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

DATE: **TUESDAY, 19 MARCH 2019**
TIME: **10:00 am**
PLACE: **Meeting Rooms G.01 and G.02 - City Hall, 115 Charles Street, Leicester, LE1 1FZ**

Members of the Committee

Leicester City Council

Councillor Cutkelvin (Chair of the Committee)
Councillor Chaplin
Councillor Cleaver
Councillor Fonseca
Councillor Dr Moore
Councillor Pantling
Councillor Dr Sangster

Leicestershire County Council

Dr R.K.A.Feltham CC (Vice-Chair of the Committee)
Mrs A Hack CC
Mr D Harrison CC
Dr S Hill CC
Mr T Barkley. CC
Mrs J Richards CC
Mrs M Wright CC

Rutland County Council

Councillor G Conde
Councillor Miss G Waller

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

For Monitoring Officer

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

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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.

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

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

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

PUBLIC SESSION

AGENDA

NOTE:

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1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

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

3. MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on 21 January 2019 have been circulated and the Committee is asked to confirm them as a correct record.

The minutes can be viewed by clicking onto the following link:

http://www.cabinet.leicester.gov.uk:8071/ieListDocuments.aspx?CId=420&MId=9014&Ver=4

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

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, or statements of case in accordance with the Council's procedures.

7. CARE QUALITY COMMISSION INSPECTION 2018 - LEICESTERSHIRE PARTNERSHIP NHS TRUST RESPONSE **Appendix A (Pages 1 - 104)**

To consider a report from the Leicestershire Partnership NHS Trust that sets out their response to an inspection report from the Care Quality Commission (CQC).

The CQC Inspection was carried out between 19 December 2018 to 13 December 2018 and their inspection report, which is attached in Appendix A1, describes their judgement of the care provided by the Trust.

8. REPORT OF BETTER CARE TOGETHER ENGAGEMENT AND INVOLVEMENT **Appendix B (Pages 105 - 142)**

To consider a report from Better Care Together (BCT) that describes the activities they have undertaken during 2018/19 to engage with communities in Leicester, Leicestershire and Rutland. The report also outlines the direction of travel and strategic approach to communications and engagement in 2019/20 and discusses the outcome they wish to achieve by adopting a consistent engagement process embedded through all BCT work streams.

A report providing an update on scrutiny work related to the Better Care Together Plan is also attached in Appendix B2.

9. UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST, BED CAPACITY PLANNING **Appendix C (Pages 143 - 148)**

To consider a briefing paper that outlines the methodology behind the University Hospitals of Leicester (UHL) NHS Trust's bed model and how this compares to expected demand in 2019 / 20.

10. SCRUTINY COMMISSION WORK PROGRAMME **Appendix D (Pages 149 - 152)**

The Scrutiny Policy Officer submits a document that outlines the Leicestershire, Leicester and Rutland Health Scrutiny Committee Work Programme for 2018/19. The Committee is asked to consider the Programme and make comments and/or amendments as it considers necessary.

11. ITEMS FOR INFORMATION / NOTING

Appendix E (Pages 153 - 192)

- Thames Ambulance Service Limited – Care Quality Commission Report: Appendix E

- Moorfields Eye Hospital proposed move – letter from NHS Camden Clinical Commissioning Group: Appendix E1

12. ANY OTHER URGENT BUSINESS

Appendix A

Leicestershire Partnership NHS Trust

Report to the LLR Health Scrutiny Committee Meeting
Tuesday 19 March 2019

Care Quality Commission Inspection 2018 – Trust Response

1. Introduction/Background

1.1. The Care Quality Commission (CQC) report published in February 2019 relates to the inspection dated 19th November 2018 to 13 December 2018. The report describes the CQC's judgement of the quality of care provided by Leicestershire Partnership NHS Trust ('the Trust).

1.2. Whilst there were a number of positives included within the report, the Trust was disappointed by the number of issues identified. It is working closely with regulators to translate the messages into action and improvements for its staff, patients and carers.

1.3. An urgent action plan has been developed in response to the nine key improvement areas; actions will be completed by the 27th May 2019. Further action plans are being drawn up to respond to additional areas of concern raised within the report.

1.4. The Trust has put a strong governance framework in place to support the oversight and scrutiny of progress to ensure that the right action is taken in timely way, which meets the needs of our regulators and our own internal commitment to improve.

1.5. This improvement work will tie in to existing work streams which are already progressing to transform some of our services. We also recognise that a number of key initiatives will support all areas of development; this includes our single electronic patient record project, our drive to strengthen quality improvement and our approach to developing a just and learning culture across the whole Trust.

1.6. The CQC inspected the following five core services:

- Acute wards for adults of working age and psychiatric intensive care units
- Community-based mental health services for older people
- Specialist community mental health services for children and young people
- Long stay / rehabilitation mental health wards for working age adults
- Wards for people with a learning disability or autism.

1.7. Ratings for the whole Trust:-

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement → ← Feb 2019	Requires improvement → ← Feb 2019	Good → ← Feb 2019	Requires improvement → ← Feb 2019	Inadequate ↓ Feb 2019	Requires improvement → ← Feb 2019

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community	Good → ← Jan 2018	Requires improvement → ← Jan 2018	Good → ← Jan 2018	Good → ← Jan 2018	Requires improvement → ← Jan 2018	Requires improvement → ← Jan 2018
Mental health	Requires improvement → ← Feb 2019	Requires improvement → ← Feb 2019	Good → ← Feb 2019	Requires improvement → ← Feb 2019	Inadequate ↓ Feb 2019	Requires improvement → ← Feb 2019
Overall trust	Requires improvement → ← Feb 2019	Requires improvement → ← Feb 2019	Good → ← Feb 2019	Requires improvement → ← Feb 2019	Inadequate ↓ Feb 2019	Requires improvement → ← Feb 2019

1.8. 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	Good → ← Jan 2018	Good → ← Jan 2018	Requires improvement → ← Jan 2018	Requires improvement → ← Jan 2018

1.9 Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Inadequate ↓ Feb 2019	Requires improvement ↓ Feb 2019	Requires improvement ↓ Feb 2019	Requires improvement →← Feb 2019	Inadequate ↓ Feb 2019	Inadequate ↓ Feb 2019
Long-stay or rehabilitation mental health wards for working age adults	Inadequate ↓ Feb 2019	Inadequate ↓ Feb 2019	Requires improvement ↓ Feb 2019	Good ↑ Feb 2019	Inadequate ↓ Feb 2019	Inadequate ↓ Feb 2019
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 →← Feb 2019	Good ↑ Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Requires improvement →← Feb 2019	Requires improvement →← Feb 2019
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 →← Jan 2018	Good ↑ Jan 2018	Good →← Jan 2018	Requires improvement →← Jan 2018	Requires improvement →← Jan 2018	Requires improvement →← Jan 2018
Specialist community mental health services for children and young people	Requires improvement →← Feb 2019	Good ↑ Feb 2019	Good →← Feb 2019	Inadequate ↓ Feb 2019	Requires improvement →← Feb 2019	Requires improvement →← Feb 2019
Community-based mental health services for older people	Good ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019
Community mental health services for people with a learning disability or autism	Good Nov 2016	Good Nov 2016	Good Nov 2016	Requires improvement Nov 2016	Good Nov 2016	Good Nov 2016
Overall	Requires improvement →← Feb 2019	Requires improvement →← Feb 2019	Good →← Feb 2019	Requires improvement →← Feb 2019	Inadequate ↓ Feb 2019	Requires improvement →← Feb 2019

1.10. Key Themes

Whilst the CQC found examples of good practice, there were a number of key themes requiring further improvement:-

- Access to treatment for specialist community mental health services for children and young people.
- Maintaining the privacy and dignity of patients and concordance with mixed sex accommodation.

- Environmental issues.
- Fire safety issues.
- Medicines management.
- Seclusion environments and seclusion paper work.
- Risk assessment of patients.
- Physical healthcare.
- Governance and learning from incidents.

1.11. The CQC issued a Warning Notice to the Trust on the 30th January 2019. This was served under section 29A of the Health and Social Care Act 2008. An immediate improvement plan (Appendix A) has been developed in response to the nine key improvement areas; actions will be completed by the 27th May 2019. A further improvement plan (Appendix B) has been drawn up in response to the must do's and should do's raised within the core services inspection report.

2. Discussion

2.1. Immediate Response

In order to protect the safety of our patients, we undertook a number of immediate actions following the CQC's initial verbal feedback; this included:-

- Daily review of seclusion paperwork
- At short breaks, all mixed sex accommodation was ceased. The Trust has moved to male and female weeks in collaboration with CCG colleagues, families and carers.
- Environmental risks have been identified and logged for repair, replacement or removal and work has commenced.
- Patients are given a choice as to where physical health observations are undertaken to maintain privacy and dignity.

2.2. Since the beginning of February 2019:-

- We have approved the appointment of two additional premises officers which are out to advert.
- The children's and young people's service has received funding for increased workforce capacity to support the reduction of the neurodevelopmental waiting list and are currently recruiting to this.
- Additional resource has been identified for our rehabilitation wards, for nursing staff to focus on individualised physical health care plans.
- An external review of our incidents and learning processes Trust wide has been commissioned and commenced on the 18th February 2019.
- Two medicines management assistants have been recruited to support medicines management within the wards at the Bradgate Unit.
- Interim labelling of medication with date specific use put in place with immediate effect, with spot checks ongoing by senior nurses.

2.3. S29A Warning Notice

The Notice details nine areas where systems and processes are not operated effectively across the Trust to ensure that the risk to patients is assessed, monitored, mitigated and the quality of healthcare improved. These relate to:-

- Access to treatment for specialist community mental health services for children and young people.

- Maintaining the privacy and dignity of patients and concordance with mixed sex accommodation.
- Environmental Issues
- Fire safety issues
- Medicines Management
- Seclusion environments and seclusion paperwork
- Risk assessment of patients
- Physical healthcare
- Governance and learning from incidents

2.4. The Trust has responded with an immediate improvement plan (Appendix A) to address each of the areas highlighted within the Notice. This has been compiled in consultation with Regulators and the relevant services.

2.5. All actions must be completed by the 27th May 2019.

2.6. Core Services Must and Should Do's

The core inspection report identified a number of must do's and should do's, these are provided in detail within Appendix B. A short and medium term improvement plan has been developed; this is an iterative process and an excerpt from this plan has been appended. Work continues to develop a robust response to the Well Led component, and for the actions to be developed into a SMART format. The actions will be subject to change following on-going review and refinement.

2.7. There are a number of themes which are common across the services:-

- Medicines Management
- Seclusion
- Sharing and Learning
- Single sex accommodation
- Estates
- Care planning
- Well led
- Staffing / workforce / recruitment
- Physical health (including smoke free)
- Infection Prevention and Control
- Performance and data
- Equality and diversity
- Mental Health Act legislation
- Patient engagement

2.8. We have mapped these themes to our clinical priorities. The Trust held a development day on the 5th March 2019 to undertake a thematic analysis with representation from medical, nursing and enabling managers; this involved a review of where overarching quality improvement actions can be included to strengthen the core service response.

3.0. **Governance**

The CQC found a number of reoccurring issues despite the Trust closing actions following the 2016 and 2017 inspections. Previous governance arrangements have not

been adequate enough to reassure regulators and commissioners that action taken this time will be timely, robust and will result in sustainable improvement. The Trust is commissioning an external review of previous governance arrangements to understand the weaknesses and strengthen these.

3.1. The key changes so far this year are:-

- Our improvement plans have been developed with pace and in collaboration with all relevant stakeholders.
- Our improvement plans are aligned to the Trust's overarching objectives, clinical priorities and quality account; the Trust has identified a number of key work streams which require Trust-wide quality improvement input. For instance, care planning, which was a reoccurring theme across the core services; there is now an executive lead, and a group identified for delivery. A separate action plan which focuses on improvement has been appended (Appendix C) as an illustration of this approach.
- We have strengthened existing governance arrangements to ensure oversight and scrutiny of progress (detailed below).
- Executive leads have been identified to support the continuation of medium term actions.
- Outcome measures continue to be identified and 'closing the loop' is a key part of the process for implementing action and being assured that sustainable improvement has been met.

3.2. Internal Governance

The first draft of the immediate improvement plan was shared with NHSI, CQC and the Trust's Commissioners. Progress against this and the short term plan will be monitored by the Regulators at the scheduled quarterly Provider Review Meetings with NHSI, and Engagement Meetings with the CQC. Ongoing liaison with the Trust's CQC Hospital Inspector will ensure that progress is monitored at frequent intervals.

3.3. The immediate and short term improvement plans will be monitored fortnightly by the Quality and Professional Practice Senior Management Team, with regular fortnightly updates provided to the Executive Team. Monthly updates will be provided to the Quality Assurance Committee and the Board.

3.4. Internally the Trust is implementing an Executive Team Task and Finish Group. The Group will scrutinise the evidence provided by service areas to demonstrate that sufficient, appropriate action has been taken. The services and the Group will also reflect on whether the action taken has been successful in addressing the original weakness identified by the CQC. This process will provide robust confirm and challenge, resulting in either a) a request for further evidence to support the existing action, b) request that further action be recommended, or c) provide a recommendation to the QAC for formal closure of the action. Where action has resulted in improvement, the panel will request on-going evidence to demonstrate that this has had a sustainable impact.

3.5. This improvement work will tie in to existing work streams which are already progressing to transform some of our services. We also recognise that a number of key initiatives will support all areas of development; this includes our single electronic

patient record project, our drive to strengthen quality improvement and our approach to developing a just and learning culture across the whole Trust.

3.6. External governance

A Quality Review Summit is planned for April 2019, to involve the Trust, NHSI, the CQC and Commissioners.

3.7. The Trust and the CCG's have been working collaboratively to ensure that robust mechanisms are in place to secure monitoring, assurance and support over the completion of actions. The existing CAMHS Quality and Performance Review meeting will be extended to enable additional focus on progress and improvement within the CAMHS service. In addition to this, the Clinical Quality Review Group will be extended to review progress against the wider improvement plan.

4. Conclusion

4.1 The Trust has responded to the warning notice and the core inspection report with an immediate improvement plan, and a plan containing short to medium term actions. The immediate plan will be delivered by the 27th May 2019.

4.2. Governance arrangements have been strengthened to support the quality and timeliness of improvements. Liaison with external stakeholders has been confirmed.

5. Appendices

- Appendix A – Warning Notice: Summary of findings and excerpt from the LPT improvement plan (page 5).
- Appendix B - Inspection Report: Summary of must and should do's and excerpt from the LPT Improvement Plan
- Appendix C - LPT collaborative care planning action

Appendix A: Warning Notice: Summary of findings and excerpt from the LPT Improvement Plan

Access to Treatment
The CQC found that since the inspection from 2015 onwards, the Trust had not taken sufficient action to ensure that all patients within the specialist community mental health services for children and young people received the service they needed in a timely way. The Trust must ensure patient waiting times for assessment and treatment meet commissioned targets and the NHS constitution for children and young people.

The following excerpt from the full plan includes the action and progress to date

Area	Objective / improvement	Action	Progress to date
CAMHS OP	Ensure patient waiting times for assessment and treatment meet commissioned targets and the NHS constitution for children and young people.	Agree a trajectory and resourcing model to deliver significant improvement by 27th May 2019.	Demand and capacity modelling complete. £315k to end March 2019 Approved and funded additional 18 WTE by 4th March.
		Continue to validate waiting lists	
		Clarify the governance arrangements for the oversight and scrutiny of long waiters	
		Recruit to staffing requirements to achieve agreed trajectory	
Neuro - Developmental	The Trust must meet in the needs of patients with neuro development issues in a timely way	Identify trajectory and resourcing model to deliver significant improvement by 27th May 2019	Seven WTE appointed. Evaluation of the Healios Service
		Recruit and deploy new staff.	
		Implement capacity improvement plan	
		Confirm on-going methodology for the validation of waiting lists	
		Add number of patients with ASD/ADHD seen by crisis onto score card and monitor reduction	
Crisis	The specialist community mental health services for children and young people crisis team to meet their commissioned target to telephone patients within two hours and assess them within 24 hours	Review of existing systems and processes to identify opportunities for improvement.	
		Completion of demand and capacity modelling to deliver required outcomes.	

Maintaining the privacy and dignity of patients and concordance with mixed sex accommodation
The Trust had not ensured that wards for people with a learning disability or autism were compliant with mixed sex accommodation guidelines. We were not assured that the Trust had taken action to ensure that they had complied with the Mental Health Act Code of Practice paragraphs 8.25-6. This issue had been raised following inspections carried out in 2014 and 2016. The Trust must ensure that all wards comply with guidance on the elimination of mixed-sex accommodation. In addition to this the Trust failed to appropriately and accurately report breaches in mixed sex accommodation to the Commission.

Area	Objective / improvement	Action	Progress to date
Short Breaks	Cease mixed sex breaches by maintaining male and female weeks and not accepting emergency patients / accommodating family preferences	Liaison with families and re-booking patients who will breach male and female weeks.	Team Manager has gathered dates of planned breaches in order to scope resolutions.
		Not admitting patients in an emergency that will breach mixed sex guidelines	Staff informed that all emergency admission requests go through the Team Manager and Service Manager
		Revise the SOP for emergency requests for short breaks	SOP revised to eliminate mixed sex breaches in an emergency.
		Communicate the revisions to practice to families, with clear rationale.	Letter signed off for distribution and sent to families
		To notify CCG Commissioning Lead of change in process with immediate effect	Email confirmation received that CCG is supportive of no breaches.
Bradgate Unit	Strengthen the process for agreeing a clinically required breach of mixed sex guidelines	Revise the bed management SOP	Draft completed and going to Executive Team for discussion 11/03/19
		Confirm the internal and external reporting of mixed sex breaches.	Confirmed that there are no additional notification forms required for breaching this guidance. Link below: https://www.cqc.org.uk/guidance-providers/notifications/notifications-nhs-Trusts Agreed with commissioners that we will externally report on all breach types - justified and unjustified. Regarding internal reporting, the IQPR includes reports of ALL breaches – not just sleep breaches.
		Strengthen the content of the e-irf	

Area	Objective / improvement	Action	Progress to date
		forms and ensure there is an accountability process supporting any admission resulting in a breach type.	
		Review and amend the Trust Policy on Same Sex Accommodation.	Policy currently being drafted to take to April PCEG
Cedar and Acacia at the Willows	Walk by mixed sex breaches will not occur as a result of accessing laundry facilities.	To establish clear practice guidance on the use of laundry facilities by males and females at the Willows.	On Cedar and Acacia, male patients now access the laundry facilities using an alternative entrance or they will use the facilities on Sycamore which is male only.

Environmental issues

The Trust had not ensured that they maintained the safety of patients due to poor ward environments. Similar environmental issues had been raised with the Trust in previous inspections. Fixtures and fittings were often worn, stained and/or in a state of disrepair and not all environmental risks had been identified or mitigated against. The Trust must ensure all environmental risks are identified and mitigated against and that risk assessments contain appropriate actions detailing plans to update, replace or remove identified ligature risks. We found the following issues in the acute wards for adults of working age and psychiatric intensive care units, and long stay or rehabilitation mental health wards for working age adults' services.

Area	Objective / improvement	Action	Progress to date
Repairs maintenance and cleaning Multiple Sites	Establish a co-ordinated and responsive repairs and maintenance process to quickly address and resolve issues promptly.	All outstanding repairs and maintenance issues highlighted within the regulatory notices will be fixed and resolved.	**Stewart House** All doors have now been replaced. The tile in the OT kitchen has been replaced. **BMHU** Ashby windows have all been replaced. Bosworth windows have started to be replaced – finish date 22/02/219. Aston & Thornton have had all of their 'high absconsion risk' windows replaced. The remaining

Area	Objective / improvement	Action	Progress to date
			windows are scheduled to be replaced during the refurbishment of the wards (date to be agreed). Ashby has all new lighting in place. Bosworth's lighting will be replaced in March 2019. Aston/Thornton – All lighting checked and those not working have been reported to estates. Upgrade to lighting planned for 2020/2021 capital programme. Review of timescales required.
		Appoint two new premises managers to replace vacancies.	Posts currently out to advert and interviews planned for mid-March.
		Premises managers to populate central log for each ward on the environmental issues and improvements.	
		Undertake a monthly review of whole unit issues to include progress and slippage going forward	
		To strengthen our internal governance arrangements and clarify the escalation process for unsatisfactory delays.	
		AMH Head of Service to confirm other responsibilities in a specification for Director of Finance.	
Ligature risk assessments Multiple Sites	Ligature risk assessments to be tailored and include actions. To ensure that systems and processes are in place to enable timely and adequate	Head of Health and Safety will co-ordinate the completion of a physical review of all ligature risk assessments across BMHU and Rehab.	Maple Ward: Football table has now been moved to the recreation room which patient's only access under staff supervision as this is a locked area. Stewart House Dining Room: The ligature risk assessment has been reviewed and updated with

Area	Objective / improvement	Action	Progress to date
	response to actions.		appropriate controls for all unlocked patient areas
		Ward sister / charge nurses will ensure there is a ward based clinical mitigation plan in place for each of the risks identified.	The review of all wards commences week 3/03/19 with Health and Safety rep., ward Sister/ charge nurse and Matron to check for further ligature risks and ensure clinical mitigations of any risks is reflected.
		Ward sister / charge nurses will ensure that the ligature risks for each individual patient is assessed through the risk assessment process and where required a person centred ligature care plan is in place.	
		Head of Health and Safety will ensure that all of the ligature risks identified through the risk assessment are collated on a central database.	
		To introduce a RAG rating for each room on the Bradgate to support staff in knowing which rooms have fixed ligature points.	
		Head of Business to develop and submit removal and replacement requests as part of capital programme.	

Fire Safety Issues
Staff did not manage the risk of patients smoking in the ward in line with the Trust smoke free policy. We found the following evidence of when patients, staff and visitors could have been placed in potential high-risk situations. The Trust reported 14 fires caused by lighters or matches brought onto the ward by patients since November 2017, this included a large garden fire in the garden of Bosworth ward.

Area	Objective / improvement	Action	Progress to date
Smoking cessation Multiple areas	To provide clear guidance to staff and patients on alternatives to smoking and maintain safe, cleaner and healthy environment	AMH Head of Service to review the Smoke Free policy to ensure clarity for staff and patients about expectations.	
		Confirm designated ward vaping areas	
		Explore options to improve communication about Smoke Free via website / leaflets / signage	
		AMH Head of Service to contact LCC Smoking Cessation Service to explore vaping and provision of vapes as alternative NRT for new admissions.	Reviewing policy from Nottinghamshire Healthcare regarding the use of e-Burns in inpatient areas and for use on escorted leave.
		Medical Director to set up workshop with Consultants to review and confirm Section 17 arrangements in line with Smoke Free Policy	Workshop with Consultants organised for 15th March.
		AMH Head of Service to liaise with Matron for Crisis to agree an advance clinical directive with CMHT / Crisis Teams for patients to confirm NRT if they were to be admitted.	
		Head of Estates to organise the removal of discarded cigarette ends within the courtyard areas of all inpatient services.	Estates Manager to obtain quote for cleaning courtyard areas.
		Head of Communications to explore options to improve communication about Smoke Free via website / leaflets / signage	
Evacuation Multiple areas	Safe evacuation in the event of a fire. Disabled patients will have	Ward Sister to send AMH PEEP and guidance sheet to all Ward Sister/charge nurses and to be point of contact for any queries.	

Area	Objective / improvement	Action	Progress to date
	a personal emergency escape plan in the event of fire	Fire Safety Management Policy to be revised to include information about General Emergency Evacuation Plan and Personal Emergency Evacuation Plan	Complete
		A flag to be introduced into SystmOne to identify patients require a PEEP.	SystmOne will be in use by 202. Interim measure will include a PEEP risk assessment on RiO.
		To flag those patients with a PEEP on nursing handover	
		All disabled patients who require a greater level of support than the standard horizontal fire evacuation procedures admitted to an acute, rehab or PICU ward will have a PEEP.	
		Suggesting that PEEP is not necessary per patient due to the approach to the Trust Policy. Director for AMH/LD to make contact with Director of Finance and Head of Health and Safety to get them to confirm approach with CQC.	Advice confirmed with CQC that PEEP is good practice and referenced in our own Fire Safety Policy. See e-mail in Ops folder 19/02/2019.

Medicine Management

The Trust had not made sufficient improvements in medicines management since the last inspection in 2017. The Trust must ensure the safe management of medicines, to include storage, labelling and disposal of medications. We found the Trust medicines management practice was unsafe in relation to the storage, disposal and medicines reconciliation for the following reasons:
We were not assured that staff were administering medication that had not expired as they had failed to record when medication was opened which meant that the expiry dates of the medication could not be determined.

Area	Objective / improvement	Action	Progress to date
Multiple areas	Strengthen medicines management systems and processes to	Head of Nursing to meet with Pharmacy to review medication management improvement plans	Further ward pharmacy checks have been implemented since the CQC visit in November 2019.
		Head of Pharmacy to contact a Head of Pharmacy in an outstanding Trust to establish a different	Northampton Pharmacy contacted – awaiting response.

Area	Objective / improvement	Action	Progress to date
	comply with standards and policy.	approach to medication labelling for start/ end/ do not use after/ medications.	Complete new labelling to be implemented in March 2019.
		Head of Pharmacy to review current process and equipment for medication returns to Pharmacy.	Current process reviewed and alternative medication returns bins have been ordered for each inpatient ward funded from ward medication budget.
		Head of Pharmacy to establish improvement in the safe administration and recording of controlled drugs (CD).	Incidents involving CD's were reviewed. To reduce human error, a computerised CD register and administration support system will be implemented which links with the Trust's current Prescription tracker system. Quote received (£4,515) and awaiting funding approval
		Head of Pharmacy to improve safe storage of medication in ward clinic rooms at the Bradgate Unit. Two Assistant Pharmacy Technicians (Band 3) will be employed to check medication storage, ensure cleanliness and support pharmacy requests and deliveries.	
		Head of Nursing for AMH and Head of Pharmacy, in the interim period of the above actions a safe storage and administration of medication briefing will be issued and Ward Sisters/ Charge Nurses will take responsibility for a weekly check of ward Clinic rooms.	Timescale revised due to Ward Sisters/ Charge Nurse leave. Now complete.
		Matron to identify a Band 6 Registered Nurse at Stewart House and Willows, to take responsibility for medication management procedures with support from Pharmacy.	

Seclusion environments and seclusion paper work

We carried out a review of seclusion practices prior to our main site visit. We reviewed 58 sets of records relating to periods of seclusion that took place between April 2018 and September 2018. We found that records did not always meet the recommendations set out in the Mental Health Act Code of Practice. The Trust must ensure that staff consistently apply and record appropriate elements of the seclusion policy in line with the Mental Health Act Code of Practice.

Area	Objective / improvement	Action	Progress to date
All inpatient areas with seclusion areas	Seclusion paperwork / process Ensure compliance with the Seclusion Policy and the Mental Health Act Code of Practice.	Head of Nursing for AMH put in place an initial action plan following the MHA and CQC inspection in November 2018: Confirm the current Seclusion Policy and seclusion documentation is being used in the Willows Rehabilitation Unit	New packs of up to date seclusion paperwork implemented on the 4th December 2018
		Review the current assurance process for seclusion documentation to ensure it is fit for purpose.	Process reviewed with Ward Sister/ Charge Nurses and Team Managers who check seclusion documentation and amendments made to the system to widen final checkers to include Matrons and confirmation of expectations of checks confirmed.
		Head of Nursing for AMH to review Seclusion Policy including the recording process and documentation for incidents of seclusion – test of policy/ documentation prior to sign off.	Meetings have commenced (2 held) with Ward Sisters/ Charge Nurses to review policy and documentation. Meeting with Drs planned 13/02/19 Further session held 28/02/19 and policy/ documents revised

Area	Objective / improvement	Action	Progress to date
			further. To distribute for final comments 8/03/19 and pilot forms from 15/03/19
		Matrons to complete a review of all seclusions and documentation 1 month after the implementation of the new policy and documentation	
Rehab wards	Ensure seclusion policy includes adequate seclusion room checks	Ensure seclusion policy includes adequate seclusion room checks will be included in the action above related to the Seclusion Policy review.	
		Ensure sink fittings identified in Acacia ward seclusion room as a ligature and safety hazard are replaced.	Estates have been asked to liaise regarding appropriate anti- ligature sink fittings, Site visit week commencing 4/03/19.
		Re-sealing of flooring in Maple ward seclusion room by estates.	Flooring re-sealed.

Risk assessment of patients

The Trust did not ensure that staff were assessing the health and safety of patients receiving care or treatment and the Trust did not do all that is reasonably practicable to mitigate any such risks. Staff on Maple ward were not completing or updating patient risk assessments in line with the Trust policy or after incidents had taken place. We reviewed eight patient records and the following six had risk assessments that staff had not updated.

Area	Objective / improvement	Action	Progress to date
Rehabilitation and (all other inpatient areas)	To ensure risk assessments are robust and completed and updated following incidents.	Rehabilitation Matron with support from the Transformation Team to establish a PDSA Group to improve the risk assessment process, including updating risk assessments. A monitoring system will be developed and assurance provided at the monthly Rehab Governance meeting.	All reportable (EIRF) incidents are reviewed by the Ward Sisters and Charge Nurses. When reviewed the patients' electronic records (RIO) will be reviewed to check that the patients risk assessment and care plan has been updated accordingly. This will be documented in the Ward Sisters and Charge Nurses sign off.

Physical health care

The Trust had failed to ensure that all patients' physical health was appropriately assessed on admission and that regular assessments of the physical health needs of patients had been undertaken. Staff had not completed a physical health examination in 14 out of 30 records. We reviewed all records and found that no physical health monitoring had been recorded since the patient had been admitted to the wards.

Area	Objective	Action	Progress to date
Bradgate and PICU	Physical health monitoring	Matrons to confirm the correct checking process is in place for equipment and the Trust calibration schedule includes the equipment.	
Rehabilitation area	All patients admitted to Rehabilitation Wards will have a physical health examination.	Consultant and ward sister / charge nurse to review the current admission process to ensure all patients receive a physical health examination by a doctor on admission to rehabilitation wards and nursing staff complete the cardio-metabolic physical health form. Establish a monitoring process to ensure compliance.	
		Most current physical health examinations are being recorded in the RIO progress notes: Head of Nursing for AMH to resolve the RIO EPR technical glitch which occurs when Doctors try to complete the physical health form within the core MH assessment.	
Willows	Physical health needs will be met in partnership with primary care.	Matron will ensure the Willows recruit 0.2 WTE RGN to work alongside the GP once a week to run clinics and focus on physical health care planning and health promotion.	Stewart House now has an RGN in post who dedicates one day a week to focus on individualised physical health care plans
Ward areas	Ensure patient's privacy and dignity is maintained when receiving physical health observations.	Ward Sisters/ Charge Nurses to establish clear written guidelines for where and how physical health observations are completed on their wards and how any exemptions to the guidelines are recorded: Guidelines to be approved by the Matrons.	All wards have participated in discussion on guidance, finalised approach by 6/03/19

Governance

The Trust did not have robust governance procedures to ensure that they could identify and address issues across the Trust in a timely way. These issues with governance procedures had been reported at the last inspection in 2017. The Trust governance processes had not identified issues around environmental repairs, medicines management, seclusion documentation and sharing lesson learnt from incidents.

Area	Objective	Action	Progress to date
Well Led	Governance Not always focussed on the most important aspects of quality / issues	Director of AMH/LD to invite Executives to review governance arrangements in AMH.LD and FYPC to improve governance systems and processes	New Head of Patient Safety starting 1st March 2019
		Heads of Service to review the systems and processes in place to share information and learning to and from front-line to Directorate level and ensure effective oversight of workforce, finance, performance and quality and safety	
		Recruit a new acting Associate Director focussed on remedial improvement.	
		Recruit a Deputy Nursing Lead for in-patient services	
Well led	Communications. Engage with staff well.	Head of Communications to develop a central communications plan. Planning for communication with staff through forums to occur for the week of the 4th March 2019.	

