coverage in meetings.
- The leadership team were knowledgeable about quality issues and priorities, understood what the challenges were and took some action to address them.

There was a positive culture of candour, openness and honesty.

Areas for improvement

We found areas for improvement in this service. See the Areas for improvement section above.

Mental health services

Background to mental health services

The trust was created in 2002 to provide mental health, learning disability and substance misuse services. In April 2011 the trust merged with Leicester City and Leicestershire County and Rutland Community Health Services as a result of the national transforming community services agenda. This has enabled joined up mental health and physical health care pathways to advance health and wellbeing for the people and communities of Leicester, Leicestershire and Rutland.

The trust delivers the following mental health services:

- Acute wards for adults of working age and psychiatric intensive care units
- Child and adolescent mental health wards
- Community mental health services for people with learning disabilities or autism
- Community-based mental health services for adults of working age
- Community-based mental health services for older people
- Forensic inpatient/secure wards
- Long stay/rehabilitation mental health wards for working age adults
- Mental health crisis services and health-based places of safety
- Specialist community mental health services for children and young people
- Wards for older people with mental health problems
- Wards for people with learning disabilities or autism

We inspected the following core services in October 2017:

- Acute wards for adults of working age and psychiatric intensive care units
- Community-based mental health services for adults of working age
- Mental health crisis services and health-based places of safety
- Specialist community mental health services for children and young people.

Summary of mental health services

Requires improvement   

Our rating of these services stayed the same. We took into account the current ratings of services not inspected this time. We rated them as requires improvement because:

- We rated safe, effective, responsive and well led as requires improvement and caring as good.

Summary of findings

- We rated four of the 11 core services as good and seven as requires improvement.

Community-based mental health services for adults of working age

Requires improvement   

Key facts and figures

The community based mental health services for adults of working age provide services to patients across the county of Leicestershire. The teams consist of consultant psychiatrists, mental health nurses, psychologists and occupational therapists, providing a range of treatments and support to adults aged 16 to 65. The psychosis intervention and recovery service provides services to patient's aged 14 to 65.

Services are provided to patients who have experienced mental health issues and referrals are made by their GP or other mental health professional involved in their care. Qualified staff conduct an assessment to establish the level of need and determine the most appropriate treatment or intervention. Healthcare professionals see patients at outpatient clinics, team bases or in their own home.

The psychosis intervention and recovery service supports people aged 14 to 65 years who have experienced a first episode of psychosis. Staff work with individuals to aid recovery, and to minimise the chance of potential future relapse. Staff also provide support to families.

Patients benefit from a range of individual and group work depending upon their needs. Individuals have a named worker who coordinates their care.

The assertive outreach team is county wide and provides support for patients with an enduring mental illness. The service aims to develop meaningful engagement in order to improve the quality of life for people who have a history of severe persistent mental illness.

We inspected the following locations and looked at all five key questions:

- Assertive outreach team
- City Central community mental health team
- City East community mental health team
- City West community mental health team
- Charnwood community mental health team.

The Care Quality Commission completed a whole trust comprehensive inspection in November 2016. Community-based mental health services for adults of working age received an overall rating of 'requires improvement'. The trust had not ensured the proper and safe management of medicines. The trust was required to make improvements including ensuring access to patient records for all staff, ensuring sufficient staffing to meet the demands of the service, ensuring staff are adequately supervised, appraised and trained and ensuring the privacy and dignity of patients is protected. Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. Before the inspection visit we reviewed information that we held about these services and information requested from the trust.

During the inspection visit, the inspection team:

- visited five of the teams, looked at the quality of the and observed how staff were caring for patients
- spoke with 19 patients who were using the service
- spoke with one carer of patients who were using the service

Community-based mental health services for adults of working age

- spoke with seven managers including team managers, service managers and head of service
- interviewed 34 staff including nurses, occupational therapists, psychiatrists, psychologists, pharmacists, health care support workers, administration managers and medical secretaries.
- reviewed 36 care records of patients
- reviewed 15 patient medication charts
- attended and observed 13 meetings and activities including outpatient reviews, home visits and multi-disciplinary meetings
- carried out a specific check of the medication management in all teams
- looked at policies, procedures and other documents relating to the running of the service.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- We rated safe, effective and responsive as requires improvement, and caring and well led as good.
- The vacancy rate was 12.9% for band 5 and 6 nurses. Staff held high caseloads and there were breaches of waiting times. This issue was on the risk register.
- In one of the waiting areas patients were able to access a room unsupervised which contained items which could cause harm.
- Staff did not review care plans regularly, we found 45% were not up to date. Staff did not always carry out physical health assessments, 52% did not have an assessment.

However:

- Staff treated patients with respect and maintained dignity.
- Staff felt supported by their managers and received regular supervision and annual appraisals.
- There was effective multidisciplinary working. Staff monitored those patients on the waiting list regarding risk levels.
- Staff had been given lone worker safety devices to ensure their safety.

Is the service safe?

Requires improvement   

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

- The vacancy rate was 12.9% for band 5 and 6 nurses. Staff held high caseloads and there were breaches of waiting times. This issue was on the risk register. Managers and staff told us caseloads were high. Nursing staff in the community mental health teams reported caseloads of between 40 and 60 patients. Consultants reported high caseloads; one consultant had a caseload of 600 patients.

Community-based mental health services for adults of working age

- At city central, staff had assessed the waiting area as medium risk. Despite this, inspection team members observed a patient sitting for 20 minutes in the waiting area without staff supervision. There was a blind spot and an unlocked room filled with items that could potentially cause harm, for example parasols, a water dispenser, plugs, cables and small tables.

However:

- Staff monitored waiting lists and responded to increases in risk levels. The trust had introduced a patient tracker tool to support managers to monitor waiting lists. Staff met weekly or fortnightly to review the patient tracker list and took appropriate action, such as bringing forward an assessment to respond to changing levels of risk.
- The service had introduced a new lone worker safety device for staff. This device was discreet and enabled staff to summon help quickly if needed.

Is the service effective?

Requires improvement   

Our rating of effective stayed the same. We rated it as requires improvement because:

- We reviewed 36 care records during the inspection. Staff had not completed and regularly reviewed care plans for 45% of patient records checked.
- Staff had not completed physical health assessments for 52% of patient records reviewed.
- Teams no longer had dedicated social worker roles. Social worker input was provided by the relevant local authority.
- Staff reported that this had been challenging, had increased caseloads and resulted in a lack of joint working.”
- Staff used an electronic records system for the majority of records. Staff told us that the system was not always accessible. Staff spoken with reported that a feature of the system, whereby records written off line would automatically upload, did not work.
- We did not find any evidence in records checked that staff had explained rights to patients subject to community treatment orders.

However:

- Managers provided staff with regular supervisions and appraisals. Psychologists provided weekly group supervisions to some teams.
- The teams held weekly multi-disciplinary meetings. All members of the multi-disciplinary team attended these. We observed a multi-disciplinary meeting. Team members discussed patients in detail and participants were encouraged to share their clinical view.

Is the service caring?

Good  

Our rating of caring improved. We rated it as good because:

- We observed staff treating patients with dignity and respect. Staff were empathic, kind, non-judgemental and supportive.

Community-based mental health services for adults of working age

- Patients told us that staff involved their families and carers with their permission. We observed staff involving carers during home visits.
- We observed staff using paraphrasing and reflection to ensure patients understood their care and treatment.
- Of 11 patients asked 82% were aware of how to access advocacy.

However:

- The involvement of patients in care planning and risk assessment was variable across the service. Of 13 patients asked, 85% said they were involved in their care and 54% said staff had offered them a copy of their care plan. In care records reviewed, 50% included patients' views.
- Patients and staff told us that there were no opportunities for patients to be involved in decision about the service, for example, recruitment of staff.

Is the service responsive?

Requires improvement   

Our rating of responsive stayed the same. We rated it as requires improvement because:

- Consultants told us that scheduled appointments had to be cancelled. At city central, 705 outpatients' appointments had to be rescheduled. The trust had identified this on the risk register. The trust reported 2891 breaches of waiting times from October 2016 to September 2017. Psychiatric outpatients were responsible for 2094 of the breaches, with city east reporting the highest of these breaches at 429. Charnwood reported that a patient referred in April 2017 would not get an appointment until February 2018. City central reported that a patient referred in July 2017 would not get an appointment until February 2018.

However:

- Except for outpatient appointments, staff rarely cancelled patient appointments and if they did, they would explain and apologise to the patient and re schedule for as soon as possible.
- Team managers used a patient tracking tool to monitor patients on the waiting list. The multidisciplinary team reviewed this every two weeks.
- Staff in the assertive outreach team applied to a charity for funds to provide activities for patients based upon their needs.

Is the service well-led?

Good  

Our rating of well-led improved. We rated it as good because:

- Team managers we met with demonstrated that they had the skills, knowledge and experience to perform in their roles. They had a good understanding of their service and many of them had worked as nurses in their teams before promotion to their current role. Team managers were visible in their services and staff told us that they were approachable.
- Staff spoken with told us they felt respected and supported by their team managers and were proud to work for their teams. There was some impact on staff morale due to high caseloads.

Community-based mental health services for adults of working age

- All staff asked told us they felt able to raise concerns without fear of retribution and knew about the whistle blowing process.
- Senior managers were implementing plans to reduce caseloads.
- The trust recognised staff success and contribution through awards schemes. We saw one staff award displayed in the reception area. Another staff member told us about a long service award they had received.

However:

- Managers and staff told us that a recent productivity exercise had resulted in a reduction of staffing levels which had left the service struggling. The impact was higher caseloads. Staff told us they were struggling to keep patient records up to date, but that they prioritised direct contact with patients. Staff in the team were not aware of the trust's plans to address this.
- Staff told us that the electronic system used for patient records was not always accessible and would crash, meaning staff could not update records. Across the teams, there was work on going to provide staff with the technology they needed to work more flexibly. For staff that did not have this technology, the systems did not work well.
- Team managers showed us monthly performance reports they received from the trust. Managers told us that the data was often incorrect and they would then have to spend time finding the correct information and feeding this back to the trust.

Areas for improvement

We found areas for improvement in this service. See the Areas for improvement section above.

Specialist community mental health services for children and young people

Requires improvement  

Key facts and figures

The child and adolescent mental health teams are provided by Leicestershire Partnership NHS Trust are part of the Families Young People and Children's division. The service is made up of a number of services. The three teams we inspected are set in Leicester City and Leicestershire.

We visited:

- Valentine Centre-county community adolescent mental health team
- Loughborough Hospital - county community adolescent mental health team
- Westcotes House - city community adolescent mental health team.
- Child and adolescent mental health crisis service
- 136 suite

The trust is registered for the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

The Care Quality Commission completed a whole trust comprehensive inspection in November 2016. The specialist community mental health services for children and young people received an overall rating of 'Inadequate.' There were requirement notices in relation to Regulations 12, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The trust had addressed storage of cleaning materials and maintenance of equipment. The trust was required to make improvements to ensure that treatments were delivered in a timely manner and care plans were in place or updated whilst patients were waiting for treatment. These two items remained unmet. At the last inspection we rated four key questions were either inadequate or requires improvement so we re- inspected all five questions.

Our inspection was announced (so staff knew we were coming) to ensure that everyone we needed to talk to was available. Before the inspection visit, we reviewed the information that was held about these services and information requested from the trust. We inspected the service looking at all five key questions.

The inspection teams visited these services on the 10 and 11 October 2017. During the inspection, the team:

- visited three child and adolescent mental health service teams. We looked at the quality of the care environment, and observed how staff cared for patients
- spoke with eight patients who were using the service
- spoke with 15 parent carers of patients who were using the service
- spoke with the team managers for each of the services
- spoke with three members of the recovery and improvement team and the head of service

Specialist community mental health services for children and young people

- interviewed 22 staff including, nurses, occupational therapists, psychiatrists, psychologists, assistant psychologists and psychotherapist
- reviewed 17 care records of patients
- attended and observed one multidisciplinary meeting and seven patient activities
- looked at policies, procedures and other documents relating to the running of the service.

Summary of this service

Our rating of these services improved. We rated services as requires improvement because:

- We rated responsive, effective and well led as requires improvement and safe and caring as good.
- There were still a high number on a waiting list for treatment. Data provided showed 945 patients on the waiting list for treatment, this included waiting for services outside of this core service such as family therapy, young people's team, primary mental health, eating disorders, home treatment, and learning disability services. The inspection that took place in November 2016, found 647 children waiting for a specific treatment within community out-patient teams following their initial access assessment and whilst this had reduced to 569 children, it was still a high number waiting. Some patients said the long waiting times had made them feel more anxious. Some patients, parents and carers felt there was poor communication between agencies, autism outreach, schools, and children and adolescent mental health services.
- We found issues with the environment. Not all sites where community child and adolescent mental health services were delivered were well designed, visibly clean, well maintained and met the needs of the patient. At Loughborough county team, there were no alarms fitted or personal alarms available; staff would call out if they needed assistance. At Valentine Centre county and Westcotes House city there were no alarms in treatment rooms although, staff held personal alarms. At Westcotes House the soundproofing between the corridors and interview rooms was poor. We could hear conversations between patients and staff. The environment was not visibly clean. The family therapy interview rooms did not have vision panels to keep patients safe.
- We found out of date equipment at the Valentine Centre in the video family therapy room. We found some issues at Valentine Centre and Westcotes House clinic rooms where the service did not have all the equipment to carry out physical health observations. The crisis service waiting area was shared with the adult learning disability community team. This was a safeguarding risk for children and young people waiting for their appointments.
- Record keeping was poor in some areas. Not all patients had a care plan and risk assessment. At Loughborough capacity and competence was not always recorded and managed well. Teams at a local level had not changed to the new systems. New care plan templates were set up but not consistently used. Care plans were not written in a holistic and personalised manner; and not focused on outcomes strengths, or age appropriate. Staff told us 924 care plans had been completed, we found 179 patients still did not have care plans in place.
- Some staff had large caseloads of up to 40. Staff told us managers reviewed caseloads with staff during management supervision. Not all staff had manageable caseloads to be able to respond to patient needs.

However:

- The rating had improved from the November 2016 inadequate rating. Managers had introduced a specialist child and adolescent mental health traffic light system, a red, amber and green rating tool for managing risk. In addition to this, risk assessments were comprehensive and reviewed as per the trust policy, six monthly or after risk incidents. Staff

Specialist community mental health services for children and young people

reviewed young people's risk at every appointment and recorded this in the case notes. Managers had introduced a duty clinician to manage caseload sizes and reduce patients' risks. The service was meeting the target for initial assessment within 13 weeks of referral with a compliance of 99%. However, 323 were waiting for their first appointment through the access team, to complete a core mental health assessment. There were no children who had waited more than a year for treatment.

- The clinic rooms across sites had all the equipment calibrated. Therefore, staff could ensure accurate measures of blood pressure were being recorded. Across the teams, we found up to date ligature audits in place. At the Valentine Centre improvements had been made to the storage of cleaning materials.
- Since the last inspection the service now had a Section 136 suite that met the standards set out in the Royal College Standards. The 136 suite is a place of safety for those who have been detained under Section 136 of the Mental Health Act. A children's adolescent mental health crisis service had been developed and commenced in April 2017.
- We observed clinicians working with young people were skilled and very positive. There was regular and effective multidisciplinary working. Staff provided psychological therapies as recommended by NICE such as group work and cognitive behavioural therapy. Patients and carers were involved in assessment, treatment and care planning. There were clear treatment pathways.

Is the service safe?

Requires improvement ● ▲

Our rating of safe improved. We rated it as requires improvement because:

- Managers provided up to date information, which showed 1180 patient risk assessments had been completed with 46 patients without risk assessments. Some staff had large caseloads of up to 40. Staff told us managers reviewed caseloads with staff during management supervision.
- One staff team did not have access to alarms in interview rooms or personal alarms available to them; staff would call out if they needed assistance. Two teams had personal alarms.
- General maintenance of two of the buildings was poor. The environment was not visibly clean; rooms were smelly, carpets, woodwork and paint work was marked and grubby. Not all electrical equipment items had an up to date safety test. In another building the soundproofing between the corridors and interview rooms was poor. During the inspection we could hear conversation between staff and patients in communal areas. The family therapy interview rooms did not have vision panels to keep patients safe.
- We found two clinic rooms that did not have equipment for staff to carry out physical health observations.
- Managers did not discuss or record learning from incidents in minutes of the team meetings we reviewed.
- The crisis service waiting area was shared with the adult learning disability community team. This was a safeguarding risk for children and young people waiting for their appointments.

However:

- Managers had introduced a specialist child and adolescent mental health traffic light system, red, amber and green rating tool for managing risk. In addition to this, risk assessments were comprehensive and reviewed as per the trust policy, six monthly or after risk incidents. Staff reviewed young people's risk at every appointment in recorded this in the case notes.
- Managers had introduced a duty clinician to manage caseload sizes and reduce patient's risks.

Specialist community mental health services for children and young people

- Since the last inspection the service now had a 136 suite that met the standards set out in the Royal College Standards. The 136 suite is a place of safety for those who have been detained under Section 136 of the Mental Health Act. A children's adolescent mental health crisis service had been developed and commenced in April 2017.
- Across the teams, we found up to date ligature audits in place.
- Staff ensured that they stored cleaning materials safely and in line with guidance.

Is the service effective?

Requires improvement ● ➡ ➡

Our rating of effective stayed the same. We rated it as requires improvement because:

- Staff had completed 924 care plans, although 179 patients still did not have care plans in place. Managers had devised a new care plan templates but staff were not consistently using it. Care plans were generally up to date but not written in a holistic and personalised manner; and not focused on outcomes strengths, or age appropriate.
- Staff had not recorded mental capacity assessments for patients in one out of the three services.

However:

- We observed clinicians working with young people were skilled and very positive.
- The service had started a pilot scheme initiative for Neurodevelopment team developing new pathways.
- There was regular and effective multidisciplinary working.
- The service had ensured all staff were trained in the Mental Health Act.
- Staff were supervised and appraised and had access to regular meetings.
- Staff provided psychological therapies as recommended by the national institute for health and care excellence, such as group work and cognitive behavioural therapy.

Is the service caring?

Good ● ➡ ➡

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

- Staff treated patients with respect and kindness. We observed two core assessments. Staff spoke in a balanced and focused way, brought humour, and had a child centred approach.
- Patients and carers spoke positively about staff knowledge, and skills of staff and their trustworthiness.
- We observed consistently positive and caring interactions between staff and patients.
- Parents and carers reported that the staff were professional, kept their boundaries and provided treatment and advice.

However:

- Some patients said the long waiting times had made them feel more anxious.

Specialist community mental health services for children and young people

- Some patients, parents and carers felt there was poor communications between agencies, autism outreach, schools, and children and adolescent mental health services.

Is the service responsive?

Requires improvement  

Our rating of responsive improved. We rated it as requires improvement because:

- The service had taken steps to reduce long waiting lists but at the time of the inspection there were 569 patients waiting to access specific specialist treatment. The longest wait was between 181-365 days for 89 patients. We found that those patients could be on the waiting list for more than one treatment due to the patients' co morbidity. (When two disorders or illnesses occur in the same person, simultaneously or sequentially, they are described as comorbid). In addition, 323 patients were waiting for their initial assessment through the access team, to complete a core mental health assessment
- Some patients, parents and carers told us their concerns were around long waiting times, and lack of communications between community adolescent mental health services and schools.
- The lift was not working in one service patients, families and carers only had access to the ground floor if they had mobility issues. Some of the buildings did not have child friendly décor and we found that the equipment used to enhance the patients' treatment were unclean and broken.

However:

- The service encouraged patients and parents /carers to complain and receive feedback. Staff knew how to handle complaints appropriately.
- The service was meeting the target for initial assessment within 13 weeks of referral with a compliance of 99%. There were no patients who had waited more than a year for treatment.
- Staff had responded to a specific need quickly. One patient told us they lived in a remote area and had requested a prescription but had difficulties travelling; the prescription had been sent to their local pharmacy. The service had ensured the patient received prompt care according to their individual need.

Is the service well-led?

Requires improvement   

Our rating of well-led stayed the same. We rated it as requires improvement because:

- The service had made some improvements and set up a recovery and improvement team. Waiting lists monitoring took place and arrangements were in place to manage unmet need and risks. However, there were still long waiting lists.
- Record keeping was poor in some areas. Not all patients had a care plan and risk assessment. Staff did not always record capacity assessments.
- Not all staff had manageable caseloads or able to respond to patient needs.
- Not all sites where community child and adolescent mental health services were delivered were well designed, visible clean, and met the needs of the patient.

Specialist community mental health services for children and young people

- Senior managers had clear vision on how to improve the service that had been shared with teams. However, teams at a local level had not changed to the new systems.

However:

- Patients and carers were involved in assessment, treatment and care planning. There were clear treatment pathways.
- This core service was learning from other trusts. Managers had established links with other community child and adolescent services and shared learning.
- Staff were supervised and appraised and had access to regular meetings
- Staff morale had improved. Most staff had enthusiasm to make the changes needed.
- Staff had been trained in the Mental Health Act and Mental Capacity Act.
- As part of the recovery, improvement and transformation phase, staff were working towards a new model of care for this core service. The THRIVE framework had been identified as a way to meet the vision of improvements to children and young people's mental health services. Events and seminars were planned from December 2017.

Areas for improvement

We found areas for improvement in this service. See the Areas for improvement section above.

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement   

Key facts and figures

The acute wards for adults of working age and the psychiatric intensive care unit (PICU) provided by Leicestershire Partnership NHS Trust are part of the trust's acute division. The wards are situated at the Bradgate Mental Health Unit in Glenfield, Leicestershire.

The Bradgate Mental Health Unit has seven acute wards for adults of working age, these are;

- Beaumont, 22 bedded male ward
- Watermead, 20 bedded male ward
- Bosworth, 20 bedded male ward
- Thornton, 24 bedded male ward
- Ashby ward, 21 bedded female ward
- Heather, 18 bedded female ward
- Aston, 23 bedded female ward

The psychiatric intensive care unit, Belvoir ward, is also located at the Bradgate Mental Health Unit and has 10 beds. The trust admits patients to the psychiatric intensive care unit if their needs cannot be safely met within the acute environment. Belvoir ward accepts only male patients. The trust currently has no intensive care facilities for females; however a female intensive care unit is due to open in November 2017.