Appendix B: Inspection Report: Summary of must and should do's and excerpt from the LPT Improvement Plan

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

Area	Objective	Action	Progress to date
Bradgate and PICU	The trust should ensure staffing requirements of 136 services do not adversely affect those of acute wards for adults of working age	The rostering team will work with operational managers to review the rosters and staffing requirements.	A proposal of options for staffing the PSAU was taken to the February Directorate business meeting by the business team and it was agreed to request additional funding from commissioners for dedicated PSAU staff.
		To develop a proposal for staffing the PSAU.	
Bradgate and PICU	The trust should ensure the use of bank staff does not impact on the delivery of consistent patient care.	A review of the safer staffing reporting requirements in line with developing workforce safeguards standard guidelines from April 2019 is taking place.	The Trust safer staffing report provides oversight of use of Temporary staff and increased utilisation due to RN vacancies, sickness and increased levels of patient acuity requiring observation support. Regular block booking of bank and agency RNs continues to manage the impact of the increase in RN vacancies across the acute inpatient wards.
		Ensure that bank staff have the skills to provide safe and effective care.	Bank staff attend core induction and are provided with the same mandatory training and competencies expected of substantive staff.
		Improve consistency by use of regular bank staff on individual wards.	Ward Matrons/charge nurses to develop a cohort of regular bank staff if possible and ensure that they are inducted to the individual ward.
Bradgate and PICU	The trust should ensure that staff have access to regular team	Wards to have at least monthly team meetings chaired by the Charge Nurse / Sister or deputy, which will be supplemented by a weekly information sharing email.	The February edition of 'Leadership Matters' which goes out to our leadership and management

Area	Objective	Action	Progress to date
	meetings.	Information from the meeting will be cascaded to all staff and be available for all staff to see.	community was focussed on the importance of team meetings. Service Manager to audit the frequency and minutes of ward team meetings as well as weekly information sharing email.
		Establish a programme of regular team development days across the service.	We have put in place a four month communications plan on importance of team working and support available. This will be rerun every quarter for the rest of the year (embedding message) The importance of teams will be emphasised on leadership development programmes.
Bradgate and PICU	The trust should ensure that the senior executive team are present and visible to staff.	Increase the number of Executive Team Boardwalks.	
		Photos and job titles of the senior executive team and local senior managers are to be made freely available in public and staff areas of the service.	
		To plan a regular programme of Q&A sessions for staff within the unit with the Executive and Service Manager team to increase leadership visibility.	
Bradgate and PICU	The trust must ensure staff involve patients in their care planning and their views are recorded	Unit matrons to drive patient involvement in care plans with clinical staff and ensuring that care plans are co-designed with patients.	The Trust care planning initiative has commenced.

Area	Objective	Action	Progress to date
	appropriately.		
Bradgate and PICU	The trust must ensure all environmental risks are identified and mitigated against. The trust must ensure that ligature risk assessments contain appropriate actions detailing plans to update, replace or remove identified ligature risks.	All environmental risks to be identified and logged for repair, replacement or removal, with mitigation action plans in the interim. Review all ligature risk assessments, replace or remove any identified fixed point ligature risks. A tri-part assessment of current ligature risk assessments for each ward including, Matron, Ward Sister/Charge Nurse and Health and Safety representative Ward Sister/Charge Nurse to develop ward mitigation plans for any ligatures identified through the review and re-assessment and shared with the staff team Ward Sisters/Charge Nurses will ensure that the ligature risks for each individual patient is re-assessed through the risk assessment process and where required a person centred ligature care plan in place.	Health and Safety Team representatives to visit all ward areas week commencing 4th March to update ligature risk assessments and ensure that ward staff are aware of these. Health and Safety Lead to collate all risks centrally.
Bradgate and PICU	The trust must ensure the safe management of medicines, to include storage, labelling and disposal.	Matrons to work with the wards and pharmacy to make sure the storage, labelling and disposal of medication is carried out as per policy. Medication bulletins regarding lessons learned and good practice to be circulated to all ward areas.	Spot checks to be completed by the ward sisters / charge nurses to check compliance. Pharmacy have sourced alternative medication disposal bins and will be rolling out a new labelling system for opened medication. Two ward-based Pharmacy technicians to start work at BMHU at the beginning of April.
Bradgate and PICU	The trust must ensure that medical equipment used by staff is regularly and accurately checked.	Establish that all of the medical equipment is on the Medical Devices database. To ensure all medical equipment is checked annually in accordance with the Medical Devices Policy. To review the process for locally checking equipment in between the annual checks.	All equipment in use has been checked against the trust Medical Devices database. Review of the local checking system has commenced.

Area	Objective	Action	Progress to date
Bradgate and PICU	The trust must ensure that staff consistently apply and record appropriate elements of the seclusion policy in line with the Mental Health Act Code of Practice.	Following an episode of seclusion, the paperwork will be reviewed for completeness and quality and reviewed against the patient's care plan.	The unit matrons are scrutinising seclusion paperwork before final sign off.
Bradgate and PICU	The trust must ensure all staff are aware of the Department of Health's guidance on eliminating mixed sex accommodation to ensure appropriate and accurate reporting. The trust must ensure that the privacy and dignity of patients is protected.	All staff to be given information on the Eliminating Mixed Sex Accommodation guidelines. Bed Management Admission Policy to be reviewed to ensure the above guidelines are considered and, in emergencies, i.e. where a temporary mixed sex breach may occur, it is reported correctly and escalated as appropriate.	DoH Guidance circulated to staff. Trust Bed Management Admission Policy and SOP being revised.
Bradgate and PICU	The trust must ensure that environments are regularly maintained and updated to ensure they provide a safe environment for patient care.	Establish a refurbishment programme for the older estate.	The four older wards at BMHU to be refurbished and windows replaced. Ashby and Bosworth ward to be completed in 2019 and followed by a proposal and application for funding for Thornton and Aston wards. Ongoing maintenance plan in place with support from Facilities.
Bradgate and PICU	The trust must ensure patients have personal fire evacuation plans in place where necessary and weekly	Weekly fire checks of the environment to be carried out. All disabled patients who require a greater level of support than the horizontal fire evacuation procedures	Fire checks being completed each week. Spot checks being undertaken by the Team Manager. Reviewed Trust Fire Safety Management Policy to include

Area	Objective	Action	Progress to date
	fire checks of environments are completed.	admitted to an acute, rehab or PICU ward will have a PEEP.	assessing whether a patient can be supported by a General Emergency Evacuation Plan (GEEP) or will require a PEEP. Guidance on developing PEEP care plans has been shared with staff.
Bradgate and PICU	The trust must ensure it reviews arrangements of dormitory accommodation with a view to eliminating this in line with national guidance.	Dormitory accommodation to be reviewed as part of the work to look at the re-provision of the four older wards.	
Bradgate and PICU	The trust must ensure that sufficient facilities are available to meet the needs of all patients.	A review of the facilities available will be undertaken.	
Bradgate and PICU	The trust must ensure that lessons from incidents and complaints are shared with staff.	Lessons learnt from incidents and complaints to be cascaded from the service business meeting down to ward level meetings and information shared with staff. Wards to have at least monthly team meetings chaired by the Charge Nurse / Sister or deputy.	Currently SI bulletin/newsletter in place and Clinical Governance Team also reviewing the way in which lessons are learnt and good progress can be shared effectively across the Directorate. Service Manager to audit the frequency and minutes of ward team meetings.
Bradgate and PICU	The trust must ensure effective governance systems are in place to monitor the service.	A full review of the Directorate's governance systems will take place.	Clinical Governance Lead working with Service Managers to agree a coherent and consistent governance process across the Directorate.

Area	Objective	Action	Progress to date
Bradgate and PICU	The trust should ensure patients have access to psychological therapy and this is delivered and recorded in line with best practice guidance.	The psychological therapies provision will be reviewed.	
Bradgate and PICU	The trust should ensure a review of the management and implementation of its smoke free policy at the Bradgate Unit.	Medical Director (lead for smoke free) to commission a review of the management and implementation of the smoke free policy at the Bradgate Unit.	Ongoing work to look at NRT alternatives for patients and identify vaping areas on wards.
Bradgate and PICU	The trust should ensure bed management arrangements are more robust in order that patients have access to an acute bed within their area.	To review the bed management processes, patient flow and availability of beds in conjunction with Commissioners.	Work around Red to Green, Housing, EDP and other initiatives are ongoing as part of the Quality Improvement work to reduce the Length of Stay chaired by the Head of Service. Service Managers and the business team are linking in with regional Out of Area Placement concordats and links with commissioners are in place for support to be able to accommodate all LLR patients locally. The transformation work is also focusing on the aim to get OaPs to zero.
Bradgate and PICU	The trust should ensure best practice and innovation within the service is shared.	Review the current processes for sharing best practice and innovation and implement changes.	Standing agenda items on the service business meeting and matrons meeting to share good practice and innovation.

Long stay or rehabilitation mental health wards for adults of working age.

Area	Objective	Action	Progress to date
Long stay or rehabilitation mental health wards for working age	The Trust should ensure all staff are supported to raise concerns about bullying.	The Trust has an anti-bullying support system and helpline in place. HR team will to review with operational managers to ensure staff are supported and aware of support systems in place. Staff side and freedom to speak up guardian to be connected also.	
	The Trust must ensure care plans are personalised and holistic. Regulation 9 (1)(a)(b)(c).	Participate in the Trust wide improvement programme for collaborative care planning	Email sent to all staff requesting care plans to be personalised. Record Keeping audit to be completed by ward matron 01.04.19
	The Trust must ensure staff involve patients in their care planning and their views are recorded appropriately. Regulation 9 (1)(c) 3(b).		
	The Trust must ensure that the privacy and dignity of patients is protected. Regulation 10 (1)	To repair the locks on the two identified toilets so that they can be locked for privacy and dignity.	Looks repaired action complete
	The Trust must ensure that all wards comply with guidance on the elimination of mixed sex accommodation. Regulation 12 (1).	A Trust wide review of the Same Sex Accommodation policy and facilities across the Trust, to include review of move to single sex accommodation where possible	
		Male patients to use the laundry room facilities on Sycamore.	
	The Trust must ensure all environmental risks are identified and mitigated	A Trust wide review of the current Ligature Risk Assessment Tool to take place	

Area	Objective	Action	Progress to date
	against. The Trust must ensure that ligature risk assessments contain appropriate actions detailing plans to update, replace or remove identified ligature risks. Regulation 12 (1) (2)(a)(b).	A tri-part assessment of current risk assessments for each ward including, Matron, Ward Sister/Charge Nurse and Health and Safety representative	
		Ward Sister/Charge Nurse to develop ward mitigation plans for any ligatures identified through the review and re-assessment and shared with the staff team	
		Ward Sisters/Charge Nurses will ensure that the ligature risks for each individual patient is re-assessed through the risk assessment process and where required a person centred ligature care plan in place.	
		The football table on Maple Ward to be moved to the recreation room so it is only accessed by patients under staff supervision.	Action complete
		The Ward Sister and Team Manager to ensure that all staff are up-to-date with risk assessment training	
		To introduce discussions regarding risk and ligatures within Team meetings.	
	The Trust must ensure that environments are regularly maintained and updated to ensure they provide a safe environment for patient care. Regulation 12 (1) (2)(a)(b)(d).	All outstanding repairs and maintenance issues and escalated.	Stewart House doors replaced Tile in the OT kitchen replaced
	The Trust must ensure that staff consistently apply and record appropriate elements of the seclusion	Review of seclusion documentation on a daily basis for any seclusion that has occurred.	

Area	Objective	Action	Progress to date
	policy in line with the Mental Health Act Code of Practice. Regulation 12 (1).		
	The Trust must ensure seclusion rooms comply with the Mental Health Act Code of Practice. Regulation 12 (1) (2)(d).	Seclusion room checks will be completed after patient seclusion is terminated	
		Ensure sink fittings identified in Acacia ward seclusion room as a ligature and safety hazard are replaced.	Estates have been asked to liaise regarding appropriate anti- ligature sink fittings, Site visit week commencing 4/03/19.
		Re-sealing of flooring in Maple ward seclusion room by estates.	Flooring re-sealed.
	The Trust must ensure staff assess and care plan patient's physical health needs. Regulation 12 (1) (2)(a).	Consultant and ward sister / charge nurse to review the current admission process to ensure all patients receive a physical health examination by a doctor on admission to rehabilitation wards and nursing staff complete the cardio-metabolic physical health form.	
		To establish a monitoring process.	
Willows	The Trust must ensure staff assess and care plan patient's physical health needs. Regulation 12 (1) (2)(a).	To recruit 0.2 WTE RGN to work alongside the GP once a week to run clinics and focus on physical health care assessment and planning and health promotion.	Stewart House now has an RGN in post who dedicates one day a week to focus on individualised physical health care plans
Long stay or rehabilitation mental health wards for working age	The Trust must ensure staff update risk assessments following incidents. Regulation 12 (1) (2) (a).	The Ward Sister/Charge Nurse to check the patient electronic record (RIO)at the time of the reportable incidents reviewed to ensure that the patients risk assessment and care plan has been updated accordingly. This will be documented in the Ward Sisters and Charge Nurses sign off.	
		To develop a monitoring system to be reviewed at the monthly governance meeting.	
	The Trust must ensure the	A Band 6 Registered Nurse at Stewart House and the Willows to	

Area	Objective	Action	Progress to date
	safe management of medication, to include storage, labelling and disposal. Regulation 12(1)(2)(g).	take responsibility for medication management procedures with support from Pharmacy.	
Long stay or rehabilitation mental health wards for working age	The Trust should ensure staff support patients to make advanced decisions.	Establish guidance for staff on supporting patients to make advanced decisions about their care and treatment.	
	The Trust should ensure there is clear criteria for admittance to the service	Clinical Director, Head of Nursing and Head of Service to review the admission criteria to the service.	
	The Trust should ensure there is a clear model for the service	Clinical Director and Head of Nursing to review the clinical service model in line with the All Age Transformation programme and clinical pathway review	
	The Trust should ensure patients are provided with food of their choice.	To ensure patient feedback on menu choice is fed into the menu service reviews with the dieticians and local food group.	
	The Trust should ensure all staff are supported to raise concerns about bullying.	Freedom to Speak up Guardian to deliver a number of staff sessions	

Wards for people with a learning disability or autism

Area	Objective	Action	Progress to date
LD Inpatient – Agnes Unit	Ensure that staff consistently apply and record appropriate elements of the seclusion policy in line with the	All staff will be advised of the appropriate recording of the seclusion policy Through the following actions a. Discussion of seclusion policy and areas for improvement in the registered nurses meeting b. Overseeing the cascading the information by deputy sister	

Area	Objective	Action	Progress to date
	Mental Health Code of Practice	at each of the three PODs to healthcare support workers c. Discussion of seclusion policy within the medical team by the consultant All seclusion paper work will be scrutinised on a day to day basis by ward sister / deputy sister. On a weekly basis the Team Manager and Matron will oversee the sign off process.	
LD Short breaks	Ensure that all wards comply with guidance on the elimination of mixed-sex accommodation	All bookings for the 2019 calendar year will be reviewed for mixed sex breaches All service user and family's bookings where breaches will occur will be contacted and advised of the changes, alternatives stays where possible will be offered to accommodate the patient and carer needs or alternative provision considered. Emergency bookings will not be accepted where a breach will occur. Standard Operating procedure and emergency booking procedure to be updated.	All bookings have been reviewed and family's contacted regarding changes to dates or cancelled stays. Emergency booking standard operating policy has been updated.
LD Short breaks	Ensure that staff adhere to infection control principles and that items such as hairbrushes are not used for different patients.	Check all staff are up to date with Infection Control training. Review the homes guidelines on use of service users personal toiletries and grooming items.	Any unlabelled grooming items have been removed from the short break homes.
LD Inpatient Wards	Ensure effective governance systems are in place to monitor the service	The LD Service leads will work with the divisional governance lead to review and develop the service governance structures.	
LD Short breaks	Ensure that medication errors, where electronic prescribing has not been introduced, are reported as incidents	Confirm the process for medication incident reporting with all staff at the homes team meetings. Review all medication error incidents that are reported for learning and share with staff in team meetings.	All incidents are considered under the Trust Medication Error Policy and these are reviewed monthly by the Matron for shared learning.
LD Inpatient Wards	Ensure that learning from incidents and complaints is discussed with all staff,	Develop a framework of shared learning from incidents and complaints as part of the Directorate governance review.	Until this is developed incident and complaint learning is being shared

Area	Objective	Action	Progress to date
	including health care assistants.		from service governance meetings with ward staff teams in their team meetings.
LD Inpatient Wards	Ensure there are clear systems to gather feedback from patients and carers and use it to make improvements to the service.	Review the current systems for gathering patient and carer feedback – Ward/ home patient meetings, complaints, service user forums, friends and family tests, patient stories and feed into service reviews and service quality improvement plans.	

Specialist community mental health service for children and young people.

Area	Objective	Action	Progress to date
	The Trust must review their recruitment processes and ensure there is adequate staff available to reduce the patient waiting lists for assessment and treatment in the children and young people's service. Regulation 18 (1).	To recruit additional resources to support using funding available.	
Neuro-developmental	The Trust must review their service provision for patients with attention deficit hyperactivity and autism spectrum disorders and reduce service waiting times in the children and young people's service. Regulation 9 (1)(a)(b)(c).	Include cohort in trajectory for reduction of waiting time	
		Agree service model and progress towards it	Diagnostic model agreed – treatment model needs more work.

Area	Objective	Action	Progress to date
Infection Control	The Trust must ensure children and young people's service staff follow the Trust's infection control procedures and processes. Regulation 12 (1) (2)(a)(b)(h).	Ensure cleaning rota's completed as part of team leader / site manager role	
		Replace beanbags with wipe clean ones	Bean bags have been disposed of. Any future purchases to be in consultation with the IPC Team.
		Review handwashing facilities in clinic rooms and develop a plan to ensure facilities are adequate	
		Link with infection control team to pick up review process for alternative sites and standards	
CAMHS Leadership	The Trust must ensure there is effective leadership of the children and young people's service across the Trust. Regulation 17 (1) (2)(a)(b)(e)(f).	Implement the new CAMHS leadership structure	
		Develop new and existing local leaders by identifying key staff to engage in the proposed development days for Team Leaders /Ward Managers	In-patient ward development day identified for 20th March.
CAMHS Governance	The Trust must ensure effective governance systems are in place to monitor the service. Regulation 17 (1).	CAMHS Operational Governance Groups to have a standard agenda which demonstrates review and learning from SI's incident and Complaints	
		Develop assurance checklist / scorecard	
		Ensure assurance processes embedded within FYPC	
		Develop and embed assurance meetings across inpatient and community settings	
Data systems	The Trust must ensure they have accessible and comprehensive data/systems for the children and young people's service to	Improve data quality by implementing comprehensive data quality plan and processes	

Area	Objective	Action	Progress to date
	measure their performance and risks. Regulation 17 (1).		
Physical health needs assessment	The Trust should review how they assess and monitor patient's physical health needs in the children and young people's service.	Ensure that the requirements for undertaking physical health checks on Children and Young People in mental health services are met	Medication reviews for ADHD. Others – interaction with other stakeholders GP Pathway leads – NICE recommendations for Physical Health Checks
Service user and carer engagement	The Trust should review and improve their systems for engaging patients and carers in development of the children and young people's service.	Implement a regular user group	
Incident reporting	The Trust should review their safeguarding children and incident reporting policies to reflect staff practice.	Confirmation of policy review and timeline for completion of updated policy	
Meeting diverse needs	The Trust should review their processes for meeting patient's diverse needs	Implement a quality improvement project for the collation and utilisation of protected characteristics information including EIA's for services	Early intervention service Service user group to link to develop a plan to meet the diversity of our community
		Ensure care planning represents the diverse needs of our patient group	
		Include in records audit programme	
Estates and Premises	The Trust should ensure that premises are suitable for purpose in the children and young people's service, such as at Westcotes House.	Agree refurbishment plan for Westcotes House with Trust Board	

Community based mental health service for older people

Area	Objective	Action	Progress to date
MHSOP CMHT	To ensure effective disposal of needles.	To ensure the effective disposal of out of date needles. The checking of date to stock needles in the CMHT bases has been added the CMHT fortnightly medicines checklist. This will reviewed three monthly for a spot check. Spot check June 2019	All out of date stock removed.
MHSOP CMHT	To ensure all environments are alarmed and environmental risk assessments completed.	All bases have access to either the integral alarm system or a hand held alarm for personal safety and to raise the alarm in an emergency. All MHSOP outpatient facilities environmental risk assessments are reviewed to ensure compliance with compliance with staff PPE. To audit compliance against the health and safety checklists monthly.	All clinical areas have been checked and staff have access to personal alarm systems.
MHSOP CMHT	To ensure all patients have access to their care plans	This links to LPT collaborative care planning action (Appendix C)	
MHSOP CMHT	To ensure the senior exec team are visible to staff	Trust wide action	
MHSOP CMHT	The Trust should ensure that the staff knowledge and training is improved around CTO	To cross reference the CTO training register to ensure all clinical community staff to identify staff who have yet to receive additional CTO training.	
MHSOP CMHT	Trust should ensure staffing levels meet the needs of the eservice.	Weekly staffing hot spot review	This is in place
MHSOP CMHT	The Trust should ensure that staffing levels meet the needs of the service.	Review staffing levels and recruitment support.	

Area	Objective	Action	Progress to date
MHSOP CMHT	The Trust should ensure that the senior executive team are present and visible to staff.	Boardwalks in place and a programme of visits occur.	
		We are launching the culture and leadership programme which is an NHSI programme and will support strengthening this area.	

Appendix C LPT collaborative care planning action

Regulatory Warning	Area	Objective	Action	Timeline	Lead	Status	Progress - DATE
Change Aim - Using a two cycle of PDSA methodology transfer the learning from MHSOP to improve the quality of recovery orientated Collaborative Care Planning conversations and practice co productively with staff, patients and carer's on all of the AMH and Rehabilitation Wards that will meet current CQC regulatory warning.							
How will we know that a change is an improvement? **Outcome Measure(s)** • Percent of patients with a collaboratively agreed care plan • Percent of staff who have demonstrated having collaboratively written and completed care plans (appointments completed & Patient Rated Outcome Measure) **Process Measure(s)** • Percent of patients with a completed care plan **Balancing Measure(s)** • Percent and description of care plans not completed collaboratively as evidenced by the PROM							

PDSA Cycle 1		
PLAN – Phase 1		
To plan to undertake phase 1 PDSA focused into improving care planning practice to improve the experience of meaningful collaborative care planning between practitioners and patients collaboratively.	**PLAN – Phase 1** 1. **Clinical Oversight** - senior clinical oversight and implementation of the care planning work programme 2. **Checklist for writing collaborative care plans and quality review (DO)** - Develop the check list from CQC report to structure care planning focus, conversations and care planning agreements to cover 4 key areas : a) Mental Health	**Phase 1** PDSA - March 18th 2019 – 31st May 2019

PDSA Cycle 1		
PLAN – Phase 1		
	b) Physical Health c) Social d) Spiritual/Cultural And will require collaborative care plans to have been written with and contain evidence of: - **Patients Voice and agreements on collaborative care:** The patients voice contained within the care as either 'I' or by their first name within the plan with their hopes and aspirations and self-management plans for recovery - **Smoking cessation support:-** Care plan contains agreements with patients are made as to the choice of use of substitute treatments for those patients experiencing physical symptoms of stopping smoking because they are dependent nicotine. That the agreed plan with the patient is in place to manage this psychologically from an emotional dependency perspective. - **Risk and Positive Risk Taking:** Risks are transferred from the risk assessment and ways of managing this to support recovery and self-management are agreed with the patient into the care plan where they can be evidenced. - **Physical healthcare** - checks are completed and identified from assessment are to be agreed with the patient to support monitoring, self-management and recovery which are evidenced as contained within the care plan - **Mental Health Act –** That the care plan contains the role of staff in advocating and providing patients' rights information on a regular basis (to be agreed with the patient) and Mental Health Advocacy is offered. - **Capacity to consent –** Evidence contained within the care plan that capacity has been assessed and consent given to share a care planning process with carer's or where capacity is not established that carer's are involved in the care planning process. - **Receipt of care plan on completion:** That it is care planned	

PDSA Cycle 1		
PLAN – Phase 1		
	that the patient will receive a copy of the completed care plan and is recorded on RIO.	
Improve the quality of nurses & AHP collaborative Care Planning conversations and practice with patients ensuring that patients have a meaningful and positive experience and receive a printed copy of their agreed care plans.	**PLAN – Phase 1** **Evidence Based Electronic Information Pack** - All practitioners on the wards who are involved in care planning will receive electronic guidance pack containing: - **Exemplars of care plans** as to what 'What good looks like' (Lloyd, 2012) to improve the writing of collaborative Care Plans including EQUIP study Guidance (2018) - **CQC brief guide** on Recovery orientated practice (March 2018) - **100 ways to support** recovery edition 2 - **CHIME** (2014) Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis - **Recovery Orientated Language Guide** (NSW, 2013) - **Ten Top Tips for Recovery Orientated Practice** (Sainsbury's Centre for Mental Health, 2008) - '**The EQUIP Programme** main findings in mental health care planning research' https://www.youtube.com/watch?v=PEjI3zq5FcQ	
	PLAN – Phase 1 - Establish Peer Review Teams - Establish process for review and timeline for returning practice comments - Establish with ward teams Collaborative Care Planning Time allocation and review dates	

PDSA Cycle 1		
PLAN – Phase 1		
	- **Recovery & Collaborative Care Planning Café (Community of practice)** Option of attendance for staff, patients and carer's at the Recovery and Collaborative Care Planning Café as the established community of practice for learning and sharing.	
	PLAN – Phase 1 **Experts by Experience** - Engage and establish patient interview group with Experts by Experience and Patient Experience Team to undertake 6 item EQUIP PROM to measure impact and receipt of care plans	
The completion of the programme in that all patients will have engaged in a care Planning conversation resulting in a collaboratively agreed care plan Completion of peer review of all care plans for quality check and to develop and improve care planning practice	**DO – Phase 1** **Undertake** the collaborative care planning conversations and writing process alongside all patients in AMH and Rehab Wards. **Undertake Peer review** of all care plans for each patient residing on each AMH and Rehabilitation ward care planning practitioners in collaboration with each individual patient residing in LPT to improve practices.	March 18th 2019 – April 30th
PROM Implement Patient Rated Outcome Measure (EQUIP) for patient receipt of care plans and experience of collaborative care planning pr0cess	**DO – Phase 1** All patients on each AMH ward to participate in completing the PROM to measure experience of collaboratively involved in care planning	March 18th 2019 – April 30th
Improve sharing of learning to drive quality improvements across the mental health wards	**Study** - Establish feedback into teams and to the patients the outcomes of the PROM's and ensure the learning is integrated into PDSA cycle 2	30th April – 31st May
Maximise the learning to informs and incorporate into the establishment of the PDSA cycle 2	**ACT - Phase 2 PDSA establishment** – Incorporate the learning from phase 1 improvements in action and put in measures to sustain the gains made in practice and learning	31st May – 30th September

PDSA Cycle 1		
PLAN – Phase 1		
Develop and establish new audit process for continuously improving collaborative care planning process		

Leicestershire Partnership NHS Trust

Inspection report

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Date of inspection visit: 19 Nov to 13 Dec 2018
Date of publication: 27/02/2019

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.

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?	**Inadequate**

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 15 active locations registered with CQC.

The trust has 614 inpatient beds across 40 wards, 10 of which are children's mental health beds.

The trust serves a population of approximately one million people across Leicester, Leicestershire and Rutland, has a budget of £270,000,000 and employs over 5,500 staff in a wide variety of roles. The trust obtained a £4.65m surplus year ending March 2018, compared to £2.24m year ending March 2017. The trust predicts a surplus of £3.27m year ending March 2019.

Services are commissioned through three local clinical commissioning groups and specialised commissioning within NHS England. The trust's key stakeholders include Leicestershire County and City Council, Rutland County Council, police and ambulance services, Healthwatch, primary care and mental health partners and local universities.

CQC undertook a comprehensive inspection of the trust in October and November 2017 with the inspection report published 30 April 2018. The overall rating was requires improvement. The trust was rated requires improvement for safe, effective, responsive and well led, and good for caring.

The areas of non-compliance were:

- Regulation 9: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person centred care
- Regulation 12: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment
- Regulation 13: Health and Social Care Act 2008 (Regulated Activites) Regulations 2014 Safeguarding service users from abuse and improper treatment
- Regulation 15: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Premises and equipment- premises not properly maintained
- Regulation 17: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance
- Regulation 18: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

At this inspection, we found that the trust continued to show they did not meet the requirements of five of these regulations and one additional regulation. However, the trust had met the requirement for Regulation 13.

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Requires improvement

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What this trust does

Leicestershire Partnership NHS Trust provides mental health and community health services across 15 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

Summary of findings

- 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
- 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 of £270,000,000 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 patient's 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 inspected five complete services which we previously rated as 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 older people
- Specialist community mental health services for children and young people
- Long stay / rehabilitation mental health wards for working age adults
- Wards for people with a learning disability or autism.

Summary of findings

We did not inspect the other four community health services or six mental health 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 a 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?

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

What we found

Overall trust

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

- We rated well-led as inadequate, safe, effective, and responsive as requires improvement and caring, as good. In rating the trust, we took into account the previous ratings of the ten core services not inspected this time. We rated the trust overall for well-led as inadequate. At this inspection, we rated two core services as inadequate, two core services as requires improvement, and one core service as good. Therefore, overall, eight of the trust's 15 services are now rated as good, five as requires improvement and two as inadequate.
- We found a high number of concerns not addressed from the previous inspections. We found significant issues with trust level governance, oversight of environments, a failure to address keys issues and a lack of pace with delivering essential improvements. Overall, the pace of change in planning and converting plans into action across the trust was disappointingly slow.
- The trust had not fully articulated their vision for how they operated as a trust. The trust had several strategies, a vision and corporate objectives, but they did not underpin all policies and practices. The trust lacked an overarching strategy which everyone within the trust knew. Staff and senior leaders could not articulate the trust's direction of travel and how this was co-ordinated. There was a lack of understanding in teams how their own plans, visions and objectives connected with the trust's vision.
- We were not assured that the trust risk register clearly documented action taken or progress of action, within agreed timescales. Many of the actions listed included plans to review process, establish an approach, or to develop areas. We felt this contributed to senior staff views that pace of change in the trust was slow. The trust's Board Assurance Framework (BAF) was lengthy, was combined with a corporate risk register and had overdue actions. Due to the lack of a trust overarching strategy, the BAF did not provide an effective oversight against strategic objectives, gaps in control and assurance.
- We had serious concerns about the trust's oversight of ward environments and safety of patients within those areas. Since our 2017 inspection, the trust had not fully ensured that clinical premises where patients received care where safe, clean well equipped, well maintained and fit for purpose. We found concerns with the environment in all five core services we inspected.
- Medication management across four of the five services we inspected was poor, despite reported trust oversight and audit. We found serious concerns with medication disposal, storage, labelling and management of controlled drugs.
- Staff did not record seclusion well. Considerable numbers of records we reviewed during our inspection, were of a poor standard, with substantial and important clinical reviews missing, as recommended by the Mental Health Act Code of Practice.

Summary of findings

- Risk management in services required improvement. Staff did not effectively complete risk assessments for patients, manage a smoke free environment, or share information about incidents or share learning from incidents within teams, across services or between services in the trust.
- In most services, we were concerned with the lack of evidence in care plans which showed patients and carers had been consulted and involved in their care. Staff did not routinely complete detailed, person centred, individualised or holistic care plans about or with patients. Staff in four of the five services we inspected did not document patient involvement in their care. Staff had not routinely recorded whether they had given patients copies of their care plans and we saw this in a considerable number of patient records we sampled. Patients and carers confirmed in most services they had not received copies of care plans. Community meetings and patient involvement in the services did not always take place. Therefore, patients were not always actively engaged in decisions about service provision or their care.
- We found concerning evidence of long waiting times for assessment in specialist community mental health services for children and young people. Whilst staff monitored patient's risk on the waiting lists, the length of time to wait was of concern, in addition to the services' lack of oversight and management of this issue. This left patients without access to treatment when they needed it most.
- The dignity and privacy of patients across three services we visited was compromised. The trust did not always manage the admission of patients into mixed sex environments well. Staff used strategies to maintain patient's safety which had an adverse effect on their dignity and privacy. Staff carried out physical observations in public areas in one service, and staff did not always record or explain why some observations of patients were required.
- Staff did not always feel connected to the wider trust. Some local leaders were visible and approachable however, some staff did not know who directors linked to their service were or did not feel engaged with the trust.
- The trust lacked a framework for co-ordinating, endorsing and therefore learning from the very many positive quality projects taking place. The teams we spoke with, felt the trust board did not set clear timescales or direction on how to move their projects forward.
- The trust had a limited approach to patient involvement. We found this across core services and within senior teams. We would expect patient involvement to be embedded at all levels of the trust, across as many departments as possible, in planning, review, evaluation and delivery. The trust mostly used surveys to gain feedback and we saw limited evidence of face to face engagement with patients about service delivery and improvement.
- There were issues within the trust of a bullying culture despite evidence that staff knew the trust values. Some teams told us about a lack of teamwork, best practice was not shared amongst services and regular meetings did not take place in some services.
- The trust's pace for implementing equality and diversity initiatives across the organisation needed improvement. This was particularly relevant to protected characteristics. The trust supported a BAME network (black and minority ethnic) however, given the diversity of the geographical area of the trust, they had not significantly developed its agenda or work streams since our last inspection.
- Supervision and appraisal compliance of three teams fell below 75%. The trust did not provide data to demonstrate medical staff appraisal compliance.