All wards accept patients detained under the Mental Health Act 1983 (MHA).

The trust is registered for the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

The Care Quality Commission completed a whole trust comprehensive inspection in November 2016. The acute wards for adults of working age and the psychiatric intensive care unit (PICU) received an overall rating of 'requires improvement'. The trust had not ensured all clinical areas were safe for patient use. The trust was required to make improvements to make the clinical environments safer, including reducing ligatures; ensuring patient alarms are in working order, improving lines of sight and ensuring the safety and dignity of patients. The trust was also required to ensure that wards are appropriately staffed and that staff are adequately trained, receive regular supervision and are up to date with mandatory training.

At the last inspection we rated three or more key questions either inadequate or requires improvement so we re-inspected all five key questions.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. Before the inspection visit we reviewed information that we held about these services and information requested from the trust.

Acute wards for adults of working age and psychiatric intensive care units

The inspection team visited all seven acute wards and the psychiatric intensive care ward on 10 and 11 October 2017. During the visit the inspection team:

- spoke with 31 patients who were using the service
- spoke with 28 staff and eight managers or acting managers for each of the wards
- spoke with four senior managers
- observed one handover and two multidisciplinary meetings
- reviewed 34 patient records relating to physical health, risk assessments and care plans
- reviewed 25 medication charts.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- We rated safe, responsive and well led as requires improvement and effective and caring as good.
- There were issues with the environment at the Bradgate unit. The older wards had blind spots which had not been completely mitigated. Repairs were not carried out in a timely manner and we found two areas on one ward which had gathered dust and this had not been picked up by the cleaning staff.
- Vacancy rates were high with the highest being on Ashby ward at 50%.
- We found out of date medications in the clinic rooms on several wards. The processes for checking had not picked these up.
- Bed occupancy meant that patients returning from leave may not return to their original ward, meaning a lack of continuity of care.
- The older wards still had dormitories of two and four beds, which reduced the ability to maintain privacy and dignity for patients.
- Staff were not always recording their supervision on the electronic system.

However:

- The wards tried to book regular bank and agency staff so they knew the ward and patients, to provide continuity of care.
- Staff kept risk assessments up to date and carried out comprehensive assessments which were holistic and recovery focused.
- Staff were kind, compassionate and respectful towards patients.

Is the service safe?

Requires improvement   

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

Acute wards for adults of working age and psychiatric intensive care units

- Ward areas were visibly clean except on Ashby ward where we found dust and dirt in the clinic room and on the floor near the ward kitchen door. A shower had been out of order for four weeks, staff had reported this to the maintenance department, and however at the time of inspection it had not been repaired. This meant there was only one shower and one bathroom for 20 patients. The cold water fountain on Aston ward had been out of order for four weeks. This had also been reported to the maintenance department and had not been repaired at the time of the inspection.
- Staff vacancy rates were variable across the service. The overall vacancy rate was 23.4%. Ashby ward reported the highest qualified nurse vacancy rate at 50% and Aston ward the lowest with no vacancies.
- Staff did not adhere to best practice in implementing the smoke free policy on all wards. We saw evidence that patients were smoking in the garden area on Thornton and Watermead wards.
- Staff did not follow good practice in medicines management. We found out of date medication on Watermead and Thornton wards and out of date urinalysis testing equipment on Thornton and Belvoir wards. Staff said they had reported one out of date controlled medication to the pharmacy department in September; however, at the time of the inspection the medication had not been removed.

However:

- Staffing levels allowed for patients to have regular one to one time with their named nurse, patients we spoke with said that one to one time, activities or escorted leave was rarely cancelled but sometimes was rearranged due to staffing issues.
- We reviewed 34 care records. Each patient had an individualised risk assessment which was completed on admission and updated on a regular basis.
- Staff were aware of, and demonstrated the Duty of candour placed on them to inform patients who use the services of any incident affecting them. Staff discussed incidents and learning points in team meetings. We saw minutes of these meetings where staff had discussed changes that needed to be made to prevent incidents.

Is the service effective?

Good  

Our rating of effective improved. We rated it as good because:

- Staff completed comprehensive mental health assessments for patients on admission. We looked at 34 care plans, they were up to date, personalised, holistic, recovery orientated and included physical health checks.
- Staff said they were given opportunities to develop their skills and knowledge by attending both internal and external training, for example personality disorder and leadership training.
- The trust had processes for identifying and managing poor staff performance, including involvement from occupational health and the human resources (HR) departments. Managers said they had good support to manage poor staff performance.
- Staff completed MHA paperwork correctly. There was administrative support to ensure paperwork was up to date and regular audits took place. Staff scanned MHA paperwork onto the electronic record for staff reference.
- Occupational therapists and therapeutic liaison workers worked as part of the ward team and we saw that they worked closely with patients. The patient's we talked with spoke positively about the support they received.

However:

Acute wards for adults of working age and psychiatric intensive care units

- Between 31 July 2016 and 30 June 2017 the average supervision rate across all eight teams in this core service was 42% against the trust's target of 85%.
- The service had one psychologist in post. Patients were referred for interventions, but staff said there was a waiting list of about four weeks for assessment. On all wards, staff (doctors and nurses) told us there was a limited amount of psychology input. No evidence was recorded as to how care was being provided in line with relevant NICE (National Institute for Health and Care Excellence) guidance, particularly relating to the provision of psychological therapies for patients. However, we were informed that four psychologists had been appointed and three were due to commence work in October 2017.

Is the service caring?

Good   

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

- Staff treated patients with kindness, compassion and respect. We observed interactions between staff and patients during the inspection and saw that staff were responsive to patient's needs, discreet and respectful. Staff treated patients with dignity and remained interested when engaging patients in meaningful activities. Staff interacted with patients in a timely way and at a level that was appropriate to individual needs.
- We spoke with 31 patients who told us that staff were generally kind and caring. Three patients said that staff helped them to access services to find accommodation in the community.
- Patients had access to advocacy services on the wards and information and contact details were contained in patient admission packs and on posters and leaflets available on the wards. Wards had information boards detailing the staff on duty and staffing levels. This informed patients of the staff available for care and treatment for that day.
- We spoke with nursing staff who described how they took patient's personal, cultural, social and religious needs into account when care planning.

Is the service responsive?

Requires improvement  

Our rating of responsive improved. We rated it as requires improvement because:

- Staff reported that when patients went on leave their beds were regularly used for patients needing admission to hospital. This meant that patients returning from leave would not have access to their bed and would be nursed on a different ward which led to inconsistency of care.
- Staff told us that three rooms intended as single bedrooms on Thornton ward were used as two bedded rooms, we looked at these rooms which were cramped and patients had very little access to private space.
- On Ashby, Bosworth and Thornton wards, we found inadequate numbers of rooms for care and treatment of patients. Wards did not have sufficient rooms for patients to access 1-1 time with nursing staff, to receive visitors or to participate in ward based activities. Patients had difficulty having confidential and private conversations with staff and visitors.
- The trust provided a choice of food to meet differing dietary needs and choices. However, patients told us that halal options were limited.

Acute wards for adults of working age and psychiatric intensive care units

However:

- Patients had access to information on how to make a complaint. Wards had information on the complaints process available to patients on ward notice boards and in leaflets. Staff supported patients to raise concerns when needed. The trust had systems for the recording and management of complaints. We saw minutes of team meetings where the outcomes and learning from complaints was discussed.
- Staff could access information leaflets in a variety of languages for patients whose first language was not English. The trust had a specific email address and contact telephone number to ensure information was available quickly when needed. We found these details contained in patient admission packs.
- Patients were able to personalise their bedrooms, for example with artwork and photographs. Patients accommodated in bed bays and dormitories had less space; however, we observed personal items in these areas.

Is the service well-led?

Requires improvement   

Our rating of well-led stayed the same. We rated it as requires improvement because:

- Managers and staff reported that supervision was taking place, however the data submitted by the trust did not reflect this. Compliance rates for acute wards and PICU was 42% which was below the trust target of 85%. Staff sickness for the service was 7% which was above the trust target of 4.5%.
- Managers did not ensure clinical areas were clean and that equipment and facilities were maintained in a timely way.
- Staff vacancy rates were variable across the service. Ashby ward reported the highest qualified nurse vacancy rate at 50% and Aston ward the lowest with no vacancies.

However:

- Managers used a standard agenda for ward meetings, items covered at the meeting included safeguarding, feedback and actions following incidents and performance data.
- Managers supported staff to work in collaboration with community teams and external agencies such as, housing and the criminal justice service to meet the need of patients.
- The ward matrons were able to provide us with an up to date picture of how the wards were performing and had a good understanding of where improvements were required.
- The trust held two weekly discharge meetings which included other agencies and commissioners to address the delayed discharges.

Areas for improvement

We found areas for improvement in this service. See the Areas for improvement section above.

Mental health crisis services and health-based places of safety

Requires improvement  

Key facts and figures

The crisis resolution and home treatment teams and health based place of safety services provided by Leicestershire Partnership NHS Trust also incorporate liaison psychiatry services, liaison mental health triage services and criminal justice and liaison services.

Crisis teams provide emergency and urgent assessment and home treatment for adults who present with a mental health need that require a specialist mental health service. Their primary function is to undertake an assessment of needs, whilst providing a range of short-term treatment as an alternative to hospital admission. The team are also gatekeepers so have the ability to admit patients to an inpatient unit if this is required. This service is available 24 hours a day, 365 days a year and covers Leicester City, Leicestershire and Rutland. The service is based at the Bradgate Mental Health Unit.

A mental health triage and deliberate self-harm service is provided for people who present to the urgent care centre or Leicester Royal Infirmary emergency department. This team aim to provide prompt assessment of a service user's needs and signpost care appropriately.

Liaison mental health triage services work from a custody suite within Leicester city. Here, mental health nurses are able to assess people within the custody suite. Further nurses are based with a paramedic or police officer and are available to respond to 999 calls which the call handler had identified that a mental health intervention may be required.

There is one health based place of safety in Leicester. A health based place of safety is a place where someone who may be suffering from a mental health problem can be taken by police officers, using the Mental Health Act, in order to be assessed by a team of mental health professionals.

The psychiatric liaison service provides assessment and treatment for adults between the ages of 16 to 65, who experience mental health problems in the context of physical illness. The team see people on inpatient wards at the three acute hospital sites. The psychiatric liaison service also provides outpatient clinics and a specialist chronic fatigue syndrome service.

Leicestershire Partnership NHS trust was last inspected in November 2016 by the CQC. During the last inspection, we rated the trust as 'requires improvement' because:

- We found out of date medication and equipment located in the health-based place of safety.
- Staff in the crisis resolution and home treatment team were not reviewing and updating risk assessments regularly or following an incident.
- Staff in the crisis resolution and home treatment team were transporting medication to patient's homes in their handbags.
- The environment in the health based place of safety and the crisis resolution and home treatment team were visibly unclean.
- The health-based place of safety at the Bradgate unit did not meet Royal College of Psychiatry guidance, access arrangements were unsafe, doors were not anti-barricade and patients were unable to lie down.

The trust is registered for the following regulated activities:

Mental health crisis services and health-based places of safety

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder or injury.

At the last inspection we rated three or more key questions as requires improvement so we re-inspected all five key questions.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. Before the inspection visit we reviewed information that we held about these services and information requested from the trust.

The inspection team visited the crisis team, the mental health triage team and the psychiatric liaison team on 10 and 11 October 2017. During the visit the inspection team:

- visited the crisis resolution and home treatment team based at the Bradgate Mental Health unit
- visited the health based place of safety at the Bradgate Mental Health Unit
- visited the liaison mental health triage team at Leicester Royal Infirmary
- visited the liaison psychiatry service at the Glenfield Hospital
- spoke with 12 patients who were using the service
- spoke with 5 managers or acting managers for the three teams we visited.
- spoke with 23 other members of the multidisciplinary team
- spoke with four senior managers
- observed three multidisciplinary meetings and a governance meeting
- reviewed 36 patient records relating to physical health, risk assessments and care plans
- carried out a specific check of the medication management at the crisis and home treatment teams, and
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- We rated responsive and well led as requires improvement, and safe, effective and caring as good.
- Interview rooms were unsafe. They did not have alarms or vision panels in the door. They contained items which could pose a danger to staff and patients.
- Staffing levels were below the expected level. The vacancy rate for the service was 12.9% and for band 5 and 6 nurses was 18.9%.
- The quality of the data produced was poor and staff needed to correct the data when reports were produced.
- The service was not meeting its performance targets.

However:

- The trust had addressed the issues previously identified with the health based place of safety.

Mental health crisis services and health-based places of safety

- Care plans were up to date and holistic.
- There was effective communication between the service and other healthcare professionals.
- Staff received regular managerial and group supervision.

Is the service safe?

Requires improvement   

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

- The crisis team had access to three assessment rooms in which they saw the most challenging patients. We considered these rooms to be unsafe as they did not have anti-barricade doors and the room only had one exit. There was lightweight furniture and office equipment which could have been used as a weapon or to barricade the door. It was not possible for staff to be visible whilst assessing in these rooms as glass panels in the doors were frosted. However staff carried working alarms.
- All areas were clean, however the décor, furniture and carpets at the crisis resolution home treatment team were stained and in need of updating.
- Between 1 July 2016 and 30 June 2017, bank staff filled 1494 shifts to cover sickness, absence or vacancy for qualified and unqualified nurses. The vacancy rate for the whole service was 12.9% and 18.9% for band 5 and 6 nurses.
- The trust did not ensure sufficient staff were available on all shifts for the safe care and treatment of patients. The trust covered 1834 vacant shifts with agency staff between 1 July 2016 and 30 June 2017. However, 321 (15%) of shifts were not filled. On these occasions, teams worked below established staffing levels,
- Staff we spoke with told us that sickness was rarely covered within the team. When staff left the team there was insufficient staffing to assess patients within the 4 hour target.
- A number of teams were below 75% for some of the mandatory training. The crisis team was below 75% training compliance for one out of 23 modules (4% of all modules). The psychiatric liaison team was below 75% training compliance for five out of 23 modules (22% of all modules). Across the service medical staff fell below 75% training compliance for six out of 18 modules (33% of all modules).

However:

- The trust had addressed environmental concerns within the health based place of safety identified during our last inspection. The environment had been refurbished and now met the Royal College of Psychiatry guidance.
- The trust stored and managed medication appropriately at each location. At the Bradgate Unit crisis team there was no clinic room, however there was a locked cupboard with stock of regularly prescribed medications secured to the wall of the team office. The health based place of safety had a fully equipped resuscitation trolley and small supply of stock medication in a locked cupboard in the nursing office.
- Staff completed a risk assessment for every patient at telephone triage and then conducted a further more detailed risk assessment which was updated regularly, including after any incident.
- The trust had devised a risk assessment tool for use across the crisis resolution home treatment team. A similar core assessment was used by the mental health triage teams and health based place of safety.
- Staff created and made good use of crisis plans with patients taking the lead in the planning of their care. However, in the records we reviewed, advance decisions were rarely used.

Mental health crisis services and health-based places of safety

- The trust had improved staffing in the health based place of safety. Designated staff were allocated to support patients on arrival and throughout their admission. When the unit was not in use, these staff worked within the acute admission wards.
- The trust had developed good personal safety protocols, including lone working practices, and there was evidence that staff followed them.

Is the service effective?

Good  

Our rating of effective improved. We rated it as good because:

- We reviewed 36 care records across the teams we visited. Records showed that staff completed a comprehensive mental health assessment of each patient. In the crisis team patients would receive a triage assessment over the telephone, a subsequent appointment would then be booked to complete a detailed assessment and care plan.
- Staff developed care plans that met the needs identified during assessment. Care plans were personalised, holistic and recovery-oriented. Staff updated care plans when necessary. Care plans were written in a way that suggested the patient was engaged in their care and had the opportunity to set goals with their key worker.
- Staff maintained communication with other healthcare professionals and GPs to ensure patients' physical healthcare needs were met, and updated the records accordingly.
- Staff we spoke with told us they received monthly managerial and group supervision as well as informal supervision within the team on a daily basis.
- Managers dealt with poor staff performance promptly and effectively.
- Staff in all teams held effective multidisciplinary team meetings. We observed two meetings with the crisis and psychiatric liaison teams and found that staff shared information about appointment allocation, risks and case formulation within these meetings.
- Staff shared information about patients at effective handover meetings.
- The community teams had good working links, including effective handovers, with primary care, social services, and other teams external to the organisation. Staff spoke about good links with GP practices and a crisis house run by an external organisation. Amongst other services several patients gave positive feedback about a local mindfulness group which had aided their recovery.
- Staff were trained in and had a good understanding of the Mental Health Act (1983) and the Mental Capacity Act (2005).
- Staff had easy access to Mental Health Act policies and procedures and to the Code of Practice on the trust internet.
- We saw evidence in patient records that if the team worked with patients who were detained under the Mental Health Act or subject to a Community Treatment Order, staff explained to patients their rights in a way that they could understand. Patients were given a leaflet explaining their rights.
- Staff had completed Community Treatment Order paperwork correctly and it was up to date and stored appropriately.
- Managers conducted audits of three case notes each on a weekly basis and any issues were addressed in supervision with staff.

Mental health crisis services and health-based places of safety

- The trust's target rate for appraisal compliance was 80%. As at 30 June 2017, the overall appraisal rates for non-medical staff within this core service was 94%.

However:

- The Liaison Psychiatry Service failed to meet the trust's appraisal target of 80% with only 67% of staff having had an annual appraisal.

Is the service caring?

Good ● → ←

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

- Staff were respectful and responsive to patients' needs providing patients with help, emotional support and advice when they needed it.
- Staff spoke positively about patients and were passionate about their work.
- Staff supported patients to understand and manage their care, treatment or condition. Patients we spoke with were positive about the care they received and told us staff treated them well and they put their needs and wishes at the centre of the care plan.
- Staff referred patients to other services when appropriate. For example, if patients in crisis needed support away from their usual home environment they were referred to a local crisis house provided by another organisation.
- Staff understood the individual needs of patients, including their personal, cultural, social and religious needs and were able to access additional support to meet the needs of the diverse patient group.
- Staff understood and maintained the boundary of patient confidentiality.
- Patients we spoke with told us they were involved their care planning and risk assessments, and were offered copies of their care plans. We found evidence of this in patient records.
- Staff involved patients when appropriate in decisions about the service. For example, patients and carers sat on the recruitment panel and interviewed new staff.
- The trust had recently devised a patient feedback survey in addition to the friends and family test. This was available electronically as well as in paper form.
- Staff ensured that patients could access advocacy, both within the trust and from an independent advocacy service.
- Carers were provided with information on how to access a carer's assessment. Some carers we spoke to had accessed this service.

Is the service responsive?

Requires improvement ● → ←

Our rating of responsive stayed the same. We rated it as requires improvement because:

- The provider had set a target for time from referral to triage/assessment and from assessment to treatment. The target time for referral to assessment for the mental health triage team was 2 hours and 4 hours. For the Crisis team the referral to assessment target was 4 hours for urgent assessments and 24 hours for other referrals. The trust was

Mental health crisis services and health-based places of safety

not meeting targets for referral to assessment. The mental health triage team were not compliant with the 2 hour or 4 hour target for referral to assessment for approximately 30% of referrals. Managers told us this was due to low staffing levels and increasing patient demand. Data for the past 2 months showed an average of 25% of referrals had not met the target for 2 hour and 4 hour assessments.

- The crisis team were not compliant with the target for 4 hour or 24 hour assessments. A subsequent data request revealed that for the period April to August 2017 an average of only 32.5% of all referrals were assessed within 4 hours. The average number of referrals seen within a 24 hour period for April to August 2017 was 75%. There was however rapid access to psychiatrists should a patient need to be assessed in an emergency.
- The psychiatric liaison team, which provides assessment and treatment for adults between the ages of 16 to 65, who experience mental health problems in the context of physical illness, were not meeting their target of 13 weeks from referral to assessment. Data showed some patients had waited between 14 and 39 weeks to see the consultant psychiatrist. The trust included failure to meet agreed waiting time targets as a risk to patient safety and experience on the trust risk register.
- This core service received 20 complaints between 1 July 2016 and 30 June 2017. Seven of these were related to attitude of staff and seven regarding all aspects of clinical treatment.

However:

- The trust had clear criteria for patients to access the service. There was no waiting list for crisis and mental health triage teams.
- The trust responded promptly and adequately when patients telephoned the service. In all teams there were designated staff available to take calls and triage patients over the telephone.
- The teams engaged with patients who found it difficult or were reluctant to engage with mental health services.
- We saw evidence in patient records that the team made follow-up contact with patients who did not attend appointments.
- Staff offered patients flexibility in the times of appointments whenever possible.
- Staff cancelled appointments only when necessary. When this was necessary, staff assisted patients to access treatment as soon as possible.
- This core service received seven compliments during the last 12 months from 1 July 2016 and 30 June 2017. All of these compliments were attributed to the Crisis Resolution Team.
- Patients we spoke with told us they knew how to complain or raise concerns. Staff protected patients who raised concerns or complaints from discrimination and harassment
- Staff knew how to handle complaints appropriately. Staff we spoke with told us that they tried to resolve as many issues as possible within the team.
- Staff received feedback on the outcome of investigation of complaints and acted on the findings. We saw evidence of learning from complaints in team meeting minutes.

Is the service well-led?

Requires improvement   

Our rating of well-led stayed the same. We rated it as requires improvement because:

58

Mental health crisis services and health-based places of safety

- Data provided by the quality dashboard was unreliable. Senior staff advised that the quality dashboard did not accurately record the team activity; therefore administration staff were required to cleanse all data to show mitigation when target times were not met.
- Managers did not have oversight of the numbers of safeguarding referrals submitted to the local authority.
- Managers and staff reported that supervision was taking place. However, the data submitted by the trust did not reflect this. Data provided showed an overall compliance rate of 60% which was below the trust target of 85%. Managers kept local records to evidence compliance with supervision for their staff.

However:

- Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care.
- Staff we spoke with told us that leaders were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff could explain how they were working to deliver high quality care within the budgets available; by linking in with other agencies in the local community, providing mutual aid and support groups.
- Leadership development opportunities were available, including opportunities for staff below team manager level.
- Staff undertook or participated in clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed.
- Staff understood arrangements for working with other teams, both within the trust and external organisations, to meet the needs of the patients.