However:

- Despite the issues we found with storage, disposal, labelling and controlled drugs, the trust had made improvements to prescribing of medication and had successfully implemented e-prescribing processes trust wide. Services had supplies of emergency medication available and this was accessible to staff. Staff in some services completed care plans with detailed information on allergies, and risks around medication.

Summary of findings

- The number of incidents reported by the trust had decreased since the last inspection and serious incident figures remained comparable. The trust had robust systems in place which allowed staff to effectively report incidents. The patient incident team carried out a review of serious incident reporting and made changes to improve the reporting process, categorise incidents in a better way and improved reporting of safeguarding. The group established a deliberate self harm and suicide group in the last year to oversee specific incidents of this nature.
- Mandatory training compliance for trust wide services was 91% against the trust target of 85%.
- We heard from most teams, positive examples of teamwork and multidisciplinary working within teams and services, and with external agencies and key stakeholders.
- Many staff we spoke with knew who their chief executive was and mentioned them by name. Staff gave examples of initiatives such as the chief executives' blog and the presentation of the valued star award. We were pleased to hear about the trust's investment in well-being events and initiatives for staff, such as 'valued star award', choir, yoga and time out days.
- Detention paperwork for those detained under the Mental Health Act was detailed and followed procedures. Staff knew and understood their role in compliance with the Mental Health Act and Mental Capacity Act.
- Staff showed caring attitudes towards their patients. We saw numerous interactions between staff and patients with very complex needs and staff managed extremely challenging situations with knowledge and compassion. Staff demonstrated a respectful manner when working with patients, carers, within teams and showed kindness in their interactions. Patients and carers gave positive feedback about the caring nature and kindness of staff and made positive comments about the positive therapeutic relationships they had with their loved ones.
- The trust had robust governance structures and they had assured any potential gaps or overlaps had been considered. The trust had a variety of measures in place to ensure that processes and reporting to board were not delayed. Every team we spoke with knew who they reported to and what to report.
- We heard positive reports of senior staff feeling able to approach the executive team and the board. Local leaders were visible and had the skills and knowledge to perform their roles. The trust delivered programmes for staff to develop into senior roles and had a clear career development programme for nursing staff.
- Engagement and joint planning between departments was well developed. The trust encouraged staff at most levels of the organisation to develop and deliver ideas for service delivery, improvement and innovation. We heard many examples of interesting innovation projects and work that staff groups had done which impacted on and improved patient care.
- The trust had made progress in oversight of data systems and collection. Staff were aligned to services to manage data and we have seen improvements in recording and monitoring of supervision and appraisal, improvement in managing risks of those on waiting lists in specialist community mental health services for children and young people and in training data.

Are services safe?

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

- The trust had not fully ensured since our 2017 inspection that clinical premises where patients received care were safe, clean well equipped, well maintained and fit for purpose. We found concerns with the environment in all five core services we inspected. Staff had not identified ligature risks in two of the five services, and where risks had been identified staff had not fully recorded or were aware of mitigation to manage such risks. Two seclusion rooms were not free from hazards. Services inconsistently completed environmental risk assessments. The trust did not respond promptly to repairs needed in four of the services inspected. This ranged from broken windows, cracked walls,

blocked toilets, poor lighting and broken furniture. Services inconsistently completed environmental risk assessments. We had concerns about fire safety in the Bradgate Unit, where staff did not complete regular fire checks or document patient fire evacuation plans, and a fire door required repair. These issues caused concern given that 14 incidents of fire setting had occurred in the last year.

- The management of seclusion documentation was poor. Despite seclusion audits taking place, the standard of documentation fell below the standard expected by the Mental Health Act Code of Practice, in relation to medical reviews, nursing reviews and care plans for those who required the intervention of seclusion. We reviewed 58 seclusion records, 34 did not record a medical review within one hour of the start of seclusion; forty did not record a nursing review by two nurses every two hours throughout seclusion. Twenty-four did not record continuing medical reviews every four hours until the first multidisciplinary review. Ten of 15 records did not record an independent multidisciplinary team review after eight consecutive hours of seclusion. Sixty-one records did not record in a care plan how de-escalation attempts would continue or how risks would be managed.
- Medicines management within four of five services inspected, was unsafe and raised serious concerns, despite trust oversight, reports to board and audits. We found issues with medication disposal, storage of medication, medicines labelling and management of controlled drugs. Medicines management was raised as an issue at our inspection in 2017.
- We were not assured the trust had full oversight of risks within core services. Staff did not consistently and effectively manage patient risk in three services. Staff at the Bradgate Unit did not safely manage the smoke free environment. Patients frequently secreted lighters onto the wards and smoked in bedrooms, gardens and close to the buildings. This continued to take place despite recent fire setting incidents. Staff inconsistently recorded safeguarding incidents in the Specialist community mental health services for children and young people. Staff did not regularly complete or update patient risk assessments in long stay / rehabilitation mental health wards.
- The trust did not comply with guidance on eliminating mixed sex accommodation in some services. Two wards in the long stay / rehabilitation mental health wards for working age adults service had unlocked doors between male and female areas, and no single sex lounges. We were not assured the trust reported mixed sex breaches accurately. Staff told us on acute mental health wards, patients were admitted in to 'breach beds', and Short Breaks Units recorded 37 occasions where breaches had occurred. This was despite data submitted from the trust prior to inspection which showed no breaches had occurred.
- Four services had ineffective processes to share learning from incidents. There was limited evidence to show how ward teams shared information about incidents with their own staff, between wards or across services within the trust. We saw limited evidence of how learning from incidents had been shared and embedded into practice to prevent reoccurrence.
- Staffing shortages, sickness and use of agency presented issues for three services we visited. Patients waited for long periods to see staff in specialist community mental health services for children and young people and within community based mental health services for older people; high use of agency in acute mental health wards reduced consistency for patients and impacted on therapeutic relationships.
- Staff did not ensure infection control measures were effective in two services we inspected. This included toy cleaning, play equipment and handwashing facilities in specialist community mental health services for children and young people, and unlabelled hairbrushes at Rubicon Close.

However:

- The trust had plans in place to re-provide environments for specialist community services for children and young people services. Plans for the Bradgate Unit were a vision for 2023. Clinical areas in two of the five services we inspected were of good quality, clean and well maintained.

Summary of findings

- Staff completed thorough risk assessments for patients in community based mental health services for older peoples and on wards for people with a learning disability or autism. Staff managed the risks of patients on waiting lists well. Significant improvements had been made since our last inspection to manage the risks of those who waited for assessment or treatment in specialist community mental health services for children and young people and in community mental health services for older people. Robust systems had been put in place to oversee these patients.
- The trust had made improvements to prescribing of medication and successfully implemented e-prescribing processes. Services had supplies of emergency medication available and this was accessible to staff. Staff in some services completed care plans with detailed information on allergies, and risks around medication.
- Staff rarely used seclusion at the Agnes Unit. Staff had completed restrictive practice training and used positive behaviour support plans and de-escalation techniques to reduce restraints and seclusion.
- The number of incidents reported by the trust had decreased since the last inspection and serious incident figures remained comparable. The trust had robust systems in place which allowed staff to effectively report incidents. The patient incident team carried out a review of serious incident reporting and made changes to improve the reporting process, categorise incidents in a better way and improved reporting of safeguarding. The group established a deliberate self harm and suicide group in the last year to oversee specific incidents of this nature.
- Mandatory training compliance for trust wide services was 91% against the trust target of 85%.

Are services effective?

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

- Staff did not routinely complete individualised, person centred and holistic care plans for or with patients. A significant number of care plans sampled across long stay rehabilitation mental health wards for working age adults and acute wards for adults of working age demonstrated this. Ward staff often used templates for care plans which generated generic wording and statements. Some care plans did not identify patient strengths or demonstrate a recovery focus. There was limited evidence of patient involvement in care plans, or that staff recorded whether patients were offered, accepted or declined care plans.
- Staff supervision and appraisal compliance on wards for people with learning disability or autism, specialist community mental health services for children and young people, long stay rehabilitation mental health wards for adults of working age teams fell below 75%. The trust did not provide data to demonstrate medical staff appraisal compliance.
- Not all teams had access to a full range of skilled staff to deliver treatment under best practice guidance. The Bradgate Unit had a vacancy for a clinical psychologist which impacted on therapy offered to patients. Not all units there, had access to therapeutic liaison workers who provided activity for patients. We heard how Accident and Emergency liaison triage staff had experience of working with adults and not children and young people in crisis. There was little evidence of how staff in acute wards for adults of working age and the psychiatric intensive care unit services recorded care delivery in line with best practice guidance.
- Staff did not routinely complete or record physical health checks on admission in long stay rehabilitation mental health wards for working age adults or annually within specialist community mental health services for children and young people.
- Staff and managers in acute wards for adults of working age and the psychiatric intensive care units did not demonstrate evidence of collaborative working between wards, learning from incidents and sharing of best practise. Some wards had good initiatives underway such as healthy eating and seclusion recording, but these positive outcomes were not shared.

However:

Summary of findings

- Staff across three services we inspected showed effective care planning and physical health monitoring.
- Services had made significant improvement with recording compliance with staff supervision and appraisal since our last inspection.
- Staff knew and understood their role in compliance with the Mental Health Act and Mental Capacity Act. Staff routinely carried out capacity assessments where necessary and consent to treatment was recorded for patients in most services. The trust provided effective support and governance to ward staff with Mental Health Act compliance, and paperwork showed correctly completed documentation.
- We saw evidence of effective collaboration amongst some teams and with external stakeholders.
- The trust engaged with national accreditation schemes and carried out frequent audits.

Are services caring?

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

- Staff showed caring attitudes towards their patients. We saw numerous positive interactions between staff and patients with very complex needs and staff managed extremely challenging situations with knowledge and compassion. Staff demonstrated a respectful manner when working with patients, carers, within teams and showed kindness in their interactions.
- Patients and carers gave positive feedback about the caring nature and kindness of staff and made positive comments about the positive therapeutic relationships they had with their loved ones.
- Patients had access to advocacy services.

However:

- Staff in four of the five services we inspected did not document patient involvement in their care. Staff had not routinely recorded whether they had given patients copies of their care plans and we saw this in a considerable number of patient records we sampled. Patients and carers confirmed in most services they had not received copies of care plans.
- The dignity and privacy of patients across three services we visited was compromised. The trust did not always manage the admission of patients into mixed sex environments well. Staff used strategies to maintain patient's safety, although these had an adverse effect on their dignity and privacy. Staff carried out physical observations in public areas in one service, and staff did not always record or explain why some observations of patients were required.

Are services responsive?

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

- Trust oversight in regard to access to care and treatment within four services we inspected was below expectation. Patients waited for long period to access community services, bed occupancy within inpatient wards was high. The trust used out of areas beds for acute wards for adults of working age, waiting lists were considerable for specialist community mental health services for children and young people, children and young people in crisis had difficulty accessing help urgently, and carers had difficulty accessing beds in short breaks units. At times, some patients were admitted into rehabilitation settings when acutely unwell and not appropriate for rehabilitation at the time.
- At all five services we visited, there were facilities that did not promote comfort, dignity and privacy. These issues included soundproofing of rooms, privacy to meet patients and carers in a confidential setting, and insufficient space for therapy and meetings. Some patients shared bedroom space at the Bradgate Unit because dormitory accommodation continued to exist within the trust and patient toilets at Stewart House were not lockable.

Summary of findings

- At times, services did not meet the diverse needs of those patients who used services. For example, we saw limited evidence of how specialist community mental health services for children and young people met the needs of a black and ethnic minority population. Patients in three services told us food was over processed or lacked variety and quality and snacks were provided at set times only.

However:

- Services planned discharges well. Staff engaged community teams, relevant services and health and care professions to facilitate effective placements and discharges. Discharge co-ordinators in several services were in post and had made improvements to discharges for patients. Staff completed detailed discharge plans in most services we visited.
- Despite long waiting times for assessment or treatment, the trust had taken proactive steps to monitor the risk of those patients on the waiting lists more effectively since our last inspection. Staff maintained contact with patients who waited and monitored their risks regularly. The trust told us of further steps they planned to make to review access to treatment pathways.
- Staff made information available to patients in a variety of languages, facilitated patient's access to interpreters and provided information on and supported patients and carers how to make a complaint where necessary. The trust held a very comprehensive data base which collated all information regarding complaints and we were assured of trust oversight for complaints.

Are services well-led?

Our rating of well-led went down. We rated it as inadequate because:

- We found a high number of concerns not addressed from the previous inspections. We found significant issues with trust level governance, oversight of environments, a failure to address keys issues and a lack of pace with delivering essential improvements. Overall, the pace of change in planning and converting plans into action across the trust was disappointingly slow.
- The trust had not fully articulated their vision for how they operated as a trust. The trust had several strategies, a vision and corporate objectives, but these did not underpin all policies and practices. The trust lacked an overarching strategy which everyone within the trust knew. Staff and senior leaders could not articulate the trust's direction of travel and how this was co-ordinated. There was a lack of understanding in teams how their own plans, visions and objectives connected with the trust's vision.
- Although the trust had a defined reporting structure to the board, the governance of the trust was poor. The trust did not have robust governance procedures to ensure that they could identify and address issues across the trust in a timely way. These issues with governance procedures had been reported at the last inspection in 2017.
- We were not assured that the trust risk register clearly documented action taken or progress of action, within agreed timescales. Many of the actions listed included plans to review process, establish an approach, or to develop areas. We felt this contributed to senior staff views that pace of change in the trust was slow. The trust's Board Assurance Framework (BAF) was lengthy, was combined with a corporate risk register and had overdue actions. Due to the lack of a trust overarching strategy, the BAF did not provide an effective oversight against strategic objectives, gaps in control and assurance.
- Frontline staff did not always feel connected to the wider trust and did not know who directors linked to their service were or did not feel engaged with the trust.
- The trust leadership and local service leadership lacked oversight and responded slowly to issues of risk and performance that affected safe delivery of patient care. Oversight of medication management, environments, seclusion documentation, staffing, waiting lists, care planning and patient involvement was variable, and in some services limited.

Summary of findings

- The trust lacked a framework for co-ordinating, endorsing and therefore learning from the positive quality projects taking place. The teams we spoke with, felt the trust board did not set clear timescales or direction on how to move their projects forward.
- There were issues within the trust of a bullying culture despite evidence that staff knew the trust values. Some teams told us about a lack of teamwork, best practice was not shared amongst services and regular meetings did not take place in some services.
- The trust had a limited approach to patient involvement. We found this across core services and within senior teams. We would expect patient involvement to be embedded at all levels of the trust, across as many departments as possible, in planning, review, evaluation and delivery. The trust used numerous surveys to seek views but this does not always replace face to face engagement.
- The trust's pace for implementing equality and diversity initiatives across the organisation needed improvement. This was particularly relevant to protected characteristics. The trust supported a BAME network (black and minority ethnic) however, given the diversity of the geographical area of the trust, they had not significantly developed its agenda or work streams since our last inspection.
- Overall, the pace of change in planning and converting plans into action across the trust was disappointingly slow. There was a lack of both grip and pace in the movement of the plans to secure resources to re-provide outdated environments.

However:

- The trust had a variety of measures in place to ensure that processes and reporting to board were not delayed. Every senior team we spoke with knew who they reported to and what to report.
- Some local leaders were visible and had the skills and knowledge to perform their roles. The trust delivered programmes for staff to develop into senior roles and had a clear career development programme for nursing staff.
- The trust encouraged staff to develop and implement ideas for service delivery, improvement and innovation. We heard many examples of interesting innovation projects and work that groups had done which impacted on and improved patient care.
- The trust had made progress in oversight of data systems and collection. The trust aligned staff to services to manage data and we saw improvements in recording and monitoring of supervision and appraisal, improvement in monitoring of waiting lists in specialist community mental health services for children and young people, and in trust wide training data. All managers in services had access to key performance data and knew how to interpret it and escalate concerns when necessary.
- The trust was proactive and promoted staff health and well-being. We heard many positive stories to support the health and well-being of staff across the trust. This included mindfulness, yoga, staff choirs, corporate events, training courses through local colleges (such as mental health first aid), physiotherapy and counselling. The trust had a health and well-being calendar for events, and health and well-being champions to promote events.

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

Our rating of this service went down. We rated it as inadequate because:

- Staff on the wards did not manage a range a safety related issues well. In particular, medicines management, implementation of the smoke free policy, lack of clarity and understanding around the requirements of same sex

accommodation, and environmental risks particularly relating to fire. Managers did not always share lessons learned effectively. Managers did not identify themes from incidents and did not address issues quickly. Patients in seclusion did not always have access to the appropriate reviews of their treatment, or the appropriate staff to maintain their dignity. Documentation relating to seclusion was poor.

- High usage of bank and agency staff on some wards had an impact on the development of person-centred therapeutic relationships. There was no dedicated staffing for the Section 136 place of safety and staff left the acute wards to staff the 136 suite when a patient was admitted. This had an impact on ward staffing and consistency of staffing.
- Wards that were built some time ago were poorly maintained and did not promote privacy, dignity and recovery. They lacked private space for patients to meet visitors or to have physical health checks. We observed patients having blood pressure and weight checks in full view of other patients and staff on three wards. Four wards had dormitory style accommodation and five wards did not have enough seating for all patients to eat together. We observed broken windows, poor lighting, stained furnishings and broken furniture in bedrooms. Staff reported a lack of responsiveness from maintenance services. Windows identified as urgently requiring replacement in September 2017 had not been fixed. Ward staff were not aware of refurbishment plans scheduled for 2019 and were pessimistic about work starting on time.
- Patients were at risk of not receiving individualised, person-centred care. Staff did not involve all patients in their care. Care plans used generic wording and statements with a lack of patient voice. 11 out of 26 patients we spoke with were either not aware of what a care plan was or did not feel involved or been given a copy of their care plan.
- There was little record of mental capacity and consent to treatment being assessed on a regular basis.
- There was insufficient opportunity for some patients to access psychological therapy. This was not in line with National Institute for Health and Care Excellence (NICE) guidance. On all acute wards, doctors and nurses told us there was a limited amount of psychology input.
- Staff across the unit did not demonstrate collaborative working. Senior managers did not encourage the sharing of best practise, innovative working and learning from incidents. Four ward managers expressed frustration that their views and concerns about patients being admitted on to their wards were not always considered. We observed staff from one ward struggling to get urgent assistance from other wards to help deal with a difficult incident.
- Staff did not feel always feel connected to the wider trust. They described visible local leadership to service manager level but felt above that role there was a lack of visibility and understanding of their service's needs. We heard examples where local leaders felt there was a lack of response from the trust regarding issues significant to their wards. Some staff members knew who the executive team were, in particular the chief executive, but were not able to name who the director was linked to the service or had seen them on a board walk.

However:

- Local ward staff and managers demonstrated passion and commitment to their roles. Staff worked hard to mitigate against the challenges of a poor physical environment.
- Staff were largely aware of the risks within the environment and permanent staff had good knowledge of their patients and their risks. The trust had implemented some environmental improvements, for example reduced ligature door frames.
- There were some examples of good initiatives taking place on wards. For example, a member of staff on one ward was assisting patients to make healthy snacks rather than ordering take-aways. Seven wards had therapeutic liaison workers employed to engage patients pro-actively in activities both on and off the ward.

Summary of findings

- Staff had the right qualifications and experience to support patients. Compliance with mandatory training and supervision had improved since the last inspection. We observed staff dealing well with a very difficult incident. Staff documented this appropriately, and at the earliest opportunity. We observed positive and caring interactions between staff and patients on the wards.

Long stay or rehabilitation mental health wards for working age adults

Our rating of this service went down. We rated it as inadequate because:

- Managers had not ensured safe and well-maintained care environments. We found unidentified ligature risks and ligature risks that were not safely managed on two wards. At Stewart House, managers had not ensured that the occupational therapy kitchen was safe and doors were in a state of disrepair. On Maple ward patients and staff told us that the toilets were continually blocked. Two wards were not compliant with mixed sex guidance, there were no locked doors between male and female areas and no single sex lounges. Two toilet doors at Stewart House could not be locked.
- Managers had not ensured compliance with the Mental Health Act Code of Practice. The seclusion rooms on two wards were not free from hazards, including blind spots. Staff had not completed the required reviews for a patient in seclusion a seclusion care plan and were using out of date seclusion documentation.
- Staff did not always complete and review the required assessments for patients. Staff had not completed a physical health examination for patients on admission in 14 out of 30 records. On Maple ward staff had not completed and updated patient risk assessments in six out of eight records.
- Staff did not follow good practice in medicines management. On two wards we found medicines that staff should have disposed of, sharps bins used to dispose of medicines, unlabelled medicines, medicated creams stored in an unlocked cupboard, loose tablets (unboxed in their foils) in the medicines trolley, two out of eight patient's medicines not reconciled on admission and staff not reviewing PRN (as required) medicines in line with national guidance.
- Staff did not always involve patients. In 20 out of 30 records there was no evidence that staff had involved patients in their care planning and there was no evidence in any records that patients had been offered a copy of their care plan. Staff had not completed care plans that were personalised, holistic or recovery orientated in 19 out of 30 records. Sycamore ward did not hold regular meetings for patients.
- The care records did not provide evidence this service provided care that would be considered best practice in a rehabilitation unit. The care plans did not indicate that people received the range of services a rehabilitation should provide.
- Staff did not always treat patients with dignity and respect when providing care and treatment. We found issues on four wards with intrusive observations of a patient, patients having to walk past bedrooms and bathrooms of the opposite sex and patient toilets unable to be locked. Patients were not happy with the quality and variety of food available. Patients had made repeated requests for more salads, vegetarian dishes and a greater choice of food. There was no evidence that staff had met these requests.
- Governance systems and processes had not ensured safety and environmental issues were addressed, that staff adhered to the Mental Health Act Code of Practice, that patient involvement was evidenced in records and that patient's requests were responded to in a timely manner. Leaders had not ensured a clear model of service. Managers did not feedback learning from incidents across the trust to staff.

However:

Summary of findings

- Staff and managers worked to keep the use of restrictive interventions to a minimum. They participated in the provider's restrictive interventions reduction programme. Staff made every attempt to avoid using restraint by using de-escalation techniques and only restrained patients when these failed and when necessary to keep the patient or others safe.
- All staff received training in safeguarding that was appropriate for their role. Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns.
- The team included or had access to the full range of specialists required to meet the needs of patients on the ward. Staff worked well as a multidisciplinary team. Ward teams had effective working relationships with other teams in the trust and external teams and other organisations.
- Despite a lack of recording in patient records, staff supported, informed and involved families or carers. Carers were provided with a welcome pack. We spoke with four carers. Carers told us that staff were brilliant, helpful and polite and looked after their relative well. Carers were invited to meetings about their relative's care and were kept updated. Staff helped families to give feedback on the service.
- The service had low numbers of delayed discharges (three in the past year). The service employed discharge nurses to enable a smooth transition for patients being discharged. Managers and staff ensured they did not discharge patients before they were ready. Staff had completed detailed discharge plans that were regularly reviewed in 26 of the 30 records reviewed.

Wards for people with a learning disability or autism

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

- The short breaks services did not comply with mixed-sex accommodation guidance. Services planned male and female only weeks at all the services to avoid breaching the guidelines but admitted patients when families required support at short notice. This had happened 37 times in the last 12 months. Carers and staff told us this gave carers less flexibility to book breaks.
- Staff did not always comply with the Mental Health Act code of practice when secluding patients and did not complete seclusion paperwork appropriately. Records did not contain seclusion care plans. In three records, there was no medical review within one hour and in two cases no regular nursing reviews throughout the seclusion. Managers had not retained oversight of this.
- There were hazards in the short breaks services which could compromise the safety of patients. These included broken items of garden furniture and uneven pathways. The keys to the 'Control of Substances Hazardous to Health (COSHH) cupboard had been left in the door and the door had been left open. Staff did not always manage medicines safely or adhere to infection control principles. Managers did not have sufficient oversight of these issues.
- Managers did not have clear oversight of data and information gathering processes. Managers did not have a robust system to ensure that essential information, such as learning from incidents and complaints, was shared and discussed with all staff, including healthcare assistants. The trust could not provide data relating to staffing on the Agnes unit prior to the inspection. We did not find clear systems in place to gather feedback from patients and carers and use it to make improvements to the service. Staff had not routinely recorded whether they had given copies of care plans to patients or to their carers where appropriate.
- Patients could not make or have access to snacks when they wanted them. Although patients could ask for a drink at any time, the patient booklet stated that snacks were at set times only.
- Some of the nursing offices at the Agnes unit were very small and could not support handovers. Staff held handovers in other rooms such as a staff kitchen.

Summary of findings

- Managers and staff at the short breaks services said they felt isolated from the trust and from each other with little sense of a shared identity. The three units showed limited joined up working. Managers spent more time in some units than others.

However:

- Internally the wards were clean and well maintained. Furnishings were generally of good quality. The Agnes unit had access to a full range of rooms to support treatment and care. There was a separate activity area and smaller rooms where staff could speak to patients privately. The clinic room was clean and well organised.
- There were enough staff deployed to keep patients safe. Mandatory training rates were high across the services. Managers at the Agnes unit provided staff with regular appraisals and supervision and new staff received an induction which was based on care certificate standards. Staff completed restrictive practice training which taught them to use positive behaviour support plans and de-escalation techniques to reduce restraints and seclusions.
- Staff completed comprehensive risk assessments and kept these updated. Staff completed ligature risk assessments which addressed all the ligature risks on the wards. The Agnes unit had been fitted with anti-ligature fittings. Staff used enhanced levels of observations based on individual risk assessments to ensure patients were safe.
- Staff managed medicines safely at the Agnes unit. The provider ensured staff stored medication at appropriate temperatures and used an electronic prescribing system to ensure they administered medicines safely. Doctors followed national institute for health and care excellence when prescribing medication for patients.
- Staff completed and updated comprehensive mental health assessments regularly. Staff completed physical health checks for patients on admission and monitored this during their stay. Patients had good access to physical healthcare services; staff referred to specialist services and procured specialist equipment when necessary. Staff completed holistic and person-centred care plans and positive behaviour support plans. Staff applied the Mental Capacity Act appropriately. Mental capacity assessments and DoLS applications were of good quality, decision specific and correctly submitted.
- Staff treated patients with kindness and compassion and were focused helping them get better by providing high quality care. We observed staff interacting with patients in a kind, caring and respectful manner. Staff involved patients in planning their care. Staff reflected this in care plans and patients confirmed it. Staff supported and involved carers and families in their relatives' care and treatment. Staff understood patient's needs and helped patients to understand why they were in hospital and how to move on.
- There were good interagency working arrangements in place to support the needs of patients. Multidisciplinary team members worked with their community colleagues to ensure smooth transitions and discharges. Staff at the Agnes unit supported moves to placements and liaised with community teams to ensure a smooth transition.
- Staff provided information in an accessible format and displayed it across the services in several different languages. Patients had access to interpreters when needed. Speech and language therapists worked with patients and staff to ensure they met patient's specific communication needs.
- Systems were in place to measure the performance of the team. Managers received regular information to help them ensure staff received training and supervision when they required it. Staff had access to equipment and information technology to do their work. The patient information system was easy to use and staff found it easy to update patient records.
- Staff teams supported each other well and said they felt respected, supported and valued. Staff felt able to raise concerns without fear of consequences and knew how to do this.

Specialist community mental health services for children and young people

Summary of findings

Our rating of specialist community mental health services for children and young people stayed the same. We rated it as requires improvement because:

- The trust had not ensured adequate higher management leadership and governance to address all actions from our previous inspections. Some issues particularly relating to the management of staff resources, waiting lists and the environments for example, infection control procedures, still posed a risk for the service. The CQC had found some of these risks since 2015. Whilst we noted the trust had made changes to the service, we had concerns about the slow pace of change as patients still faced long waits for assessment and treatment.
- As of 19 November 2018, 498 patients waited for a routine assessment at city or county teams, 136 patients waited over 30 weeks across services for assessment. There were 969 patients waiting for treatment. Staff including managers told us there was a 34 week wait for patients with 'medium' and 'low' risks who needed a 'routine' assessment.
- The trust did not meet the needs of patients with neurodevelopment issues in a timely way as patients often faced the longest waits for this service. As of 19 November 2018, 454 patients with attention deficit hyperactivity disorder (ADHD) and autism spectrum disorder (ASD) waited for either further specialist assessment or treatment, 161 patients waited one to two years. The crisis team supported a lot of these patients who presented in crisis.
- The trust had taken remedial action to make changes to decrease the waiting times including a 'a demand capacity review'. However, at the time of the inspection this work had not addressed the current issues in regard to the length of time patients remained on the waiting list and not in receipt of care and treatment.
- The trust had not ensured there were enough staff to meet the needs of the service. Many patients still faced long waits for assessment and treatment. Seventeen out of 35 staff we spoke to raised concerns about this. Sickness rates for county and crisis teams were at times above the national average (of 4.2%) for NHS mental health and learning disability services at 5.7%. The trust had not ensured that all managers had access to data systems to assess and monitor risks in their services.
- The trust had not fully ensured since our 2017 inspection that clinical premises where patients received care were safe, clean, well equipped, well maintained and fit for purpose. The trust's infection control processes were not robust as most sites did not have cleaning rotas for treatment rooms and toys. The trust had not ensured that Westcotes House reception was fully private and confidential as visitors could overhear the receptionist conversations and trust information.
- The trust staff gave limited examples of how they met the diverse needs of patients. Twenty out of 26 patient's records checked held limited information about patients protected characteristics for example race, religion or belief or sexual orientation. This was despite Leicester black and minority ethnic population being significantly greater (49.5%) when compared against the England average. (Joint Strategic Needs Assessment). The trust did not have a system in place to regularly engage with patients and carers and involve them in the service delivery. Whilst staff showed they were considering patients physical health needs, they did not routinely or annually assess patient's them and instead relied on the patient's GP to do so.
- The service did not follow the process for reporting safeguarding incidents on the trust's electronic record.

However:

- Staff contributed to discussions about the service's strategy and changes to the service. Managers said their access to data had improved and they were more confident they knew who was waiting for assessment and treatment and why.

Summary of findings

- The trust had made improvements to ensure staff completed clear comprehensive and holistic care plans which showed patient's needs, the care required and involved them in the development of them. The trust had ensured since our last inspection that staff documented, where required, assessments a of patient's mental capacity and their consent to treatment.
- Managers showed compassion and understanding when explaining how they supported their staff when they had been unwell. The trust more actively promoted staff wellbeing through events. Staff developed their skills and competencies through managers giving regular supervision and appraisal.
- The trust had a range of specialist services. These included a young peoples' team which worked with vulnerable young people in care and those who are involved with the youth offending service; a specialist perinatal outreach mental health service and other teams to support patients with an eating disorder or with psychosis.
- Staff provided a range of care and treatment interventions that were recommended by and were delivered in line with National Institute for Health and Care Excellence guidance. The trust gave staff some time and support to consider opportunities for improvements. Staff had effective multidisciplinary working with internal and external teams such as primary care and education. Specialist community mental health services for children and young people, staff had effective working relationships, including good handovers, with other teams within the organisation (for example, community to crisis team).