Areas for improvement

We found areas for improvement in this service. See the Areas for improvement section above.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Our inspection team

Julie Meikle, Head of Hospital Inspection, CQC and Margaret Henderson, Inspection Manager, CQC led this inspection. Two specialist professional advisors with board experience and a knowledge of governance supported our inspection of well-led for the trust overall.

The team for the core services included four inspection managers, eight further inspectors, 11 specialist advisers, and two experts by experience.

Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.

HEALTH AND WELL BEING SCRUTINY COMMISSION

REPORT OF LLR CCGs

UPDATE ON WINTER PLAN 2017/2018

Summary/Purpose of Report

1. To provide an update on winter pressures, the response of the local health and care system to winter pressures and the effectiveness of winter plans.
2. Acknowledging that the health and care system is still in mid-winter, this report to the HWB Scrutiny Commission summarises performance issues and lessons learnt to date.

Background

- 3 Across the health and social care system, winter planning is co-ordinated to ensure that there are robust arrangements to cope with demand and surges in activity, and that agencies are working together to manage pressures to ensure that residents continue to receive safe and appropriate care.
- 4 Winter planning arrangements are led by the LLR A&E Delivery Board, supported by the Urgent and Emergency Care (UEC) team hosted by West Leicestershire CCG. The UEC team led a winter planning group responsible for pulling together the LLR plan. The Winter Plan is attached to this report as Annexe 1.
- 5 From November onwards, daily system management calls and situation reporting (SITREPs) have been in place, reporting into the regional and national winter management system.
- 6 The key elements of the winter plan for LLR are:
 - 6.1 Clear organisational and system-wide surge and escalation management protocols, with the management of system escalation levels led by the WLCCG UEC team
 - 6.2 Multi-agency on call training in relation to escalation protocols
 - 6.3 Multi-agency Discharge Events pre and post the Christmas and New Year period, to accelerate discharge flows and free up maximum bed capacity to cope with times of anticipated bed pressures
 - 6.4 Use of additional escalation bed capacity when required in response to admission rates and occupancy levels
 - 6.5 Additional social care capacity in-reach to hospitals over the winter period
 - 6.6 Demand forecasting by individual organisations, informing rota planning with additional capacity over key days
 - 6.7 Additional capacity in some GP practices, primary care hubs and Urgent Care Centres from December onwards
 - 6.8 System flu plan

7 In addition to the measures outlined in the winter plan, additional NHS funding was made available in December to support STP areas in managing winter pressures. LLR received £4.2 million in total, of which £2.3 million was directed to University Hospitals Leicester to reflect the costs of winter already in Trust plans. The remaining £1.9m was allocated in response to bids submitted by LLR to deliver additional capacity and winter schemes, directed at areas of the greatest pressures in the system.

7.1 The additional winter schemes in LLR include:

- 14 additional beds at Glenfield Hospital
- Additional imaging capacity at weekends to maintain patient flow
- ED floor managers to oversee patient flow
- Additional pharmacy support
- More support within the Integrated Discharge Team
- Additional discharge capacity (discharge to assess capacity and spot beds)
- Additional clinical triage in the clinical navigation hub, including green ambulance triage within NHS 111
- Additional capacity in primary care hubs and UCCs to deliver additional clinical appointments
- Additional Home visiting capacity
- Additional EMAS vehicles to move GP patients to hospital in a timely way
- Additional patient transport capacity to ensure that transport does not contribute to delayed discharges

8. In addition to the Urgent Care winter monies, there was a national allocation of winter monies for Mental Health services. LLR received £299K to support the mental health triage car, additional psychiatric liaison capacity in ED and expansion of home treatment services.

Winter performance and key issues affecting LLR services and patients

9. Acknowledging that we are still in the winter period, the LLR system has experienced some real challenges over the winter period to date, which have been reflected in a worsening of A&E waiting times at Leicester Royal Infirmary (LRI) and some worsening in other performance indicators, such as Delayed Transfers of Care and ambulance handover times.

9.1 A summary of activity and performance across the main urgent care services, covering each day over the Christmas and New Year period is attached as Appendix 1.

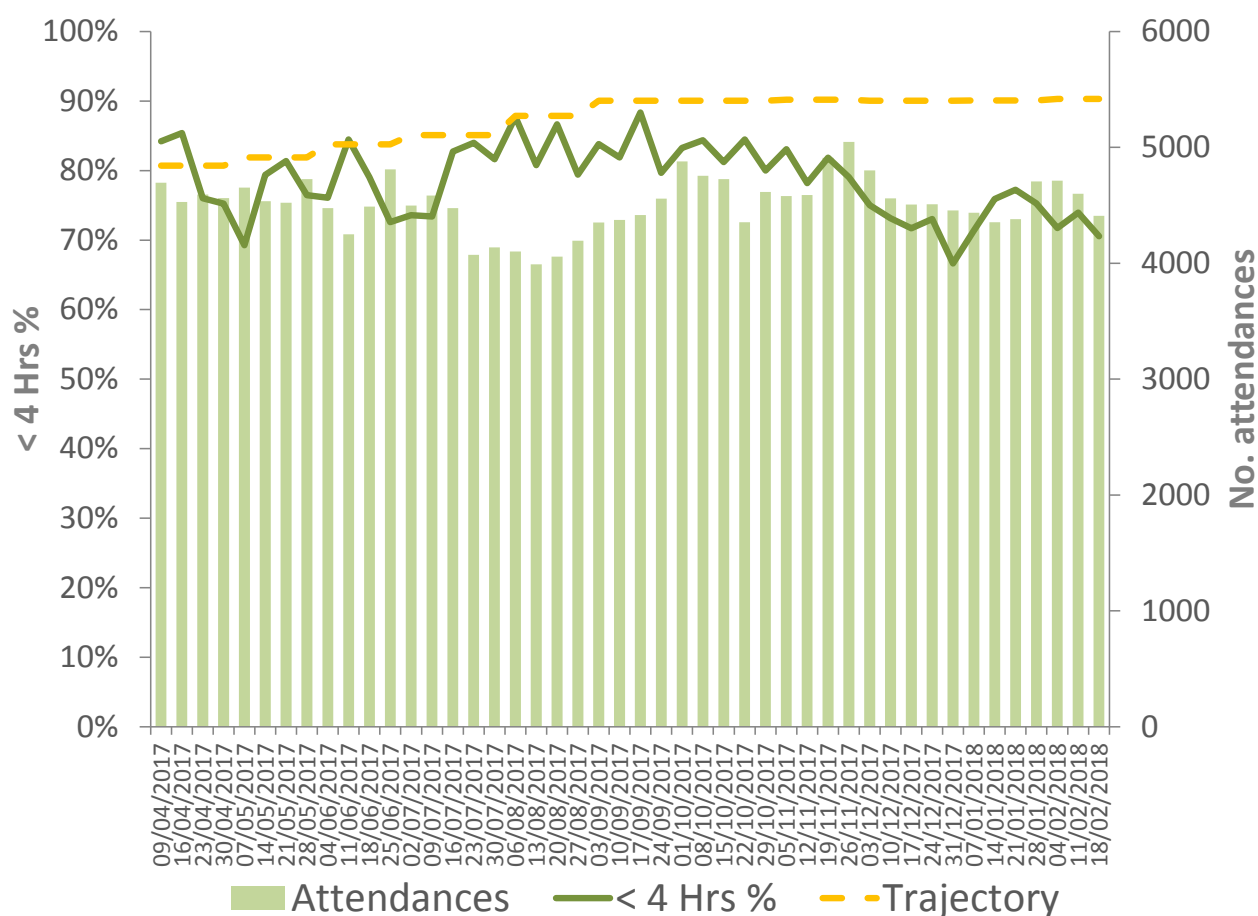
9.2 A fuller review of winter activity pressures and performance will be undertaken towards the end of March by the LLR Resilience Group, which reports into the AEDB and has representation from all the main health and social care partners. This group has responsibility for winter planning, and will use the learning in developing the winter plan for winter 2018/2019.

10. Key headlines in terms of activity and performance are:

10.1 Activity levels at LRI ED overall were not been particularly high over December, although they have increased in February. December attendances were 1% lower than the same period in 2016. There was a volatile pattern of attendances on the individual days over Christmas and New Year, which did not follow the same pattern as the previous year. For instance, Christmas Day was -7% on last year, but the 23rd December was +20%.

10.2 Performance against the 4 hour target at LRI ED over the week 25/12 – 1/1 was 66%. January performance was 75%, showing some recovery, although performance then dipped in February, 71.5% to the 21st Feb with a YTD figure of 78.5%.

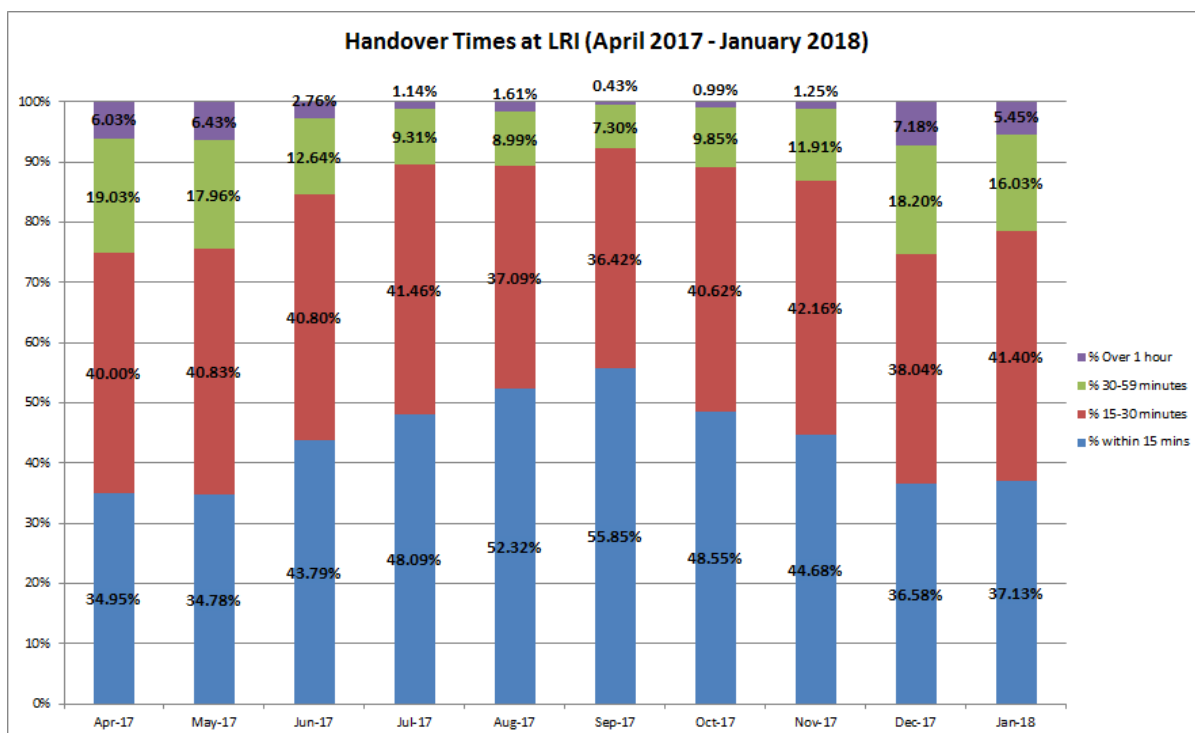
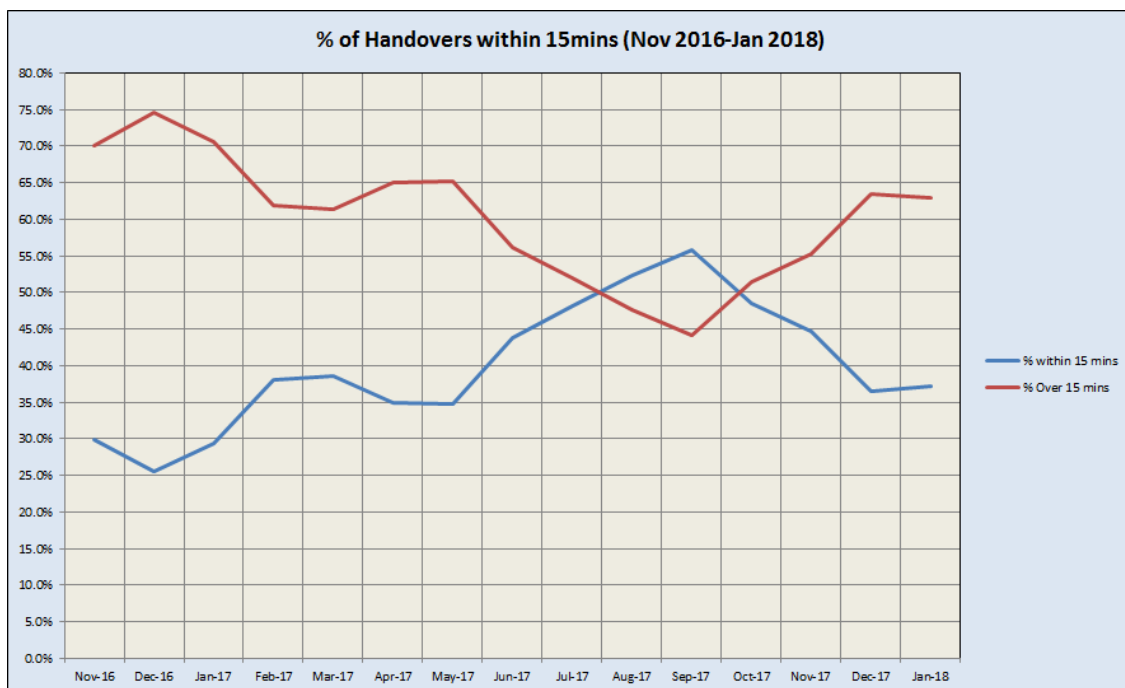
The table below shows ED attendances and waiting time trends for the year to date.



10.3 Activity in out of hospital services, including Urgent Care Centres, Primary Care Hubs, Home Visiting and Clinical Navigation has been higher both than forecast and last winter. NHS111 experienced an 18% increase in activity over Christmas. Local out of hours service activity was 11% higher than forecast, despite planned increases to capacity. This increase in out of hospital activity is in line with the Urgent Care strategy for LLR, however, at times it has created pressure on services.

Ambulance Handover times at LRI

10.4 Ambulance handover times have been significantly better this winter than last winter, driven by improvements in handover processes and capacity since the move to the new ED in April 2017, within consistently improved performance over the summer and autumn. However, delays have increased over the winter period, and there have been some extremely difficult days in terms of ambulance handover over New Year and repeated on a number of days in February. These long waiting times are related to times of increased 'surges' of activity coupled with poor flow within the ED and capacity problems in majors.



Key actions in place to assist with handover times include:

- Utilisation of blue zone to accommodate ambulatory patients off ambulances
- Conveyance direct to GPAU from ambulances
- 'Fit to Sit' from the ambulance assessment bay to front door
- Escalation protocol in place when the ambulance assessment bay has >8 patients
- EMAS HALO presence on site to liaise with ED staff and support flow
- Additional winter funding for EMAS crews to bring GP patients in earlier, to smooth late pm surges.

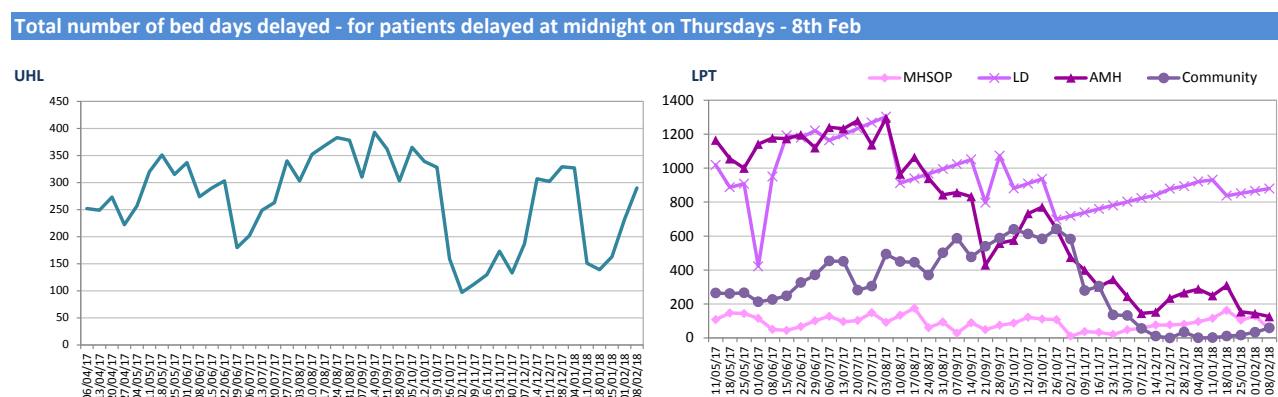
Bed occupancy and discharge delays

10.5 As part of the winter plan, the AEDB led a Multi-Agency Discharge event for a week in mid-December, followed by a week of enhanced 'Red to Green' discharge management. However, DTOC rates built slowly through December, following a period of good progress in reducing DTOCs, particularly at LPT, in November and in previous months. Some of this related to difficulties in getting packages of care initiated, or patients moved to care homes before Christmas. Patient acuity was high in the run up to Christmas, with high numbers of medically ill patients with respiratory viruses who could not be discharged, which further increased inpatient numbers.

10.6 There were some ward and bed closures due to infection control (Noro virus) at both UHL and LPT in the week running up to Christmas, with a number of beds still closed on Christmas Eve.

10.7 As a result of the above, and despite significant multi-agency efforts, occupancy rates at LRI on the 24th December were unusually high. Whereas there are normally large numbers of empty beds on Christmas Eve, which allows a buffer to absorb admissions over the following 10 days of the holiday period, this winter this has not been the case. Almost inevitably, the hospital became progressively fuller into the New Year bank holiday, with increasing numbers of medical outliers (40 – 50 on a daily basis) and the LLR system reached OPEL level 3 by the 2nd January.

10.8 The DTOC rate trend for UHL and LPT is shown below:



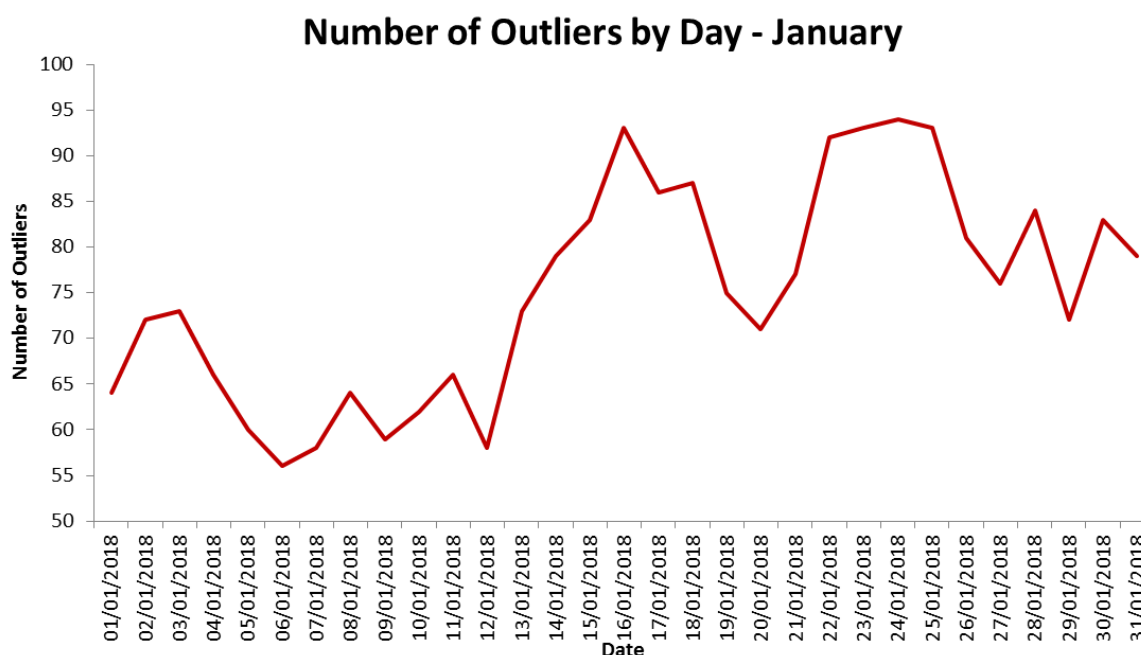
10.8.1 Note this is a combined DTOC picture for LLR. The DTOC position has been variable across County and City CCGs, with performance worse in County, generally. City DTOCs reduced in December, with achievement of the BCF target in that month.

10.9 It can be seen that there was a clear 'spike' in DTOCs at UHL from the end of November and over Christmas, which added to be pressures. The position was corrected to some extent in early January, following intensive support to UHL and LPT discharges since 2nd January. However, the DTOC rate has increased again at UHL in recent weeks. As patients have become medically fit, pressure has to some degree transferred from UHL to LPT, and the LPT bed occupancy rate has been problematic from the end of January to date. This was an expected phenomenon, to some extent, and close working between UHL/LPT and social care has been co-ordinated by the UEC team to maximise patient flow. Actions taken to support discharge and reduce bed occupancy in January and February have included:

- Securing additional care home placements to take patients medically fit for discharge
- Identifying additional case management and assessor capacity to support discharge to assess and the Continuing Healthcare (CHC) pathways
- Accelerated CHC approvals process
- Discharge 'task force' supporting UHL
- County Social Care looking for additional domiciliary care capacity to accelerate discharge flow

10.10 High occupancy rates have a direct impact on the 'flow' of patients who need admitting from ED into beds, and therefore have a negative impact on ED waiting time performance. This was experienced at LRI over Christmas and New Year this year to a greater degree than in previous years, and contributed to the performance dip over the Christmas period. Although the position de-escalated immediately after New Year, the second half of January and February has seen a further increase in pressures, evidenced by increasing handover delays and a decline in ED performance. Occupancy rates and stranded patients remains an area of concern, with action being taken to support improved discharges. UHL's analysis of stranded patients indicates that Length of Stay is increasing, and that this is linked to acuity of patients as well as to issues with discharge processes both within hospital and across the wider health and social care system.