Community-based mental health services for older people

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

- Safety was a sufficient priority for the service. Staff managed and assessed medicines risks safely. This was an improvement since the last inspection. Staff ensured all depot injection cards and care plans contained allergy information. Staff ensured all care plans contained individual patient risks with medication and how risks had been reduced.
- The service improved the monitoring of waiting lists and patient risk. Team managers reviewed waiting lists weekly and breaches of waiting times were minimal. Team managers called patients on the waiting list to assess risk and referred them to the unscheduled care team for urgent assessments. Staff risk assessed all patients regularly and responded appropriately to changes in risks. Staff understood how to protect people from harm and abuse and had good working knowledge of safeguarding adults and children. Staff had all completed their mandatory training.
- Patients received individualised treatment. We reviewed 27 care plans that were up to date, person centred and involved patients. Staff developed care plans collaboratively with patients and patients could identify their goals and objective. Staff discussed care plans with carers and family members with the patient's consent and involved them in meetings, which was evidenced in the care records we reviewed.The service had positive multi-disciplinary team relationships across which enabled staff to refer patients to other professionals easily. Individual teams had good relationships with local third sector organisations such as; the advocacy service and veteran charities who staff regularly referred patients to.
- We observed staff to be compassionate, respectful and responsive to the needs of patients and carers. Feedback from patients and carers was positive. Staff were aware of the demographics within the county and understood the individual, cultural needs of patients. For example, we saw interpreters were used to facilitate appointments where English was not the first language of the patient to ensure the patient had the opportunity to talk to staff alone if required. Carers and family members informed us that they felt supported by staff in understanding how to care for the patient. Carers and family members felt their concerns were always taken on board and resolved and support was always provided to them as well as the patient. The service held recovery cafes with carers, patients and staff to ensure the service delivered was person centred.

Summary of findings

- Staff adhered to the principles of the Mental Capacity Act 2005. The trust had changed the delivery of training to be face-to-face and prioritised mental capacity training within learning lunches. Staff evidenced consideration of mental capacity in care records. Staff obtained consent to treatment and conducted mental capacity assessments and best interest decisions. Team managers conducted weekly audits on care records, risk assessments and progress notes. Staff self-audited their records using a document filled monthly and discussed this within supervision.
- The leadership, governance and culture of the service actively encouraged the delivery of person-centred care. Staff received regular supervisions, appraisals and training relevant to their role. Managers allowed staff, within working hours, to focus on their well-being and encouraged team building through activities like bowling and yoga. The trust held a well-being week for staff to try and reduce sickness rates. Managers provided individual feedback to staff members who reported incidents and lessons were shared across the service in team meetings.
- The service had positive multi-disciplinary team relationships across all teams. Multi-disciplinary members felt included in the service and individual teams had good relationships with third sector organisations such as the advocacy service and veteran charities.

However:

- There were environmental issues in two of the team locations. In one location, staff had not conducted a ligature risk assessment for patient areas. In a second location, staff did not have access to personal alarms. The rooms in one location lacked soundproofing and privacy glass in areas where staff met with patients.
- Staff felt disconnected from the executive team.
- Staff did not always give care plans to patients and this was confirmed by the patients we spoke to.
- Staff and managers highlighted issues with the electronic recording system and reported a loss of data such as care plans which had already been entered by staff. This increased staff workloads as they had to re-enter information onto the system.
- The service recalled a patient on a Community Treatment Order twice to extend the period of detention, which was not in line with the Mental Health Act 1983.

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, 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 factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice in in two core services we inspected. For more information, see the Outstanding practice section of this report.

Areas for improvement

We found areas for improvement including six breaches of legal requirements that the trust must put right. We found 29 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 of this report.

Summary of findings

Action we have taken

We issued six requirement notices to the trust and took three enforcement actions. Our action related to breaches of six legal requirements at a trust-wide level and in four 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 check 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.

Outstanding practice

We found examples of outstanding practice in two core services.

In community-based services for older people, managers provided staff with time during working hours to focus on their well-being and prioritised staff needs. Staff could feedback activities they enjoyed to managers such as yoga, bowling, massages and sports. Managers then provided staff with protected time during working hours to conduct those activities, which provided staff time to focus on well-being and team building. Staff responded positively to us when discussing this and felt it was a good initiative to minimise sickness.

Also, staff were aware of the county demographics and diversity. Staff adapted their practice to help breakdown any barriers by speaking to patients and family members in a culturally appropriate way. Staff would bring interpreters regardless of family members being present, to allow patients to have the opportunity to voice any concerns separate to their family if required.

Staff prepared patients if they were leaving the trust or if they were due to be on annual leave, giving specific plans of what would happen in their absence which reduced anxiety for patients.

Staff wrote comprehensive notes, detailing their visits, for families and carers who could not attend meetings, so they would receive an update on the same day. Staff followed this up with a phone call the following day to clarify any issues. Both carers and patients were extremely positive about this.

In specialist community mental health services for children and young people staff at Westcotes House had greatly improved the visual decoration of their site. Westcotes house was an older style building that previously not been decorated in a child or young people friendly. Staff had gained money from the trust's charity and had worked with another local charity to 'brighten lives as well as walls'. They had decorated the building with a range of stimulating, fun and friendly artworks in differing colours, shapes, sizes and textures. For example, there were small pictures of well-known animation characters for children (and adults) to point out and count around various points and heights of the corridors, walls and rooms. Large pictures/posters included a whale and mythical characters. They had involved patients, carers and staff in the development of this to create a range of pieces loosely themed around 'diversity' and difference. The overall effect helped create a welcoming and non- threatening environment for patients and carers, particularly if this was their first visit to a mental health service. This was also despite the limitations of their building environment. The trust held a formal celebration event for this work and invited senior trust staff, stakeholders and the CQC inspection team.

Summary of findings

Areas for improvement

Action the 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.

Action the trust MUST take to improve

We told the trust that it must take action to bring services into line with six legal requirements. This action related to the whole trust and four core services.

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

- The trust must ensure all environmental risks are identified and mitigated against. The trust must ensure that ligature risk assessments contain appropriate actions detailing plans to update, replace or remove identified ligature risks. Regulation 12 (1) (2)(a)(b).
- The trust must ensure the safe management of medicines, to include storage, labelling and disposal. Regulation 12 (1) (2)(g).
- The trust must ensure that medical equipment used by staff is regularly and accurately checked. Regulation 12 (1) (2)(e).
- The trust must ensure that staff consistently apply and record appropriate elements of the seclusion policy in line with the Mental Health Act Code of Practice. Regulation 12 (1).
- The trust must ensure that lessons from incidents and complaints are shared with staff. Regulation 17 (1).
- The trust must ensure all staff are aware of the Department of Health's guidance on eliminating mixed sex accommodation to ensure appropriate and accurate reporting. Regulation 12 (1).
- The trust must ensure it reviews arrangements of dormitory accommodation with a view to eliminating this in line with national guidance. Regulation 10 (1).
- The trust must ensure staff involve patients in their care planning and their views are recorded appropriately. Regulation 9 (1)(c) 3(b).
- The trust must ensure that the privacy and dignity of patients is protected. Regulation 10 (1).
- The trust must ensure that sufficient facilities are available to meet the needs of all patients. Regulation 15 (1)(e).
- The trust must ensure that environments are regularly maintained and updated to ensure they provide a safe environment for patient care. Regulation 12 (1) (2)(a)(b)(d).
- The trust must ensure effective governance systems are in place to monitor the service. Regulation 17 (1) (2)(a)(b).
- The trust must ensure patients have personal fire evacuation plans in place where necessary and weekly fire checks of environments are completed. Regulation 12 (1).

Long stay or rehabilitation mental health wards for working age adults:

- The trust must ensure all environmental risks are identified and mitigated against. The trust must ensure that ligature risk assessments contain appropriate actions detailing plans to update, replace or remove identified ligature risks. Regulation 12 (1) (2)(a)(b).

Summary of findings

- The trust must ensure that environments are regularly maintained and updated to ensure they provide a safe environment for patient care. Regulation 12 (1) (2)(a)(b)(d).
- The trust must ensure that all wards comply with guidance on the elimination of mixed sex accommodation. Regulation 12 (1).
- The trust must ensure that staff consistently apply and record appropriate elements of the seclusion policy in line with the Mental Health Act Code of Practice. Regulation 12 (1).
- The trust must ensure seclusion rooms comply with the Mental Health Act Code of Practice. Regulation 12 (1) (2)(d).
- The trust must ensure staff assess and care plan patient's physical health needs. Regulation 12 (1) (2)(a).
- The trust must ensure staff update risk assessments following incidents. Regulation 12 (1) (2) (a).
- The trust must ensure the safe management of medication, to include storage, labelling and disposal. Regulation 12 (1) (2)(g).
- The trust must ensure care plans are personalised and holistic. Regulation 9 (1)(a)(b)(c).
- The trust must ensure staff involve patients in their care planning and their views are recorded appropriately. Regulation 9 (1)(c) 3(b).
- The trust must ensure that the privacy and dignity of patients is protected. Regulation 10 (1).
- The trust must ensure effective governance systems are in place to monitor the service. Regulation 17 (1) (2)(a)(b).

Wards for people with a learning disability or autism:

- The trust must ensure that staff consistently apply and record appropriate elements of the seclusion policy in line with the Mental Health Code of Practice. Regulation 12 (1).
- The trust must ensure that all wards comply with guidance on the elimination of mixed-sex accommodation. Regulation 12 (1).
- The trust must ensure that staff adhere to infection control principles and that items such as hairbrushes are not used for different patients. Regulation 12 (2)(h).
- The trust must ensure effective governance systems are in place to monitor the service. Regulation 17 (1) (2)(a)(b).

Specialist community mental health services for children and young people

- The trust must ensure patient waiting times for assessment and treatment meet commissioned targets and the NHS constitution for children and young people. Regulation 9 (1)(a)(b)(c).
- The trust must review their service provision for patients with attention deficit hyperactivity and autism spectrum disorders and reduce service waiting times in the children and young people's service. Regulation 9 (1)(a)(b)(c).
- The trust must ensure children and young people's service staff follow the trust's infection control procedures and processes. Regulation 12 (1) (2)(a)(b)(h).
- The trust must ensure there is effective leadership of the children and young people's service across the trust. Regulation 17 (1) (2)(a)(b)(e)(f).
- The trust must ensure effective governance systems are in place to monitor the service. Regulation 17 (1).
- The trust must ensure they have accessible and comprehensive data/systems for the children and young people's service to measure their performance and risks. Regulation 17 (1).

Summary of findings

- The trust must review their recruitment processes and ensure there is adequate staff available to reduce the patient waiting lists for assessment and treatment in the children and young people's service. Regulation 18 (1).

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 29 actions related to the whole trust and the five core services.

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

- The trust should ensure staffing requirements of 136 services do not adversely affect those of acute wards for adults of working age.
- The trust should ensure the use of bank staff does not impact on the delivery of consistent patient care.
- The trust should ensure patients have access to psychological therapy and this is delivered and recorded in line with best practice guidance.
- The trust should ensure that staff have access to regular team meetings.
- The trust should ensure a review of the management and implementation of its smoke free policy at the Bradgate Unit.
- The trust should ensure bed management arrangements are more robust in order that patients have access to an acute bed within their area.
- The trust should ensure best practice and innovation within the service is shared.
- The trust should ensure that the senior executive team are present and visible to staff.

Long stay or rehabilitation mental health wards for working age adults:

- The trust should ensure staff support patients to make advanced decisions.
- The trust should ensure there is clear criteria for admittance to the service.
- The trust should ensure there is a clear model for the service.
- The trust should ensure patients are provided with food of their choice.
- The trust should ensure all staff are supported to raise concerns about bullying.

Wards for people with a learning disability or autism:

- The trust should ensure that medication errors, where electronic prescribing has not been introduced, are reported as incidents.
- The trust should ensure that learning from incidents and complaints is discussed with all staff, including health care assistants.
- The trust should ensure there are clear systems to gather feedback from patients and carers and use it to make improvements to the service.

Specialist community mental health services for children and young people

- The trust should review how they assess and monitor patient's physical health needs in the children and young people's service.

Summary of findings

- The trust should review and improve their systems for engaging patients and carers in development of the children and young people's service.
- The trust should review their safeguarding children and incident reporting policies to reflect staff practice.
- The trust should review their processes for meeting patient's diverse needs.
- The trust should ensure that premises are suitable for purpose in the children and young people's service, such as at Westcotes House.

Community-based mental health services for older people

- The trust should ensure that staffing levels meet the needs of the service.
- The trust should ensure that environments are effectively alarmed and environmental risk assessments are completed.
- The trust should ensure effective disposal of out of date needles.
- The trust should ensure that the senior executive team are present and visible to staff.
- The trust should ensure that staff knowledge and training on Community Treatment Orders is improved.
- The trust should ensure that every patient is provided a copy of their care plan and that this is documented. The trust should ensure care plans are provided in accessible formats for patients.
- The trust should ensure that all environments respect privacy, dignity and safety by introducing privacy glass in rooms where patients are seen and alarm systems for staff.

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.

Our rating of well-led at the trust went down. We rated well-led as inadequate because:

- We found a high number of concerns not addressed from the previous inspections. We found significant issues with trust level governance, oversight of environments,a failure to address keys issues and a lack of pace with delivering essential improvements. Overall, the pace of change in planning and converting plans into action across the trust was disappointingly slow.
- The trust had not fully articulated their vision for how they operated as a trust. The trust had several strategies, a vision and corporate objectives, but these did not underpin all policies and practices. The trust lacked an overarching strategy which everyone within the trust knew. Staff and senior leaders could not articulate the trust's direction of travel and how this was co-ordinated. There was a lack of understanding in teams how their own plans, visions and objectives connected with the trust's vision.
- Although the trust had a defined reporting structure to the board, the governance of the trust was poor. The trust did not have robust governance procedures to ensure that they could identify and address issues across the trust in a timely way. These issues with governance procedures had been reported at the last inspection in 2017.

Summary of findings

- We were not assured that the trust risk register clearly documented action taken or progress of action, within agreed timescales. Many of the actions listed included plans to review process, establish an approach, or to develop areas. We felt this contributed to senior staff views that pace of change in the trust was slow. The trust's Board Assurance Framework (BAF) was lengthy, was combined with a corporate risk register and had overdue actions. Due to the lack of a trust overarching strategy, the BAF did not provide an effective oversight against strategic objectives, gaps in control and assurance.
- Frontline staff did not always feel connected to the wider trust and did not know who directors linked to their service were or did not feel engaged with the trust.
- The trust leadership and local service leadership lacked oversight and responded slowly to issues of risk and performance that affected safe delivery of patient care. Oversight of medication management, environments, seclusion documentation, staffing, waiting lists, care planning and patient involvement was variable, and in some services limited.
- The trust lacked a framework for co-ordinating, endorsing and therefore learning from the positive quality projects taking place. The teams we spoke with, felt the trust board did not set clear timescales or direction on how to move their projects forward.
- There were issues within the trust of a bullying culture despite evidence that staff knew the trust values. Some teams told us about a lack of teamwork, best practice was not shared amongst services and regular meetings did not take place in some services.
- The trust had a limited approach to patient involvement. We found this across core services and within senior teams. We would expect patient involvement to be embedded at all levels of the trust, across as many departments as possible, in planning, review, evaluation and delivery. The trust used numerous surveys to seek views but this does not always replace face to face engagement.
- The trust's pace for implementing equality and diversity initiatives across the organisation needed improvement. This was particularly relevant to protected characteristics. The trust supported a BAME network (black and minority ethnic) however, given the diversity of the geographical area of the trust, they had not significantly developed its agenda or workstreams since our last inspection.
- Overall, the pace of change in planning and converting plans into action across the trust was disappointingly slow. There was a lack of both grip and pace in the movement of the plans to secure resources to re-provide outdated environments.

However:

- The trust had a variety of measures in place to ensure that processes and reporting to board were not delayed. Every senior team we spoke with knew who they reported to and what to report.
- Some local leaders were visible and had the skills and knowledge to perform their roles. The trust delivered programmes for staff to develop into senior roles and had a clear career development programme for nursing staff.
- The trust encouraged staff to develop and implement ideas for service delivery, improvement and innovation. We heard many examples of interesting innovation projects and work that groups had done which impacted on and improved patient care.
- The trust had made progress in oversight of data systems and collection. The trust aligned staff to services to manage data and we saw improvements in recording and monitoring of supervision and appraisal, improvement in monitoring of waiting lists in specialist community mental health services for children and young people, and in trust wide training data. All managers in services had access to key performance data and knew how to interpret it and escalate concerns when necessary.

Summary of findings

- The trust was proactive and promoted staff health and well-being. We heard many positive stories to support the health and well-being of staff across the trust. This included mindfulness, yoga, staff choirs, corporate events, training courses through local colleges (such as mental health first aid), physiotherapy and counselling. The trust had a health and well-being calendar for events, and health and well-being champions to promote events.

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 ➔➔ Feb 2019	Requires improvement ➔➔ Feb 2019	Good ➔➔ Feb 2019	Requires improvement ➔➔ Feb 2019	Inadequate ↓ Feb 2019	Requires improvement ➔➔ Feb 2019

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	Good ➔➔ Jan 2018	Good ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018
Mental health	Requires improvement ➔➔ Feb 2019	Requires improvement ➔➔ Feb 2019	Good ➔➔ Feb 2019	Requires improvement ➔➔ Feb 2019	Inadequate ➔ Feb 2019	Requires improvement ➔➔ Feb 2019
Overall trust	Requires improvement ➔➔ Feb 2019	Requires improvement ➔➔ Feb 2019	Good ➔➔ Feb 2019	Requires improvement ➔➔ Feb 2019	Inadequate ➔ Feb 2019	Requires improvement ➔➔ Feb 2019

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	Good ➔➔ Jan 2018	Good ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018	Requires improvement ➔➔ 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	Inadequate ↓ Feb 2019	Requires improvement ↓ Feb 2019	Requires improvement ↓ Feb 2019	Requires improvement →← Feb 2019	Inadequate ↓ Feb 2019	Inadequate ↓ Feb 2019
Long-stay or rehabilitation mental health wards for working age adults	Inadequate ↓ Feb 2019	Inadequate ↓ Feb 2019	Requires improvement ↓ Feb 2019	Good ↑ Feb 2019	Inadequate ↓ Feb 2019	Inadequate ↓ Feb 2019
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 →← Feb 2019	Good ↑ Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Requires improvement →← Feb 2019	Requires improvement →← Feb 2019
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 →← Jan 2018	Good ↑ Jan 2018	Good →← Jan 2018	Requires improvement →← Jan 2018	Requires improvement →← Jan 2018	Requires improvement →← Jan 2018
Specialist community mental health services for children and young people	Requires improvement →← Feb 2019	Good ↑ Feb 2019	Good →← Feb 2019	Inadequate ↓ Feb 2019	Requires improvement →← Feb 2019	Requires improvement →← Feb 2019
Community-based mental health services for older people	Good ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019
Community mental health services for people with a learning disability or autism	Good Nov 2016	Good Nov 2016	Good Nov 2016	Requires improvement Nov 2016	Good Nov 2016	Good Nov 2016
Overall	Requires improvement →← Feb 2019	Requires improvement →← Feb 2019	Good →← Feb 2019	Requires improvement →← Feb 2019	Inadequate ↓ Feb 2019	Requires improvement →← Feb 2019

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.

Long stay or rehabilitation mental health wards for working age adults

Inadequate 

Key facts and figures

Leicestershire Partnership NHS Trust provides long stay or rehabilitation mental health wards for working age adults from two locations:

The Willows is located in Leicester and comprises of four wards;

- Maple, an eight bedded male high dependency rehabilitation unit
- Acacia, a ten bedded mixed sex community rehabilitation unit
- Cedars, a ten bedded mixed sex community rehabilitation unit
- Sycamore, a ten bedded male community rehabilitation unit.

Stewart House is located in Leicester and comprises of two units;

- Arran, a 15 bedded female community rehabilitation unit
- Skye, a 15 bedded male community rehabilitation unit.

The service provides treatment and recovery for adults over 18 with a complex and enduring mental illness.

The service was rated as requires improvement following the comprehensive inspection in November 2016. The caring key question was rated as good. The safe, effective, responsive and well led key questions were rated as requires improvement. We found breaches of the following regulations:

- Regulation 11: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 need for consent
- Regulation 12: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safe care and treatment
- Regulation 17: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 good governance
- Regulation 18: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 staffing.

We identified areas for improvement and told the trust to take the following actions:

- The trust must ensure the environment is safe, clean and well maintained and there is sufficient storage to safely store equipment and patients' belongings.
- The trust must ensure the safe management of medicines, including storage, disposal and patients' consent to treatment is documented clearly and accurately.
- The trust must ensure staffing skill mix meets patient need.
- The trust must ensure patient records are organised clear and contain the necessary information to provide a safe and effective service.
- The trust should ensure all patients prescribed high doses of anti-psychotics are identified and appropriate physical health monitoring completed.
- The trust should ensure managers follow the trust's policy on managing attendance.

We have identified the issues which remain in this report. The trust had completed some but not all of the actions from the November 2016 inspection.

Long stay or rehabilitation mental health wards for working age adults

Our inspection, carried out between 19 to 23 November 2018, was comprehensive and announced at short notice (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 this core service and information we had requested from the trust.

During the inspection visit, the inspection team:

- visited all six wards
- spoke with 13 patients who were using the service
- spoke with four carers of patients who were using the service
- spoke with the managers or deputies for each of the wards
- spoke with 29 other staff members; including doctors, nurses, occupational therapists, psychologists, discharge nurses and domestic staff
- observed five episodes of care
- reviewed 30 patient records relating to physical health
- reviewed 30 records relating to patient risk assessments and care plans
- reviewed 31 medication records.

Summary of this service

The summary for this service appears in the overall summary of this report.

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate because:

- Managers had not ensured safe and well maintained care environments. This was raised at the inspection in 2016. We found unidentified ligature risks on Maple ward and ligature risks that were not safely managed at Stewart House. Managers had not ensured that the occupational therapy kitchen at Stewart House was safe.The gas cooker had not been serviced and cooker dials were worn. We observed a tile falling off the wall whilst a patient was cooking. At Stewart House the door from the female lounge to the garden was in a state of disrepair and could not be closed. On Maple ward patients and staff told us that the toilets were continually blocked and at Stewart House, two toilets could not be locked.
- Two wards were not compliant with guidance on elimintating mixed sex accommodation. There were no locked doors between male and female areas and no single sex lounges on Cedar and Acacia wards.
- Managers had not ensured compliance with the Mental Health Act Code of Practice. The seclusion rooms on Maple and Acacia were not free from hazards. There was a blind spot in the en suite area of Maple's seclusion room. Staff had not completed the required reviews for a patient in seclusion. Staff had not completed a seclusion care plan and were using out of date seclusion documentation.

- Staff on Maple ward were not completing or updating patient risk assessments. We reviewed eight patient records and six had risk assessments that staff had not updated. Managers did not feedback learning from incidents to staff. We reviewed 14 team meeting minutes and found brief references made to incidents that had occurred on that ward but no evidence of wider learning across the service or from other incidents in the trust.
- Staff did not follow good practice in medicines management. This issue was raised in the inspection in 2016. At Stewart House we found medicines that staff should have disposed of and staff using sharps bins to dispose of medicines. Staff had not labelled one in use medicine with the date of expiry. Staff had stored two medicated creams in an unlocked cupboard in the clinic room. We found loose tablets (unboxed in their foils) in the medicines trolley. On Maple ward, staff had not reconciled two out of eight patient's medicines on admission. Staff were not reviewing PRN (as required) medicines in line with national guidance.

However:

- The service had enough staff with the right skills, qualifications and experience for each shift. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. At Stewart House additional nursing staff were employed for three days a week to cover meetings and ward rounds.
- Staff and managers worked to keep the use of restrictive interventions to a minimum. Staff participated in the provider's restrictive interventions reduction programme. Staff made every attempt to avoid using restraint by using de-escalation techniques and only restrained patients when these failed and when necessary to keep the patient or others safe.
- Staff had completed and were up to date with their mandatory training. The mandatory training programme met the needs of staff and patients in the service. Managers kept track of staff and their mandatory training and staff received alerts so they knew when to update or complete training modules.
- All staff received training in safeguarding that was appropriate for their role. Staff knew how to recognise adults and children at risk of, or suffering harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Is the service effective?

Inadequate 

Our rating of effective went down. We rated it as inadequate because:

- Staff had not completed a physical health examination for patients on admission in 14 out of 30 records. Staff had not developed care plans to meet patient specific physical health needs for four patients. Staff had completed a physical health examination on admission for another patient at Stewart House over a year ago and indicated that the patient required an electro cardiogram. We were unable to find a record that this had been done.
- Staff had not completed care plans that were personalised, holistic or recovery orientated in 19 out of 30 records. Ten of these records were at Stewart House, four on Maple ward, three on Sycamore ward and two on Cedar ward.

However:

- The team included or had access to the full range of specialists required to meet the needs of patients on the ward. As well as doctors and nurses, teams included occupational therapists, clinical psychologists, substance misuse workers, discharge nurses, activities leads and pharmacists. Staff were able to refer patients to social workers, speech and language therapists, dieticians and physiotherapists.

Long stay or rehabilitation mental health wards for working age adults

- Staff worked well as a multidisciplinary team. Staff held regular multidisciplinary meetings to discuss patients and improve their care. We observed two care programme approach meetings and a discharge meeting which evidenced this. Staff made sure they shared clear information about patients and any changes in their care during handover meetings. Ward teams had effective working relationships with other teams in the organisation and external teams and organisations.
- Managers provided staff with supervision and appraisal. Apprasial compliance was at 82% and superivison compliance was between 78% and 100%.

Is the service caring?

Requires improvement 

Our rating of caring went down. We rated it as requires improvement because:

- Staff did not always involve patients and give them access to their care planning and risk assessments. In 20 out of 30 records checked there was no evidence that staff had involved patients in their care planning and there was no evidence in any records that patients had been offered a copy of their care plan. Managers told us that they were working with staff to ensure they improved how they evidenced patient involvement in care planning. Community meetings on Sycamore had not taken place regularly, in the past 12 months there had only been four meetings.
- Staff did not always treat patients with dignity and respect when providing care and treatment. A patient on one to one observations told us he had complained that staff were observing him when he used the toilet and had a shower. We reviewed this patients care records and found evidence in staff observation records that they were observing the patient in these situations. The trust observation policy stated that any decision regarding observations during personal care would be recorded by the doctor in the patients' care records. We did not find evidence that this had been done. On Cedar and Acacia wards staff escorted male patients past female bedrooms and bathrooms to access the laundry room.
- Staff did not always support patients to make advanced decisions on their care. In 20 out of 30 records staff had not supported patients to do this.

However:

- Patients said staff treated them well and behaved kindly. Patients told us that staff were brilliant, really caring and supportive. Staff introduced patients to the ward and the services as part of their admission. Staff provided patients with a welcome pack on admission.
- Staff supported patients to produce a newsletter at the Willows that was shared with patients and staff across the service. We observed an occupational therapy session where patients were in the process of producing the latest newsletter. One patient had produced a video of his recovery journey.
- Staff supported, informed and involved families or carers. Carers were provided with a welcome pack. We spoke with four carers. Carers told us that staff were brilliant, helpful and polite and looked after their relative well. Carers were invited to meetings about their relative's care and were kept updated. Staff helped families to give feedback on the service. The service had recently implemented carers meetings and was planning a carers event. Staff gave carers information on how to find the carer's assessment. One carer told us that they were in the process of accessing a carer's assessment.

Long stay or rehabilitation mental health wards for working age adults

Is the service responsive?

Good ↑

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

- The service had low numbers of delayed discharges (three in the past year). The service employed discharge nurses to enable a smooth transition for patients being discharged. Managers and staff ensured they did not discharge patients before they were ready. Staff had completed detailed discharge plans that were regularly reviewed in 26 of the 30 records reviewed.
- Each patient had their own bedroom, which they could personalise. Staff risk assessed patients before giving them their own room key. Patients had a secure place to store personal possessions. Patients could make their own hot drinks and had access to snacks. Each ward had a hot drink making 'station' that patients could access freely. We observed staff responding promptly to patients requests for snacks.
- The service had a full range of rooms and equipment to support treatment and care. Staff and patients could access the rooms. The occupational therapy kitchen at the Willows and the patient kitchens at Stewart House had been refurbished. The service had quiet areas and a room where patients could meet with visitors in private. The service had an outside space that patients could access easily.
- Staff made sure patients could access information on treatment, local services, their rights and how to complain. The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff and patients could get hold of interpreters or signers when needed. We observed a member of staff communicating with a patient using Makaton.

However:

- Managers told us they were receiving referrals for patients who were acutely unwell and were reviewing the service criteria. The number of patients requiring one to one observations had increased over recent months. Managers had escalated this issue within the trust as a potential service gap.
- Patients were not happy with the quality and variety of food available. Patients had made repeated requests for more salads, vegetarian dishes and a greater choice of food. There was no evidence that staff had met these requests.
- We found that two patient toilets at Stewart House were not able to be locked. This impacted on patients' privacy and dignity.

Is the service well-led?

Inadequate ↓

Our rating of well-led went down. We rated it as inadequate because:

- Governance systems and processes had not ensured safety and environmental issues were addressed, that staff adhered to the Mental Health Act Code of Practice, that patient involvement was evidenced in records and that patients' requests were responded to in a timely manner.
- Leaders had not ensured that staff were fully informed about the new model of service. Most leaders at the service were new in post. Leaders were working on a transformation programme for the service but this was not yet embedded or communicated to all ward staff.

Long stay or rehabilitation mental health wards for working age adults

- The care records did not provide evidence this service provided care that would be considered best practice in a rehabilitation unit. The care plans did not indicate that people received the range of services a rehabilitation should provide.
- Managers did not feedback learning from incidents to staff. We reviewed 14 team meeting minutes and found brief references made to incidents that had occurred on that ward but no evidence of wider learning across the service or from other incidents in the trust.
- Three staff raised concerns related to bullying and feeling overloaded and pressurised. Two staff told us that communication could be better between the trust and staff.

However:

- The majority of staff (14 out of 16) understood the whistle-blowing policy and were aware of who the speak up guardian was. One staff member, who had started recently, had been given a card with details of the speak up guardian.
- Staff knew and understood the trust's visions and values and could describe how they applied to their work. Out of 16 staff asked, all of them were able to describe the trust's vision and values. Staff told us vision and values were discussed in induction, supervision and appraisal.
- The trust gave opportunity for leaders to develop their skills and for other staff to develop leadership skills. Leaders told us they had accessed leadership courses through the trust, including a 'building leaders' course. One staff member told us they were completing a course in line management as part of a leadership pathway. The trust had an agreement in place with the local university enabling staff to access some of their courses.

Areas for improvement

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

Wards for people with a learning disability or autism

Requires improvement 

Key facts and figures

The Agnes unit is a 12-bed assessment and treatment unit for adults with learning disabilities. The unit provides an inpatient service for individuals living in Leicestershire who require to be supported in a hospital setting because of their mental health, behaviour and levels of risk posed to themselves or others.

The short breaks services provide support for adults with learning disabilities and associated physical and sensory disabilities, challenging behaviour or autistic spectrum disorders. The services plan regular short breaks with families and carers. In addition, the services will provide breaks for families at short notice where this is possible. There were three units, The Grange and Gillivers, which were next door to each other, and 3 Rubicon Close. All three units admitted male and female patients. Since the last inspection, the service planned male and female only weeks to comply with mixed-sex accommodation guidelines. Patients at the Agnes unit may be voluntary/informal, detained under the Mental Health Act 1983 or subject to Deprivation of Liberty Safeguards (DoLS). The short stay units do not admit patients under the Mental Health Act.

The Care Quality Commission last inspected this location in November 2016 as part of a comprehensive inspection of Leicestershire Partnership NHS Trust. At that inspection we found that this service had breached the following regulations:

- Regulation 10: Health and Social care Act 2008 (Regulated Activities) Regulations 2014 dignity and respect – the short stay services did not comply with mixed-sex accommodation guidelines. There were no separate areas for male and female bedrooms. There were no separate male and female bathrooms and toilets.
- Regulation 11: Health and Social care Act 2008 (Regulated Activities) Regulations 2014 need for consent – staff were assessing for capacity to consent to admission after admission had taken place and after they had made a Deprivation of Liberty Safeguards (DoLS) application. Capacity assessments were not decision specific.
- Regulation 18: Health and Social care Act 2008 (Regulated Activities) Regulations 2014 staffing – staff did not receive regular supervision in line with the trust policy.