The chart below shows the trend in medical patients outlying into other wards at UHL over January. High numbers of medical outliers create additional challenges for hospital medical and nursing staff as it creates additional problems in reviewing patients spread over a number of wards, and makes discharge planning more difficult. High numbers of medical patients outlying into surgical beds also has a knock on effect on capacity to treat surgical patients and can result in cancellations of surgical procedures. See later for more detail.

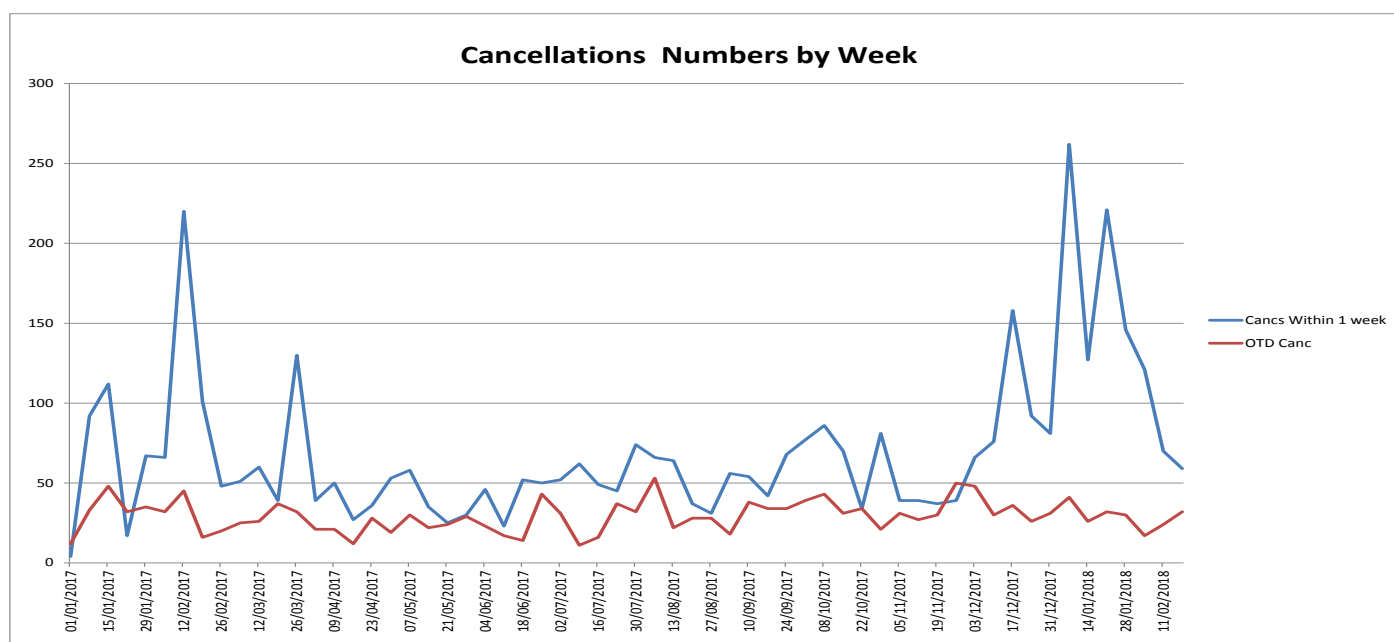


Elective and non-elective cancellations

- 10.11 NHS England issued instructions to all A&E Delivery Boards and NHS providers that they should stop undertaking elective activity through January in order to free up capacity (beds and staff) to respond to emergency demand. Elective activity is normally stepped down over the Christmas and New Year period anyway, but this year, the national direction was for a significantly extended elective slow down.
- 10.12 Within LLR, UHL has responded to this requirement. Elective inpatients in most cases were cancelled, although day cases and operations which would not have an impact on emergency care were continued. In addition, there were some urgent and cancer cancellations made in the first week of January. These were made following a review of ITU and recovery area capacity, and led to a number (32) of cancer cancellations between the 2nd January and the 8th January.

All patients who had their procedures cancelled were subsequently been treated within the month. There have been further, albeit small numbers of urgent procedures cancelled on the day over January and February, with decisions to cancel made only when there is no capacity to operate or provide a bed for patients , and Chief Executive sign off is required for cancer cancellations. It is recognised that cancellations of urgent and cancer procedures are extremely regrettable and are avoided wherever possible. UHL are undertaking an internal review of the cancer cancellations in January.

The chart below shows all UHL cancellations over the past year, which includes elective as well as non-elective cancellations. The chart shows cancellations within a week of surgery as well as on the day cancellations. It can be seen that the numbers of advance cancellations this year have been significantly higher this January than the previous ones, largely in response to the NHS England directive. On the day cancellations have not been significantly higher this winter,



10.13 Winter funding notification was received on the 18th December, which allowed very little time to implement schemes before the Christmas holiday. However, despite this, some schemes were mobilised in the run up to Christmas, such as additional capacity in the Urgent Home Visiting Service. The AEDB has reviewed all 13 winter schemes, and where recruitment difficulties have made the original scheme impossible to mobilise in a timely way, the AEDB has agreed modifications to schemes, aiming to achieve the maximum impact on reducing system pressures. The UEC team are monitoring the implementation progress on schemes fortnightly, and all schemes are now on track.

Flu

11.0 Nationally and locally, flu cases have been higher this winter than they have been for a number of years. This has had an effect on the health and care system, affecting both staff and patients. However, there has been no epidemic level of infections to date and transmission rates appear to have peaked by the end of January.

11.1 During the second week of January there was an increase in flu cases across the Country including LLR. Flu B was the dominant strain at this point and this was not covered by the triple vaccine which was being administered by GPs and all pharmacies other than Boots. At this point Flu B in the elderly was presenting with minimal symptoms which made it difficult to spot. The CCG and PHE put in place anti-viral procedures should this turn into a pandemic situation. UHL began screening patients for flu from 10 January which in turn showed higher cases of flu within the Trust. However, inpatient flu cases did not impact on bed availability or ward closures.

11.2 Further communications were sent out to the public and care homes stressing the need to be vaccinated. LPT and UHL also ran further vaccination clinics for staff that had been missed and UHL offered the quadrivalent vaccine to staff in high risk areas (ITU, Oncology etc). Social Services also encouraged any staff that had not yet been

vaccinated to take up the offer of the flu vouchers. NHS staff vaccination rates have been variable, 71.99% in UHL and 51.5% in LPT (below the target).

Next Steps – Winter review

12.0 An initial analysis of winter has been carried out, as reflected in this report. A further review of the LLR activity and performance data will be undertaken in early March, covering the period November – February. This will inform a ‘winter de-brief’ workshop, led by the AEDB Resilience sub-group, to identify key lessons learnt.

12.1 Winter planning for 2018/2019 will begin in March, earlier than in previous years, in response to national planning guidance. The winter plan for 2018/2019 will need to clearly set out demand and capacity modelling to ensure an improvement in performance compared to 2017/2018.

A number of actions or system changes to improve winter 2018/19 have already been identified, including:

- Review of thresholds for admission to community hospitals
- Review of community hospital bed capacity
- EMAS ‘non-urgent’ dedicated crews to reduce late pm ambulance presentations
- Improvements to UHL and LPT LOS to create capacity
- Improvements to the transport booking and interface process at UHL
- Further multi-agency escalation training
- Review of UHL internal escalation protocols and plans
- Improved ‘discharge to assess’ pathways to be put in place before winter
- Risk sharing arrangements between CCGs and Local Authorities to fund discharge to assess pathways
- Redesign of the ICS to develop integrated home based rapid response/re-ablement support

Resource Implications

13.0 None other than detailed in the winter monies section 7

Conclusions

14. Winter performance has been challenging in LLR, particularly in relation to ED waiting times at LRI. Overall, the urgent care system has seen more patients outside of hospital this year than in previous years. Some improvements have been seen, such as improved ambulance handover times.

High medical bed occupancy and increased delayed discharges have contributed to the challenging position, although action taken to reduce delays has started to take effect over January.

Background papers:

LLR Winter plan (previously shared with HWB) Annexe 1

Officer to Contact

Tamsin Hooton, Director of Urgent Care Performance

Telephone: 01509 567729

Email: Tamsin.hooton@westleicestershireccg.nhs.uk

List of Appendices

Appendix 1 – summary of system activity and performance over Christmas

Annexe 1 – LLR Winter Plan

Urgent Care System Heat Map - Period 23-Dec-17 to 07-Jan-17

Column Labels																	
System.	23-Dec-17	24-Dec-17	25-Dec-17	26-Dec-17	27-Dec-17	28-Dec-17	29-Dec-17	30-Dec-17	31-Dec-17	01-Jan-18	02-Jan-18	03-Jan-18	04-Jan-18	05-Jan-18	06-Jan-18	07-Jan-18	Key / Target
NUMBER OF CALLS OFFERED NHS 111.	1622	1526	925	1509	777	738	872	1791	1621	1421	797	744	787	876	1319	0	> 1155
NHS 111 ACTUAL % ANSWERED.	83.8%	81.4%	89.0%	91.9%	90.9%	91.1%	89.4%	76.3%	77.2%	90.4%	83.7%	92.5%	90.9%	89.6%	91.7%	0.0%	< 90%
111 No. OF ED DISPOSITIONS.	52	52	34	53	40	47	51	63	57	55	50	48	54	42	0		> 12%
Sum of 111 No. OF ED DISPOSITIONS %	3.8%	4.2%	4.1%	3.8%	5.7%	7.0%	6.5%	4.6%	4.6%	4.3%	7.5%	7.0%	7.6%	5.4%	0.0%		> 12%
111 No. OF AMBULANCE DISPATCH CALLS.	115	123	102	137	83	81	104	132	108	146	87	97	81	76	85		> = 80
Sum of 111 No. OF AMBULANCE DISPATCH CALLS %	8.5%	9.9%	12.4%	9.9%	11.8%	12.1%	13.3%	9.7%	8.6%	11.4%	13.0%	14.1%	11.3%	9.7%	7.0%		> 12%
Total EMAS (LRI) Handovers	175	196	160	191	205	195	205	198	185	201	186	191	197	204	189	188	> 192
EMAS (LRI) Handovers >15 mins.	96	134	90	118	154	142	142	146	140	152	143	122	136	119	129	116	
EMAS (LRI) % Handovers >15 mins.	54.9%	68.4%	56.3%	61.8%	75.1%	72.8%	69.3%	73.7%	75.7%	75.6%	76.9%	63.9%	69.0%	58.3%	68.3%	61.7%	
SYSTEM OPEL.	2	2	0	2	2	3	3	3	3	3	3	3	3	3	3	3	> 15 Minutes
ED Attends (total).	667	661	449	668	727	683	665	689	576	654	683	599	668	662	594	577	3 & 4
ED PERFORMANCE.	75.4%	70.3%	73.5%	74.3%	63.3%	65.7%	67.7%	59.8%	64.9%	66.2%	62.4%	67.9%	70.4%	77.8%	73.6%	82.8%	>719
East (VoCare) Type 3 Total.	202	194	68	177	72	88	94	201	194	168	100	102	100	102	220	149	< = 85%
West (DHU) Type 3 Total.	176	173	103	144	113	114	127	188	160	171	136	128	123	102	139	122	> = 139
Type 3 Combined % < 4Hrs.	95.0%	94.3%	98.8%	89.7%	94.6%	97.0%	99.5%	93.1%	96.3%	96.8%	100.0%	100.0%	93.7%	93.6%	98.1%	97.8%	> = 139
CNH.	730	582	358	587	150	170	199	637	678	480	143	136	152	202	603	522	< = 85%
HVS.	178	187	107	173	103	113	139	181	214	149	125	108	112	120	187	181	> = 396
LUCC (walk in).	176	173	103	144	113	114	127	188	160	171	136	128	123	102	139	122	> = 149
M VAS.	116	190	86	102	62	75	64	212	223	134	65	85	50	81	167	162	> = 139
UHL OCCUPANCY RATE.					86.9%	89.9%	87.7%	86.5%	89.5%	93.8%	95.6%	94.7%	92.1%	92.5%	92.2%	90.6%	> = 117
ICS Occupancy.					76.0%	78.0%	79.0%				84.0%	87.0%	93.0%	92.0%			> = 92%
																	Average
																	10% less
																	>10% under

Notes & Assumptions

NUMBER OF CALLS OFFERED NHS 111.	No plans for Dispatch	Calls - Average calls for the Dec/Jan two week period used as target - key used based on this value - Red >Average No. of calls, Amber between Average & 10% less, Green 10% under - resource should be available
NHS 111 ACTUAL % ANSWERED.		
111 No. OF ED DISPOSITIONS.	Target 8% of Total Dispositions/Calls	
Sum of 111 No. OF ED DISPOSITIONS % (Target 8% of Total Dispositions/Calls)	Target 8% of Total Dispositions/Calls	
111 No. OF AMBULANCE DISPATCH CALLS.	No plans for Dispatch	Calls - Average attends for the Dec/Jan two week period used as target - key used based on this value - Red >Average No. of attends, Amber between Average & 10% less, Green 10% under - resource should be available
Sum of 111 No. OF AMBULANCE DISPATCH CALLS % (Target 9% of Total Dispositions/Calls)	Target 9% of Total Dispositions/Calls	
Total EMAS (LRI) Handovers	Reporting the % of Handovers >15 mins - All Red(?)	
EMAS (LRI) Handovers >15 mins.	Handovers for >15 mins - will always be Red(?) could use a percentage / range to RAG rate(?)	
EMAS (LRI) % Handovers >15 mins.	Handovers for >15 mins - will always be Red(?) could use a percentage / range to RAG rate(?)	
SYSTEM OPEL.	OPEL Escalation levels	
ED Attends (total).	Average Daily attends for Dec'16 of 654 + 10% tolerance used as the target - key used based on this value - Red >Average No. of attends, Amber between Average & 10% less, Green 10% under - resource should be available	
ED PERFORMANCE.	Target > = 95%	
East (VoCare) Type 3 Total.	No plans for Attends -	Average attends for the Dec/Jan two week period used as target - key used based on this value - Red >Average No. of attends, Amber between Average & 10% less, Green 10% under - resource should be available
West (DHU) Type 3 Total.	No plans for Attends -	Average attends for the Dec/Jan two week period used as target - key used based on this value - Red >Average No. of attends, Amber between Average & 10% less, Green 10% under - resource should be available
Type 3 Combined % < 4Hrs.	Target > = 95%	
CNH.	No plans for Attends -	Average attends for the Dec/Jan two week period used as target - key used based on this value - Red >Average No. of attends, Amber between Average & 10% less, Green 10% under - resource should be available
HVS.	No plans for Attends -	Average attends for the Dec/Jan two week period used as target - key used based on this value - Red >Average No. of attends, Amber between Average & 10% less, Green 10% under - resource should be available
LUCC (walk in).	No plans for Attends -	Average attends for the Dec/Jan two week period used as target - key used based on this value - Red >Average No. of attends, Amber between Average & 10% less, Green 10% under - resource should be available
M VAS.	No plans for Attends -	Average attends for the Dec/Jan two week period used as target - key used based on this value - Red >Average No. of attends, Amber between Average & 10% less, Green 10% under - resource should be available
UHL OCCUPANCY RATE.	85% occupancy used as benchmark - > 92% = risk	
ICS Occupancy.	85% occupancy used as benchmark - > 92% = risk	

LEICESTER, LEICESTERSHIRE & RUTLAND HEALTH AND SOCIAL CARE ECONOMY

WINTER PLAN

2017 -2018

Document Control	
Document Name	LLR Winter Plan 2017-18
Purpose of Document	This document sets out the steps that are being undertaken across the LLR health and social care community to ensure that appropriate arrangements are in place to provide high quality and responsive services throughout the winter period.
Document Version Number	V4 September 2017
Document Status	Adopted
Document Owner	A&E Delivery Board
Document Author	Jennie Smith – Head of Operational Resilience and Emergency Planning
Last Updated Date	8 th September 2017
Contributors	University Hospitals of Leicester Leicestershire Partnership Trust ELR Urgent Care Centres Loughborough Urgent Care Centre TASL Patient Transport Social Care City Social Care County EMAS East Leicestershire and Rutland CCG West Leicestershire CCG Leicester City CCG DHU – 24/7 Home Visiting and Clinical Navigation NHS 111

LLR Winter Plan 2017/2018

Contents:

1. Introduction
2. 2017/2018 LLR Winter Planning
 - 2.1 Governance and Assurance
 - 2.2 2016/2017 Lessons Learnt and key actions taken to support winter 2017/2018
3. LLR System Wide Winter Plan
 - 3.1 In-flow (including Primary Care)
 - 3.2 Flow
 - 3.3 Discharge
4. Whole System Resilience/ Escalation Arrangements
 - 4.1 Operational Pressures Escalation Levels (OPEL) Framework
 - 4.2 On- Call Arrangements
5. Communications Plan
6. Flu Planning
7. LLR UEC Service Provider Winter Plans:
 - University Hospitals of Leicester NHS Trust
 - Leicestershire Partnership Trust
 - ELR Urgent Care Centre
 - Loughborough Urgent Care Centre
 - TASL PTS
 - Social Care City
 - Social Care County
 - EMAS
 - CCG – Commissioners
 - DHU – 24/7 Home Visiting and Clinical Navigation
 - NHS111
8. Appendices:
 - Appendix A – Winter 2016/2017 Review
 - Appendix B – Care Home Benchmarking Appendix
 - Appendix C – Care Home Support Action Plan
 - Appendix D – LPT Red to Green Action Plan
 - Appendix E – Tool High Impact Changes for Managing Transfers of Care
 - Appendix F – DTOC Action Plan
 - Appendix G – LLR Winter Communication Plan

1. Introduction:

This document provides planning and readiness information to support all aspects of Leicester, Leicestershire and Rutland (LLR) Service Delivery throughout the winter period 2017/18.

Winter is defined in this document as running from the beginning of October 2017 through to the end of April 2018, to include the management of surge during the Easter period.

The winter period is recognised as a time when significant additional demand is placed upon LLR Unscheduled Care Services. This relates primarily to higher prevalence of winter illness and an increase in the ageing population with co-morbidities resulting in complex care needs.

LLR urgent and emergency care economy is currently seeing increased levels of demand. Although the number of emergency attendances has remained stable (YTD against 2016), at approximately 113,500, there has been a rise of 6% (YTD against activity over the same time period in 2017) in emergency flow, specifically to short stay and through GPAU. The system experiences peaks of demand which can be fairly predictable, associated with Mondays and the days immediately after bank holidays.

2. LLR 2017/2018 Winter Planning:

2.1 Governance and Assurance

LLR A and E Delivery Board has overall responsibility for leading on surge and resilience plans , and proactively planning for the increase in patient demand throughout the winter period.

To effectively manage system pressures, the A and E Delivery Board (AEDB) acknowledge that performance is dependent on maintaining strong multi- agency collaboration; and particularly improving acute patient flow. The Board currently manage a work plan consisting of four key areas:-

- Supporting the current structure and performance of LLR urgent and emergency care economy;
- Reforming and redesigning the wider Urgent and Emergency care system
- Delivering the nationally mandated best practice guidance - the delivery of the 95% four hour wait emergency standard and the 75% standard for the 8 minute emergency ambulance response.
- Leading on assurance and oversight of plans in preparation for the winter period.

To ensure alignment to national winter planning protocols, the AEDB and A&E Improvement Group (AEIG) have developed an improvement plan and High Impact Action plan, structured around three main themes of in-flow, flow and discharge work streams. This approach incorporates:

- Demand and Capacity Plans

- Front Door Processes and Primary Care Streaming
- Flow through the Urgent and Emergency care pathway
- Effective discharge processes
- Planning for peaks in demand
- Ensuring the adoption of best practice.

As in previous years, LLR Urgent Care system, supported by the Urgent and Emergency Care Team hosted by WLCCG has taken a collaborative approach to planning for winter. The Operational Winter Planning Group, reporting into the AEDB, has representation from all relevant service providers integral to all stages of planning. This ensures that comprehensive preparation for winter challenges are in place. Historical data, and lessons learned from previous years, are also utilised to ensure robust planning for the winter period.

2.2 2016/2017 Lessons learnt and key actions taken to support winter 2017/2018

Key risks identified for the LLR System from winter 2016/2017:

In March 2017 the AEDB undertook a review of winter 2016/2017 which identified a number of key issues and made some recommendations for winter planning 2017/2018 (Appendix A). The following section details the key learning, the known risks in the system and the actions we have taken to address those areas of risk for the coming winter.

Inaccurate demand and capacity planning in some providers:

A contributing factor of this inaccuracy was the unusual way that Christmas and the bank holidays fell. In particular, DHU (NHS111) did not have historical data for a Christmas falling on a Sunday followed by two bank holidays.

Action: Capacity plans for winter 2017/2018 will be adjusted using this learning. In particular we are mindful that there will again be a four day 'long weekend' when core general practice capacity is not operational and patients requiring immediate treatment will need to be directed to access the alternative services that exist across LLR. We are undertaking a system wide analysis of demand and capacity, including looking at trends from last winter, and this will be used to inform operational capacity planning for winter and the Christmas and New Year period particularly. We have strengthened community based urgent care services in 2017/2018 (more details given in inflow section) which will help to mitigate the expected surge of patients after the Christmas and NY break.

Poor capacity and flow in ED leading to very long ambulance handovers:

This issue resulted in poor ambulance response times and raised risk in the community. Long handover times were a feature of the LLR system in 2016/2017 and were one of our key performance risks.

Action: The opening of the new LRI ED in April has led to a very significant improvement in ambulance handover times, as a result of increased major's capacity and improved handover processes. In July 2017, average pre-clinical handover times at LRI stood at 18m 11 sec and, total lost hours 438. This compares to 29:43 in July 2016 and 32:18 pre-clinical handover in Jan 2017, with 1381 lost hours in July 2016 and 1617 lost hours in Jan 2017.

The system is therefore at lower risk of ambulance handover delays compared to last winter. Where these do occur at times of pressure, there is a SOP for a cohort area in the LRI ED which has been signed off by both EMAS and UHL.

High occupancy rates/poor flow and medical capacity:

Actions:

UHL have increased medical capacity by 38 beds compared to 2016/2017 plan. Flow and discharge planning processes have been improved across both acute and community providers as a result of closer system working; and the implementation of SAFER and R2 has been rolled out across medical wards and is much more embedded than in winter 2016, where there was limited implementation, which was halted over the Christmas and New Year period.

DTOCs at UHL are historically low at around 2% of bed days, and improved system oversight of discharge processes has seen external delays drop since the processes were introduced in February 2017. More details of our plans to support flow and hospital bed capacity are contained in the section on DTOCs and in UHL's provider plan.

We have reviewed our system surge and escalation protocols, including how we escalate actions in response to raised occupancy rates in hospitals. A particular issue identified by our review of winter and the work of the AEIG, has been the need to improve discharge processes from UHL to LPT and a workshop was held on this over the summer, leading to revisions to operational processes and the escalation protocols. This should result in more balanced actions to support flow in both UHL and LPT to avoid bottlenecks in community hospitals and support more consistent discharges from UHL to community hospitals.

Aligned to this, we have undertaken **Director on Call training for CCGs**, and plan to undertake further joint training with LPT and UHL DoC teams to improve understanding of the surge and escalation plan and improve organisational response to pre-empt increasing escalation levels by ensuring that the agreed actions are taken forward at relevant points.

Insufficient communications to patients:

Specifically in relation to when GP practices are open, and communications stressing the many alternative urgent care services that are open in LLR out of hours, routes to get repeat prescriptions etc.

Action: This is addressed in our communications plan, (outlined in section 3). There is good availability of extended primary care and Urgent Care Centre provision in LLR so alternatives to GP practices and ED are open 24/7, 7 days a week. We have strengthened clinical navigation and the ability to directly book patients into alternatives to ED from NHS 111 and clinical navigation and the LRI front door compared to last winter. This will enable providers to direct patients to an appropriate urgent care service.

Lack of real time information to support system response to surges:

Action: As part of our Vanguard work, we have developed a predictive modelling tool which takes real time information from UHL and EMAS and uses it to predict forward weekly demand patterns

which will be used to plan organisational capacity and response. We expect this to be in operational use from November 2017, in time for the peak winter period.

System wide capacity and demand modelling has commenced to identify specific surge points and bottle necks, relating to individual service providers. It has been agreed by all service providers that undertaking analysis of organisational activity over the last 3 years, (focussed specifically on the winter period), will identify trends in relation to system capacity pinch points, enabling pre-emptive alignment and wider system support by all system partners. The outcomes of the system capacity and demand modelling, will enable each organisation to submit detailed plans for the festive period, outlining the service and resources gaps seen in previous years and the mitigating actions being taken to avoid duplication. The expected completion date to ensure accurate system modelling is the end of September 2017.

There is an expectation that organisations plan to increase staffing levels and discharge activity both before and immediately after the bank holidays, to provide assurance that predicted surges in activity will be effectively managed, without putting additional pressure on the system.

3. LLR System Wide Winter Plan

The following section describes out processes for managing pressures in the urgent care system for winter 2017/2018 and gives some detail on specific initiatives and services that are in place. It concentrates on some of the key themes in the winter planning guidance, and supplements the detailed provider plans by giving a system overview of the main elements of our plan.

3.1 Inflow (including primary care)

Clinical Navigation

One of the key differences in the LLR system in comparison to last winter is the embedding of The Clinical Navigation Hub forms which is an integral part of the LLR Integrated Urgent Care Model. The hub sits alongside a number of 24/7 urgent care services across LLR including LLR Home visiting service, LRI front door assessment and streaming service and NHS 111.

The hub has a single entry point via NHS 111 from which there is access to 24/7 fully integrated urgent care services in which organisations collaborate to deliver high quality, clinical assessment, health advice, sign-posting and multi-disciplinary care and treatment.

The LLR Clinical Navigation Hub offers those who need it access to a wide range of advice, assessment, care, signposting and information and support from a range of clinicians, both experienced generalists and specialists either via the telephone or referrals to face to face services, for example the Home Visiting Service, primary care hubs and UCCs.

Clinical advice is also provided to staff within care homes who have direct access to the Hub – during the Out of Hours period & where appropriate, onward referral to the Home Visiting Service.

Since the integration of the clinical navigation service in directing patients to the most appropriate care settings, positive outcomes have been seen in the reduction in ambulance demand and ED referrals (80% of green ambulance dispatches are avoided and up to 70% of ED dispositions are

directed to alternative services). This has contributed to ED attendances being down 2.2% year on year at August 17 compared to the previous year.

LRI Front Door and integrated primary care service

Alongside the implementation of the clinical navigation hub, a primary care streaming model is in place at LRI ED to support in the appropriate signposting of patients to the right pathway within the integrated ED.

The model utilises a single front door approach, which is delivered by an integrated workforce made up of nursing staff, ANP's, ENP's and GP's supported by medical staff, which incorporates previous UCC capacity and the OOH overnight base, to provide 24/7 access to urgent primary care at the LRI site.

One of the key elements of the model is its capability of redirecting patients to primary care. The front door has the ability to directly book patients into City Hubs and UCCs.

Primary Care:

Primary care capacity includes core general practice services, GP Out of Hours provision and extended primary care as well as pharmacy and dental services. Extended primary care in LLR is delivered through a combination of practice based extended hours arrangements, and activity provided through primary care hubs and UCCs in each of the three CCGs. LLR has good coverage of extended and enhanced primary care, and the changes to urgent care put in place in 2016/2017 and from April 2017 as part of our re-procurement of integrated primary and community urgent care have strengthened capacity to meet patients' needs both in and out of hours. Details of individual services and their winter plans are given in the organisational appendices for each of the LLR CCGs and Derbyshire Health United services. This section summarises some of the key services in place and actions taken to ensure there is sufficient access to primary care across LLR through the winter period.

The key services in place in LLR which supplement core general practice to provide a 24/7 model of primary care include:

- Loughborough Urgent Care Centre (24/7 walk in access plus bookable appointments, including day time urgent primary care and overnight OOH services).
- Primary care hubs in WLCCG at Hinckley and Coalville (bookable through NHS 111 and CNH)
- Leicester City CCG Primary Care Hubs (Westcotes, Brandon St, Saffron, Merlyn Vaz) delivering walk in and booked appointments, 12 hours a day 7 days a week
- ELR CCG UCC capacity including: Oadby Walk in Centre 12 hours a day 7 days a week, bookable from NHS111 and clinical navigation, and 3 additional sites providing daytime minor injury services, evening and weekend urgent care provision integrated with GP OOH services (at Market Harborough, Oakham and Melton Mowbray)
- 24/7 Urgent Home Visiting Service providing a rapid home based response to patients who require medical review and care at home. The service is accessed via NHS 111 or directly by care homes and has a strong focus on admission avoidance. From August 2017 this service

also incorporates a night time nursing service, therefore providing a fully integrated GP and nursing service across LLR.

- Out of Hours service based at LRI ED, operating 7 days a week.

There is therefore really good availability of additional services which provide additional access to same day urgent and primary care across LLR. All the a

Additional capacity in 2017/2018

Primary and community urgent care services in LLR have been strengthened since winter 2017/2018 in the following ways:

An additional 13,500 appointments in WLCCG UCCs (4,400 of which are in the new sites of Coalville and Hinckley). These appointments are also used by patients from ELRCCG and LCCG when necessary. In addition to this, from October there will be a 'test bed' of general practice in hours referral to LUCC to provide additional primary care access for Charnwood patients, using existing commissioned activity within LUCC.

643 additional appointments in ELR general practices over 8 weeks of the winter period

City Hub Challenge Fund capacity has now been consolidated into 4 hubs, including a recommissioned service at Merlyn Vaz

Increased coverage of 24/7 visiting, particularly to provide increased capacity and cover for all ELRCCG patients. Clinical staffing will be increased over key days over winter, based on modelling of activity peaks in 2016/2017 (i.e. the long Christmas weekend and immediately after the NY).

DHU intend to increase GP coverage at the LRI ED OOH service and on selected days over the Christmas and New Year period and weekends in response to analysis of activity in 2016/2017.

If additional financial resources are received by the CCGs this will be channelled through hubs and UCC services as well as to those practices which are able to offer additional appointments over the winter period.

Plans are being put in place to ensure that we pre-empt anticipated surges in demand over weekends and bank holidays over the winter period, by working pro-actively with patients identified as being at higher risk. These patients will be given enhanced access to booked appointments at hubs and UCCs in each of the LLR CCGs and given direct access to the Home Visiting service. This scheme has developed out of a 'passport' scheme put in place in WLCC in previous winters which was effective in ensuring that patients at highest risk of admission or ED attendance are directed into alternative urgent care services.

Pharmacy

We have implemented the NUMSAS pharmacy service across LLR, accessible via NHS 111

There is an emergency repeat prescription service available from community pharmacies which prevent the need for patients to access OOH or attend ED for repeat prescriptions. NHS England has

the information on which practices operate extended hours and we expect that community pharmacies will be open to cover those hours.

Core General Practice

The three CCGs will write to GP practices to stressing contractual expectations and asking all practices to confirm their opening hours and capacity. This will enable the CCGs to ensure that access to core general practice does not dip over the holiday season.

WLCCG requests that practices which are closed on Thursday 21st December do not close.

The communications plan (see later in this document) will stress messages that general practice is open as normal, and that there are evening and weekend services available both in General practice and in hubs.

If there is additional funding we would seek to commission practices to deliver additional capacity. Increasingly, this would be done on a hub basis or via UCCs, and patients would be booked into those services by their registered practice or by NHS111.

Core general practice appointments will be directly bookable by NHS111 and clinical navigation in LLR from October, following pilots within the Vanguard and we are rolling this out over the three CCGs between October and December.

Extended Hours :

The CCGs are working with practices to make sure that the DES activity for the bank holiday and weekend days are redistributed, and where access is on 24th December practices are expected to deliver that access, as per the DES.

The changes to the EOH DES from October are still to be worked through. This could mean that some practices that are currently providing EOH via the DES will no longer be able to if they have in hours closures during the week. As this relates to registered lists the impact will be small, however,

2017/2018 Admission Avoidance Schemes:

As a part of the urgent care service improvement programme, system wide initiatives have been devised to support admission avoidance into secondary care services.

We commissioned a new 24/7 visiting service from April 2017 which incorporates daytime acute visiting and support to care homes, overnight home visiting and night nursing. The integrated service has a strong focus on avoiding unnecessary admissions and since April we have seen evidence of impact including a drop in care home admissions, particularly in ELR, where there was previously no service. As the service works 24/7 it will enable continuity of admission avoidance over the Xmas and NY bank holidays.

Other initiatives in the AEDB plan include:

PHEM GEM – training on management of frailty supporting EMAS crews and care home staff to keep patients at home or in their normal place of residence

Consultant Connect – telephone based support to primary care to prevent unnecessary admissions. We will strengthen this service by December 2017 to put in place dedicated clinical time to respond to calls, and open up the service to EMAS crews

EMAS are providing a see and treat service in Leicester town centre, to deal with individuals incurring injuries over the Christmas and bank holiday periods, specifically focused to avoid ED attendances. UHL are creating a number of admission avoidance initiatives to support the system over the winter period but also a long term solutions to support system escalation. The plans include: Increased early frailty unit's capacity and frailty at front door, specialty presence within the emergency department including therapies, increased utilisation of GPs within primary care and assessment zones and the increased utilisation of hot clinics. The Integrated Discharge Team described elsewhere will have an ED facing role to turn people around without full admission.

Social care services have planned increased staffing levels in ED to avoid admission where needs are social care, not clinical. Crisis Response Service will aim to avoid admissions by providing urgent support to people in the community and CRS/HART will take referrals and broker support until 10pm, including weekends and bank holidays.

Additional accommodation in Community services is coming online in October to help with patient flow to enable capacity throughout the urgent care system.

Care Home Support:

LLR recently completed the self-assessment against the Enhanced Health in Care Homes Benchmarking Tool (Appendix B), from which we have identified our areas of priority that are reflected within the action plan attached (Appendix C).

The implementation of the 'Red Bag' scheme across LLR care homes has been identified as a priority within the LLR Care Home Sub-Group. Currently the work is being scoped with learning from the Vanguard Site in Sutton and funding from LLR STP has been identified to support acceleration of the work through the purchase of the red bag, with the view to implementing scheme within the year.

Scoping work for the utilisation of a telehealth solution, to support the reduction in 999 calls and Ambulance Conveyance to ED from Care Homes across LLR, is to commence within September to consider and develop a local tailored model of delivery, with a view to pilot the scheme once a viable solution has been identified.

3.2 Flow

Improving the access to emergency care is a priority within the UHL Trusts 2017/18 Quality Commitment via the 'Organisation of Care Programme'. At a high level the plan to address the gap includes:

Increase (in the short term) the bed base - New actions to increase our bed base at the LRI and GGH
Improved internal efficiency - Delivery of all pre-existing actions including, SAFER flow, red to green & GPAU expansion

A new model of step down care - UHL working more effectively downstream to care for step down patients in a non-acute setting

A new pathway for frail complex patients

This programme aims to take a more rigorous approach to improve access to emergency care for patients via 3 work streams:

- Emergency Department & Acute Medicine
- Medical and Cardio-respiratory beds
- Interface & Integration

The plans underpinning these improvements have been split into 3 work streams:

Efficient & Effective Emergency Department:

Objective – Reduce time to see a decision maker and time to decision.

The key action across the whole of the work stream is providing a solution for improving evening and overnight resilience of the demand and capacity for senior decision makers, largely senior medical staff. This is a key element of the 'September Surge' (1st to 15th September) where there is a high fill percentage of uptake for senior shifts overnight. This is expected to keep the waiting time to be seen by a decision maker lower in the evening and night.

A new standard operating procedure for Majors has now been developed by the ED teams and approved by Emergency Department Group, this describes what patients can expect at each stage of the 4 hour wait within the department. This SOP will now be monitored to assess our progress against its implementation.

The command structure has now been revised as part of the 'September surge' with changes in the meeting times and reporting of actions, along with a strengthening of the 'Silver' tier of the rota with more senior management support. This has also included basing a Duty Manager within the ED. It is forecast this will lead to more robust whole hospitals leadership and problem solving during the day.

Additional portering has been introduced to the ED for the 'September Surge' to provide logistics support to the ED clinical teams.

An Efficient and Effective Bed Capacity:

Objective - Mitigate the 105 bed capacity gap for 17/18 and Increase the % of patients in majors who move to a bed within 120 minutes to 95% from 78%.

The Trust commenced the year with a bed demand and capacity gap of 105 beds and had a plan to mitigate this by the opening of 55 extra beds and improving the efficiency of the specifically the medical and cardio-respiratory bed bases by c. 50 beds mainly through the rigorous roll out of 'Red to Green'. Figure 5 below shows the positive progress being made on reducing the gap. During July, an unmitigated gap would have been 110 beds and the Trust planned to have a gap of 53 beds. The actual position in July was a gap of 30 beds.

This performance better than plan was mainly associated with bed efficiency of 23 beds from both Medicine and Cardio-respiratory (which is also demonstrated on Figure 2 showing the reduction in the average length of stay in medicine). Unfortunately, some of this efficiency is being used for the

8% (662 patients) increase in emergency admissions above plan being seen by the end of July for ESM.

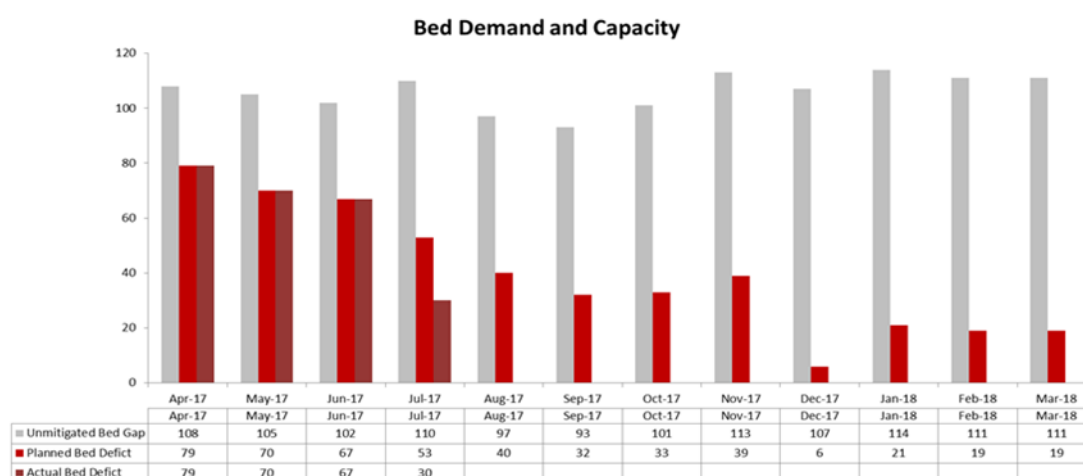


Figure 1 – unmitigated, planned and actual bed demand and capacity gap

Work on the physical bed expansion is progressing positively, with 36 beds open at LRI Medicine pathway.

Beds 'taskforces' are now in place for both LRI Medicine (chaired by the Chief Operating Officer) and GH Cardio-Respiratory (led by the Clinical Director for RRCV) to drive the improvement in 'Red to Green' They continue to focus on 3 key areas; firstly ward team reviews on their progress against the metrics, secondly ensuring the delivery of reductions in turnaround times against the top 3 delays, and finally delivering intensive support to wards that are not making required progress in this area.

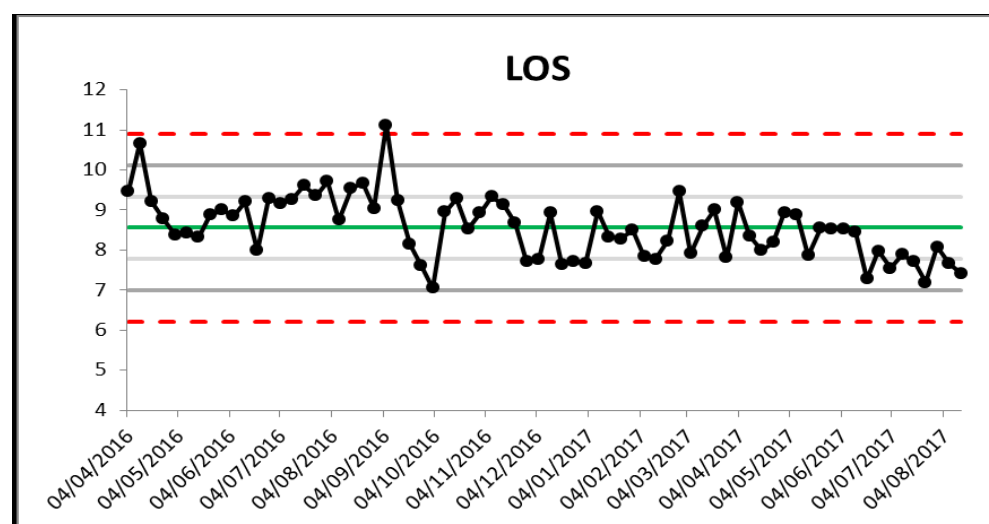


Figure 2. Average Length of stay in Medicine base wards LRI

This is having some success in reducing the length of stay for patients within medicine (as shown in figure 2) and it is now around 1 day lower than in corresponding period in 2016, but there is still work to do to ensure patients are discharged earlier in the day, as well as increasing the discharges at the weekend. These are two current focusses of Red to Green for medicine at LRI.

A plan has been developed by the Head of Service for imaging to delivery Keogh standard turnaround times (a maximum of 1 day) and a new TTO process is being trialled as part of the 'September Surge' that is likely to support the earlier prescribing and therefore production of those TTO's.

Within Cardio-respiratory, the Glenfield is much earlier in its journey on Red to Green having launched in July, but there remains a great deal of opportunity for improved efficiency which is being progressed with the teams there over the next 8 weeks.

In addition, UHL are mobilising resources to support the increasing demand going into winter. This includes:

- Additional paediatric medical shift (ST4 or above) between 1800 to 0300hrs
- Additional adult medical shift (ST4 or above) between 1800hrs to 0600hrs
- All senior nursing teams matron & above are booked into clinical sessions to support the teams
- Duty management team has been doubled up to enable one DM to be based in ED and the other to support the wards.
- Additional bed coordinator shifts have been requested as overtime.
- Requested 1 additional ambulance crew per day between 1600hrs to 12midnight via CCG
- GPAU staffed until midnight with senior consultant presence
- Additional surgical registrar on both sites 0800-2000 hours

External Interface and Integration Medical Step down Project:

Objective - To create a Medical Step down facility to support the mitigation of the current imbalance of demand and capacity gap.

The proposal of this scheme is to define the cohort and number of patients who would be applicable to use the medical step-down facility and then develop the clinical model and staffing model to support these patients outside of a UHL acute setting. An options appraisal will confirm the best location for the new facility and finally a business case for any new facility and deliver the new facility by November 2017. This scheme also has a key role in the system wide STP and hence is also reporting into the 'Home First Board' as one of the work streams of the STP ensuring that is in line with the overall approach to home first for patients.

As the Medical Step Down Project seeks to close the gap between demand and capacity (amongst other things), there is a key interdependency with the overall reconfiguration projects.

This project seeks to improve flow throughout the hospital which benefits all reconfiguration projects. This project will support the newly opened Emergency Department by helping to ensure performance does not decline over the winter.

SAFER and Red to Green Alignment

UHL:

A work stream to ensure alignment to the Red to Green principles is in place. Its remit is to:

- Review of current implementation on medical wards at LRI for learning with reference to a re-launch on these wards
- Refocus the implementation of Red to Green and SAFER as a priority on the Medicine wards at LRI relentlessly tackling the top 3 delays (including the implementation of Inter professional standards)
- Rigorous implementation of SAFER/Red to Green at Glenfield Cardiology & Respiratory wards
- TTO project started with an aim of achieving standards relating to TTO writing 'day before' and discharges before noon
- Review of AMU performance against SAM guidelines ensuring demand & capacity are optimised.

The project began in June 2017 and is on course to be fully implemented by the end of December 2017.