At this inspection, the trust had addressed the findings of the inspection in November 2016 and was no longer in breach of regulation 11 and regulation 18 but continued to be in breach of regulation 10.

This was an announced comprehensive inspection at short notice (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 the Agnes unit and three short breaks services to look at the environment and observe the care being given to patients
- spoke with eight patients who were using the service
- spoke with eight carers of patients who were using the service
- interviewed the managers for each of the wards
- spoke with 20 nurses, healthcare assistants and other members of the multidisciplinary team
- observed two multi-disciplinary meeting, one care and treatment review and observed four episodes of care

Wards for people with a learning disability or autism

- reviewed 13 patient care and treatment records relating to physical healthcare, risk assessments and care plans
- reviewed staff meeting minutes and staff rotas
- carried out a specific check of the medication management and viewed 14 prescription charts
- reviewed a range of policies, procedures and other documents related to the running of the service.

Summary of this service

The summary for this service appears in the overall summary of this report.

Is the service safe?

Requires improvement 

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

- Staff did not always comply with the Mental Health Act code of practice when secluding patients and did not complete seclusion paperwork appropriately. We looked at four seclusion records. None of the notes contained a seclusion care plan. In three cases, there was no medical review within one hour and in two cases no regular nursing reviews throughout the seclusion. In one of the four notes we looked at there was also no evidence of four-hourly medical reviews taking place.
- The short breaks services did not comply with guidance on eliminating mixed-sex accommodation. Services planned male and female only weeks at all the services in order to avoid breaching the guidelines. However, managers told us that breaches happened regularly because they would admit patients when families were in need and required support at short notice. Data from the trust stated that in the last 12 months, the service admitted men and women at the same time on 16 occasions at The Grange, 12 occasions at Gillivers and on nine occasions at Rubicon Close.
- The short breaks service did not always adhere to infection control principles. We found a jug on the edge of the bath at Rubicon Close containing several used hair brushes, labelled with the name of the service.
- Staff did not always manage medicines safely in the short breaks services. At Gillivers and 3 Rubicon Close, staff used a paper system to record the administration of medication. At 3 Rubicon Close, it was not clear on one of the charts whether the patient had received their medication or not. The Agnes Unit did not have facilities to dispose of medicines on the ward.
- There was no system in place to ensure that learning from incidents, complaints and concerns was effectively communicated to non-registered staff.
- There were hazards in the short breaks services which could compromise the safety of patients. We saw broken items of garden furniture and uneven pathways. At one of the services the keys to the cleaning cupboard, containing 'Control of Substances Hazardous to Health (COSHH) materials, had been left in the door and the door had been left open.

However:

- Internally the wards were clean and well maintained. Cleaning scheduled showed that the wards were cleaned daily. Furnishings were generally of good quality.

Wards for people with a learning disability or autism

- Staff completed comprehensive risk assessments and kept these updated. Staff completed ligature risk assessments which addressed all the ligature risks on the wards. The Agnes unit had been fitted with anti-ligature fittings. Staff used enhanced levels of observations based on individual risk assessments to ensure patients were safe.
- There were enough staff deployed to keep patients safe.
- Mandatory training rates were high across the services.
- The Agnes unit had low rates of seclusion. Staff completed restrictive practice training which taught them to use positive behaviour support plans and de-escalation techniques to reduce restraints and seclusions.
- Staff managed medicines safely at the Agnes unit. The provider ensured staff stored medication at appropriate temperatures which were monitored electronically. Emergency medications, appropriate for the service, were stocked and managed in accordance with trust policy and Resuscitation Council guidance. The provider used an electronic prescribing system to ensure staff administered medicines safely and in line with prescriber's instructions. Doctors prescribed medicines in line with national institute for health and care excellence. The electronic prescribing system reduced the possibility of medication errors and allowed easy access to historical prescribing.

Is the service effective?

Good ↑

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

- Staff completed comprehensive mental health assessments at the Agnes unit on or shortly after admission. Short breaks units updated assessments on new admission dates or before if needed. Staff completed holistic and person-centred care plans and positive behaviour support plans.
- Staff at the Agnes unit completed physical health checks for patients on admission and ensured monitored this during their stay. The short breaks services updated physical health check on each new admission or prior to this if they received information from families or GPs.
- Patients had access to physical healthcare services. We saw examples of patients managed with chest infections and pressure sores. Staff referred to specialist services when necessary and procured specialist equipment to address patient need, for example, an air bed. Staff at the short breaks services liaised with patients' families and GPs. A number of the patients they supported had profound physical needs and required specialist care.
- Doctors followed national institute for health and care excellence when prescribing medication for patients.
- Managers at the Agnes unit provided staff with regular appraisals and supervision. Compliance with appraisal was 94% and Agnes Unit supervision compliance was 92%.
- There was a full range of multi-disciplinary staff at the Agnes unit. Staff were experienced, appropriately qualified and attended regular multi-disciplinary meetings for patients including Care Programme Approach meetings and Care and Treatment Reviews. Staff undertook specialist training to ensure they had the relevant skills to undertake their role. New staff received an induction which was based on care certificate standards.
- Staff applied the Mental Capacity Act appropriately. In the short breaks units, staff completed mental capacity assessments and DoLS applications; these were of good quality, decision specific and correctly submitted.

However:

- Supervision compliance in the short breaks units was lower than the trust average and target at 70%.

Wards for people with a learning disability or autism

Is the service caring?

Good ➔➔

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

- Staff treated patients with kindness and compassion and focused on recovery by providing high quality care. We observed staff interacting with patients in a kind, caring and respectful manner.
- Staff involved patients in planning their care. Staff reflected this in care plans and patients confirmed it. Staff understood patients' needs and helped patients to understand why they were in hospital and how to move on.
- Staff supported and involved carers and families in their relatives' care and treatment. Carers were positive about the way staff had supported them and their relative.

However:

- Staff had not routinely recorded whether they had given copies of care plans to patients or to their carers where appropriate.
- The dignity and privacy of patients was compromised. The trust could not comply with mixed-sex accommodation guidance when they admitted males and females into short breaks units at the same time. On some occasions, patients were placed on enhanced observations to keep them safe which they would not have needed had they been in single sex accommodation.

Is the service responsive?

Good ➔➔

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

- Beds were available when needed for people living in the catchment area. Patients on home leave did not return to a different bed and patients were not moved from one pod to another during an admission unless there were clinical grounds to do so.
- Staff at the Agnes unit supported moves to placements and liaised with community teams to ensure a smooth transition. The average length of stay over the previous six months varied from 4.5 days in August 2018 to 157 days in October 2018. The Agnes unit's discharge co-ordinator liaised with professionals and families to ensure discharges were planned and patients were discharged in the most appropriate way.
- Community treatment reviews were person centred, compassionate and discharge focused. The meeting we attended identified progress and future plans, working in partnership with the patient.
- The Agnes unit had access to a full range of rooms to support treatment and care. There was a separate activity area and smaller rooms where staff could speak to patients privately.
- Staff provided information in an accessible format and displayed this across the services. There were posters on the ward and in information booklets. These were written in several different languages offering information on request, including how to complain, an information booklet about the Agnes unit, information on treatments and access to advocacy. Information was in simple language and in an easy-read form.

- Patients had access to interpreters when needed. Speech and language therapists worked with patients and staff to ensure they met patients' specific communication needs.

However:

- In the short breaks services, carers and staff told us that it was more difficult for some carers to book into because of the policy to offer male and female only weeks.
- Patients could not make or have access to snacks when they wanted them. Although patients could ask for a drink at any time, the patient booklet stated that snacks were at set times only.
- Some of the nursing offices at the Agnes unit were very small and could not support handovers. We attended one handover in a staff kitchen, which contained information on the walls about patients' needs, including some personal information.

Is the service well-led?

Requires improvement 

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

- The trust had not ensured that wards for people with a learning disability or autism were compliant with mixed sex accommodation guidelines. The trust was in breach of this guidance but these breaches were unavoidable to meet the needs of the people and families that used this service. Carers felt passionate about the accommodation being mixed sex.
- Managers had not ensured that seclusion took place in accordance with the Mental Health Act code of practice and that staff completed seclusion paperwork correctly.
- Managers and staff at the short breaks services said they felt isolated from the trust and from each other with little sense of a shared identity.
- Managers did not have oversight of some issues affecting the short breaks services, for example medication errors and infection control issues. Managers did not have a robust system to ensure that essential information, such as learning from incidents and complaints, was shared and discussed with all staff, including healthcare assistants.
- We did not find clear systems in place to gather feedback from patients and carers and use it to make improvements to the service. The trust could not provide data relating to staffing on the Agnes unit prior to the inspection.

However:

- Systems were in place to measure the performance of the team. Local managers received regular information in relation to the performance of the service, staffing and patient care. Information was easy to understand and help managers ensure staff received training and supervision when they required it. Managers had a good understanding of the services they managed. The ward manager was frequently on the unit and available to staff. Staff knew who were the senior managers in the service and they visited the ward on occasions.
- Staff had access to equipment and information technology to do their work. The patient information system was easy to use and staff found it easy to update patient records.
- There were good interagency working arrangements in place to support the needs of patients. Multidisciplinary team members worked with their community colleagues to ensure smooth transitions and discharges.

Wards for people with a learning disability or autism

- Staff felt positive about working in their teams. Staff teams supported each other well and staff said they felt respected, supported and valued for their work and were proud to work for the team. Staff felt able to raise concerns without fear of consequences and knew how to do this.

Areas for improvement

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

Community-based mental health services for older people

Good ↑

Key facts and figures

The community-based mental health teams (CMHT) for older adults in Leicestershire provide, multidisciplinary assessment and intervention for patients of any age, with a complex presentation of dementia or those over 65 with a complex functional illness.

We inspected six community-based mental health teams for older adults. These were Charnwood CMHT, Leicester City East CMHT, Leicester City West CMHT, Melton, Rutland and Harborough CMHT, South Leicester CMHT and West Leicester CMHT.

This core service was last inspected in November 2016. Following that inspection, we rated this core service as requires improvement overall, with a rating of requires improvement for safe, effective, caring, responsive and well-led. We issued the trust with two requirement notices which related to:

- Regulation 11: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Consent - consent to treatment not being routinely sought, a lack of capacity assessments and best interest decisions not properly recorded within care records
- Regulation 12: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment - medicine risk assessments were not in place for medication kept in patient homes, medicine records did not include allergy information, care plans did not detail the care and treatment the patient needed to manage risks appropriately for their health and safety and assessing risks for referrals and waiting lists were not managed effectively.

We found the service had met these requirements at this inspection.

Before the inspection visit, we reviewed information that we held about these services. Our inspection was announced at short notice (staff knew we were coming) to ensure that everyone we needed to talk to was available. This was in line with CQC guidance.

During the inspection visit, the inspection team:

- interviewed 29 staff including nurses, consultant psychiatrists, occupational therapists, clinical psychologists, administrators and healthcare workers
- interviewed three team managers and two community managers.
- spoke with 15 patients
- spoke with 11 carers
- attended three home visits
- reviewed 27 patient care and treatment records
- toured the premises of each service we visited and conducted a check of the clinic rooms, medication and clinical equipment where appropriate
- reviewed a range of other documentation, policies and procedures related to the services we visited.

Community-based mental health services for older people

Summary of this service

The summary of this service appears in the overall summary of this report.

Is the service safe?

Good ↑

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

- Staff completed risk assessments of patients at initial assessment and reviewed individual patient risk regularly. Patients were also provided with numbers to call if they needed to speak to a duty worker whilst on the waiting list. Where risks increased managers referred patients to the unscheduled care service who arranged urgent assessments
- The service improved on medicine risk assessments. Staff added allergy information on depot cards and individual risk assessments. Care plans contained individual patient risks with medication and how risks had been reduced.
- All areas were clean and well maintained and we observed staff adhering to infection control principles including handwashing.
- The service improved monitoring of waiting lists. Team managers checked waiting lists weekly. The number of patients on the caseload of the teams, and of individual members of staff, was appropriate. The service had introduced a case complexity tool which to ensure caseloads were manageable.
- Staff received safeguarding training which included how to recognise and report abuse and/or exploitation and had a good working knowledge of safeguarding.
- Managers debriefed staff after incidents and ensured regular team meetings took place to discuss lessons learned from incidents.
- The trust had a lone working policy and managers in each team implemented their own local lone working procedure that was location specific. Staff spoken with had knowledge of it.
- Patients had rapid access to a psychiatrist when required.

However:

- There were three fulltime vacancies across three teams for qualified nurses. The vacancy for a consultant psychiatrist was filled with a locum. Prior to the locum consultant being in post and the nurse vacancies had impacted on the waiting lists. As a result, the team were put on the trust risk register. However, managers had a plan to recruit vacant posts and used staff from other teams to ensure there were minimal breaches and a short waiting list.
- Not all interview rooms within the service were fitted with alarms in West Leicester and staff did not have access to personal alarms.
- In the City East team, managers failed to undertake an environmental risk assessment of rooms where patients were seen by staff.
- City East staff had failed to dispose of needles that were out of date.

Community-based mental health services for older people

Is the service effective?

Good ↑

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

- During this inspection staff knowledge and understanding of the Mental Capacity Act 2005 had improved. Staff followed the Mental Capacity Act principles and assumed capacity unless there was a reason to doubt this. Staff assessed capacity appropriately, in a time and decision specific way when appropriate. Staff informed us that delivery of training changed from being online to face-to-face which was better and mental capacity was always discussed at learning lunches.
- We reviewed 27 care plans and all of them were up to date, person centred and involved patients. Staff developed support plans which were kept by patients at home to help patients with coping techniques in crisis.
- Staff received regular appraisals and both clinical and management supervisions. Staff told us they were supported and felt valued by team and community managers. New staff, including agency staff, received a trust-wide and local induction.
- The service offered psychological therapies which were delivered in line with national institute for health and care excellence guidance such as cognitive behavioural therapy and dialectical behaviour therapy. Staff used recognised rating scales to assess and record severity and outcomes.
- The multidisciplinary team worked together as a team to benefit patients. They supported each other to make sure that patients received the right care for them. Staff had good working relationships with third sector organisations specialising in help for: housing, veteran support, advocacy and benefits. The service also specialised in helping patients with an early onset of dementia with employment support.
- Staff considered physical healthcare checks and worked closely with GPs and psychiatrists to monitor physical health.
- Staff participated in audits, benchmarking and quality improvement initiatives. Staff self-audited their records using a template which was discussed in supervision. Team and community managers also performed random audit checks on records.

However:

- Managers recognised that staff knowledge on Community Treatment Orders was lacking. We checked four Community Treatment Orders and found that the responsible clinician had recalled a patient on a Community Treatment Order twice, to extend the 72-hour holding period which is not in line with the Mental Health Act 1983.

Is the service caring?

Good ↑

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

- Patients and carers gave positive feedback about their experiences of using the services. They made positive comments about their relationships with staff and how compassionate and supportive staff were. Staff involved patients in decisions about their care and treatment. The service held recovery cafes which involved patients and carers who could provide feedback on their care.

Community-based mental health services for older people

- Staff were aware of demographics within the county and provided interpreters for patients where English was not their first language. This ensured the patient was involved in all aspects of their care.
- Staff signposted patients to other services including day centres and third sector organisations that met their needs. Staff also signposted carers for support.
- We observed staff interacting with patients in a caring and kind manner. Staff demonstrated that they were aware of patients' needs and understood how best to support them.

However:

- Staff did not provide all patients and carers with a copy of their care plan. We reviewed 27 records and 11 records showed that patients had not been given a copy of their care plan. Patients and carers confirmed this.

Is the service responsive?

Good 

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

- The service improved monitoring of waiting lists. Team managers checked waiting lists weekly and breaches of waiting time targets were minimal.
- Staff were able to send patient referrals to the unscheduled care team or the crisis team if the patient was in crisis. Teams had a duty worker to respond to calls from patients and had capacity to conduct visits if required.
- Staff only cancelled appointments when necessary. Patients informed us that appointments were only cancelled to be brought forward if staff had capacity, so patients could be seen quicker.
- The teams met the needs of all people who use the service – including those with a protected characteristic. Staff supported patients with communication, advocacy and cultural needs and preferences.
- All teams demonstrated good working relationships with external organisations and teams displayed leaflets within all bases for patients.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

However:

- At Leicester West CMHT, staff saw patients in rooms that lacked soundproofing and privacy glass, compromising patient privacy and confidentiality.

Is the service well-led?

Good 

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

Community-based mental health services for older people

- Leaders had the skills, knowledge and experience to perform their roles, a good understanding of the services they managed and were visible in the service and approachable for patients and staff. Managers supervised staff regularly and appraised their work yearly. Team and community managers had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed and 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.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect such as updated guidance on clinical practice.
- Managers shared lessons learned in team meetings and during supervisions, this included learning from complaints.
- The service used KPIs and other indicators to gauge team performance. This included waiting list time, breaches and care records.
- Staff engaged actively in local and national quality improvement activities.

However:

- Staff felt disconnected from the executive team and felt they were not listened to.

Outstanding practice

We found areas of outstanding practice in this service. See outstanding practice section above.

Areas for improvement

We found these areas for improvement in this service. See areas of improvement section above.

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

Inadequate 

Key facts and figures

The acute wards for adults of working age and the psychiatric intensive care units (PICUs) 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 mixed sex ward
- Watermead, 20 bedded mixed sex ward
- Bosworth, 20 bedded male ward
- Thornton, 21 bedded male ward
- Ashby ward, 21 bedded male ward
- Heather, 18 bedded female ward
- Aston, 19 bedded female ward.

The Trust admits patients to a psychiatric intensive care unit (PICU) if their needs cannot be safely met within the acute environment. There are two PICUs at Glenfield:

- Belvoir PICU is also located at the Bradgate Mental Health Unit and has 10 beds for acutely unwell male patients.
- Griffin PICU is located at the Herschel Prins Centre and has 6 beds for acutely unwell female patients. This service opened in October 2017.

This was an announced comprehensive inspection at short notice (staff knew we were coming) to ensure that everyone we needed to talk to was available.

The service was last inspected in November 2017 with reports published in April 2018. The overall rating for the Trust was 'Requires Improvement' and a warning notice was issued to the Trust following this inspection for the following regulatory breaches:

- Regulation 9: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person-centred care
- Regulation 12: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment
- Regulation 13: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment
- Regulation 15: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safety and suitability of premises
- Regulation 17: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

At this inspection we found the trust had addressed issues relating to Regulation 13 and 15, but remained in breach of the other regulations and one further regulation.

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

During the inspection visit, the inspection team:

- spoke with 26 patients who were using the service and five carers
- spoke with the managers/leaders for each of the wards
- spoke with 27 other staff members; including doctors, nurses, healthcare assistants, occupational therapists, psychologists and members of the bed management team
- observed one bed management meeting and one ward round
- observed nine episodes of care and one meal time
- reviewed documentation relating to the service, including meeting minutes, incident forms, policies and procedures and ward complaints and compliments.
- reviewed 43 care records and 48 patient medication records
- reviewed records relating to 58 episodes of seclusion
- reviewed the Mental Health Act 1983 (MHA) detention paperwork of 43 patients.

Summary of this service

The summary for this service appears in the overall summary of this report.

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate because:

- Safety was not a sufficient priority. Ward environments were poor, and managers did not address issues relating to safety quickly. Windows identified as an urgent safety risk in 2017 had not been replaced. Lighting on some wards was poor and affected the visibility of the area. Staff did not identify all ligature risks on the ligature risk assessments or record how to mitigate against them. Staff did not update ward risk assessments when new environmental risks presented. This included broken fixtures and fittings, protruding screws and fractured Perspex. We were concerned about fire safety. Patients with disabilities did not have personal evacuation plans. Staff did not complete fire warden checks regularly on Watermead ward. Over 24 months staff completed less than 50% of the required weekly checks. Staff did not store and manage medicines and equipment safely. We identified a breach of regulation for medicines management at our last inspection and issues remained. This included; inappropriate management of controlled drugs, storage of medication, disposal of medication and the calibration of equipment to ensure it was working correctly.
- The trust did not support staff to safely manage a smoke free environment. Managers and staff did not uphold the smoke free policy. We observed patients smoking in the gardens and saw evidence of smoking in seven out of nine ward gardens. One ward smelt of cigarette smoke. Staff did not feel supported by senior leaders in addressing the difficulties of implementing the policy. Additionally, staff reported that they did not feel confident to challenge patients who had lighters in their property on or their person and remove the lighters to maintain the safety of the ward, patients, staff and visitors.

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

- There was no evidence of learning from events or action taken to improve safety. Senior managers did not share lessons learned from incidents effectively across the wards. Staff were not aware of incidents on other wards. For example, there was a recent fire on Beaumont ward set by a patient with a contraband lighter. The trust did not initially report this fire as a serious incident. Although the trust was still awaiting the final report, there was no evidence of immediate lessons being shared.
- Substantial and frequent use of agency and bank staff increased the risk to people using the service. Despite attempts to use regular bank staff, three managers described a lack of consistency for patients, impacting on their ability to form therapeutic relationships with staff and understand the risks posed to or by individual patients. Regular staff were often moved to cover absences on other wards. Six patients told us they did not always know the staff on duty and experienced delays in responding to requests due to staff numbers. In October 2018 the average number of shifts filled by bank and agency staff was 43.6%.
- Staff did not always assess, monitor or manage risks to people who use the services appropriately. Staff missed opportunities to prevent or minimise harm. We reviewed 58 episodes of seclusion. In 72% of records there was no medical entry to demonstrate a doctor completed a medical review within an hour, or without delay. In 76% of records it was not clear patients had access to appropriate nursing reviews of their care. No records contained a care plan detailing the ways in which seclusion could be ended at the earliest opportunity. On two wards that accommodated patients of both sexes staff could not describe what resulted in a breach of mixed sex accommodation guidance. Managers could not assure us they understood what resulted in a breach and how this would be reported. Therefore, we were not assured that the data provided showing no mixed sex breaches in 12 months was accurate.
- The trust did not have dedicated staffing for the health-based place of safety. Staff were taken from the acute wards to staff the 136 suite when required. Senior staff told us that there had been a significant increase in patients admitted over the past year.
- A more senior nurse, rostered on a management day, was on call to staff the place of safety. However, they were frequently needed to cover shortfalls on the wards and therefore not always available. In these instances, one of the duty managers attended. This had an impact on duty cover for the wards, as well as staff consistency in the place of safety.

However:

- Staff administered medicines in accordance with the prescribers' intentions and we saw evidence of the pharmacy team input to patients e-prescribing records.
- The electronic prescribing system alerted staff when medicines were due. When staff omitted medications, reasons were recorded. Staff described awareness of schedules for medicines requiring non-standard times for administration We saw emergency medicines and equipment were available, appropriate to each setting and were accessible to staff.

Is the service effective?

Requires improvement 

Our rating of effective went down. We rated it as requires improvement because:

- Staff did not complete individualised, person centred care plans with patients. Wards used templates for care plans which contained generic wording and statements. They consistently showed no evidence of patient involvement, no patient voice, views or wishes. Care plans appeared holistic, in that they covered many areas, but they did not identify patient strengths and did not demonstrate a recovery focus.

- There was insufficient opportunity for some patients to access psychological therapy and therefore the range of treatment offered was not in line with best practice guidance and National Institute for Health and Care Excellence guidance. There was a vacancy in the psychology team which impacted on patient's ability to access psychology input. Some wards employed therapeutic liaison workers to develop activities for patients but not all wards had this resource.
- Staff and managers did not demonstrate evidence of collaborative working between wards, learning from incidents and sharing of best practise. Some wards had good initiatives underway such as healthy eating and seclusion recording. These positive outcomes were not shared.

However:

- Staff were given opportunities to develop their skills and knowledge by attending both internal and external training. Supervision and appraisal rates had improved since the last inspection. During October 2018 five wards had supervision rates of over 90% with two wards achieving 100% supervision attendance.
- 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.

Is the service caring?

Requires improvement 

Our rating of caring went down. We rated it as requires improvement because:

- Staff did not involve patients in care plans. None of the patients we spoke to could describe the contents of their care plan. Staff wrote care plans in formal language and plans lacked the patients' voice. Staff did not record whether patients were offered and had accepted, or declined, a copy of their care plan. Only two patients had a simplified version called 'My Care Plan'. Staff told us that paper copies of these were completed with patients. There was no evidence of these being uploaded onto their electronic files. Five patients told us they had 'no idea' what a care plan was.
- On three acute wards, we observed staff undertaking physical observations in public areas of the ward which compromised their dignity and privacy. Two patients reported having blood pressure and blood sugar monitoring daily despite there being nothing in their care plans to indicate a need for this frequency of checks.

However:

- Staff treated patients with kindness, compassion and respect. We observed interactions between staff and patients during the inspection and saw that staff were respectful and responsive to patient's. We spoke with 26 patients who told us that staff were generally kind and caring. During the inspection, we observed staff dealing with a very unwell patient in a respectful and caring way with an emphasis on maintaining the patient's safety and dignity throughout.
- Staff gave patients opportunities to provide feedback via community meetings. Patients had access to advocacy services on the wards. Staff gave contact details to patients upon admission routinely. We also saw posters and leaflets available on the wards. Wards had information boards detailing the staff on duty, planned activities and times of ward rounds. These informed patients of the staff available for care and treatment for that day.
- Four out of five of the carers we spoke to were happy with their involvement, information shared with them and the level of care provided to their loved ones on the wards.

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

Is the service responsive?

Requires improvement ➔➔

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

- On Aston, Ashby, Bosworth and Thornton wards there was an inadequate number of rooms for care and treatment of patients. There were not sufficient rooms for patients to access one to one 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.
- Aston, Ashby, Bosworth and Thornton wards still had four bed dormitory accommodation. Patients disliked these because of the lack of privacy and private space. We observed one room intended as a single bedroom on Thornton ward used as a two-bedded room. This room was very cramped, and patients had very little access to private space.
- High bed occupancy across the wards meant that bed management was challenging. Some patients had to be sent out of area or moved to a rehabilitation ward. At the time of the inspection, 18 patients had been admitted to beds out of area because of lack of acute beds. A member of staff told us that very occasionally seclusion rooms were used when patients needed to be admitted in an emergency.

However:

- The trust provided a choice of food to meet differing dietary needs and choices.
- Discharge planning was done well. Staff worked pro-actively from admission to prevent barriers to discharge, despite the difficulties with social care and housing resources in the community.
- 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.
- The Unit had an Involvement Centre which offered a range of activities and resources for patients. Where occupational therapists and therapeutic liaison workers worked as part of the ward team we saw that they worked closely with patients to pro-actively engage them. The patient's we talked with spoke positively about the support they received.
- Four patients told us that the food was over-processed with poor consistency, quality and flavour.

Is the service well-led?

Inadequate ➔

Our rating of well-led went down. We rated it as inadequate because:

- There remained significant concerns relating to the proper and safe management of medicines which were raised at the last inspection.
- Requirements relating to maintenance issues being dealt with in a timely way, consideration of removing dormitories, and implementation of the smoke free policy, raised as concerns at the previous inspection had not been addressed.

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

- The trust did not identify, investigate and attempt to reduce significant issues that threatened the delivery of safe care and treatment. We found serious incidents and risks relating to the environment, fire and management of the smoke free policy. The trust had not identified links between incidents to identify wider trust learning. Staff were not always aware of incidents that had occurred within the service.
- There was a lack of cohesion across the unit and staff talked about lack of teamwork between individual wards and between wards and the bed management team. Best practise and innovation were not shared. Staff talked about how it could be difficult to get support from colleagues on other wards during difficult incidents. High vacancy rates and usage of bank and agency staff was negatively impacting on patient care.
- Not all ward teams were having regular team meetings and minutes were not always up to date nor comprehensive. There was little evidence of how information from minutes was shared with non-attendees.
- Staff did not feel always feel connected to the wider trust. They described visible local leadership to service manager level but felt above that role there was a lack of visibility and understanding of their service's needs. We heard examples where local leaders felt there was a lack of response from the trust regarding issues significant to their wards. Some staff members knew who the executive team were, in particular the chief executive, but were not able to name who the director was linked to the service or had seen them on a board walk.

However:

- Ward managers demonstrated commitment and passion and had a good understanding of the services they managed. They could explain clearly how the teams were working towards high quality care. Staff on all wards spoke highly of their ward managers and felt well supported and listened to.
- Senior managers were visible on the wards and accessible to staff. A range of wellbeing initiatives, including protected time off the wards, yoga and free fruit, were offered to all staff to improve staff wellbeing and morale.
- Supervision and appraisal rates had improved significantly since the last inspection and staff spoke positively about supervision, as well as the learning and development opportunities that were available to them.

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

Leicestershire Partnership NHS Trust provides specialist community mental health services for children and young people for patients aged 0 to 18 years under one registered location: Bridge Park Plaza.

The service sits within the Families, Young People and Children's services within Leicestershire Partnership NHS Trust. Specialist child and adolescent mental health service (CAMHS) provides specialist mental health services for children and young people experiencing moderate to severe mental health problems and disorders up to the age of 18 years living in and registered with a GP in Leicester Leicestershire and Rutland.

Specialist community mental health services for children and young people comprises several teams. These include outpatients' teams, access team, eating disorder team, group work team, paediatric psychology team, learning disability team, young people's team, inpatient unit, crisis team and the primary mental health team.

We inspected teams to look at those parts of the service that did not meet legal requirements and as we received information giving us concerns about the safety and quality of the services.

- City outpatients team: Based at Westcotes House, Westcotes Drive, Leicester LE3 0QU.
- CAMHS access team: Based at The Valentine Centre, Gorse Hill Hospital Site, Anstey Lane, Leicester LE7 7GX.
- County outpatients team: Based at The Valentine Centre, Gorse Hill Hospital Site, Anstey Lane, Leicester LE7 7GX and Loughborough Hospital, Hospital Way, Loughborough, Leicestershire, LE11 5JY.
- CAMHS crisis home treatment team: Based at the Agnes Unit, Gorse Hill Hospital Site, Anstey Lane Leicester LE7 7GX.
- Young people's team: Based at Westcotes House, Westcotes Drive, Leicester LE3 0QU.

We did not inspect all other specialist community mental health services for children and young people previously rated as 'requires improvement'. We are monitoring the progress of improvements to services and will re-inspect them as appropriate.

At this inspection we found that this core service had not fully addressed actions from our 2017 inspection. We found breaches of:

- Regulation 9: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Patient centred care
- Regulation 12: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and Treatment
- Regulation 17: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance
- Regulation 18: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

The trust had addressed some findings of the inspection in 2017 and was no longer in breach of:

- Regulation 13: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment
- Regulation 15:Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safety and suitability of premises.

Specialist community mental health services for children and young people

Our inspection of this core service in November 2018 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 teams to look at the environment
- spoke with two patients who were using the service
- spoke with 24 carers of patients who were using the service
- spoke with six managers, including managers for the teams and the service group manager
- spoke with 35 staff including nurses, support workers, doctors, occupational therapists, psychologists, social workers and administration staff
- observed six staff meetings or contacts with patients including a multi-disciplinary team meeting, a professional leads meeting, observation of access and duty staff and staff appointments with patients
- reviewed 26 patient care and treatment records including, referral information, risk assessments and care plans
- reviewed two staff records relating to appraisals
- reviewed a range of policies, procedures and other documents relating to the running of the service.

Summary of this service

The summary for this service appears in the overall summary of this report.

Is the service safe?

Requires improvement  

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

- The trust had not ensured there were enough staff to meet the needs of the service. Many patients still faced long waits for assessment and treatment. Seventeen out of 35 staff (excluding managers) we spoke to raised concerns about this. Staff said this was due to having two consultant psychiatrist, one clinical psychologist and 1.4 band 6 mental health practitioner post vacancies, short term and long-term sickness and parental leave. Sickness rates for county and crisis teams were at times above the national average of 4.2% at 5.7%. Examples of how this had affected the service included crisis team staff held on to patients longer than they had intended to help manage risks. Staff had challenges arranging urgent appointments for patients with doctors due to their availability.
- The trust had not fully ensured since our 2017 inspection that clinical premises where patients received care were safe, clean, well equipped, well maintained and fit for purpose. For example, Westcotes House building was old and not built for purpose. There was a large crack both sides of an archway and it had taken the trust five weeks to get a civil engineer assessment. In addition, some window catches had decayed.