LPT:

Although the SAFER Patient Flow Bundle was designed to support acute adult inpatient wards, the principles outlined have been adapted by Leicester Partnership Trust (LPT) Community Hospital wards to ensure a consistent, all system approach to inpatient bed management across Leicester, Leicestershire and Rutland (LLR)

The implementation of the Red to Green approach commenced in March 2017 and the aim is for the roll out to be completed by the end of December 2017. The full roll out plan is attached as Appendix D.

Monitoring and managing 'stranded patients' – MADE

We plan to undertake a Multi-Agency Discharge Event (MADE) in preparation for Christmas, to create improved discharge flow in the second half of December and again in January, to maximise medical capacity over Christmas and to assist with coping with the surge in admissions in early January. One of the aims is to get as many patients into packages of care before the Xmas break as possible, as care agency response has been known to slow down over the holiday weeks. This will build on the process we have already put in place for the weekly escalation of discharge delays, and bring together senior leads from each agency to activity plan for escalated discharge activity in anticipation of and response to the peak period of admissions after the New Year.

The continuous support of all services throughout the winter period includes the ability to utilise flex bed capacity effectively. Flexible bed options are available within UHL to manage increased demand, which is in turn supported LPT community based services, increasing their flex capacity to divert activity into lower settings of care. Where appropriate patients are discharged into interim beds whilst awaiting the procurement of appropriate services to support discharge. In addition there are flexible bed and service capacity available within Adult mental health and Learning disability services for both step up (admission avoidance) and step down purposes, for utilisation in times of significant pressure.

3.3 Discharge

Discharge processes and reducing delayed transfers of care

The Eight High Impact Changes for Managing Transfers of Care tool was implemented across LLR in September 2016, with a system wide review and update in May 2017. Furthermore, many service and system leaders attended the locally arranged regional event on 5th July where speakers from across England came to share service developments. (Document attached as appendix E).

Health and Social Care discharge capacity

A bed based patient step down audit was completed across UHL and LPT beds in July 2017. The review demonstrates where additional capacity may be required across the discharging services and where existing beds could be used differently. Plans are being discussed to create short term actions for Winter (e.g. review criteria for access into community services such as OPAT and ICS) and medium to longer term plans for the rest of the financial year (e.g. procurement for an improved discharge to assess service). The review will provide data and insights for the following pieces of work:

- ICS review
- Community Hospital bed utilisation plans
- STP bed based work streams
- Pathway 3 – Discharge to assess plans

An Integrated Discharge Team commenced within LRI Medical Wards on 3rd July 2017. The team brings together existing staff groups in Social Care, Primary Care Coordinators and Hospital Discharge Sisters to work as a single team to manage and progress complex cases and provide ward teams with skills to plan simpler discharges (such as re-starts of domiciliary care packages).

The team are working towards acting as trusted assessors on behalf of each other's services, which will provide a flexible capacity to complete assessments and procure services for discharge and reduce duplication of effort and reduce confusion about which local authority should be involved with the patient. The Integrated Discharge Team approach will roll out to specialty medical wards and an approach will be designed for surgical wards. These plans are in discussion with a completion date for delivery by March 2018.

The Urgent and Emergency Care Team has commissioned a system flow modelling tool which the first draft has been demonstrated. It aims to give predictive modelling for the acute trust for 7-10 days in advance. The model provides enough information to predict a surge in community hospital beds and a surge in requiring discharge assessment teams.

Commission additional home-care packages

There is capacity within the discharge to assess domiciliary care packages (Hart for the County and ICRS for the City) to take more patients during surges in demand. Full capacity is not currently utilised due to a number of internal actions that need to be completed especially for 'health' patients. (See appendix F – DTOC action plan for details of actions).

Implement a 'placement without prejudice' process

LLR already has a discharge to assess process which has agreed funding structures with the CCG, for placing patients into a non-acute bed whilst their CHC needs are assessed. There are further actions to enhance this within the LLR DTOC action plan (see appendix F for details).

Trusted Assessor Guide

The LLR Tiger Team for IDT is aware of the trusted assessor guide and is building it into the Trusted Assessment training and development within the IDT. Programme leaders are in the process of attending the webinars, and links have been made with Lincolnshire to view the service they provide.

Trusted assessment is already in place for the majority of current Discharge to assess placements into care homes, and for reablement domiciliary care packages.

4. Whole System Resilience / Escalation Arrangements

LLR has in place a system to provide daily capacity and performance monitoring of operational pressures, across providers throughout the year (not just the winter and Easter periods).

LLR manages surge and capacity utilising a whole system approach, which acknowledges predictable peaks in demand, for example over the Christmas and New Year period (As well as unusual peaks in demand as experienced throughout the year). Our commitment is to ensure that we have adequate 'system wide' resilience plans, to respond to operational difficulties in parts of the system, occurring in isolation or as a building pressure across LLR.

The key element is each organisations response to escalation. A common escalation policy has been agreed with each organisation and an agreed definition set to aid consistency and communication.

The LLR Surge and Capacity Management Plan seeks to have in place:

- Clear identification of the escalation process, agreed by all partners
- Key organisational contacts are identified
- That potential risks have been identified and contingency measures agreed
- That the provision of high quality patient services are maintained through periods of pressure
- That national targets and finance are managed during pressured periods
- That processes are in place to meet local and National reporting requirements

The underlying principle is that sufficient capacity has been planned to be in place to enable providers, under expected levels of planned activity and within expected levels of tolerance, to provide emergency care services and planned elective capacity in accordance with agreed targets.

Each organisation within LLR has developed their own internal Surge and Capacity and winter resilience plans and provides detailed confirmation of their preparedness across a number of areas.

Any organisation within LLR is able to 'call' for a health economy wide alert, but it is the responsibility of the CCG's as the lead commissioners for health services to 'declare' the health economy status.

Without prior discussion, no action will be undertaken by one constituent part of the system, which may undermine the ability of other parts of the system to manage their core business. The CCG will communicate system pressures to NHS England.

To support all organisations in the safe management of patients in times of high escalation, the LLR system wide escalation protocol enables a multi organisational approach to risk sharing.

4.1 Operational Pressures Escalation Levels (OPEL) Framework:

The LLR escalation policy is based upon an integrated status report, which details differing levels of capacity availability and trigger indicators. Listed below are the summary actions:

Escalation level 1 actions summary

- Situation monitored to prevent escalation
- Potential whole-system causes of escalation identified and dealt with
- Communication of any actual escalation

Escalation Level 2 actions summary

- Situation monitored to prevent further escalation
- Action to improve situation carried out
- Potential whole-system causes of escalation identified and dealt with
- Plan formed and being acted upon to re-establish level 1 working

Escalation Level 3 actions summary

- Situation monitored to prevent further escalation
- Action to improve situation carried out
- Potential whole-system causes of escalation identified and dealt with
- Command and Control within individual organisations and co-ordinated through LLR Emergency Care Director /CCG Director level, plan formed and being acted upon to re-establish level 1 working.

Escalation Level 4 actions summary

- Situation monitored to prevent system failure
- Action to improve situation carried out
- Potential whole-system causes of escalation identified and dealt with
- Command and Control led by CCG Managing Director/ On-Call Director: plan formed and being acted upon to enable de-escalation. Co-ordination of action plans led by CCG.

Commencing on the 1st December and continuing through the winter period, a daily escalation call is held system wide support, with the focus on swiftly de-escalating specific parts of the system in times of high pressure.

The call is undertaken where rapid system engagement is required in response to individual or LLR pressures, to collectively take action and plan for recovery. Examples of escalation issues rectified on the call include:

- The agreement of funding and operational provision of additional ambulance crews, to support flow.
- The utilisation

The aim of the call is to:

- To establish an operational escalation position for each organisation in order to understand the wider risks across the health and social care.
- Identify the risks within individual organisations and collectively the implications to the wider system.
- Agree actions to mitigate risk individually and collectively and identify who is leading on progressing the action.
- To update on actions taken on previous calls and if appropriate agree further actions required.
- Agree timeframes and feedback
- Plan for recovery

The teleconferences will be held in response to:

- declaration of a level 3/4 escalation within the LLR Health Economy
- as a proactive measure to prevent declaration of level 3/4 escalation
- commissioner initiated to escalate, communicate and plan a response to the management of urgent care system pressures (for example during periods of expected peak activity – BH, winter)

Any organisation can trigger a T/C based on deteriorating escalation status by conversation with the CCG - On-call Director or Urgent Care Lead.

In addition, an online escalation tool is used, providing all service providers with partner updates and identified issues that may lead to increased escalation levels within the respective organisations.

This tool is updated twice daily (10am and 4pm) and is utilised to enact proactive solutions prior to increases in escalation levels; and moves the system away from reactive modelling.

UHL provide daily capacity updates to the system, outlining gaps in capacity against specific specialties across the 3 hospital sites. This report is used as an indicative measure to alert the wider system of building pressures within the hospitals. LLR wide Surge and Escalation protocols are in the process of being reviewed, including how we escalate actions in response to raised occupancy rates in hospitals. A particular issue identified by our review of winter and the work of the AEIG, has been the need to improve discharge processes from UHL to LPT and a workshop was held on this over the summer, leading to revisions to operational processes and the escalation protocols. This should result in more balanced actions to support flow in both UHL and LPT to avoid bottlenecks in community hospitals and support more consistent discharges from UHL to community hospitals. The

proposed plan outlines available system support from each service provider to the wider system, specifically in times of high escalation.

To support effective management of escalation protocols, the LLR Urgent and Emergency care team provide in hours support to the system, with an Out of Hours on call rota in place. As mentioned above, we have undertaken Director on Call training for CCGs, and plan to undertake further joint training with LPT and UHL Director on Call teams, to improve understanding of the surge and escalation plan and improve organisational response.

4.2 On-Call Arrangements:

We are in the process of reviewing the LLR system surge and escalation protocols, this forms part of the work plan of the A&E Improvement Group and will be commenced at the next group meeting on 13th September, with a further workshop to be held to agree and align actions.

Following on from the lesson's learnt last winter and throughout the year, we identified that a weakness across the system, was the inconsistent training for on-call directors in regards to managing significant escalating issues. With this in mind, we have undertaken Director on Call (DoC) training for CCGs, and plan to undertake further joint training with LPT and UHL DoC teams to improve understanding of the surge and escalation plan; and improve organisational response to pre-empt increasing escalation levels by ensuring that the agreed actions are taken forward at relevant points.

To support UHL further, in times of increasing pressure and escalation, the UHL and CCG Directors on call (DOC) work collaboratively, the UHL DoC will update the CCG DoC after each gold command meeting or calls, which are held twice daily as required. The outlined support and required system actions will be discussed and the CCG DoC will convene further system wide escalation calls throughout the day as required.

5. Communication Plan

Increasing the number of eligible patients who need the flu jab

- Raising awareness of the flu jab amongst target groups and the potential risk associated with not getting it
- Supporting GPs to deliver more jabs through support for booking appointments

Supporting patients to seek help earlier before their condition becomes acute

- Raising awareness of the benefit of early intervention with some of the most common conditions seen in ED which cover the early warning signs of each condition and how people can seek help early.

Supporting patients to understand the services available to them over the winter period

- Early communications of service opening times and repeat prescriptions ordering
- Raising awareness of the options when services are closed over Christmas

Improving internal communications on ED pressures to practices and care home partners

- Improving communications to primary care, avoiding messages that can be seen as blaming any part of the system for inappropriate behaviour and alerting them to new initiatives which can help, including hot clinics
- Improving communications channels to care homes to ensure that we can effectively distribute the messages that they need
- Working with the care homes sub group to understand what care homes need and how they want to be communicated with.

Ensuring as far as possible messages are co-ordinated and do not overwhelm the system

- Identifying and recording all campaigns being run by our partners particularly around self care
- Identifying where possible potential areas where we will need to issue reactive communications, such as upcoming icy weather and preparing messages and materials in advance.
- Agreeing which organisations lead and who speaks on each area so that we can react quickly to more unexpected pressures
- Capitalising on joint working opportunities across LLR whilst avoiding silo working.

Raising awareness of the benefits of NHS 111 and clinical navigation hub

- Communicating areas where the clinical navigation hub makes a difference, such as booking appointments
- Raising awareness of services for both physical and mental health needs to ensure parity of esteem.

Improving the perception of NHS111 and the clinical navigation hub

- Increasing trust and countering myths around NHS 111

Improve the understanding of discharge process and benefits with patients

- Raising awareness of the patient benefits of speedy discharge with both patients and family members.
- Supporting patients to choose appropriate settings

The full communications plan to support winter 2017/2018, is included in Appendix G

6. Flu Planning:

Following on from our Flu planning and vaccination success from last winter, we want to build on this further this coming winter, to have a system wide vaccination uptake of 75%. Our plans have been informed following exercise CYGNUS in October 2016 and July 2017.

System wide, Flu immunisation is offered by all NHS organisations in LLR to all employees directly involved in delivering care.

The guidance of vaccination against flu is included in all organisations policies for the protection of transmission of flu to protect patients, staff and visitors and is an integral part of the infection prevention policies and protocols.

Although we are aware that the uptake of the vaccination is on a voluntary basis, all services across LLR are providing easily accessible and alternative methods for immunisation to staff to increase the uptake and to minimise the risk of infection. As in previous years, the roll-out of immunisation primary school-aged children will continue, against the new PHE guidelines and we are aiming to increase vaccine uptake rates, particularly among those who are most vulnerable to the effects of flu.

All services are commencing their flu campaigns and clinics from the beginning of October. The details of each organisations plan is outlined in their individual winter plans in section 2.3.

.

7. LLR UEC Service Provider Winter Plans

University Hospitals of Leicester Winter Plan 2017/2018	
Assurance	
Identified service lead for winter planning:	Chief operating officer Tim-Lynch
Reporting and Escalation process:	Three times Daily operational command meetings Silver Command On call cover 24/7 Daily LLR escalation calls Director on call level
Identified risks and mitigating actions:	<p>Risk: Bed Capacity Mitigation utilisation of SAU. Opening of additional capacity on EDU (x 6 beds) /AMU (x 4 beds) /Ward 21 Spec Med (x 28 beds) R2G/safer officially launched over Spec Med / RRCV Opening of escalation paediatric capacity Front door admission avoidance schemes Early opening of GPAU/Ambulatory (November 2017)</p> <p>Risk: Workforce Mitigation: Corporate/specialist nursing to support inpatient nursing Continued recruitment in all areas Utilisation of support staff i.e. trainee assistance practitioners to relieve trained nurse</p> <p>Risk: Not funded for 7 day service in all areas Mitigation: bespoke additional shifts agreed at peak times of pressure.</p>

System Capacity
Additional capacity planned in comparison to winter 16/17:
Additional paediatric capacity planned to cope with winter pressure (CSSU x 5 beds 24/7) Early opening (November) of GPAU Flexible capacity in EDU (x 6 beds) and SAU (x 6 beds)
Capability to Flex above planned capacity:
Utilisation of EDU/EFU capacity Utilisation of AMU escalation area Flexible use of SAU (LRI site only) Opening of discharge lounge area as overnight capacity (LRI only) Ambulatory Surgical Unit (ASU) should be considered when the organisation is on an

internal critical incident Opel 4+ but balanced against cancellation of elective activity.
Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:
<p>Safer/red to green implemented in January 2017 to focus on reduction in stranded patient (focussed on Speciality Medicine wards at LRI and RRCV at the GGH site)</p> <p>To act on all patients in excess of seven days length of stay</p> <p>There is further role out planned for Gastro and Orthopaedics</p> <p>Integrated discharge team to extend services to all wards within UHL to focus on DTOC and MFFD</p>
Impact of planned bed or service reductions on winter planning:
<p>No planned bed reductions</p> <p>Possible impact of planned elective surgical reduction may release capacity during peak months i.e. December/January</p> <p>GGH site had 28 additional beds opened in 16/17 to absorb respiratory/cardiology emergency patients. This ward has now been handed to Vascular surgery. There is currently no solution to increasing bed capacity at the GGH site.</p>
Plan to maintain system capacity (staffing and service) in the occurrence of an outbreak e.g. D&V/Norovirus/Flu
<p>Flu staff campaign in place and starts in October 2017</p> <p>Management against all IP policies and procedures</p> <p>Planned to maintain system capacity during an outbreak will follow success of previous years utilising cohorting within wards/bays.</p> <p>Increased cleaning presence and focus on prevention of spread</p>

Planning for Peaks in Demand

Outline of current demand management processes:

Senior clinical presence at all front doors
Hot clinics for appropriate surgical and medical specialities
Utilisation of ambulatory medical assessment units (GPAU)
Senior clinician in all ambulance assessment areas
Possible utilisation of GP in cars visiting nursing homes etc.
Primary care co-ordinators at front door

What additional demand management schemes are in place or planned in comparison of winter 16/17

plans in place to support demand surges are outlined in section, namely:
Increased GPAU capacity from November 2017 and Specialities at front door (such as GI

Surgery).
What additional resource (service and staffing) has been planned to meet this demand?
<p>Additional paediatric medical shift (ST4 or above) between 1800 to 0300hrs</p> <p>Additional adult medical shift (ST4 or above) between 1800hrs to 0600hrs</p> <p>All senior nursing teams matron & above are booked into clinical sessions to support the teams</p> <p>Duty management team has been doubled up to enable one DM to be based in ED and the other to support the wards.</p> <p>Additional bed coordinator shifts have been requested as overtime.</p> <p>Requested 1 additional ambulance crew per day between 1600hrs to 12midnight via CCG</p> <p>GPAU staffed until midnight with senior consultant presence</p> <p>Additional surgical registrar on both sites 0800-2000 hours</p>
What gaps have been identified that may impact on the successful maintenance of patient flow 7 days a week?
Workforce gaps both at middle grade and nursing levels to maintain consistent flow and management of escalation areas.

Admission Avoidance Schemes

Admission avoidance schemes in place vs. winter 16/17:

Increased early frailty unit's capacity and frailty at front door

DCC presence within the emergency department including therapies

Increased utilisation of GP's within primary care scheme and assessment zone

Increased utilisation of hot clinics

Predicted service impact:

Reduced medical take onto the assessment units

Reduction in non-admitted breaches

Increased ambulatory throughput to avoid admission onto a base ward

Improved patient experience

Leicestershire Partnership NHS Trust (LPT)

Assurance

Identified service lead for winter planning:	<ul style="list-style-type: none"> Pete Cross: Director of Finance Business, Estates and Facilities (Accountable Emergency Officer) Rachel Bilsborough: Director for Community Health Services, with support from Pat Upsall, Clinical & Operational Lead, IM&T, Data Quality and Information Governance CHS Helen Thompson: Director for Adult Mental Health with support from Samantha Wood Helen Thompson: Director for Families, Young People and Children's Services with support from Julia Bolton Bernadette Keavney: Head of Trust Health and Safety Compliance (Overall lead for winter planning) Michael Ryan: Resilience and Security Manager (EPRR Manager) Vicky Hill: IM&T Business Continuity Lead
Reporting and Escalation process:	<ul style="list-style-type: none"> Operational Escalation Tool Whole System Conference Call Community Services Daily Bed State –submitted at 0830
Identified risks and mitigating actions:	<ul style="list-style-type: none"> Surge in Operational Pressure – Mitigating documents LPT Winter Arrangements 2017/18 Leicestershire and Rutland 4x4 Policy (To Support Community Service Delivery) Flexible Bed Management Policy Seasonal Flu Campaign 2017/18 IPC Policy SAM Policy

System Capacity

Additional capacity planned in comparison to winter 16/17:

CHS - Flexible Bed Management agreement in operation for Community Hospital physical health beds
 AMHLD – A further 6 bedded female PICU ward opening in Oct 2017

Capability to Flex above planned capacity:

Yes – As per the agreed timelines set out in the LPT Flexible Bed Management agreement.

AMHLD have a set bed stock that is open 24/7 – This is managed by the AMHLD Bed Management Team and report on 3 x daily.

Going forward the LPT daily capacity will be reported on the operational escalation tool

Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:

Limited evidence of impact on delayed transfers at this stage of roll out however evidence suggests a reduction in LoS and therefore increased capacity for admissions

Impact of planned bed or service reductions on winter planning:

Nil

Plan to maintain system capacity (staffing and service) in the occurrence of an outbreak e.g. D&V/Norovirus/Flu

- Isolation Beds opened to support operational delivery
- IPC Policy offers guidance and support in managing these situations.
- Seasonal Flu Vaccine available from October to support the campaign to protect frontline staff from seasonal flu
- SAM Policy sets out direction for managing staff during infectious outbreak. Bank staff would be rostered in to cover gaps or off framework agency would be used to provide staff.
- If a Business Critical Incident was declared, a priority of work would be agreed and staff would be moved to deliver the trust priorities.

Planning for Peaks in Demand

Outline of current demand management processes:

LPT Winter Arrangements 2017/18 are aligned to the Operational Escalation Level Framework, and provide direction on actions to be carried out as operational triggers are met.

AMHLD Bed management team to manage, out of area placements, demand and capacity reviewed 3 times daily by bed management.

What additional demand management schemes are in place in comparison of winter 16/17

What additional resource (service and staffing) has been planned to meet this demand?

Reviewed Winter Arrangements Plan 2017/18
Bed management team capacity can manage this with existing resources.

What gaps have been identified that may impact on the successful maintenance of patient flow 7 days a week?

Therapy and ANP working 5 days. Mitigation in place which supports nurse led discharge on physical health wards to support discharges at the weekend.

Admission Avoidance Schemes

Admission avoidance schemes in place vs. winter 16/17:

AMHLD - Crisis House.
Crisis team gatekeeping.
Home treatment via the crisis team.
Move on accommodation coming online in October to help with patient flow to enable capacity.

Predicted service impact:

No predicted impacts at this stage – LPT are able to deliver a safe level of service going into winter 2017/18

East Leicestershire and Rutland Urgent Care Centres	
Assurance	
Identified service lead for winter planning:	Rachel Taylor
Reporting and Escalation process:	<ul style="list-style-type: none"> • Senior team leader on call during weekend at peak times • Operations Manager on call 24/7 • Clinical Manager on call 24/7 • Chief Executive on call 24/7 • Daily Handover reports • Conference calls during peak times (internal and external with partners as per LLR requirements)
Identified risks and mitigating actions:	<ul style="list-style-type: none"> • Surge over and above predicted contracted activity – internal escalation process and mutual aid from within Vocare group. • Weather restrictions – severe weather, deployment of 4x4 staff transport as required. • Reliance on Agency and Locum staffing has significantly reduced following successful recruitment campaigns • Operational winter Plan in place

System Capacity
Additional capacity planned in comparison to winter 16/17:
Currently running with full staffing levels, standard appointment slots in place as per weekend and bank holiday plans.
Capability to Flex above planned capacity:
Bank holidays will be fully operational at all sites
Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:
NA
Impact of planned bed or service reductions on winter planning:
NA
Plan to maintain system capacity (staffing and service) in the occurrence of an outbreak

e.g. D&V/Norovirus/Flu

All frontline staff within Vocare will be offered vaccination.
Planned vaccinations planned to commence October/November supply dependant.
The plan is for all staff to take up the offer of vaccination, however our current target is 75%

Planning for Peaks in Demand

Outline of current demand management processes:

Swift export of additional staffing from other areas if support required.
Continue to use agency staff to help support existing team

What additional demand management schemes are in place in comparison of winter 16/17

Annual Leave Embargo is in place for peak times.
List of clinicians available who will support the service at short notice is in place.
Additional nurse to be deployed on all BH to manage festive period surge in demand.

What additional resource (service and staffing) has been planned to meet this demand?

Recruitment underway for more bank staff to ensure that peak times (weekends and bank holidays) are well staffed.

What gaps have been identified that may impact on the successful maintenance of patient flow 7 days a week?

Limited to number of staff able to work at any one time due to space restrictions in the centres.

Admission Avoidance Schemes

Admission avoidance schemes in place vs. winter 16/17:

NA

Predicted service impact:

NA

Loughborough Urgent Care Centre

Assurance

Identified service lead for winter planning:	Rob Haines
Reporting and Escalation process:	Standard Daily to Organisation Monthly to Commissioners Enhanced Organisation and escalated to Commissioners
Identified risks and mitigating actions:	Space may be a contributing factor for enhanced treatments and reviews.(limited space) Unexpected referrals out from the LUCC may have prolonged wait from other Emergency services (EMAS) if under pressure. Potential unstable patients not being transferred as LUCC seen as place of safety..

System Capacity

Additional capacity planned in comparison to winter 16/17:

The service has been recommissioned since winter 2016/2017. Additional activity has been purchased through the contract at LUCC to reflect the new service model. In addition, primary care hub 'spokes' at Hinckley and Bosworth provide bookable appointments via 111 and clinical navigation in evenings and weekends (Hinckley) and Saturday mornings (Coalville). These new services provide a net increase in appointment capacity of 13,500 appointments, 4,400 of which are in the new primary care spokes.

Capability to Flex above planned capacity:

Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:

NA

Impact of planned bed or service reductions on winter planning:

NA

Plan to maintain system capacity (staffing and service) in the occurrence of an outbreak e.g D&V/Norovirus/Flu

Vaccinations will be available through local Occupational Health. There will also be the opportunity for staff to attend the drop in clinic provided by DHU on site. It is hoped all staff will take up the opportunity in receiving this treatment.

Planning for Peaks in Demand

Outline of current demand management processes:

Swift export of additional staffing from other areas if support required.
Continue to use agency staff to help support existing team

What additional demand management schemes are in place in comparison of winter 16/17

Practices in WLCCG can e-refer patients to LUCC for ambulatory assessment and diagnostics as an alternative to ED referral, this has an admission avoidance impact.

In addition, we are running a 'Test bed' with Charnwood practices to provide a direct referral to LUCC from GP practices in hours for 'acute' primary care patients. This provides additional resource to same day access and supports the UTC model at LUCC.

Annual Leave Embargo is in place for peak times.

List of clinicians available who will support the service at short notice is in place.

Additional nurse to be deployed on all BH to manage festive period surge in demand.

What additional resource (service and staffing) has been planned to meet this demand?

Recruitment underway for more bank staff to ensure that peak times (weekends and bank holidays) are well staffed.

What gaps have been identified that may impact on the successful maintenance of patient flow 7 days a week?

Limited to number of staff able to work at any one time due to space restrictions in the centres.

Admission Avoidance Schemes

Admission avoidance schemes in place vs. winter 16/17:

NA

Predicted service impact:

NA

TASL PTS (contract does not commence until October 2017)

Assurance

Identified service lead for winter planning:	Stewart Briggs – Operational
Reporting and Escalation process:	Lee Barham – Chief Operating Officer
Identified risks and mitigating actions:	<ul style="list-style-type: none"> • Seasonal Flu – Encourage Flu Vaccine take up by key staff • Severe weather <ul style="list-style-type: none"> – Implement Resource Escalation Action Plan – Prioritise patients' activity – Conference Calls with CCG & Health Care Partners – 4 x 4 vehicles mobilised • Disruption to base <ul style="list-style-type: none"> – key staff to use laptops – scheduling still possible via pda – request support from alternative bases – relocate operational support to nearby base if required – organise overtime, ready bank staff and review rotas • Staff unable to get to work <ul style="list-style-type: none"> – available staff to work additional hours to cover absence and service demand – request operational support vehicles/staff from other bases – liaise with CCG/Providers to prioritise transport priorities if service disruption to be severe • Regular communications with staff <ul style="list-style-type: none"> – Conference calls at appropriate frequency with Operational and Senior Staff to provide overview of situation, escalating in frequency if the situation deteriorates.

System Capacity

Additional capacity planned in comparison to winter 16/17:

Capability to Flex above planned capacity:
Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:
NA
Impact of planned bed or service reductions on winter planning:
NA
Plan to maintain system capacity (staffing and service) in the occurrence of an outbreak e.g. D&V/Norovirus/Flu
Staff are encouraged to obtain the seasonal flu vaccine and TASL has, where possible, all linked into local provider arrangements for staff to attend their OH sessions.

City Social Care

Assurance

Identified service lead for winter planning:	Mat Wise
Reporting and Escalation process:	Ruth Lake
Identified risks and mitigating actions:	Most obvious risk is that resources have been diverted from Hospital Discharge Teams to support the Integrated Discharge Team. Should this appear to be creating problems, the Service Lead will discuss with the IDT Systems Lead and escalate if appropriate.

System Capacity

Additional capacity planned in comparison to winter 16/17:
No plans to increase capacity vs. 16/17 as there were no issues with delays last winter. Locality Teams not who are responsible for a very small percentage of discharges will be advised to prioritise these to maintain flow.
Capability to Flex above planned capacity:
Currently in discussion with ASC Strategic Commissioners as to whether additional Assessment Beds can be purchased from current contracted residential homes over the winter period. In addition, hospital discharge is a relatively small part of ASC activity and there is scope, should it be needed, to utilise community facing staff to increase assessment capacity.
Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:
Acute DtoCs attributable to City ASC are practically zero so we do not foresee a problem. We are trying to increase the number of discharges before formal assessment notices are received.
Impact of planned bed or service reductions on winter planning:
We have no plans for service reduction prior to winter 17/18. We will continue to provide services in accordance with statutory requirements as a minimum but will always look to work in a multi-agency, integrated way, in order to assist partner organisations where we can.
Plan to maintain system capacity (staffing and service) in the occurrence of an outbreak e.g. D&V/Norovirus/Flu
Corporate Business Continuity and Incident Response Plan 2017/18 in place and more specific Health Transfers Business Continuity Plan 2017/18 also signed off.

Planning for Peaks in Demand

Outline of current demand management processes:

As above, there are additional community facing staff that can be called upon in the event of increased demand for assessments. Reablement provider service can also exclusively support discharges if demand peaks.

What additional demand management schemes are in place in comparison of winter 16/17

None

What additional resource (service and staffing) has been planned to meet this demand?

Current talks to temporarily expand number of assessment beds over the winter period.

What gaps have been identified that may impact on the successful maintenance of patient flow 7 days a week?

None. We have presence 6 days a week with ICRS taking over on Sundays and any bank holidays not covered by the Hospital Discharge Teams.

Admission Avoidance Schemes

Admission avoidance schemes in place vs. winter 16/17:

No change in avoidance admission vs winter 16/17. ICRS continue to respond to referrals from pre-admission wards to facilitate return to the community.

Predicted service impact:

N/A

County Social Care

Assurance

Identified service lead for winter planning:	Jackie L Wright
Reporting and Escalation process:	Surge and Escalation Plan
Identified risks and mitigating actions:	

System Capacity

Additional capacity planned in comparison to winter 16/17:

HTLAH Domiciliary providers:

- More stability within live HTLAH lots with greater security and sustainability for providers in the market
- Re-procurement of 3 vacant HTLAH lots nearing completion. Transition stabilisation measures will be put in place for new providers
- Work ongoing with Providers in closed Lots to enable these to be opened prior to the winter.
- Working with providers to increase capacity across all lots
- Domiciliary care 'await care' data is improving
- Monitoring and liaising with providers regarding time to pick up packages
- Evidence that reablement packages are reducing numbers of service users requiring maintenance packages

Residential/Nursing Care

- There is confidence that there will sufficient capacity to support

HART (Leicestershire County Council in House Reablement Service)

- Reduced demand on HART for maintenance packages, with improved stability of reablement throughput;
- Maintenance of existing staff resources, no reductions during 2017/18;
- Average weekly contracted hours for care staff is 20-25 hours, therefore there is some ability to increase these on a short term basis without impacting on working time directive;
- Effective use of Crisis Response Service (CRS), which currently operates 7.00am – 10.30pm;
- Development of 24/7 CRS – implementation due in November 2017.

Leicestershire County Council – Occupational Therapy Service

- Single Handed Care project – review of double-up care packages to ascertain if single handed equipment reduces the need for two carers, releasing capacity into the domiciliary sector.

Operational - Social Work Capacity /functions

- Increased number of staff at UHL in the IDT/ hospital social care team and A&E over 7 days (subject to funding)
- Continuation of NWB pathway to include residential and domiciliary services (subject to funding)
- Continuation of the Pathway 3 (Peaker Park) initiative (subject to funding)
- Daily communication with health and ASC staff with appropriate levels of skill and authority. The triggers for these are described in the LLR Surge and Resilience Plan

Integrated working at UHL

3 July saw the start of the Integrated Discharge Team – the overall aim is to reduce duplication of assessments; IDT members linked to busy medical wards; more effective throughput of patients; ensuring patients are identified for the correct discharge pathway thus reducing readmissions.

Integrated working between ASC and CCHS/Integrated Locality Leadership

Joint working is established and continued to develop in in four main areas:

- Joint approach to community hospital discharge and a monthly joint discharge MDT meeting
- Joint ‘early intervention’ monthly community MDT meeting for our shared complex community caseload
- Building a local published contact directory to make contact with each other easier
- Establishing a joint locality monthly management oversight meeting to drive and build upon the above activities, bringing teams closer together.-

Each locality has a timetable for bringing these mechanisms to life, being led by Service Managers and CCHS Operational Leads.

Integrated Locality Leadership Meetings are in place/developing to review our shared caseload and the opportunity to improve outcomes for patients/service users and staff. Implementation is led by the CCG’s.

Capability to Flex above planned capacity:

- Continued work to support HTLAH providers with regard to expectations, and multi-agency working through a HTLAH joint management group
- Contingency HTLAH providers adding extra capacity where required
- Residential/Nursing care provision – option to contract with additional providers
- Business Contingency Plans specify minimum staffing levels at times of predicted surge in demand and also actions in the event of unplanned staff loss to protect critical business functions.

Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:

Impact of planned bed or service reductions on winter planning:

**Plan to maintain system capacity (staffing and service) in the occurrence of an outbreak
e.g. D&V/Norovirus/Flu**

Internal frontline staff

- Subject to Corporate Management sign off (which we do not expect to be a problem) the County Council will be expanding the arrangements regarding the seasonal flu vaccination of internal front line staff and other key personnel, such as those in our Customer Service Centre.
- Based on an evaluation on last year's scheme, we will be offering surgeries across the county, vouchers and re-imbursement options to identified staff groups.
- Staff get individual emails (or for those not on the email system information through their line manager) about booking into a surgery, ordering a voucher or information on how to get reimbursed for a vaccination purchased in a local pharmacy etc. It will also encourage those eligible for a free vaccination from their GP to do so.
- A communication plan will support the roll out and which will also include how to stay safe and well over the winter, infection control - pertinent to flu and other outbreaks (hand hygiene, respiratory etiquette) etc. This information is also available on our intranet.
- The authority is considering possible incentives – but no decision has been made regarding this matter.
- The scheme is cross authority and includes all departments and is endorsed by unions.
-

Examples of eligible staff groups

- Adult and Children's social work staff
- Quality & Contracts staff visiting providers
- HART (in-house home care)
- Visiting Finance and Benefits Officers
- Passenger Transport Driver Attendant Loaders and Escorts for adults and children
- Staff working in adults and children's day services
- Staff working with vulnerable adults in Adult Learning

External Providers (Residential and Domiciliary Care)

- We do not reimburse our providers for the seasonal flu vaccinations that their staff may have; but we do encourage them to do this and provide information in line with that produced internally regarding those who might be eligible for a free vaccination through their GP, potential to reduce sickness rates and minimising risk to their vulnerable service users and infection control. We also send a letter to them from the Director of Adult & Communities (Adult Social Care) Director Children and Families Services and Director of Public Health to support seasonal vaccinations.
- The Infection Prevention Team (IPT) and Quality Improvement team and Contracts Officers support this initiative each year. The Infection Prevention Champions in each home receive information and the IPT undertakes training.

Planning for Peaks in Demand

Outline of current demand management processes:

What additional demand management schemes are in place in comparison of winter 16/17

What additional resource (service and staffing) has been planned to meet this demand?

Service resource – HTLAH

- More stability once final three lots awarded
- Assisting providers with recruitment and retention plans

See also Additional Capacity Section

What gaps have been identified that may impact on the successful maintenance of patient flow 7 days a week?

- 3 HTLAH lots vacant; however, re-procurement is underway and there are contingency arrangements in place for vacant lots
- Operational staff (Social Work) are not contracted to work over 7 days but we will mitigate for this by negotiation with staff and commissioning of additional staff/agency over the winter period (subject to funding)

Admission Avoidance Schemes

Admission avoidance schemes in place vs. winter 16/17:

Admission Avoidance

- Increased staffing levels in ED to avoid admission where needs are social care, not clinical.
- Crisis Response Service will aim to avoid admissions by providing urgent support to people in the community.
- CRS/HART will take referrals and broker support until 10.00 p.m. and over weekends and bank holidays.

Predicted service impact:

EMAS Winter Plan

Assurance

Identified service lead for winter planning:	Dave Whiting Chief Operating Officer - EMAS
Reporting and Escalation process:	Ben Holdaway Deputy Director of Operations - EMAS
Identified risks and mitigating actions:	<ul style="list-style-type: none"> • Severe Weather - 4x4 Activation Plan / EMAS Winter Operational Plan • Increase in Demand and Key Dates – REAP / CMP Action Plans / Local Surge & Escalation Action Cards / Review of available Resources for known key dates. • Hand over delays at LRI due to increase demand at front door & reduced patient flow through the Acute Trust. Halo / Conference Calls with CCG & Health Care Partners / Opel actions. • Seasonal Flu – Flu Vaccine program for EMAS Staff & Community Responders / EMAS Pandemic Influenza Plan

System Capacity

Additional capacity planned in comparison to Winter 16/17:

Additional A&E Resource for identified key dates being planned to help manage the predicted increase in demand.

Multi Treatment Centre Unit will be deployed in the city centre for Key dates building up to and over the Christmas & New Year Period to help reduce attendance at LRI A&E department.

POLAMB vehicles will be deployed on a Friday & Saturday Night in Leicester City & Loughborough to help manage the night time economy.

Capability to Flex above planned capacity:

- Reap Action Plan
- Capacity Management Plan
- Proactive Halo cover for LRI acute unit to manage Clinical coordination and to support Ambulance hand over and turn around activity, when capacity / flow issues are being experienced within the local A&E department.
- A senior EMAS manager will also be available to discuss options with LRI management team re EMAS hand over delays and look at working with the LRI management to formulate & implement solutions to help reduce extended hand

<p>over delays.</p> <ul style="list-style-type: none"> Review Predicted activity on key dates for possible increase in demand over & above expected activity
Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:
Impact of planned bed or service reductions on winter planning:
<p>Increase in Ambulance Turn Around Times at A&E due to poor flow at front door will lead to Impact on ability to reach 999 calls / patients in the community leading to impact on Ambulance Service delivery and Performance.</p>
Plan to maintain system capacity (Staffing & Service) in the occurrence of an Outbreak e.g. D&V/ Norovirus/Flu
<p>EMAS Trust IPC Policy & Procedures EMAS Trust Business Continuity Plan EMAS Trust Influenza Plan</p> <p>EMAS Vaccination Plan EMAS brings together a team of 'flu fighters' from across the Trust to plan and implement the flu campaign, the team is drawn from each of the divisions, Emergency Operations Centre (EOC) and enabling services ensuring the planning approach is Trust wide, including input and flu vaccine delivery by our occupational health provider.</p> <ul style="list-style-type: none"> Each year drop in clinics are held across all of our divisions within the region with specified dates and times. EMAS also use a mobile vehicle to reach staff that is not able to attend any of the available clinics. An e-learning package has been created to train/refresh paramedics and nurses in the flu vaccination procedures Influenza vaccination available to all EMAS staff <p>The clinics usually begin in October running through until the end January</p> <p>We aim to reach the national target of 100%, but some staff refuse to have the vaccine for personal reasons. Last year we achieved a 60.5% across EMAS NHS Trust.</p>
Planning for Peaks in Demand
Outline of Current demand Management Process:
<p>Ambulance Response Programme (ARP)</p> <ul style="list-style-type: none"> ARP has been introduced into EMAS from the 19th July 2017 to identify life

threatening conditions quicker and to ensure the most appropriate response is provided for each patient first time.

Resource Management Centre now operating at divisional HQ at Birstall in Leicester - responsible for planning of Divisional operational A&E work force.

Local review of predictive demand & forecasting activity, and management of resource to enable planning of resources to meet divisional activity & demand.

Christmas and New Year arrangements

- Suspend all annual leave from 18th December 2017 to 7th January 2018
- Focus on Christmas & New Years staffing with dynamic deployment of Relief / Flexible Working / Bank staff over this two week period.

What Additional demand management schemes are in place in comparison of Winter 16/17:

- Review use of VAS/PAS
- Manage Increase in supplies of essentials (Medicines / Blankets / Vehicles & Winter Vehicle Supplies)
- Review of Current Alternative Care Pathways available to EMAS with local CCG & Health Care Partners
- Monitor & proactively manage peaks in demand, use REAP and Capacity Management Plan to manage available resources to meet demand and maintain regular updates to local Stake Holders.
- Monitor illness trends/ patterns in local community that may effect specific patient cohorts, escalate to local Stake Holders re increase of trends / patterns of certain illness currently being seen / managed by EMAS within the local community.
- Encourage use of alternative care pathways (Hear & Treat & See & Treat) with staff following Pathfinder / NEWS guidance.
- Proactively Manage Booking On & Mobilisation Times, review extended on scene times.
- Proactively Manage Turn Around times at the Acute Hospital with Acute Trust Partners
- Proactively Manage Sickness with early referrals to Occupational health

What Additional Resource (Service & Staffing) has been planned to meet this demand:

Multi Treatment Centre Unit will be deployed in the city centre for key dates building up to and over the Christmas & New Year Period to help reduce attendance at LRI A&E.

POLAMB vehicles will be deployed on a Friday & Saturday Night in Leicester City & Loughborough to help manage the night time economy.

Additional A&E Resource on identified key dates to help manage the predicted increase in demand.

Increase in management cover within the division and 24/7 on call Strategic & Tactical management cover.

What gaps have been identified that may impact on the successful maintenance of patient flow 7 days a week?

Admission Avoidance Schemes

Admission avoidance schemes in place vs. winter 16/17:

Alternative Care Pathways available to EMAS are available via the SPA these include:

Cellulitis Pathway
Acute Urinary Retention
Falls Pathway
Community Hospital Bed
Rapid Intervention Team (City only)
Intermediate Care Team (County & Rural)
Hypoglycaemic Pathway
OOH GP
Urgent Care centre LRI
Overnight Nursing Assessment Unit
Integrated Crisis Response Service
Loughborough Urgent Care Centre

Predicted Service Impact:

East Leicestershire and Rutland CCG

Assurance

Identified service lead for winter planning:	Paula Vaughan, Deputy Chief Operating Officer ELR CCG
Reporting and Escalation process:	<p>In line with NHS England requirements, the LLR CCGs will be involved in multi-agency conference calls and meetings facilitated by the NHS England, to discuss the operational position across the whole LLR health and social care system.</p> <p>The CCGs will direct any appropriate communications to primary care providers highlighting operational issues as required.</p> <p>The 3 CCGs have a leadership role to ensure that the health and social care systems across the LLR system are co-ordinated to respond to the increased needs and/or service demands throughout the winter period, particularly where there is increased activity exceeding the seasonal norm and where response and recovery is beyond the internal capabilities and escalation procedures of an individual NHS commissioned service.</p> <p>Situation Reports (SITREP) and Winter Reporting In order to manage the day to day activity, daily SITREPs will commence in December. In the event of significant issues being reported, NHS England will also be notified at the same time as the SITREP is submitted.</p>
Identified risks and mitigating actions:	All risks and actions will be taken via the A&E Delivery Board and A&E Improvement Group

System Capacity

Additional capacity planned in comparison to winter 16/17:

This is based on a number of assumptions and will require ratifying.

2016/17 the CCG provided 643 additional appointments per week for an 8 week period, we anticipate being able to increase this by 50%, however, there is a dependency on mobilisation taking place earlier than in 2016/17.

Currently ELR CCG is working closely with our GP federation to develop a plan to integrate the evening and weekend services provided by the out of hours provider, GP extended hours and the service provided in the 4 urgent care centres to have a single GP led service that includes both walk in, pre-bookable appointments.