Specialist community mental health services for children and young people

- Staff did not always follow the trust's policy for infection control as they had not ensured that toy and clinic cleaning rotas were available or routinely completed across all sites. Fabric beanbags in Westcotes House's group room had stains. Loughborough House clinic room had no handwashing facilities or gloves for staff in the room.
- The trust's safeguarding and incident policies did not clearly state the process for staff to report safeguarding incidents on the trust's electronic system. Two out of three city team meeting minutes did not capture how managers were sharing learning from incidents.

However:

- Staff reported that they received support to reduce their caseloads. Managers had arranged for some locum staff to assist with managing workloads and were reviewed what resources they had and needed to deliver a service. The trust had systems to risk assess and manage patients referred or waiting for a service.
- The trust stated Westcotes House was on their disposal list and they were looking for alternative premises. The trust had developed a protocol with staff to reduce risks for patients visiting the crisis team using the same entrance and reception as adults with learning disabilities. The trust had ensured that staff had access to personal alarms to use in case of emergency.
- Staff's compliance with role essential training was above 80%. Managers had systems in place to monitor when staff attended training and had systems to prompt and remind them when they did not.

Is the service effective?

Good ↑

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

- The trust had made improvements to ensure staff completed clear comprehensive and holistic care plans which identified patients' needs and the care required. The trust audited records to check they were up to date. Staff gave a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with National Institute for Health and Care Excellence guidance. Staff used recognised rating scales and other approaches to rate severity and to monitor outcomes. Staff used technology to support patients effectively for example, giving online access to therapies and other resources.
- The trust had ensured since our last inspection that staff documented assessments as relevant of patients' mental capacity and their consent to treatment. Staff had considered patients capacity in the 26 records we checked.
- Staff had effective multidisciplinary working with internal and external teams such as primary care, social services, education, paediatrics, police, and other community teams – including adult services. CAMHS staff had effective working relationships, including good handovers, with other teams within the organisation (for example, community to crisis team).
- Managers delivered regular supervision and appraisal to staff and gave staff opportunity to develop their skills and competencies. As of October 2018, the percentage of staff that had had an appraisal was 91%. The percentage of staff that received regular supervision was 79%. Staff additionally said they had access to reflective practice and case discussions.

Is the service caring?

Good →←

Specialist community mental health services for children and young people

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

- The trust had involved patients in their care plans. Staff offered them and carers a copy of their care plan. The trust audited care records to check that staff had involved patients and care plans had a recovery focus.
- Two patients and 18 of 24 carers we spoke with, gave positive feedback about staff, and stated they treated them with kindness dignity and respect. We saw this in our observations of care and treatment delivered. Staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties. Family and friends test results for October 2018 showed 100% would recommend the service to others.
- Staff informed and involved families and carers appropriately and provided them with support when needed.

However:

- The trust did not have a system in place to regularly engage with patients and carers and involve them in the service delivery.
- Six carers gave negative feedback stating staff could be more responsive.

Is the service responsive?

Inadequate 

Our rating of responsive went down. We rated it as inadequate because:

- Since our inspections from 2015 onwards, the trust had not taken adequate action to ensure that all patients received the service they needed in a timely way. A number of patients waited longer than expected for assessment and treatment. Staff could not always respond as quickly as they wanted to patient referrals due to a lack of resources. As of 19 November 2018, 498 patients waited for a routine assessment at city or county teams, 136 patients waited over 30 weeks across services for assessment. There were 969 patients waiting for treatment 654 for county and 315 for the city team. This was an increase from our last inspection in 2017 (945); of these approximately 230 children were waited 1-2 years for treatment. Fourteen of 24 carers we spoke with, said there were difficulties accessing the service and they had to wait a long time.
- Managers said the crisis team was not always able to meet their commissioned target to telephone patients within two hours and assess them within 24 hours. Staff including managers told us there was a 34 week wait for patients with 'medium' and 'low' risks to receive a 'routine' assessment despite the NHS constitution recommending no more than an 18 week wait for treatment. The trust did not meet commissioned targets for assessment of routine of children within 13 weeks.
- The trust did not meet the needs of patients with neurodevelopment issues in a timely way as patients often faced the longest waits for a service. As of 19 November 2018, 454 patients with attention deficit hyperactivity disorder (ADHD) and autism spectrum disorder (ASD) waited for either further specialist assessment or treatment, 161 patients waited one to two years. The crisis team said that approximately 50% of patients on their caseload had ASD.
- The trust staff gave limited examples of how they met the diverse needs of patients. Twenty out of 26 patient's records checked held limited information about patients protected characteristics for example race, religion or belief or sexual orientation. This was despite Leicester black and minority ethnic population being significantly greater (49.5%) when compared against the England average. (Joint Strategic Needs Assessment). Twenty out of 26 patients' records checked held limited information about patients protected characteristics for example race, religion or belief or sexual orientation.

- The trust had not ensured that Westcotes House reception was fully private and confidential as visitors could overhear receptionist conversations and trust information.

However:

- The trust had a range of specialist services. These included a young people's team which worked with vulnerable young people in care and those who are involved with the youth offending service; a specialist perinatal outreach mental health service and other teams such as to support patients with an eating disorder or with psychosis.
- The trust had developed a pathway and process for staff to follow to meet the national children and young people transitions commissioning for quality and innovation.

Is the service well-led?

Requires improvement 

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

- The trust had not ensured adequate higher management leadership and governance to address all actions from our previous inspections. This included management of staff resources, waiting lists and the environmental infection control procedures, still posed a risk for the service. The CQC had identified some of these risks since 2015. Not all managers gave clear timeframes or assurance for when patient's waiting times for assessment and treatment would reduce. Whilst we noted the trust made changes to the service, we had concerns about the slow pace of change as patients continued to face long waits for assessment and treatment.
- The trust had not ensured that all managers had access to data systems to assess and monitor risks in their services, for example waiting list times and staff sickness despite these areas being risks for service delivery. Prior to our inspection the trust had not sent us data about waiting times, despite our request. We requested further data from the trust after our site visit. However, some data provided conflicted with what we found at our site visit and therefore we were not assured that the trust had systems to effectively assess, monitor and mitigate risk to patients who waited for a service.
- Administrative staff morale was mixed. Some staff reported they did not feel part of the clinical teams and had equal opportunities for development.

However:

- Staff contributed to discussions about the service's strategy and changes to the service. Managers said their access to data had improved and they were more confident they knew who was waiting for assessment and treatment and why.
- Managers said their access to data had improved and they were more confident they knew who was waiting for assessment and treatment and why. Staff maintained and had access to the risk register either at a team or directorate level and could escalate concerns when required from a team level.
- Managers showed compassion and understanding when explaining how they supported their staff when they had been unwell. The trust more actively promoted staff wellbeing though events such as mindfulness, massage or yoga. Administrative staff said they met with therapists to confidentially discuss workplace pressures or issues. Staff said their immediate line managers were approachable and supportive.
- The trust gave staff some time and support to consider opportunities for improvements. For example, teams were incorporating 'iTHRIVE' into their work. This was an integrated, person centred and needs led approach to delivering mental health services for children, young people and families which conceptualises need in four categories: 'getting advice and signposting'; 'getting help'; 'getting more help' and 'getting risk support'.

Specialist community mental health services for children and young people

Outstanding practice

We found areas of outstanding practice in this service. See the Outstanding Practice section above.

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	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Enforcement actions

We took enforcement action because the quality of healthcare required significant improvement.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Our inspection team

Julie Meikle, head of hospital inspection, mental health, chaired this inspection and Tracy Newton, inspection manager, mental health led it. Two governance specialist advisors, supported our inspection of well-led for the trust overall.

The team included three further inspection managers, 13 inspectors, nine specialist advisers, and one expert by experience.

Governance specialist advisors are senior healthcare managers who support our inspections of the leadership of trusts. 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.

LEICESTER, LEICESTERSHIRE AND RUTLAND
JOINT HEALTH SCRUTINY COMMITTEE
19 MARCH 2019

REPORT OF BETTER CARE TOGETHER ENGAGEMENT AND INVOLVEMENT

INTRODUCTION

1. Better Care Together (BCT) partners are committed to greater involvement of patients, the public and stakeholders in the proposed improvements to services – particularly those that are likely to result in significant changes to the way in which services are delivered.

2. This paper briefly describes the activities undertaken during 2018/19 to engage with communities in Leicester, Leicestershire and Rutland (LLR).

3. It also outlines the direction of travel and strategic approach to communications and engagement in 2019/20. The paper also discusses the outcomes that we wish to achieve by adopting a consistent engagement process that is embedded through all BCT work streams.

ENGAGEMENT ACTIVITIES 2018/19

4. While the latter part of 2018 saw intensive communication and engagement discussing the acute and maternity reconfiguration, Better Care Together partners collectively and individually have engaged and involved patients, carers, staff and other stakeholders in the various aspects of Better Care Together work stream activities throughout the whole of 2018/19.

5. This work has included engagement on the Carers' Strategy, the Dementia Strategy, All Age Transformation for Mental Health and Learning Disabilities and Community Health Services. We have also undertaken a formal consultation on Planned Care Policies. Each of the programme areas have been led by one BCT partner with the support of all partners.

6. In addition, in October and November 2018 BCT partners undertook engagement to primarily discuss the proposal for acute and maternity reconfiguration in Leicester's Hospitals.

7. Nine public events provided opportunities for patients, the public and wider stakeholders to discuss changes to the care they receive through primary and secondary care services in ways that suit them. This included talking through the rationale for the proposed changes and what it would mean in practical terms for patients using services. Particularly those being provided by the three hospitals in Leicester run by University Hospitals of Leicester NHS Trust and those provided in a community setting. The events also discussed and answered questions and responded to concerns regarding changes to the Intensive Care Service.

8. We offered a series of Member Briefings with the three upper tier local authorities in LLR. We had good take up of this offer. We are committed to continuing this dialogue with councillors to ensure they are updated of proposals and plans. We are also working with

the three Health Overview and Scrutiny Committees as well as the Joint Overview and Scrutiny Community to ensure that appropriate and timely reports are presented and discussed.

9. We continue to work with MPs and a series of briefings will commence in March 2019 to update and discuss all BCT work. These briefings are supported by all NHS BCT partners.

10. A programme of communications activities has surrounded all engagement and consultation in 2018/19, using off and online media to amplify messages to wider communities.

11. NHS partners are continuing engagement in February and March through a programme of outreach by working with different communities particularly - seldom heard groups and those people who are vulnerable and often extensively impacted on changes to NHS services.

12. This work has and is still being done by reaching out and working within communities using their existing meetings and events to discuss BCT programmes. We are particularly working through voluntary and community sector agencies and local support networks to involve these communities.

13. We are also completing the production of a video and brochure to support messages around the proposals for the acute and maternity reconfiguration. They will be published in late February/early March.

14. While extensive engagement has been undertaken during 2018/19, the most successful work has been undertaken at a work stream level. Various engagement models have been adopted including Experience Led Commissioning, with a drive to undertake more activities that go out to communities and stimulate discussions, rather than expect communities to engage with the programmes. They have produced robust insights and business intelligence representing patient, carer and staff voices which have been fed into the work streams and influenced the redesign of our local health and care services.

15. However, communication has often been spasmodic and inconsistent when viewed at an overall BCT programme level. There have been times of intense communication and amplification of messages. While this has reached LLR communities it is not being picked up by key influencers in communities broader than the ‘active groups’ and therefore we aren’t creating and sustaining relationships and building trust with wider communities who then propagate our messages.

16. In addition, we have high volumes of engagement and interactions with some communities, whilst many other key communities and voluntary and disease specific groups still feel excluded from the involvement processes of BCT. We need to strengthen links with these communities, many of which have particular or even greater healthcare needs than the communities where we have high levels of engagement.

17. The BCT brand is either not always used by BCT partner leads when undertaking engagement in work streams or has not been used prominently and extensively enough. This has led to criticism by some patient groups that we have not engaged or

communicated enough on BCT, an understandable viewpoint when we have not used the opportunity that the BCT partnership brand affords the health and care community.

18. We also have some work streams communicating their work using various methods including social media. While this is welcomed, some guidance to work streams on how to deliver appropriate and timely messages would be beneficial. This will avoid situations where staff are inadvertently giving the perception externally that this work is happening without engagement and if required consultation.

19. In addition, very few of approximately 1.1 million people living in LLR take part in formal public consultations and those who do respond, often come from similar demographics or backgrounds.

STRATEGY FOR PUBLIC AND PATIENT INVOLVEMENT PROGRAMMES AND INITIATIVE 2019/20

Objectives

20. The learning from 2018/19 has clearly identified that we need a consistent and integrated strategy for communication and engagement. The strategy is based on delivering activities and actions which support the following key objectives:

- Develop a robust approach to engagement planning processes that are driven by and through work streams and work stream Senior Responsible Officers (SROs).
- Ensure that work streams have a greater level of understanding of the importance of public, patient and staff engagement, co-design and co-production and are provided guidance of what 'good' communication looks like.
- Create a structure and network for public and patient involvement, understood by work streams, with a consistent approach to capturing patient and service user experiences through co-design ensuring the insights and business intelligence impacts on service redesign and commissioning decisions.
- Work with leaders across BCT and work streams to create a culture where engagement is 'an always event' and there is knowledge of legal and statutory duties to involve people in service redesign which is respected and adhered to.
- Ensure that BCT partners are committed to one strong BCT brand identity to place the programme in a stronger position with the public and ensure messages are amplified.
- Ensure that all work streams have a consistent approach to communications and engagement and, where appropriate, consultation.
- Build permanent and continuous relationships with NHS and social care staff enabling them to shape and contribute to BCT and plans for improvement by involving them in work streams and their engagement activities.
- Build effective relationships with key stakeholders including local councillors and MPs and establish informal and formal two-way communication channels with them.

- Have commitment by BCT partners to communicate the vision of BCT and partners to the wider public and present a realistic picture of challenges and the achievements of the work streams through proactive, consistent and ongoing promotion and media relations.
- Ensure that BCT partners are committed to demonstrating the impact of engagement and consultation and show how it has influenced change. Also to collectively work to communicate change and key achievements through the BCT brand.
- Build a sense of community and build trust and ultimately improve health outcomes and enhance the quality of experience of patients and the professionals who support them as service redesign will be seen to be done in genuine partnership with the public rather than being perceived as tokenistic.

Positioning

21. BCT needs to strengthen its position externally and internally to ensure that it stands out in what is a very complex and confusing sector and develop a positive reputation through a set of simplified messages that take people through a journey with us.

22. Whilst key stakeholder groups including our own PPI Group may have an interest in NHS and social care plans, patients, the public and the media have more of an affinity with the frontline services and the people who deliver these services than the planners and commissioners of the service. This is due to the fact that services and health and care staff are tangible and easy to associate with and conjure up a meaningful image which people recognise.

23. To capitalise on this, BCT will strengthen its' position using a number of messages in order to raise awareness, enhance perceptions and stimulate interest in involvement, engagement - and subsequently for some work streams consultation. These messages will be based on the BCT vision "*To development an outstanding, integrated health and care system that delivers excellent outcomes for the people of Leicester, Leicestershire and Rutland."* They will also be based on our principles of:

    - Working as one team
    - Providing high quality, person centred care
    - Working efficiently and getting best value
    - Supporting and nurturing a committed health and social care workforce

Approach to communications and engagement

24. A consistent approach to communications, engagement and consultation should be driven through work streams and the Senior Responsible Officers. With the support of a named Communications and Engagement Officer, activities should be led and implemented - whether communications, engagement or consultation, using a consistent planning and implementation process. The BCT branding (person's perception of service, experience

and organisation – not just a logo) should be adopted in all BCT work streams to increase brand awareness amongst LLR communities. A general approach will encompass:

Staff engagement

25. Staff are our most important asset and communications with them both informs and assures them and in turn it is hoped that they can pass this information and assurance to their patients and those other individuals/influencers with which they routinely come into contact.

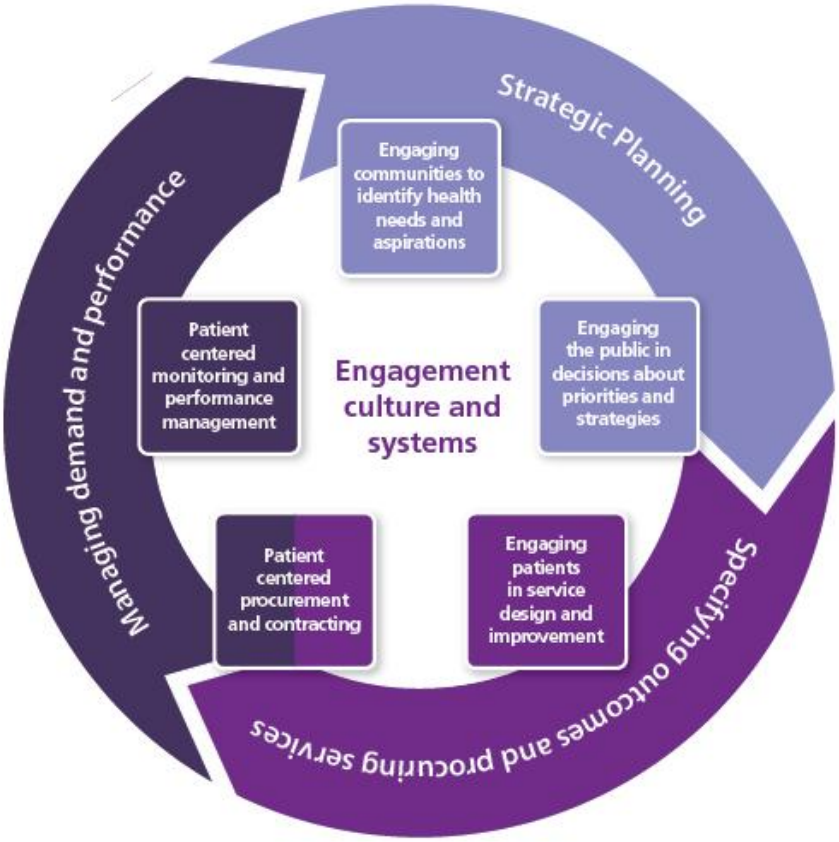
26. All partners have in place well established methods for communicating and engaging with staff. Concurrent to external engagement, BCT partners should enhance opportunities for staff to be engaged as well as continue to use existing mechanisms available through organisations to reach staff including newsletters and online briefings. To support this, regular messages will be produced and supplied to individual organisations to utilise as effectively as possible through their own channels and mediums.

Public Engagement

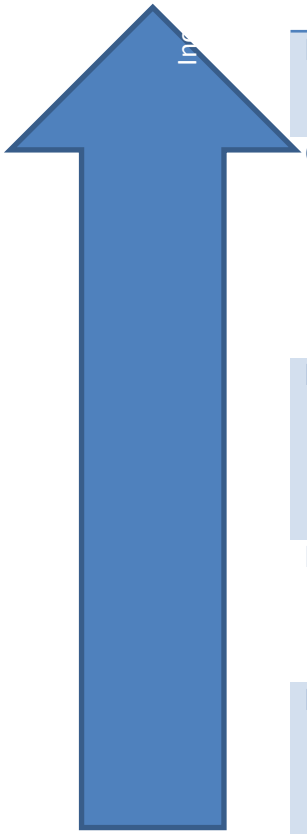
We aim to:

- Be clear about our plans and what the public can and can't influence and why
- Ensure the public have the right information so that all engagement can be fully informed
- Develop a Citizens' Panel to further support a consistent approach to communications and engagement, and to connect with local networks
- Utilise better our relationships with the voluntary and community sector and look to use joint working to support us to do this
- Make sure we engage with the right target audience and consider equality and the impact on diverse groups
- Provide an opportunity to engage with us at any time through our attendance at meetings and input into discussions when invited
- Demonstrate that we have listened to people's views in all our plans
- Demonstrate what changes have been made as a result of engagement activity
- Provide information on our website, through newsletters, in local print and broadcast media and on social media
- Create a structure of engagement for BCT to ensure we are capitalising on indirect marketing using the strength and reach of patient groups, voluntary sector and clubs and societies

We will advocate the use of the following engagement cycle to drive our inclusion process so that the public is at the centre of everything we do.



27. We will aim to increase community participation, empowerment and control by moving relationships through the engagement and communications ladder:



Levels of engagement and communication	
Devolving	Placing decision-making in the hands of the community and individuals in partnership with BCT partners
Collaborating	Working in partnership with communities and individuals in each aspect of the decision, including the development of alternatives, and the identification of the preferred solution. For example joint coordinating joint events
Involving	Working directly with communities and individuals to ensure that concerns and aspirations are consistently understood and considered. For example attendance at communities group meetings and events
Engaging	Obtaining community and individual feedback on analysis. Alternatives and/or decisions. For example surveys, Citizens' panel and focus groups
Informing	Providing communities and individuals with balanced and objective information to assist them in understanding problems, alternatives, opportunities, solutions. For example, website, newsletter and press releases

- **Engagement and where appropriate consultation**

28. In engagement activities we will develop the principle of co-designing services with people who have lived experiences of health and care across work streams. This involves gathering experiences from patients, carers, staff through in-depth interviews, observations and group discussions, identifying touch points (emotionally significant points) and assigning positive or negative feelings. It also involves asking and understanding what matters most to people regarding aspects of their care.

29. Co-design has been used within BCT work streams. This has used a variety of methods as adaption is always required depending on the cohort of patients and carers being engaged including vulnerable people with mental health problems, dementia, young people or those with learning disabilities.

30. Due to the qualitative nature of the work, it is only necessary to continue to interview different cohorts of patients until we are hearing the same themes.

31. Once insights have been collated, evaluated and analysed then high impact actions should be developed and used to influence service redesign or service change.

32. Where consultation is appropriate through work streams, we will use the Cabinet Office principles for public consultation (updated January 2016) and NHS England guidance 'Planning, assuring and delivering service change for patients' (published in November 2015). We will also adhere to the range of legislation that relate to decision making for clinical commissioning groups.

33. To ensure that work streams are conversant of the requirements of responsibilities of engagement and consultation and the legislative framework we will coordinate a reference workshop for representatives from work streams prior to Spring.

34. In addition we will also develop engagement and consultation protocols and a supporting toolkit that brings clarity of our responsibilities and greater consistency of communications, engagement and consultation across all BCT work streams.

35. In 2019/20 there are many initiatives within work streams that require engagement with communities across LLR, while others require formal consultation. In addition, other initiatives are at the stage of implementation where communications with health and care staff is required to ensure a streamlined operational process. These programmes of work are outlined in Appendix 1.

36. A consistent and integrated approach will assist in combating public confusion of the BCT programme and partners and combat the danger of engagement fatigue', given the breadth and depth of the activities required in 2019/20.

- **Communications techniques used whilst engaging and consulting**

37. Using BCT narrative and where appropriate work stream narrative we will target communities using a variety of techniques when engaging and undertaking formal consultation. These techniques are outlined in sections a to f below. In addition, Appendix 2 shows some of the key components that would be included in a typical communications and engagement plan for large scale formal consultation e.g. on the acute and maternity reconfiguration.

a. *Deliberative events*

38. When appropriate we will hold deliberative events in Leicester, Leicestershire and Rutland to enable elected members, members of Health and Wellbeing Boards and Scrutiny Committees to receive a BCT update and share their views and give us an understanding of the impact of proposals on the people they represent. Table top as well as open forum sessions will allow people to share their views. The sessions should be led by clinical leads and Senior Leadership members.

39. All feedback from the events will be captured and the key themes and points of any discussions recorded. These insights will be provided to work stream senior accountable officers. We will also capture any questions and draw up a question and answer section on our website, so that answers can be viewed by everyone.

b. *Briefings*

40. We will hold briefings with key stakeholders – including Healthwatch, patient participation groups and other patient groups and the voluntary and community sector. We aim to provide information to these groups on BCT and get an understanding of any change on them and the groups their represent. We will also provide Briefing Updates (video streaming, presentation and newsletter) to these groups to enable them to cascade information to their membership and contacts.

c. *Monthly work stream features*

41. Over the next twelve months we will coordinate work stream features concentrating on the activities and improvements being implemented. Working with each work stream we will use the variety of communications to engage with target audiences and profile the achievements of the work stream and benefits the work has to patients

d. Digital media

42. We will raise awareness of BCT and associated engagement activities and involvement through a range of communication channels including media, social media, website, webinars, video streaming, e-newsletter, stakeholder communications channels and if budget permits undertaking online advertising.

43. All communications and collateral will be available on a dedicated section of the BCT website and will be promoted via social media channels such as Facebook, Twitter and YouTube.

44. We will also explore hosting Webinars and producing simple online videos – hosted by senior managers and clinicians introducing people to BCT and individual work streams.

e. *Networks and contacts*

45. We will work with our voluntary sector colleagues and those local organisations that have newsletters and magazines both off and online, to publicise BCT and signpost people to our website and social media platforms. This will include providing, on a regular basis, articles and web copy to these organisations asking them to support communications.

46. We will also look to develop a closer working relationship with key voluntary and community sector organisations to empower groups to enable the communities they represent to be involved in NHS and social care improvements.

f. Communication activities – newspaper and broadcast media

47. We will improve communications with print and broadcast media to providing regular updates and negotiate features on each work stream. To support this work regular briefings sessions will be held with prominent local journalists to explore opportunities for collaboration.

ENHANCED PUBLIC AND PATIENT STRUCTURES

PPIG proposed new structure

48. Starting in the Summer of 2018 a comprehensive PPIG review was undertaken with group members. The review concluded that there was a desire of the group to create two complimentary parts of a BCT PPIG.

    - Assurance – the need to ensure the PPIG was able to assure itself that engagement and involvement was an integral part of all system design and redesign
    - Networking – the need to ensure that PPIG had connection with and influenced patient and community focussed groups to identify key areas for engagement.

49. It is proposed that Patient and Public Involvement Assurance group will be established (PPIAG) in 2019, which will replace the existing Patient and Public Involvement Group. The PPIAG will work within an agreed assurance framework to review, comment on and recommend actions in respect of patient involvement and engagement in specific BCT projects or areas of work. It will also liaise with work streams to ensure that insights and business intelligence gained through involvement and engagement influences decision making. PPIAG shall be represented on and report findings to the BCT Partnership Group (when established). The Partnership Group shall agree a programme of review with input from the Senior Leadership Team, Work stream SRO's, PPIAG and the Communications and Engagement Group.

50. The PPIAG will triangulate information from Work stream / Project leads, Communications and Engagement Officers, the Citizens' Panel and patient groups.

51. The PPIAG membership will consist of 10 – 12 people with experience of patient engagement and ability to analyse information to identify key issues and develop specific action points.

Citizens' Panel

52. In order to further support a consistent approach to communications, engagement, BCT and to support the PPIG review to connect with local networks, we secured £40k from NHS England to develop a Citizens' Panel. The Panel, which will be largely online, will provide BCT with an additional systematic approach to gathering insights and feedback on a range of health and care issues from a representative sample of our circa 1.1 million population. It will also assist in aligning the PPIAG with the views of citizens that demographically and attitudinally are representative of the citizens of LLR.

53. It is important to state that the Citizens' Panel will be an additional but complementary tool to other existing involvement and engagement activities and provide an additional avenue to reach local people. Whilst it will be part of the new structure of patient involvement, it will in no way replace the broader engagement, involvement and communications undertaken with our stakeholders, patients, carers and the population that are harder to reach, particularly those led by BCT partners through the BCT work streams.

54. To assist with the creation of a representative Citizens' Panel we will identify and bring in additional support to set up the Panel. This additional capacity will enable us to establish the Panel and set up systems and processes for engagement and involvement. After the first twelve months of the project we will look to embed the Panel into the engagement processes of three clinical commissioning groups in the area.

55. We will look to develop the Panel with the support of all BCT partners, the PPIAG and our upper and second tier local authorities and parish councils.

56. National guidance shows that an accepted way of determining the required sample size is to aim for a confidence interval of +/- 3% at the 95% confidence level. For a population of circa 1.1 million this equates to approximately 1,100 people.

57. We will work with local authority Public Health Teams, to ensure that through our Joint Strategic Needs Assessment and demographic profile data that we know the make-up of people living in our area and can create a Panel aligned to it ensuring it is representative – statistically and demographically and, in tune with the attitudes of the entire population and meets a pre-determined quota.

58. Panel recruitment will concentrate on reaching out to those individuals who could be deemed as 'hard to reach'. We will work hand-in-hand with specialised voluntary and community groups/faith groups at a very local level and undertake intensive recruitment methods. We will also work with district, local and parish councils to enlist their support in reaching the communities they represent and also engage with local schools, colleges and universities to explore their involvement in developing the Citizens' Panel.

59. Prospective Panel members will be asked a number of screening questions to ensure they meet the Panel make-up requirements. BCT will also ensure clarity at the recruitment stage about what is expected of each Panel member and what their membership is likely to entail. Panel members will be advised that their involvement will be for between a one to three year period, and will receive a commitment from BCT to be contacted at least monthly to either:

    - Answer a small number of questions
    - Participate in a face-to-face focus group driven through BCT work stream (panel members recruited applicable to their stated interest)
    - Up to four times a year to complete a full survey

Non-response participants would be removed after one year and panel members refreshed after three years.

60. Our engagement strategy will take into consideration the interests of individuals and how each community receives information and ensure that they are regularly informed and communicated with about how their involvement is used to influence the work of BCT.

61. When implemented the inputs and outputs of the Citizens' Panel will be reviewed and commented on by a restructured PPIAG. They will also make recommendations in respect of specific projects of work involving the Citizens' Panel.

62. Appendix 3 shows a 'mind map' of the Citizens' Panel – the main component parts and the interdependencies.

EVALUATION AND MONITORING

63. Appendix 4 shows a top line work plan of the intended activities to be undertaken in 2019/20. It is important that we monitor our activities and evaluate their success to ensure that the work has the desired impact.

64. We will set key performance indicators for each programme initiative which will be monitored through BCT work streams. The evaluation will be based on:

- The understanding of the patients, service users, staff and stakeholders of the scale of the challenge that we collectively face and their recognition that services will have to change e.g. through polls and surveys.
- The understanding that health and social care organisations are working together to address these challenges e.g. through polls and surveys
- The understanding of our vision for health and social care services and what it means for patients, their families or organisations, including the impact that any changes may have e.g. though workshops and outreach .
- The understanding that everyone has a role to play in the services changes and engaging in the debate e.g. through the number of people attending events, engaging on social media, joining the Citizens' Panel etc.

Appendix 1

Engagement across LLR communities		
Initiative and Accountable Officer (AC)/Senior Responsible Officer (SRO)	**Description**	**Approximate timing for engagement**
Planned care Referral Support Service **AO:** Sue Lock **SRO:** Ket Chudasama	Pilot for the provision of a Referral Support Service for a range of speciality areas	Beginning in February 2019 and will be ongoing
Planned care Diagnostics **AO:** Sue Lock **SRO:** Ket Chudasama	Currently at notional stage	Patient experience work to inform from March 2019
Community services redesign **AO:** Karen English **SRO:** Tamsin Hooton	Reorganisation of some of the current services provided by Leicester Partnership Trust including community nursing and Intensive Community Support Services	Commenced July 2018 and is on going Depending on the model implemented – consultation may be required towards the end of 2019/20
Acute and Maternity Reconfiguration ***AO:*** John Adler/ Sue Lock	Reorganisation and improvement of services in hospitals in Leicester Further engagement to describe in more detail the following: • Plans for General Hospital site • Travel and access plan • Plans for environmental improvements to enhance patient experiences • Details on assumptions for bed numbers	Continuation of engagement activities. Depending on outcome of approvals process and outcome of capital bid preparation could be required in financial year, however timing unknown.
Mental Health IAPT **AO:** Karen English **SRO**: Sarah Warmington	Informing procurement of service from June 2019 to support specification and redesign	From February 2019
Mental Health All age mental health transformation **AO:** Peter Miller **SRO**: Sarah Warmington/John Edwards (Project Leads)	LPT is on a five-year journey to transform the care they deliver through mental health and learning disability services, by co-designing improvements With service users, carers, staff and other key stakeholders. They are changing access and assessment to these services as well as crisis and community care.	Ongoing engagement throughout year

Cancer **AO:** Sue Lock **SRO**: Paul Gibara	Leicester's Hospitals, Macmillan Cancer Support, GP and other healthcare professional are developing and expanding the support offered to people living with and beyond a cancer diagnosis	March – November 2019
Formal Consultation across LLR communities		
Initiative	**Description**	**Approximate timing**
Primary care **AO:** Karen English **SRO**: Tim Sacks	Detailed plans to be developed with consultation required on aspects within the primary care strategy	From March 2019
Learning disability Short breaks **AO:** Karen English **SRO**: Sarah Warmington	Full service review	Timeline to be determined for 5 week engagement following by 90 day consultation in June 2019
Gamete and Embryo Cryopreservation Policy (Leicester CCG leading on behalf of 19 East Midlands CCGs)	Nationally driven policy changes including changing wording to consider and incorporate transgender patients.	April 2019 (TBC)
Dental (lead by NHS England requiring local support)	Details unknown	Details unknown
Consultation (specific communities)		
Initiative	**Description**	**Approximate timing**
Hinckley and Bosworth Community service review **AO:** Caroline Trevithick **SRO**: Spencer Gay	£8 million investment to make better use of existing space and improve services	From June 2019
Engagement (specific communities)		
Initiative	**Description**	**Approximate timing**
Health inequalities in Oadby and Wigston ***AO: Karen English***	Engaging on action plan to reduce health inequalities	From February 2019
Engagement with health and care professionals		
Initiative	**Description**	**Approximate timing**
Planned care Pathology **AO:** Sue Lock **SRO:** Ket Chudasama	Transformation of pathology services providing GPs with higher level of knowledge and support	Timeline unknown
Planned care Avastin **AO:** Sue Lock **SRO:** Ket Chudasama	Exploration of use of Avastin where clinically appropriate for patient with AMD	Timeline unknown

Planned care Reduction in follow-up **AO:** Sue Lock **SRO:** Ket Chudasama	Reduce number of unnecessary follow-up appointments	Timeline unknown
Ongoing communications across LLR		
Initiative	**Description**	**Approximate timing**
Planned care Ophthalmology and Dermatology **AO:** Sue Lock **SRO:** Ket Chudasama	Change in pathway to services moving elements of service from UHL into primary and community settings	From March 2019
Self-care and prevention **AO:** Steven Forbes **SRO:** Mike Sandys and Ivan Browne	Ongoing communications	Ongoing
IM&T **AO:** Peter Miller **SRO**: Ian Wakeford	Ongoing communications	Ongoing
Areas being scoped which may require communications, engagement and or consultation		
Initiative	**Description**	**Approximate timing**
Children's care (prescribing) **AO:** Chris West **SRO**: Mel Thwaites/Ian Scudamore	TBC	TBC
Right Care (e.g. Gastro, respiratory) **AO:** Sue Lock **SRO:** Ket Chudasama	TBC	TBC
Planned care (e.g. audiology, pathology, diagnostics) **AO:** Sue Lock **SRO:** Ket Chudasama	TBC	TBC
Long Term Conditions TBC Part of Integrated Community Board	TBC	June (TBC)
End of Life **AO:** Caroline Trevithick **SRO:** Tamsin Hooton	TBC	April – May 2019

Appendix 3

Typical components of a communications and engagement plan for a large scale consultation

Consultation plans use Cabinet Office principles for public consultation (updated January 2016) and NHS England guidance 'Planning, assuring and delivering service change for patients' (published in November 2015).

They also take account of the range of legislation that relates to CCG decision making including:

- Equality Act 2010
- Public Sector Equality Duty Section 149 of the Equality Act 2010
- Brown and Gunning Principles
- Human Rights Act 1998
- NHS Act 2006
- NHS Constitution
- Health and Social Care Act 2012
- Communities Board Principles for Consultation

1. Aims and objectives of consultation

The aim of a consultation exercise is:

- To inform people about how the proposals have been developed
- To describe and explain the proposals
- To seek people's views, and understand the impact of the proposals on them
- To ensure that a range of voices are heard which reflect the diverse communities involved in the consultation
- To understand the responses made in reply to proposals and take them into account in decision-making
- To ensure that the consultation process maximises community engagement and complies with our legal requirements and duties

2. The role of consultation in review processes

Public consultation is essential in the development of NHS services. It provides people with an opportunity to help shape proposals for change and improvement and to comment on those proposals before any final decisions are made. This includes those who use services, their carers and advocates; community organisations, local government; community leaders and stakeholders, NHS partners and NHS staff.

Public consultation is one of a number of methods used by the NHS to develop better care and better services.

Before the formal public consultation process we have undertaken engagement with all those likely to be involved with, affected by or interested in the services being considered.

3. Consultation document and materials

We develop a consultation briefing document which conveys key messages.

We ensure that the main consultation document is relevant to people who currently use and are likely to use services that we are consulting on.

The document explains why change is needed, what the proposals are and what benefits they will bring for patients, as well as how the proposals, if agreed, might be implemented.

It also clearly explains how people can participate, feedback comments and ask for further information by post, email, social media and website. The document also provides links to where additional information for those people who want a greater level of detail e.g. on workforce, financial information etc.

We produce an online questionnaire and hard copy questionnaires (including an equalities monitoring form) for use at events including an easy read version.

People involved in the engagement will be from a variety of backgrounds, therefore we ensure that the consultation document is made available in different formats e.g. easy read. We also explore the translation of the documents into other languages spoken locally. We produce a summary document to provide people with a quick overview of proposals which we circulate to key outlets e.g. libraries, sports centres, GP practices and community venues.

All information produced as part of the consultation is written in a language that can be easily understood. Technical phrases and acronyms are avoided, and information is produced in other formats as required to reflect population needs.

All consultation documents will be available on a dedicated section of each CCG and BCT partner websites and the BCT website, which will contain further documents that support a consultation. Sites are promoted via social media channels such as Facebook, Twitter and YouTube.

Posters and flyers are produced for distribution, and displays and stands for use at public events and in public places and at roadshows.

4. How we consult – summary of typically activities in large scale consultations

We develop and implement a range of activities for different audiences to ensure that we give everyone equal opportunity to participate in the consultation process and trigger the necessary motivation for communities to participate. Outlined in this section is a summary of typical activities. We monitor and

evaluate the process consistently to ensure that all activities are meeting the requirements of a robust consultation.

We also undertake a stakeholder analysis including specific communities that may be hard to reach that is informed by the Equality Impact Assessment undertaken for each consultation.

Existing mechanism

There are a number of mechanisms that BCT partners already have in place which help provide information and communicate with a range of stakeholders. These mechanisms are used during a consultation process:

- Staff – through a number of methods including briefings, newsletters etc.
- Local councillors and MPs are updated through discussions at scrutiny and Health and Wellbeing Boards and through briefings at committee meetings. They also receive a monthly BCT newsletter
- BCT partner websites
- Presentations at Healthwatch, Voluntary Action Leicester and other voluntary groups
- Local media including TV, radio and newspapers
- Patient groups and members including PPG networks
- GP newsletters and locality/federation meetings
- Twitter, Facebook and Youtube

Other mechanisms

Focus groups

Under the Equality Act 2010, we have a duty to consider potential impacts of service change on people with protected characteristics. In order to help us understand these potential impacts in detail, we run focus groups with these populations using existing meetings and events held by other support groups, particularly the voluntary and community sector.

We also use focus groups to engage with individual practice patient participation groups and other patient groups.

We also utilise the support of local organisations, voluntary and community groups and local support networks to reach out and involve these communities.

Planned public events

We hold a number of planned public event across LLR to enable members of the public, voluntary and community sector stakeholders, parish councils and other interested groups to share their views and give us an understanding of the impact of proposals on them and the people they may represent with information given by local providers including clinicians and CCG leaders. Table top, as well as open forum sessions allow people to share their views and respond to the consultation questions.

To cater for people who work and those that don't, we hold the events at differing times, both day-time and evening.

All feedback from events are captured and the key themes and points of any discussions recorded along with the attendance in terms of equality and diversity requirements. These records form part of the evidence to inform the final decision-making process. We also capture any questions and draw up a question and answer section on our websites, so that answers can be viewed by everyone.

Road shows on NHS sites

To provide opportunities for staff and existing patients to find out about any consultation and share their views, we run a road show at hospitals and other NHS and care premises. During these sessions we raise awareness of the consultation and signpost people to our consultation website and response form. We also provide copies of the summary consultation document and response form so they can be either take it away to consider or complete it immediately.

Outreach

We arrange for displays and/or manned or unmanned exhibition stands to be situation in prominent areas where there is a high footfall to engage with the public and signpost them to further information.

Briefings

We hold briefings with key stakeholders – including Healthwatch, the PPI Group, local authorities and other key interest groups. We aim to hold these briefings early on in a consultation period to enable these stakeholders to cascade information to their membership and contacts.

E- newsletter

In order to keep the consultation in the public's eye and ensure continuing engagement with the local population, we produce a regular e-newsletter updating people on the opportunities for getting involved. We use it to publicise our public events and road shows and signpost people to our website and response forms.

Networks and contacts

We work with our voluntary sector colleagues and those local organisations that have newsletters and magazines both off and online, to publicise the consultation and signpost people to our website and response form. This will include providing on a regular basis throughout the consultation articles and web copy to these organisations asking them to support our communications.

Communications activities

We raise awareness of consultation, associated engagement activities and call to action through a range of communication channels including media, social media, websites, consultation newsletter, stakeholder communications channels and by distributing a range of communications materials.

We work with newspapers and print media to coordinate regular features and updates. We also engage with weekly newspapers, TV and radio stations including commercial stations e.g. Sabras

Reaching different communities

We further segment our communities including those over our borders and develop other methods of engagement to reach them e.g. outreach work, presence on community website, through local employers

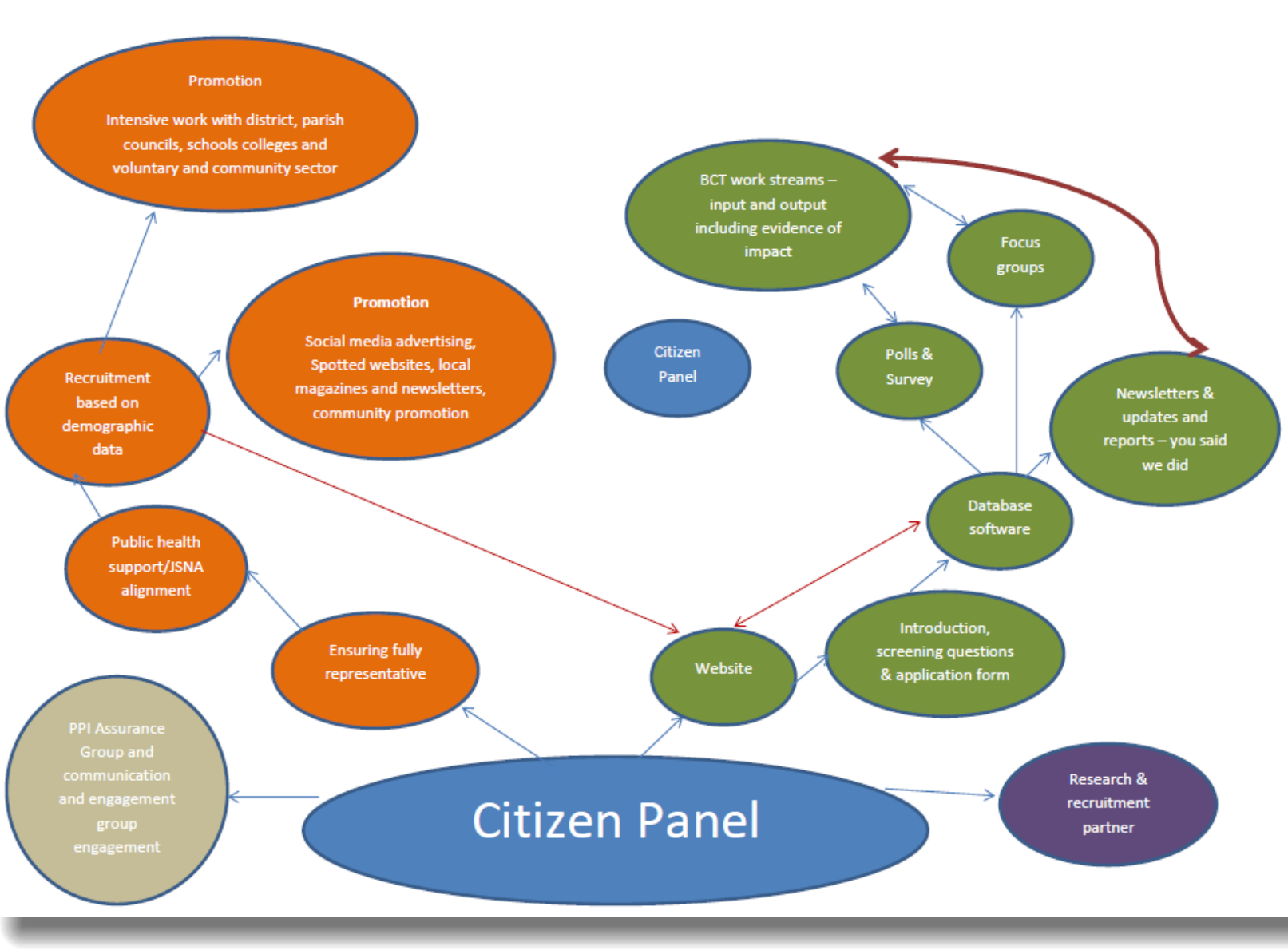
5. Equalities considerations

As both a legal requirement, but also a moral requirement we ensure that the consultation process reaches out to all those who have an interest in the proposals and that they are empowered to take part in the consultation.

An equality impact assessment ensures that the process for consultation and decision making is fully compliant with our legal duties under the 2010 Equality Act and the NHS Act and that we are taking account of people's protected characteristics.

We will also undertake an Equality Risk Assessment to highlight key areas of concern or issues and identify mitigating actions.

Appendix 3


Promotion
Intensive work with district, parish councils, schools colleges and voluntary and community sector
Promotion
Social media advertising, Spotted websites, local magazines and newsletters, community promotion
Recruitment based on demographic data
Public health support/JSNA alignment
Ensuring fully representative
PPI Assurance Group and communication and engagement group engagement
BCT work streams – input and output including evidence of impact
Focus groups
Citizen Panel
Polls & Survey
Newsletters & updates and reports – you said we did
Database software
Website
Introduction, screening questions & application form
Citizen Panel
Research & recruitment partner

Better care together
Leicester, Leicestershire & Rutland health and social care

Appendix 4 – Communications, engagement and consultation work plan

Communication, engagement and consultation delivery timeline	2018										2019			
Activity and timeline (known as at 5 March 2019)	March	April	May	June	July	August	September	October	November	December	January	February	March	April
Support work streams														
Coordinate a workshop to provide guidance on the statutory and legal responsibilities of NHS organisations														
Provide engagement protocols and toolkit of support														
Staff engagement														
General BCT messages/bulletin														
Messages pertinent to work streams e.g. CSR, Acute Reconfiguration														
Public engagement														
Planned care referral support service engagement														
Planned care – ophthalmology and demonology														
Primary care														
Community services engagement														
Acute and maternity reconfiguration														
Mental health (IAPT)														
Mental health – all age mental health transformation														
Outreach with groups and organisations														
Long Term Conditions														
End of Life														
Cancer														
Self-care and prevention														
IM&T														
Planned care – ophthalmology and dermatology														
Public consultation														
Learning disability														
Hinckley community health services														
Dental (led by NHS England) TBC														

Gamete and Embryo Cryopreservation Policy TBC														
Communications														
Monthly newsletters														
Briefing Healthwatch (face-to-face and written)														
Briefing councillors and MPs (face-to-face and written)														
Digital media														
Print and broadcast media features														
PPI Structure development														
PPI Assurance Group development														
PPI Assurance Group Implementation														
Citizens' Panel development														
Citizens' Panel first launch and recruitment commences														

Leicestershire, Leicester and Rutland Joint Health Scrutiny Committee – 19th March 2019

Report on scrutiny work related to the Better Care Together Plan

1. Introduction

1.1. At the LLR Joint Health Scrutiny Committee Meeting in December 2016, the committee were informed that the Sustainability and Transformation Plan identified the following 5 key priorities for areas which it was considered required fundamental changes over the next 5 years to address the challenges set out above: -

a) New models of care focused on prevention and moderating demand growth.
b) Service configuration to ensure clinical and financial sustainability.
c) Redesign pathways to deliver improved outcomes for patients and deliver core access and quality.
d) Operation efficiencies.
e) Getting the enablers right.

1.2. Following a discussion on the paper it was agreed that scrutiny from the three authorities would divide the different areas up to look at, but that it would not be exclusive to this. This was agreed as follows:

	Leicester City Council	Leicestershire County Council	Rutland County Council
New Models of Care	Primary Care	Integrated Teams	Community Rehabilitation
Service Reconfiguration	UHL Acute Hospital Sites	Community Hospitals (excluding Rutland Memorial)	Rutland Memorial Hospital
Other	Mental Health Services	STP Proposals of neighbouring CCGs outside the LLR area	STP Proposals of neighbouring CCGs outside the LLR area

1.3. This report updates on the work done to date at each authority and combined.

2. Leicester City Council

2.1. 4 January 2017

The Commission looked at the ***Primary Care elements of the Sustainability and Transformation Plan*** which was published on 21st November 2016.

It was noted that:

- More care will be provided in community in next 2-5 years.
- GPs would work more in a team approach to expand services available to patients.
- GPs would be taking a more focused lead and approach on complex patient care.
- There would be more locality-based care rather than hospital-based care.
- There would be more hub-based patient care when GPs practices where not open.
- There would be more patient diagnostic services provided in the in community.
- There would be more demands upon social care services and carers and the primary care sector would need to be more involved in prevention measures.

RESOLVED:

That the CCG be asked to provide the overarching Equality Impact Assessment for the overall STP and that each individual Equality Impact Assessment be provided to the Commission as they are finalised.

2.2. 2 March 2017

The Commission received an update on ***maternity services proposals in the STP***.

The commission from UHL on their intention within the STP to consolidate maternity care onto the Leicester Royal Infirmary site with the potential for a midwifery led birthing centre at the Leicester General Hospital, subject to formal public consultation.

RESOLVED:

That the proposals be noted but the Commission has some concerns about the planned building work and how this will be funded.

The Commission received an update on ***acute hospital site proposals in the STP***.

It was heard that the proposal to reduce the number of acute sites from three to two sites was dependent upon the proposals in the wider STP because the reconfiguration of the acute service provision could only happen if other reconfigurations in the STP were in place. Members commented that it was difficult to comment effectively on proposals that were dependent upon other elements of change and was reliant upon capital allocations that may or may not be available.

RESOLVED:

a) That the report be received and the officers be thanked for their responses.

b) That the Commission cannot offer its views on the proposals until it has heard the views of public, patient groups and other interested community organisations at the meeting on 29 March 2017.

c) That the Commission consider that transitional funds should be made available to improve, enhance and expand existing community services so they are operating at the levels required to cope with the current demands before considering further re-configurations of acute hospital services.

d) That the Commission receive a briefing paper on the PF2 initiative and implications for funding capital project by this method, once UHL have been informed of whether their capital bids to NHS England have been successful.

e) That copies of the workforce and financial plans be submitted to the Commission.

2.3. <u>29 March 2017</u>

The Commission received an update on how ***mental health would be catered for within the proposals in the STP***.

Members stated that the draft STP had little content on mental health mainly and it was difficult to understand the overall picture when the Dementia and CAMHS services were in different STP workstreams, as it was not easy to see how all the mental health services fitted together. There was also no reference to mental health services provided to the Criminal Justice Service, and there were significant mental health issues affecting inmates in prisons and detention centres.

RESOLVED:

That the officers be thanked for their presentation and for responding to Members' questions and the Commission would continue to consider and comment upon the proposals as the STP process progressed.

Scrutiny had an agenda item on ***views from public, patients' groups and other interested community organisations on the draft sustainability and transformation plan***, prior to public consultation.

The primary purpose of people presenting their submission was for the Commission to hear at first hand the views being expressed and there would be no opportunity for members of the Commission to ask questions on the presentations. Representatives of the CCG were present, but they would not be asked to respond to the submissions, but they would take note of the submissions for future reference.

RESOLVED:

That the members of the public and the representatives of community organisations be thanked for their submissions.

2.4. 23 August 2017

The commission received a report on the ***General Practice Forward View***.

Leicester City Clinical Commissioning Group submitted a report providing an update on the development and delivery of the Leicester City CCG Primary Care Strategy and how it linked with the General Practice Forward View delivery across the STP footprint of LLR.

RESOLVED:

That the report be received and that Members' comments be taken into consideration as part of the public engagement process.

2.5. 4 October 2017

The commission received an update on the ***Mental Health STP Workstream***.

Members had received information on the Five Year Forward View for Mental Health. This had been useful to improve Members' understanding of the issues involved and would be useful in considering mental health as part of the STP.

Members noted there were weaknesses with the FYFW and there were areas where the LPT were working to mitigate the risks associated with recruitment, staff training, parity of funding, increasing the understanding of mental health and dealing with increased demand and socio-economic pressures.

RESOLVED:

That a further report be submitted in 6 months' time focussing on the work to address issues such as 24/7 services in acute hospitals, improved services for prevention and children having access to mental health services, improved access to perinatal mental health services and better access to physical health support.

UHL provided an update on the current state of play since the move to the ***new Emergency Department***.

RESOLVED:

That a further update be submitted in the spring of 2018 following the full implementation of Phase 2 of the Emergency Floor.

2.6. 5 July 2018

UHL provided a report updating on ***Phase 2 of the new Emergency Department.***

It was reported that the new emergency floor had been designed to meet the needs of patients and the recent completion of the move of all five acute assessment units next to the emergency department had created the emergency floor. The commission heard the positive impact of the revised layout and the improved hospital environment and move away from single event emergency care. Greater collaboration and corporate working of staff, specialist nurses and physicians had resulted since the implementation of phase 2 of the works. It was recognised that the situation was evolving and difficulties in recruitment were reported and noted.

RESOLVED:

a) Receive and note the update on phase 2 of the Emergency Department improvements;

b) Request a review of signage, including internal signage, and external car parking and highway signage as part of the next phase of works;

c) Support the need to provide bursaries for nurses and write to the Secretary of State for Health to emphasise this position;

d) To enhance the advertisement of opportunities within the NHS, with a Task Group being established in due course to consider proposals to remove barriers and increase employment opportunities in the local NHS workforce;

e) Note the data concerning patient flow;

f) Request a review of the 20-minutes permitted waiting time outside the Emergency Department; and

g) Arrange a Members' site visit to the Emergency Department.

2.7. 29 November 2018

UHL submitted a progress update on the ***Leicester, Leicestershire and Rutland Frailty programme***

It was heard that although there were successes in that people now had a longer life expectancy, those people were not necessarily living healthier lives in their later years. It was noted that during the winter months, approximately 80% of the beds within the UHL were occupied by patients over 70 years of age who were frail and had two or more long term health conditions (known as multi-morbidity).

RESOLVED:

That an update be brought back to the Commission after the winter period to see how the outcomes have progressed.

2.8. 15 January 2019

The Commission received an update on the ***General Practice Forward View in Leicester City.***

Members heard that one of the biggest challenges faced was the Primary Care workforce; the CCG were trying hard to resolve this and were having discussions as to what else they could do. It was noted that other levels of practitioners were being offered at GP surgeries; for example, people could see nurses or pharmacists but there were issues around managing patients' expectations.

RESOLVED:

That the report be noted.

3. Leicestershire County Council

3.1. 23 January 2017

The HOSC considered a report on the ***Better Care Together Information Management and Technology workstream*** which provided an update on development of the Summary Care Record and interoperability of Information Technology Systems.

It was noted that Patients had to opt in to the scheme in advance to enable their Summary Care Record to be shared and then further consent from the patient would be required at the time of treatment. This was due to Information Governance rules. Concerns were raised by Members that a patient might not be capable of giving consent at the time treatment was required.

RESOLVED:

That the work being undertaken with regard to the Summary Care Record and interoperability of Information Technology Systems be supported.

3.2. 1 March 2017

The HOSC considered a report on ***Leicestershire Better Care Fund Plan for 2017/18 – 2018/19***.

Members raised concerns regarding technical problems with the First Contact web-based referral form and reassurance was given that consideration would be given to how to resolve these problems.

RESOLVED:

That the contents of the report be noted

3.3. 19 June 2017

The HOSC considered a report on the ***Development of Integrated Locality Teams in Leicester, Leicestershire and Rutland***

It was noted that the structure of the Integrated Locality Teams was based on GP practice boundaries. It was queried whether this accurately reflected larger GP practices, particularly in the Market Harborough locality, which might have additional services in other localities. The Director undertook to give further consideration to delineation issues in Market Harborough in the light of this query.

RESOLVED:

That the update on the development of Integrated Locality Teams in Leicester, Leicestershire and Rutland be noted.

The HOSC received a ***Presentation from Better Care Together which provided an update on progress with the GP Five Year Forward View implementation.***

In response to questions from Members reassurance was given that there was no shortage of capital funding for GP practices however there was a shortage of revenue funding.

RESOLVED:

That the update on the implementation of the GP Five Year Forward View be noted.

The HOSC received a presentation from Better Care Together which provided an update on progress with ***implementation of the Sustainability and Transformation Plan*** (STP) for Leicester, Leicestershire and Rutland.

RESOLVED:

(a) That the update on the Sustainability and Transformation Plan be noted.

(b) That officers be requested to provide Members with a briefing on the refreshed Sustainability and Transformation Plan in due course.

3.4. 7 November 2018

The HOSC received an update regarding the **Hinckley and Bosworth Community Services review**.

Members welcomed the bid that had been submitted by WLCCG for funding from NHS England for capital investment in Hinckley and Bosworth.

Concerns were raised by Members that less people would be able to walk or use public transport to access services at the Sunnyside site due to it not being in the centre of the town and therefore car parking would become an issue. Reassurance was given that there was good car parking availability at the Sunnyside site, and also once existing staff and services had moved out of the Mount Road site then car parking space at Mount Road which had previously been used for staff parking would be able to be used by patients.

A member raised concerns that there was no Urgent Care Centre in Hinckley and patients were expected to travel to Nuneaton for urgent care despite high levels of traffic between Hinckley and Nuneaton which caused delays.

It was moved by Mr Bill, seconded by Mr Barkley and carried that the Committee, recognising the seriousness of the situation, should write to NHS England and the Secretary of State for Health and Social Care in support of the bid for funding for capital investment to maintain services within Hinckley and Bosworth.

RESOLVED:

(a) That the update regarding Hinckley and Bosworth Community Services, and in particular the proposals for Hinckley and District Hospital, be noted;

(b) That the Committee write to NHS England and the Secretary of State for Health and Social Care in support of the bid for funding for capital investment to maintain services within Hinckley and Bosworth.

3.5. Future item - summer 2019

Public consultation for the Hinckley and Bosworth Community Health Service Review.

4. Rutland County Council

4.1. 5 April 2018

Scrutiny received a paper on ***STP: Leicester, Leicestershire and Rutland Dementia Strategy***

RESOLVED:

The panel NOTED the LLR Dementia Strategy 2018-2021

For the agenda item on ***Scrutiny Programme & Review of Forward Plan***, Mrs Stephenson noted that the panel had been expecting an update on the Sustainability and Transformation Plan from the CCG, but that this had been cancelled as the information was not yet ready for publication. Mrs Stephenson had received an email from the CCG outlining the situation which would be shared with Members, but would write to the CCG to express the concerns of the panel regarding the delay in the availability of any further information

4.2. 28 June 2018

Scrutiny received a paper on ***STP Update***

The purpose of the report was to provide an update on the STP for Leicester, Leicestershire and Rutland and the work being undertaken by partners to improve the health and wellbeing of people locally. The programme was known locally as Better Care Together (BCT).

RESOLVED:

The Panel **NOTED** the update and work of the Better Care Together partners.

The Panel **AGREED** that their Member, Mrs June Fox, would send the details of her resident's experience with the district nurse service directly to the Chief Operating Officer of ELR CCG for investigation.

The Panel **AGREED** that Healthwatch Rutland should assess residents' knowledge and usage of the 111 service by examining the data already collected, taking further information if needed, and reporting back to the Panel.

4.3. 7 February 2019

The Panel received a paper on ***Community Services Redesign.***

Purpose of the report: The Community Services redesign project (CSR) is a piece of work led by the three CCGs in LLR. The paper provides an overview of the CSR project. It summarises the service issues, case for change and project methodology. It also describes the work undertaken to date to review community services including the significant engagement to support development of

proposals for the future. The report also outlines the principles of the proposed community health services model which is emerging from the ongoing work.

The Panel noted;

- The new model would look to strike the right balance between the following three services; Community Nursing, Home First Services (including crisis response and community beds) and community beds.
- The review of current patient demand for the Rutland memorial hospital (RMH) did not warrant the opening of the moth balled ward although it needed to be reviewed whether over time this would change.
- Demand for RMH beds was not based on the growing Rutland population but instead looked at the clinical needs of patients and their preferences, with most people wanting to stay at home.

RESOLVED

The Panel **NOTED** the progress to date in redesigning community health services and the next stage of the work.

5. Leicestershire, Leicester and Rutland Joint Health Scrutiny Committee

5.1. 4 September 2018

The committee received an update on ***plans to consolidate Level 3 Intensive Care***.

UHL explained that there were three Intensive Care Units in Leicester providing level 3 and level 2 services and the pressures were such that 2014 it was considered that it was no longer possible to sustain safe level 3 services at the LGH. The training status of the unit had been downgraded at LGH because it wasn't seeing the complexity of work going through and trainees could not get the training they required to become intensive care clinicians. Several consultants were due to retire and multiple efforts to recruit were unsuccessful because of the loss of training status and because it was a very poor environment to work in due to the facilities. There were also considerable problems in maintaining ICU nursing levels. These pressures meant that it was not safe to keep the services at LGH open long term. Numerous reviews had been carried out to say that the services were not sustainable.

RESOLVED:

a) that the Leicestershire, Leicester and Rutland Joint Health Scrutiny Committee note the report and note that the University Hospitals Leicester had put forward a clinical case, but they are not in a position to make any suggestions as to whether or not the UHL should consult; and

b) that the further meeting be reconvened to continue the debate.

The committee received a report on the ***Planned Care Policies***.

The report explains that the Planned Care Policies enable the Clinical Commissioning Groups to prioritise their resources using the best evidence about what is clinically effective and to provide the greatest proven health gain.

RESOLVED:

a) that the committee have concerns about some of the wording in the Gynaecology Policy and seek assurances as to how that will be rectified;

b) that the committee note that the Planned Care Policies document is complex with numerous different policies and express a hope that engagement can be broken down to make it more meaningful for service users. The committee however also recognise that there was a reason why it was considered easier to implement all the policies in one go;

c) that the committee express concerns relating to the continuity of care and the application of policies across different postcodes;

d) that the committee want to see a full Equality Impact Assessment to include impacts on mental health. The committee are of the view that a procedure might not be needed medically but any impact on a person's mental health should allow for some discretion in the way the policy is applied;

e) that the CCG ensure that GPs and locums are fully trained and where treatments cannot be provided in the settings where they are, that primary care provide the treatment, particularly in relation to patients who require ear wax removal prior to having a hearing aid fitted; and

f) that Members of the committee be given the opportunity to submit further questions with responses to be sent out and included in the minutes.

The committee received a report on ***Next steps to better care in Leicester, Leicestershire and Rutland***.

It was explained that BCT was a partnership that came together across all health care organisations. The Next Steps document set out the important things that had been done and would be done for local people. The Chair expressed a view that rather than looking at issues they would have little power to influence, it would be most useful for the committee to focus on what service improvements there would be for patients, and public engagement and consultation.

RESOLVED:

That Members be invited to submit further questions; these to be consolidated and emailed round before sending to officers for responses and for the Chair to agree a timeline for questions and responses.

5.2. 28 September 2018

The committee continued discussion on ***plans to consolidate Level 3 Intensive Care***.

The Head of Law from Leicester City Council was invited to clarify the position regarding consultation with scrutiny committees and the public. The Head of Law stated that the issue of public consultation was a matter for the CCGs and they had sought their own independent legal advice, so she could not comment on that. The CCGs however had a duty to consult with scrutiny and scrutiny's power lay in deciding whether adequate consultation had taken place with them.

The Chair stated that consultation with the public was therefore a different issue to consulting with scrutiny. The committee could decide whether the CCGs had discharged their duty to consult scrutiny, however the committee could only make recommendations for the CCGs to undertake public consultation.