Capability to Flex above planned capacity:
We are currently exploring appetite with member practices and Federation for additional shifts during the Christmas and New Year period, however, the CCG is committed to ensuring services are funded that offer value for money.
Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:
NA
Impact of planned bed or service reductions on winter planning:
NHS England and NHS improvement assess that providers should aim to operate at a bed occupancy level of 92% or below to support patient flow. Therefore it is vital that UHL ensure patients are being placed in the most appropriate setting or ward. This will be reviewed and assessed by the CCG and the Integrated Care Co-ordinators via the daily 11am and 2pm.
Plan to maintain system capacity (staffing and service) in the occurrence of an outbreak e.g. D&V/Norovirus/Flu
<p>All East CCG staff will be offered vaccination from Sept 2017 and appointments are currently being arranged, this is supported across all member practices.</p> <p>Both CCG and member practice Business Continuity Plans have been reviewed and where necessary, recommended changes to pathways have been implemented.</p>

Planning for Peaks in Demand

Outline of current demand management processes:
The CCG monitors peaks in demand such as illness patterns in the local community and weather changes that may affect specific patient cohorts. A dedicated demand management lead has been identified within the CCG, and they report to the CCG Executive Committee. The ELR Out of Hospital Care Board also reviews and considers performance in areas such as A&E attendances, availability of community beds/step down, DTOC etc.
What additional demand management schemes are in place in comparison of winter 16/17
The CCG has specifically commissioned a Demand Management Community Based Service which all its member practices are signed up to deliver via the GP SIP scheme. This scheme includes regularly reviewing
What additional resource (service and staffing) has been planned to meet this demand?
ELR federation are supporting its 31 member practices, full details are being finalised at the moment, but this includes resourcing of additional staff and premises at short notice to

meet surge in demand.

What gaps have been identified that may impact on the successful maintenance of patient flow 7 days a week?

Funding release

Admission Avoidance Schemes

Admission avoidance schemes in place vs. winter 16/17:

Effective care planning is integral to delivery. Revisions have been made to the Integrated Care Planning template to support GPs and Nurses in active sign posting, discussions around staying well over winter etc. Each of the CCG localities are committed and support the Integrated locality Team model and a number of Test Beds are currently underway.

Predicted service impact:

At the moment we predicate a reduction in attendances circa 10,000 over the winter period.

Assurance

Identified service lead for winter planning:	Ian Potter
Reporting and Escalation process:	<p>In line with NHS England requirements, the LLR CCGs will be involved in multi-agency conference calls and meetings facilitated by the NHS England, to discuss the operational position across the whole LLR health and social care system.</p> <p>The CCGs will direct any appropriate communications to primary care providers highlighting operational issues as required.</p> <p>The 3 CCGs have a leadership role to ensure that the health and social care systems across the LLR system are co-ordinated to respond to the increased needs and/or service demands throughout the winter period, particularly where there is increased activity exceeding the seasonal norm and where response and recovery is beyond the internal capabilities and escalation procedures of an individual NHS commissioned service.</p> <p>Situation Reports (SITREP) and Winter Reporting</p> <p>In order to manage the day to day activity, daily SITREPs and system escalation calls will commence in December. In the event of significant issues being reported, NHS England will also be notified.</p>
Identified risks and mitigating actions:	All risks and actions will be taken via the A&E Delivery Board and A&E Improvement Group

System Capacity

Additional capacity planned in comparison to winter 16/17:
Capability to Flex above planned capacity:
Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:
NA
Impact of planned bed or service reductions on winter planning:
NA
Plan to maintain system capacity (staffing and service) in the occurrence of an outbreak e.g. D&V/Norovirus/Flu
GP Practices are planning now (August) for the Flu Campaign (commencing September) to ensure that patients in the 65+ and At Risk cohort are able to receive a flu vaccination in a timely way ahead of the winter period. Public Health England monitor flu vaccination uptake rates and the CCG is a stakeholder on the regular Flu

planning meeting.

Planning for Peaks in Demand

Outline of current demand management processes:

Following the cessation of support from Arden GEM CSU, all 48 practices have had the opportunity to download risk stratification data allowing them to plan appropriately for patients most at risk of hospital admission, and those where risk factors increase in the winter months. This risk stratification will continue locally at practice level until the completion of a new risk stratification tool being developed in partnership with Midlands and Lancashire CSU.

Practices are already producing care plans for their at risk and frailty patients as part of core contractual requirements. These care plans are developed in collaboration with patient and their carers, including nursing and residential homes patients, and are refreshed at least annually and / or post a hospital attendance / admission and subsequent discharge.

Practices are expected to plan for any surge in demand as a result of exacerbations in patients with Long Term Conditions; this links with effective care planning and supporting patients to self-manage. This includes maintaining links with the home visiting service as part of the integrated urgent care offer and supporting patients to access services appropriately.

Practices are also expected to ensure that they have a robust business continuity plan in place, and that this is refreshed such that it is reflective of current circumstances and arrangements that can be quickly effected to mitigate potential service disruption as a result of adverse weather conditions e.g. flash flooding, snow drifts, or in the event of staff illness e.g. flu, norovirus. Wherever possible, these plans should demonstrate contingency arrangements and often depict a 'buddying' arrangement with other practices locally to ensure continuity for patients. Practices are encouraged to alert the CCG where there are specific issues in order that they can be supported to address these.

WLCCG write out to all 48 practices confirming the expected contracting arrangements for the Christmas and New Year period. This approach will be in alignment with Leicester City CCG and East Leicestershire & Rutland CCG, ensuring appropriate cover arrangements are in place for all patients and allowing ample time for practices to plan and confirm capacity arrangements to the CCG accordingly.

Offer of the Emergency Repeat prescription service from a community pharmacy without the need to access OOHs and reduce the risk of patients attending ED as a result of running out of their medication.

What additional demand management schemes are in place in comparison of winter 16/17

Practices will be reminded of the importance of updating any current Special Patient Notes and ensuring that these are shared appropriately with DHU to enable visibility of care plan details to out-of-hours clinicians.

<p>Practices currently routinely closed on a Thursday afternoon will be requested to open on Thursday 21st December ahead of the four day closure from Friday evening at 6.30pm through to Wednesday morning at 8.00am. This will include a request to:</p> <ul style="list-style-type: none"> ○ Provide clinical sessions across the entire day and not just the morning ○ Telephone lines to be manned throughout the day ○ Practice buildings to be open for patients from 08.00 – 18.30 to manage any queries from patients <ul style="list-style-type: none"> • The rationale for asking practices to open on the 21 December 2016 is to: • Support the overall surge for Christmas and New Year period. <p>Provide additional access to patients during an already stretched time of year</p>
What additional resource (service and staffing) has been planned to meet this demand?
What gaps have been identified that may impact on the successful maintenance of patient flow 7 days a week?

Admission Avoidance Schemes

Admission avoidance schemes in place vs. winter 16/17:

UHL Admission Avoidance Pathways

Please refer to attached UHL Directory of Services which details all ambulatory admission avoidance pathways, which includes hot clinics and rapid access clinics. This includes how to access bed bureau and SPA. Admission avoidance pathways are also available to practices through PRISM.

Electronic Referrals

Please refer to attached list of specialities covered through the E-Referral Service. The E-Referral Service offers specialist advice and guidance to GPs, there is also an opportunity to discuss cases with consultants through Consultant Connect.

CDU Ambulatory Pathway

Direct referral to CDU for respiratory and cardiac problems.

Loughborough Urgent Care Centre Ambulatory Care Pathways

A number of ambulatory care pathways have been commissioned through the Loughborough Urgent Care Centre;
Asthma, Diabetes, Gastroenteritis, Heart Failure, Hyperkalaemia, Pneumo/Chest Infection and Sepsis.

Integrated Urgent Care Offer - NHS 111 Clinical Navigation Hub

Patients clinically triaged through NHS111 are referred to the most appropriate care setting through the clinical navigation hub.

Predicted service impact:

Leicester City CCG

Assurance

Identified service lead for winter planning:	Rachana Vyas
Reporting and Escalation process:	<p>In line with NHS England requirements, the LLR CCGs will be involved in multi-agency conference calls and meetings facilitated by the NHS England, to discuss the operational position across the whole LLR health and social care system.</p> <p>The CCGs will direct any appropriate communications to primary care providers highlighting operational issues as required.</p> <p>The 3 CCGs have a leadership role to ensure that the health and social care systems across the LLR system are co-ordinated to respond to the increased needs and/or service demands throughout the winter period, particularly where there is increased activity exceeding the seasonal norm and where response and recovery is beyond the internal capabilities and escalation procedures of an individual NHS commissioned service.</p> <p>Situation Reports (SITREP) and Winter Reporting</p> <p>In order to manage the day to day activity, daily SITREPs and system escalation calls will commence in December. In the event of significant issues being reported, NHS England will also be notified.</p>
Identified risks and mitigating actions:	All risks and actions will be taken via the A&E Delivery Board and A&E Improvement Group

System Capacity

Additional capacity planned in comparison to winter 16/17:
All urgent care centres are open 12 hours a day seven days a week and are fully integrated with local urgent care services. All appointments are bookable through 111 as well as GP referral.
Capability to Flex above planned capacity:
Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:
NA
Impact of planned bed or service reductions on winter planning:
NA
Plan to maintain system capacity (staffing and service) in the occurrence of an outbreak e.g. D&V/Norovirus/Flu

Flu clinics have been arranged and all LC CCG staff will be offered flu vaccinations.

Planning for Peaks in Demand

Outline of current demand management processes:

LLR CCG's look to create capacity in both the clinical navigation hubs and home visiting services, this includes an increase in night nursing capacity and the number of slots available in community integrated urgent care services for 111 and CNH referrals.

What additional demand management schemes are in place in comparison of winter 16/17

3 x extended hour primary care centres will be in place offering a mixture of walk-in, 111 and health professional booked appointments. With support of GP/RN and ECP if required.

City GP's have been sent a proforma to outline their Christmas and New Year opening plans. This has been undertaken to ensure that practices are meeting their contractual requirements and to deter patients away from utilising alternative healthcare services.

What additional resource (service and staffing) has been planned to meet this demand?

What gaps have been identified that may impact on the successful maintenance of patient flow 7 days a week?

Admission Avoidance Schemes

Admission avoidance schemes in place vs. winter 16/17:

GP's encouraged to utilise clinical navigation hubs for variety of options (clinician to clinician conversations, hot clinics, ambulatory care pathways, home visiting service etc) to promote admission avoidance where clinically appropriate.

Predicted service impact:

NA

DHU – 24 /7 Home Visit Service

Assurance

Identified service lead for winter planning:	Rob Haines / Malcolm King
Reporting and Escalation process:	
Identified risks and mitigating actions:	Current volume and contract agreements

System Capacity

Additional capacity planned in comparison to winter 16/17:

Currently running the 24 hours HV service. Previously tap switched off. We will not do this. Increase in number of clinicians that have kit and can undertake home triage. Pick up at short notice.

Can increase by an additional crew car

Pharmacist support

Increase clinician numbers

Capability to Flex above planned capacity:

We have an on call service where clinicians sit in on-call shifts. These will be looked at and increased based on the discussions above.

We have communicated with clinicians that there needs to be flexibility and movement to where the demand is. Triage training is in place so that clinicians have the ability to move to triage if required.

Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:

N/A

Impact of planned bed or service reductions on winter planning:

N/A

Plan to maintain system capacity (staffing and service) in the occurrence of an outbreak e.g. D&V/Norovirus/Flu

Flu vaccinations being ordered for all staff. Current training and meticulous standards in relation to IPC.

We have a plan for extra capacity if required in relation to any outbreak

Planning for Peaks in Demand

Outline of current demand management processes:

- Review of daily and weekly volumes, linked to same period last year.
- Duty Manager presence at Fosse House, escalation to CCG and Directors on-call.
- Liaison with DHU 111 duty manager. Review in-bound call types and volumes.
- Consider mutual aid from City UCC: identify types and number of patients that may be redirected. Early liaison with UCC managers.
- Hourly monitoring/reporting and review

What additional demand management schemes are in place in comparison of winter 16/17

- Indemnity cover – increase employed workforce. People coming forward
- Senior Manager on site at Fosse House with other DHU managers mobilised (clinical bases presence)
- Senior Manager maintains liaison with DHU Director on call
- Continue to deploy additional resources available.
- Liaison with CCG in place
- Review 111 dispositions against capacity – defer patients with appropriate dispositions (e.g. “Contact practice within 24 hours” not seen within NQR of 6 hours).
- Collaborative working with City UCC and LUCC in place. Streaming of appropriate patients to agreed numbers, types and acuities. Hourly review with UCC leads.
- Public communications strategy (in conjunction with CCG) to advise and promote appropriate use of all available services.

What additional resource (service and staffing) has been planned to meet this demand?

- All off duty staff contacted, leave cancellation
- Maximise all LLR remote locations to increase capacity. Liaison with LPT Community Hospitals.
- Consider collaborative working with other DHU sites.
- Liaison with cross-border providers of OOH/UCCs/WICs. Consider diversion of patients via 111 or following clinical advice.
- Deployment of additional clinical and operational resources throughout the service to meet service demands (telephone advice, base/home visits) by locality from within DHU and engagement of locums.
- All non-essential meetings cancelled.
- Planned training reviewed and cancelled where possible.
- Consider redeployment of staff appropriate to skills (e.g. administration/management staff able to perform patient navigator/dispatcher, supervisor or HCA/driver roles, and management team with current clinical

qualification/practice skills).
What gaps have been identified that may impact on the successful maintenance of patient flow 7 days a week?
<ul style="list-style-type: none"> • Discussions currently taking place with Commissioners • Communicating processes regarding increased liaison with other services EMAS etc real time if trends r peaks are identified.

Admission Avoidance Schemes
Admission avoidance schemes in place vs. winter 16/17:
<ul style="list-style-type: none"> • Currently re triaging of ED disposition cases • Looking at purchase of D Dimers for HV vehicles • Re triage of 111 green 2 etc can be put in place if required • Liaison with EMAS for real time trend activity if we see a spike in any area / conditions
Predicted service impact:

NHS 111

Assurance

Identified service lead for winter planning:	David Hurn, NHS 111 Head of Performance
Reporting and Escalation process:	
Identified risks and mitigating actions:	High absence rates. Dedicated 111 HR resource for absence management with Team Management restructure.

System Capacity

Additional capacity planned in comparison to winter 16/17:

DHU 111 have increased forecast by 3.1% for Oct17-Jan18, compared with actual demand for same 4 months last year. Forecast staffing requirement increased in line with projected demand.

Capability to Flex above planned capacity:

Reasonable capability to flex resource using internal contingency process on/off site.

Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:

N/A

Impact of planned bed or service reductions on winter planning:

N/A

Plan to maintain system capacity (staffing and service) in the occurrence of an outbreak e.g. D&V/Norovirus/Flu

Internal contingency to be invoked with relocation to be considered. Internal processes to be followed.

Planning for Peaks in Demand

Outline of current demand management processes:

Reviewed demand for same period last month, increased by 2.5%, staffing increased accordingly.

What additional demand management schemes are in place in comparison of winter 16/17

On-going recruitment to target service needs, G2 ambulance validation line, pharmacists cover.

What additional resource (service and staffing) has been planned to meet this demand?

Increased capacity with home working clinicians, review of rota patterns to meet peak requirements (Health Advisors, Clinical Advisors, Dental Nurses, Pharmacists, Shift Leads, Team Managers and Senior Management), and a review of internal processes to improve efficiency, targeted training to reduce call lengths and support needed. Continued work on 999 and ED referrals rates.

What gaps have been identified that may impact on the successful maintenance of patient flow 7 days a week?

High absence rates.

Admission Avoidance Schemes

Admission avoidance schemes in place vs. winter 16/17:

N/A

Predicted service impact:

N/A

8. Appendices:

Appendix A – Winter 2016/2017 Review



APPENDIX A 1617
winter Review.docx

Appendix B – Care Home Benchmarking Tool



APPENDIX B CH
Benchmarking tool.xls

Appendix C – Care Home Support Action Plan



APPENDIX C Care
Homes Support Action

Appendix D –



APPENDIX D SAFER
Patient Flow Bundle.doc

Appendix E – High Impact Changes for Managing Transfers of Care



APPENDIX E - LLR 8
high impact changes for

Appendix F - DTOC Action Plan



APPENDIX F DTOC
PLAN.xlsx

Appendix G – Winter Communications



APPENDIX G Winter
communications and e

Health and Wellbeing Scrutiny Commission

Work Programme 2017 – 2018

Meeting Date	Topic	Actions arising	Progress
21 Jun 17	1. Lifestyle Services Review 2. Infant Mortality Rates	1. Information on workshops to be circulated to Members.	
23 Aug 17	1. Sexual Health Review 2. Settings of Care Policy – Verbal Update 3. STP – Primary Care	1. A letter highlighting concerns about the lack of engagement of schools to be sent to Strategic Director, Children's Services 2. Further update to come to a future meeting. 3. Questions/comments to be sent to the CCG.	
4 Oct 17	1. STP – Mental Health 2. EMAS – Handovers with LRI 3. Accident & Emergency Services at UHL – progress report on new facilities and phase 2 4. Services for Lower Back Pain	1. Questions/comments to be sent to the LPT and CCG with a further report in 6 months' time. 2. Update on the Quality Improvement Plan to come in 6 months' time. 3. Further update on Phase 2 to come in spring 2018.	
29 Nov 17	1. CQC Inspection of LPT – Update 2. Settings of Care Policy 3. Repeat Prescriptions and Pharmacies 4. Sexual Health Review 5. Oral Health Update	1. Further update to come to the Commission in spring to include information on agency staffing and estate investment. 2. Letter to be written to the CCG to request the threshold remains at 25%. Chris West to pass on this view to Commissioning Collaborative Board. 3. CCG to share copy of recommendations to NHS England following engagement exercise on community needs and pharmacy locations. 4. Cllr Clarke to invite commission members to a site visit once preferred site agreed.	

Meeting Date	Topic	Actions arising	Progress
11 Jan 18	1. CQC Inspections on GP practices 2. Drugs & Alcohol Services (Turning Point) – CQC Inspection 3. Anchor recovery hub – Update on how it is progressing following a move to the new site 4. Public Health Performance Report 5. Draft Revenue Budget 2018/19 Report	1. An update the CCG's workforce strategy and international recruitment to come to a future meeting. 2. It was recommended that signposting be improved at the centre on Granby Street to ensure service users are directed to the correct centre if Granby Street was not appropriate; and a further report with performance data be brought to a future meeting of the Commission.	
7 Mar 18	1. CQC Inspection of LPT 2. Winter Care Update 3. STP – Verbal Update 4. Lifestyle Services Review – Update		

Draft Work Programme 2018-2019

Meeting Date	Topic	Actions arising	Progress
1 st Meeting	<ol style="list-style-type: none"> 1. NHS Operational Planning and Contracting Guidance 2017 – 2019 2. Joint Health and Wellbeing Strategy 3. EMAS Quality Improvement Plan 4. LRI Phase 2 5. Oral Health Update 		
2 nd Meeting	<ol style="list-style-type: none"> 1. UHL Cancer Treatment Performance 2. Lifestyle Services Review – Consultation Findings and Proposals 3. CCG's workforce strategy and international recruitment. 		
3 rd Meeting	<ol style="list-style-type: none"> 1. Public Health Performance Report 2. Turning Point – Performance Report 		

Leicestershire, Leicester and Rutland Joint Health Scrutiny Committee

Meeting Date	Topic	Actions arising
29 Sep 16	1) NHS England's Proposals for Congenital Heart Disease Services at UHL NHS Trust 2) UHL NHS Trust's View on NHS England's Proposals for Congenital Heart Disease Services 3) Other Viewpoints on NHS England's Proposals	Contact NHS England to inform them that the committee would like the review process to be stopped but if it is to go ahead then they will need to attend another joint meeting once the consultation is announced.
14 Dec 16	1) Sustainability and Transformation Plan	All three council scrutiny committees agreed to consider elements of the STP separately based on local concerns. Another joint meeting will convene when each council has had separate consideration.
14 Mar 17	1) NHS England's Proposals for Congenital Heart Disease Services at UHL NHS Trust	It was agreed to have a further meeting of the committee before the consultation ends to hear views from Members of the public and other stakeholders.
27 Jun 17	1) NHS England's Proposals for Congenital Heart Disease Services at UHL NHS Trust	It was agreed for the committee response to be collated following information heard at the meeting and submitted to NHS England. It was also agreed to write to the Secretary of State to request he looks at the process and reconsiders the review and drop proposals to close the CHD centre at Glenfield Hospital.
11 Dec 17	1) NHS England's Decision for Congenital Heart Disease Services at UHL NHS Trust 2) Paediatric Critical Care and Specialised Surgery in Children Review	To be rearranged in the New Year
TBC	1) Sustainability and Transformation Plan	

Joint Children Young People and Schools and Health and Wellbeing Scrutiny Commission

Meeting Date	Topic	Actions arising
7 Nov 17	1) Children's Mental Health <ul style="list-style-type: none"> - Future in Mind - CAMHS 2) CQC Review of Health Services for LAC and Safeguarding	1) The following is requested at a future joint meeting: <ul style="list-style-type: none"> • Further meeting to look at the specific services available and at what stage these interventions/services are provided; effectively mapping all services for children's mental health and what is offered and by whom. • What governance structures in place, who is accountable to whom for different elements, including LA, LPT, schools etc, as well as what services are available. • Examples of anonymised case studies which help understand a child's journey through services as part of this report. • Clarity about the role of schools and how they fit into the process and their role in identifying young people and how they are supported to help young people into the right pathway. • Commission Members to have sight of the Local Transformation Plan • Invite headteachers to the next meeting to get their viewpoint. • Further information on the CAMHS 'improvement journey' with particular information on how the improvements have impacted on outcomes. • More detail about what happens to those who are not 'accepted' by CAMHS
Apr 18	1) Children's Mental Health	1)

Forward Plan Items

Topic	Detail	Proposed Date
Dementia, Dental Care, Diabetes, GPs, Obesity, Smoking, COPD and Substance Misuse	Progress to individual strategies/services	
Patient experience of the system	Work with Healthwatch to gain an understanding of how patients feel about health services	
GP Workforce Plan	To be shared with the Commission.	
Impacts of Brexit on staffing in NHS	What has the immediate impact been? What will continue to happen when we exit the EU? What contingencies are being put in place? Where will the biggest impacts be?	