RESOLVED:

1) This Committee recognises the strong argument in clinical case to consolidate level 3 Intensive Care Services at the Leicester Royal Infirmary and Glenfield Hospital, and understands the proposals to move the service.

2) The Committee also believes that the CCGs and UHL have now fulfilled their statutory duty to consult scrutiny via this Committee and it would therefore be inappropriate to refer to the Secretary of State on these grounds.

3) It is not for the Committee to comment on whether the CCGs and UHL have discharged their duty to consult the public. This may be a matter, that the Committee notes, could be tested by a Judicial Review against the CCG's decision.

4) There is deep regret that the CCGs and UHL did not listen to public calls for increased engagement/consultation after the business case had been passed by the Board in November 2017. The Committee believe it was an oversight not to go to public consultation whilst they were in the formative stage of their proposals.

5) This committee therefore requests the UHL Trust and CCG to:

    a) Provide the Committee with a detailed project plan for the relocation of services.

    b) Provide regular updates on the progress of works and any variations to the plans.

    c) To meet with the Committee or its representatives if there are any concerns raised by them about the implementation of the proposals.

d) Provide the Committee more detailed information around the sustainability of existing services at the Leicester General Hospital once the Level 3 services have been removed, and more detail around the escalation process.

e) Immediately undertake public engagement on the major reconfiguration plans.

f) Undertake as soon as possible formal public consultation on the major reconfiguration plans.

A further vote was then taken, and it was agreed that:

g) Despite all the information provided to the committee by the CCGs and UHL, the committee are not convinced that any of the reasons given preclude their responsibility to carry out public consultation. As such, in the interests of openness and transparency, the committee recommend that the CCGs and UHL undertake public consultation before continuing with the proposals.

5.3. 21 January 2019

The Committee received a report updating on progress with ***proposals to appoint a joint accountable officer and management team across the three CCGs in LLR.***

RESOLVED:

a) that the report be noted;

b) that the Commission request more information on the Integrated Locality Teams; and

c) that the Commission request information on the discussion relating to the merger model and on how the proposals to appoint a Joint Accountable Officer are progressing.

The Committee received a report on ***Better Care Together engagement and involvement***.

The report described the activities undertaken in October and November 2018 to engage with communities in Leicester, Leicestershire and Rutland and the ongoing activities to take place between January and March 2019.

RESOLVED:

a) that the LLR Joint Scrutiny Committee note the report;

b) that the Committee recommend that the CCGs and UHL take advice from the local authority communication teams as to which communities to reach out to and what worked best in respect of outreach;

c) that the UHL and CCGs proactively bring issues to the attention of Scrutiny;

d) that the Committee receive assurances as to what the formal consultation will look like;

e) that the Committee receive a report on capacity planning as members seek assurance that the plans are fit for purpose; and

f) that the Committee would like it to be demonstrated as to how the comments made by members of the public and Scrutiny are taken on board.

The Committee received a report on ***Better Care Together community health services redesign***.

Members heard that the Redesign project was led by the three Clinical Commissioning Groups in LLR which looked at the future model of community health. Members heard that the CCGs were about to commence engagement exercises and the Director said that she took on board the comments made by Members about the need to feed those comments into the process going forward.

RESOLVED:

a) that the Committee note the report;

b) that Committee note that better capacity planning is a key element of the redesign model and Members will be carrying out further scrutiny in respect of that;

c) that the Committee ask the CCGs to be mindful of the need for proper engagement with the local authority executive teams and the scrutiny committees;

d) that the Committee ask the CCGs to work closely with the local authorities;

e) that the Committee request there is effective governance to ensure that the service meets the need and is delivered consistently, and for a report on this be brought back to a future meeting to reassure Members.

Leicestershire, Leicester and Rutland Joint Health Scrutiny Committee
Briefing paper – UHL Bed Capacity
19th March, 2019

Sam Leak, Director of Operational Improvement & Mark Wightman, Director of Strategy and Communications.

Context:

This briefing paper outlines the methodology behind the UHL bed model and how this compares to expected demand in 19/20.

National picture:

The number of beds needed to provide health care effectively, and how they are used, depends on a number of interrelated factors. These can be thought of in three broad categories: underlying patient demand; national policy – including funding, workforce supply and access standards; and local circumstances – such as availability of other services and internal hospital processes. The interplay of these factors changes over time and varies across the country. Consequently, the number of beds that the health service needs to maintain to deliver an optimal service changes over time.

The total number of NHS hospital beds in England has more than halved over the past 30 years, from around 299,000 to 142,000, while the number of patients treated has increased significantly.

Though bed numbers have been falling consistently across the UK for a number of years; NHS England data suggests that the numbers of beds closed, particularly general and acute beds, has slowed from around 13.1 per cent between 1987/8 and 1991/92 to 2.3 per cent between 2012/13 and 2016/17. As bed numbers have fallen, England's population has grown, from around 47.3 million in 1987 to approximately 55.2 million in 2016 (Office for National Statistics 2017a). As a result, the number of beds per head of population has fallen faster than the absolute reduction in number of beds.

The fact that the population has increased and aged over time and yet the NHS bed base has decreased seems counterintuitive. However, when we consider that there have been significant reductions in the *average length of stay*, (e.g. patients after hip surgery would previously have stayed at least a week post operatively) and that clinical improvements (e.g. the increase in *minimally invasive* keyhole surgery) enable many patients who once would have stayed in hospital overnight to now be seen as *day cases*. And the fact that older concepts like 'bed rest' are increasingly found to be detrimental to patient outcomes, a logic to the reductions emerges.

The national picture, and the changes in the way that surgery and medicine are practiced is recognised locally. However, taking all this into account and factoring in the increased demands of multi-morbidity, an ageing population and the deliverability

of system-level demand management schemes, we have modeled a modest increase in the number of acute beds from a baseline of 1,994 to 2048 over the life of our current plan. This remains under constant review at hospital and system level.

UHL bed modelling – 2018/19-2022/23:

The UHL bed model is built using the following methodology:

- The model covers a five year period from 2018/19 to 2022/23
- The baseline activity is a midday bed state count derived from ward stay data
- For emergency activity, the baseline used was 2017/18 actual occupancy, uplifted by 1% as contracted in 18/19. An annual growth rate of 1.4% has then been applied each year.
- For elective day case and inpatient activity 2016/17 data has been used. (The distribution of elective activity would have been skewed if 17/18 data had been used due to the high number of cancellations during the winter period as mandated by NHS England). The baseline has then been uplifted to 18/19 with a growth rate of 1.4% applied (as advised by Public Health colleagues).
- Annual growth rate of 3% applied for ICU demand. (As previously discussed with JHOSC, ICU demand is growing faster than typical acute demand)

This modelling resulted in a projected bed base requirement of 2,269 beds by 2022/23 *if nothing were to change in terms of models of care or efficiency*:

	Change	Total beds
Baseline inpatient & day case beds (Dec 2017)		1994
1.4% growth to 22/23	157	2151
Additional ICU growth (3%)	28	2179
Reduced bed occupancy	90	2269

This modelling was validated with acute clinicians and with our wider LLR health and social care system partners.

Once models of care and efficiency opportunities were taken into account through the work of our system and hospital based transformation programmes we have revalidated the number of beds required across our acute sites. A number of evidence-based schemes have been tested with our clinicians and our primary and community services partners, including:

- Improving internal efficiencies (based on Model Hospital, GIRFT, benchmarking)
- Preventing c4,000 avoidable admissions (based on evidence from NHS RightCare case studies)
- Reducing elective demand (based on NHS Right care case studies)

These plans have also been validated with the East Midlands Clinical Senate with validation of the bed model also undertaken by NHS England at a regional level.

This has resulted in a reduction in the total number of beds required in 2023 by between 164 and 237 beds:

	Change	Total beds
Baseline inpatient & day case beds (Dec 2017)		1994
1.4% growth to 22/23	157	2151
Additional ICU growth (3%)	28	2179
Reduced bed occupancy	90	2269
Minimum efficiency	(164)	2105
Maximum efficiency	(237)	2032
Planned bed numbers 22/23		2048

In undertaking this modelling, UHL has considered a number of scenarios in terms of growth and occupancy levels together with sensitivity around the delivery of all the bed efficiency opportunities identified. As a result of detailed work internally and with our partners, we are assured as we can be that the planned future bed base of 2,048 remains sufficient to accommodate growth in demand and does not overstate the opportunities afforded by efficiencies and new models of care.

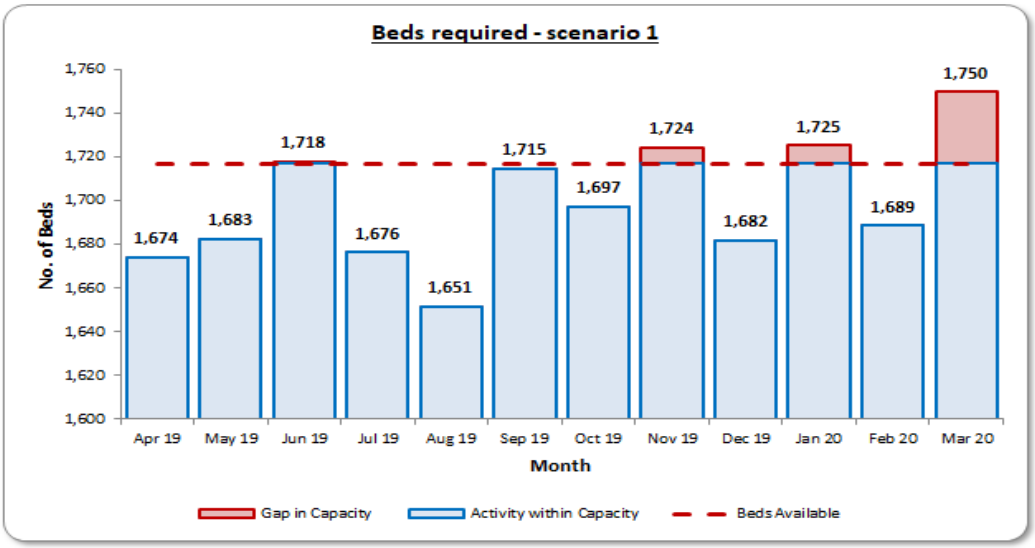
It is worth noting that since this model was completed, the NHS 10 year plan has been published – and much of what was our local system wide planned efficiency programme has now become a national requirement, strengthening our case for change. For example, our programmes of work relating to the prevention of avoidable admissions; improving same day emergency care, cross-sector networks of care and the adoption of 'Home First' principles; are all now mandated within the NHS 10 year plan.

UHL bed modelling – learning from 18/19 to plan for 2019/20:

Through the planning for last year (2018/19), the Trust made a fundamental change to capacity planning, switching from a model based on demand to a model based on capacity; this assumed that at times of high pressure all emergency demand will be accommodated with resulting 'spare' capacity used for elective demand. This has proved successful in terms of patient flows for 18/19, with a positive impact noted for both emergency *and* elective pathways:

2018	2019
Jan/Feb 2018, most planned procedures postponed due to the NHS E mandated elective freeze	Jan/Feb 2019, c1,800 more planned procedures taking place during this time
48% of days during winter 2017/18 spent under Opel Level 4 alert	9% of days during Jan/Feb 19 spent under Opel Level 4 alert
One third of days between Sept 2017 and Sept 2018 spent under Opel Level 4 alert	3% between Sept 18 and Feb 19 (based on hours) spent under Opel Level 4 alert

This learning has been applied to our 19/20 bed model with the same methodology applied. The resulting bed modelling (at a whole hospital level) shows that there will be a small bed deficit during some months of the year… the range being 1-33 beds, as the graph and table below show.



Beds required - scenario 1

Actual Management	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
Day Case	12	12	12	10	11	12	11	12	10	11	11	11
Inpatient	184	199	211	212	196	216	215	219	181	189	191	211
Emergency	1,478	1,472	1,495	1,454	1,444	1,487	1,471	1,494	1,490	1,525	1,487	1,528
Total Beds Required	**1,674**	**1,683**	**1,718**	**1,676**	**1,651**	**1,715**	**1,697**	**1,724**	**1,682**	**1,725**	**1,689**	**1,750**
Beds Available	1,717	1,717	1,717	1,717	1,717	1,717	1,717	1,717	1,717	1,717	1,717	1,717
Gap	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**7**	**0**	**8**	**0**	**33**

(Note – The calculations above are based on **Dec 2018** baseline bed model of 1974 beds – this excludes 183 day case beds, 46 escalation beds, 28 EDU/EFU beds. The daycase beds that *are* included above are for + 6 hr LoS)

However, the model does not include any efficiencies, for example LoS stay reductions as yet; nor does it include the potential to open extra winter capacity wards which would completely bridge the gap.

The Trust is therefore assured that at a whole hospital level given current circumstances, capacity is sufficient to meet the projected demand for the year and in line with our longer term modelling.

Risks:

Of course, there are risks:

- If Emergency demand is greater than predicted this will impact on beds required reducing Elective Capacity
- Mid-year pathway changes have been difficult to quantify and account for in the model.

- Changes in case mix, length of stay, acuity of patients, number of stranded patients, etc. from historic data could impact on beds required
- Any variation from the phasing of the activity could impact on beds required/available
- The availability, ease of access and acuity of bedded and non-bedded health and social care services outside of hospital settings

These risks are under constant review and are managed at system level through the System Leadership Team, with quarterly reviews of the bed model to ensure that any variations are understood and taken into account as early as possible in the year.

Summary:

Capacity modelling in the NHS is, to be frank, part science part art; in other words absolute predictions of the numbers of patients requiring acute hospital stays varies from *year to year* based on, for example, the particular strain of influenza in circulation. Equally, looking further ahead the numbers of patients requiring a bed in 10 years' time will be influenced by developments in medical and surgical techniques, new and novel treatment regimens and the success or otherwise of the development and funding for new and improved community services and primary prevention. This is why the NHS locally and nationally will continue to review bed requirements in year and between years.

Leicestershire, Leicester and Rutland Joint Health Scrutiny Committee

Work Programme 2018 – 2019

Meeting Date	Topic	Actions arising
4 Sept 18	1) Consolidation of Level 3 Intensive Care 2) Update on EMAS's direction of travel 3) Update on Non-Emergency Transport (TASL – Thames Ambulance Services Ltd) 4) CCGs Engagement on Planned Care Pathways 5) Update on the STP	1) Further meeting to be arranged to convene this item. 2) A further report on the progress of EMAS come back to the committee. 3) A further report including performance data, and information relating to contractual obligations and conditions be brought back in six months' time and that a representative from TASL comes to the meeting. 4) The committee asked for the wording in the Gynaecology Policy be rectified. The committee asked that the numerous different planned care policies be broken down during engagement to make it more meaningful for service users. The committee expressed concerns relating to the continuity of care and the application of policies across different postcodes. It was requested to see the full EIA, including impacts on mental health. The CCG were asked to ensure that GPs and locums are fully trained and where treatments cannot be provided in the settings where they are, that primary care provide the treatment, particularly in relation to patients who require ear wax removal prior to having a hearing aid fitted. Questions from Members be submitted separately, outside of the meeting. 5) Questions from Members be submitted separately, outside of the meeting.
28 Sept 18	1) Consolidation of Level 3 Intensive Care	1) Despite all the information provided to the committee by the CCGs and UHL, the committee were not convinced that any of the reasons given preclude their responsibility to carry out public consultation. As such, in the interests of openness and transparency, the committee recommended that the CCGs and UHL undertake public consultation before continuing with the proposals.

21 Jan 19	1) Update on CCG Management Structure 2) Better Care Together Engagement Update 3) Better Care Together – Community Health Services Redesign	1) More information on the Integrated Locality Teams and information on the discussion relating to the merger model and on how the proposals to appoint a Joint Accountable Officer are progressing be brought to a future meeting. 2) The Committee recommend that the CCGs and UHL take advice from the local authority communication teams as to which communities to reach out to and what worked best in respect of outreach. Also, a report on capacity planning be brought to a future meeting. The Committee requested it be demonstrated as to how the comments made by members of the public and Scrutiny are taken on board. 3) The Committee requested there is effective governance to ensure that the service meets the need and is delivered consistently, and for a report on this be brought back to a future meeting.
19 March 19	1) Leicestershire Partnership Trust – CQC Inspection Findings 2) Better Care Together Update 3) Bed Capacity Planning	
Date TBC	1) Update on CCG Merger Model and Joint Accountable Officer 2) Planned Care Update 3) Update on Non-Emergency Transport (TASL – Thames Ambulance Services Ltd) 4) Better Care Together Update	
Date TBC	1) LLR Workforce Update 2) Information on Integrated Locality Teams 3) Update on CHD Services in East Midlands 4) Better Care Together Update	
Date TBC	1) Community Services Redesign Update 2) EMAS Update 3) Better Care Together Update	

Previous Meetings

Meeting Date	Topic	Actions arising
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.
27 Apr 18	1) Update on LPT NHS Trust Improvement Plan following their CQC Inspection 2) Update on CHD Services in East Midlands and the NHS England review into PICU and ECMO services nationally 3) Update from UHL NHS Trust following their CQC Inspection 4) Update on EMAS Quality Improvement Plan	1) A further update from the LPT to come back in a years' time. 2) Continue to monitor performance against the targets set by NHS England and an update be brought to the committee in a year's time, and to include targets, issues around winter pressures and the numbers of referrals. Also a letter to be sent to Nottingham City Council to request that they encourage the University Hospitals of Nottingham to refer their congenital heart patients to UHL and to share with them the minutes of the meeting. 3) Further CQC inspection reports of UHL, along with the resulting action plans, are brought to future meetings of the committee. 4) A further update from EMAS is brought back to the committee in a years' time.

Thames Ambulance Service Limited

Thames Ambulance Service

Quality Report

Lincoln Head Office
Danwood House
Harrisson Place
Whisby Road
Lincoln
LN6 3DG
Tel:01522308304
Website:www.thamesambulance.co.uk

Date of inspection visit: 23 October 2018
Date of publication: 13/02/2019

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, other information known to CQC and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this ambulance location	Inadequate
Patient transport services (PTS)	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

Thames Ambulance Service is operated by Thames Ambulance Service Limited. The service provides a patient transport service from 16 sites nationwide.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 23 October 2018.

We previously carried out an announced comprehensive inspection of the service on 22 November 2016 and an unannounced inspection on 8 December 2016, both were at the service's Canvey Island base, which was one of only two sites operated by the service at the time. We also carried out unannounced inspections of the service at two local hospitals and at the Milton Keynes base on 9 December 2016. At this inspection there were a number of safety and quality concerns identified. Following this inspection, the service voluntarily ceased their urgent and emergency work and became a solely patient transport service. During 2017 the provider expanded their patient transport significantly, taking on a number of patient transport contracts nationwide.

We carried out another comprehensive inspection of the service on 22 September and 9 October 2017 at the service's Canvey Island, Grimsby and Scunthorpe sites. Following this inspection, we issued a warning notice for breach of Regulation 17: Good governance. We followed this up in February and March 2018 and extended the compliance date due to extenuating circumstances, because there had been significant changes in the management and governance structures.

We had also issued requirement notices in relation to Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment; Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints; Regulation 18 HSCA (RA) Regulations 2014 Staffing.

The service was last inspected on 15 May 2018 where we carried out a focused inspection to follow up a warning notice we had issued to the provider in October 2017 under Regulation 17: Good governance.

In April 2018 we issued and published details of two fixed penalty notices for breaches of Care Quality Commission (Registration) Regulations 2009: Regulation 12 Statement of Purpose and Regulation 15: Notice of changes. These were paid in full by the service in May 2018.

Over 2018, Thames Ambulance Service Limited has been attending regular risk review meetings with CQC, NHS England and clinical commissioning groups, due to the level of concern. Given our level of concern at this service we contacted NHSE and they commenced risk review meetings to oversee the actions the provider was taking.

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?

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005 (MCA).

The main service provided by this service was non-emergency patient transport services (PTS).

- Generally, staff we spoke with during our inspection of the ambulance stations said they had not completed safeguarding or mandatory training and station managers told us they had no access to training data. At the time of our inspection, the provider was unable to tell us staff compliance rates with safeguarding or mandatory training.
- Generally, ambulance staff we spoke with during our inspection said they had no training on the MCA or meeting the needs of bariatric patients. Staff said they had not received handling and moving training and felt unsafe transferring bariatric (morbidly obese) patients. However, we could not corroborate this

Summary of findings

- At the Grimsby ambulance station, managers told us they had no access to staff contact information and didn't know how to contact staff if they needed them to cover shifts or inform them of any changes.
- We found infection control issues at the ambulance stations we visited, this included staff not having access to running water at the Spalding location and staff were unable to clean vehicles, and records of deep cleaning were unavailable. At the time of our inspection, the Grimsby ambulance station had ongoing issues with cleanliness and bird control. Following our inspection, the provider took action to install pest control equipment to eliminate this. We found visibly unclean vehicles at the Spalding and Lincoln ambulance stations.
- Generally, ambulance staff and managers we spoke with during our inspection did not understand risk at the stations we visited, we found out of date policies in use and some of the ambulance staff had no personal digital assistants (PDA) to support their day to day activities limiting their access to information. This was particularly evident at Grimsby, where nine PDA were out of use.
- Ambulance staff we spoke with during our inspection told us they had no access to equipment for transporting children, despite the provider offering this service and we found limited equipment for this purpose during our inspection.
- Medical gasses at Spalding site were not being stored safely, there were environmental issues with the base being on a second level and staff access to equipment provided.
- Generally, ambulance staff told us they had not received appraisals or supervision, and data supplied by the provider showed appraisal rates below the providers compliance target.
- Generally, ambulance staff we spoke with during our inspection told us of their concerns regarding the safe transport of patients with mental health needs or dementia and questioned how the provider was assessing patient needs and if staff were competent to transfer these patients.
- Generally, ambulance staff told us they did not receive feedback from complaints or incidents, unless they were directly involved. Information sharing was not routine and we found staff lacking in information about the new organisational structure and proposals for the business going forward.
- Managers and ambulance staff were not using key performance data at ambulance station level, generally staff we spoke with were unaware of how this was used or how it impacted on the business or quality of the service.
- The provider monitored call centre handling times and at the time of our inspection we saw compliance against call handling targets was not being achieved. Some ambulance staff we spoke with questioned how work was allocated to the ambulance teams as they often felt patients were not assessed correctly.
- Generally, staff we spoke with at the ambulance stations didn't know the providers vision or strategy, staff did say they wanted to provide good care, but they were not aware of the providers vision or strategy.
- We found limited records of team meetings at the stations we visited, staff told us they have had very few meetings, if any, in the last six to 12 months.
- Leadership was not embedded throughout the service, staff described a culture of significant change, consistent changes in management and a lack of senior management presence throughout the organisation.
- Generally, ambulance staff we spoke with told us that relationships with the transport booking and call handling teams was fractious and there were difficult relationships between front line and office staff. Ambulance staff said that workloads often led to them not getting breaks or correct information about patients.
- Generally, staff told us that staff morale was low at the ambulance stations we visited. Staff said they had no contact with the senior team and that managerial posts had changed so much they were unsure who was in managerial roles.

Summary of findings

However, we also found:

- The provider had recruited a fleet manager, we noted an improvement from our last inspection in terms of fleet management and the provider had detailed records of vehicle maintenance and scheduling.
- Staff we spoke with across the providers teams, demonstrated caring attitudes towards patients and a will to provide them with the right level of care and support.
- The complaints team had increased in size and the provider now had a system to log and respond to complaints formally.
- The provider had implemented a corporate risk register, strategic plan, vision and business plan.
- The provider had introduced a quality team and was beginning to review some areas of performance data.
- The provider had increased the number of staff trained to safeguarding level 3 and 4.

Following this inspection, we told the provider that it must make other improvements, to help the service improve.

Amanda Stanford

Deputy Chief Inspector of Hospitals, on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)	Inadequate 	The main service provided was non-emergency patient transport. We rated caring as good. We rated the service as inadequate for being safe, effective, responsive and well-led because staff were not trained or appraised to ensure their competency. Safeguarding training was inadequate. We found infection control issues at the ambulance stations we visited, staff not having access to running water, not able to clean vehicles, and records of deep cleaning unavailable. We found out of date policies in use and some of the ambulance staff had no personal digital assistant (PDA) to support their day to day activities limiting their access to information. During inspection ambulance staff raised concerns with us regarding the transport of patients with mental health needs or dementia and questioned how the provider was assessing patient needs and if staff were competent to transfer these patients. Ambulance staff told us they did not receive feedback from complaints or incidents, unless they were directly involved. Information sharing was not routine and we found staff lacking in information about the new organisational structure and proposals for the business going forward. Managers and ambulance staff did not understand risk at the stations we visited, and not using key performance data at ambulance station level, staff we spoke with were unaware of how this was used or how it impacted on the business or quality of the service. Staff we spoke with at the ambulance stations didn't know the providers vision or strategy. Leadership was not embedded throughout the service, staff described a culture of significant change, consistent changes in management and a lack of senior management presence throughout the organisation. Ambulance staff told us that relationships with the transport booking and call handling teams was fractious and there were difficult relationships between front line and office staff. Ambulance staff said that workloads often led to them not getting breaks or correct information about patients. The staff morale was

Summary of findings

low at the ambulance stations we visited. Staff said they had no contact with the senior team and that managerial posts had changed so much they were unsure who was in managerial roles.

However, we also found the provider had recruited a fleet manager, we noted an improvement from our last inspection in terms of fleet management and the provider had detailed records of vehicle maintenance and scheduling. Staff we spoke with across the providers teams, demonstrated caring attitudes towards patients and a will to provide them with the right level of care and support. The complaints team had increased in size and the provider now had a system to log and respond to complaints formally. The provider had implemented a corporate risk register, strategic plan, vision and business plan. The provider had introduced a quality team and was beginning to review some areas of performance data. The provider had increased the number of staff trained to safeguarding level 3 and 4.

Inadequate

Thames Ambulance Service

Detailed findings

Services we looked at
Patient transport services (PTS)

Detailed findings

Contents

Background to Thames Ambulance Service

Thames Ambulance Service Limited (TASL) provided non-emergency patient transport services (PTS) nationwide. The service had locations in Hull, Grimsby, Scunthorpe, Lincoln, Louth, Boston, Grantham, Spalding, Leicester, Loughborough, Canvey Island, Sussex, Kettering, and Northampton. During our short notice announced inspection on 23 October 2018, we inspected at the Lincoln Head Office and the Lincoln, Spalding and Grimsby locations.

The majority of Thames' PTS services were contracts awarded by local commissioning groups.

At the time of our inspection there were approximately 400 non-emergency patient transport (NEPT) vehicles in service and two bariatric ambulances.

At the time of our inspection the provider was in the process of completing the registered manager application process in post for the service. In October 2018 we wrote to the registered provider in respect of a criminal offence of failure to comply with conditions of registration (section 33 of the Health and Social Care Act 2008). This raised significant concerns regarding the competencies of mangers and their understanding of regulation within the service.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, four other CQC inspectors and three assistant inspectors. The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection.

How we carried out this inspection

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely.

We carried out an announced inspection of the service on 23 October 2018 and visited the providers Lincolnshire head office, and ambulance stations in Lincoln, Grimsby and Spalding.

Detailed findings

Facts and data about Thames Ambulance Service

During this inspection we spoke with the chief executive officer, executive assistant, director of operations, head of quality and clinical governance, associate director of corporate services, head of patient experience team, fleet manager, head of clinical training the senior human resource business partner, and the head of call centre operation. We spoke with three team leaders, four area managers, 15 ambulance care assistants, six control room staff, a quality and governance lead for the northern region and a member of the domestic team. We also inspected 12 ambulances, two cars and associated equipment, listened into four call bookings and records relating to the running of the service.

Activity from October 2017 to October 2018

In the reporting period October 2017 to October 2018 the service undertook 697,137 patient transport journeys, 117,783 (17%) of journeys were cancelled and 98 journeys included the transportation of children.

Track record on safety

- No Never events
- The provider supplied us with complaints data from June 2018 to October 2018, showing 37 complaints over seven locations.
- Data supplied by the provider post inspection showed that between April 2018 and September 2018 they reported 282 incidents.

Our ratings for this service

Our ratings for this service are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Inadequate	Inadequate	Good	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Good	Inadequate	Inadequate	Inadequate

Patient transport services (PTS)

Safe	Inadequate
Effective	Inadequate
Caring	Good
Responsive	Inadequate
Well-led	Inadequate
Overall	Inadequate

Information about the service

The service was led by a chief executive officer and executive team. The provider employed a wide range of staff including ambulance care assistants, managers, call handling and control room staff, human resource and training staff, domestic staff and administrative staff amongst others.

At the time of our inspection the provider was in the process of completing the registered manager application process in post for the service. In October 2018 we wrote to the registered provider in respect of a criminal offence of failure to comply with conditions of registration (section 33 of the Health and Social Care Act 2008). This raised significant concerns regarding the competencies of mangers and their understanding of regulation within the service.

The provider supplied a non-emergency patient transport service (PTS) to commissioners across various areas of the United Kingdom. The service operated non-emergency patient transport service (NEPTS) vehicles, including ambulances, cars and wheel chair accessible vehicles from dedicated ambulance stations.

Thames Ambulance Service Limited (TASL) operated approximately 400 non-emergency patient transport vehicles, including ambulances, cars and wheelchair accessible vehicles. The provider employed a full time fleet manager, responsible for oversight of the vehicles.

The provider did not hold controlled drugs (CDs) at its locations for use on patient transport services.

Summary of findings

The main service provided by this service was non-emergency patient transport services (PTS).

- Generally, staff we spoke with during our inspection of the ambulance stations said they had not completed safeguarding or mandatory training and station managers told us they had no access to training data. At the time of our inspection, the provider was unable to tell us staff compliance rates with safeguarding or mandatory training.
- Generally, ambulance staff we spoke with during our inspection said they had no training on the MCA or meeting the needs of bariatric patients. Staff said they had not received handling and moving training and felt unsafe transferring bariatric (morbidly obese) patients. However, we could not corroborate this
- At the Grimsby ambulance station, managers told us they had no access to staff contact information and didn't know how to contact staff if they needed them to cover shifts or inform them of any changes.
- We found infection control issues at the ambulance stations we visited, this included staff not having access to running water at the Spalding location and staff were unable to clean vehicles, and records of deep cleaning were unavailable. At the time of our inspection, the Grimsby ambulance station had ongoing issues with cleanliness and bird control.

Patient transport services (PTS)

Following our inspection, the provider took action to install pest control equipment to eliminate this. We found visibly unclean vehicles at the Spalding and Lincoln ambulance stations.

- Generally, ambulance staff and managers we spoke with during our inspection did not understand risk at the stations we visited, we found out of date policies in use and some of the ambulance staff had no personal digital assistants (PDA) to support their day to day activities limiting their access to information. This was particularly evident at Grimsby, where nine PDA were out of use.
- Ambulance staff we spoke with during our inspection told us they had no access to equipment for transporting children, despite the provider offering this service and we found limited equipment for this purpose during our inspection.
- Medical gasses at Spalding site were not being stored safely, there were environmental issues with the base being on a second level and staff access to equipment provided.
- Generally, ambulance staff told us they had not received appraisals or supervision, and data supplied by the provider showed appraisal rates below the providers compliance target.
- Generally, ambulance staff we spoke with during our inspection told us of their concerns regarding the safe transport of patients with mental health needs or dementia and questioned how the provider was assessing patient needs and if staff were competent to transfer these patients.
- Generally, ambulance staff told us they did not receive feedback from complaints or incidents, unless they were directly involved. Information sharing was not routine and we found staff lacking in information about the new organisational structure and proposals for the business going forward.
- Managers and ambulance staff were not using key performance data at ambulance station level, generally staff we spoke with were unaware of how this was used or how it impacted on the business or quality of the service.
- The provider monitored call centre handling times and at the time of our inspection we saw compliance against call handling targets was not being achieved. Some ambulance staff we spoke with questioned how work was allocated to the ambulance teams as they often felt patients were not assessed correctly.
- Generally, staff we spoke with at the ambulance stations didn't know the providers vision or strategy, staff did say they wanted to provide good care, but they were not aware of the providers vision or strategy.
- We found limited records of team meetings at the stations we visited, staff told us they have had very few meetings, if any, in the last six to 12 months.
- Leadership was not embedded throughout the service, staff described a culture of significant change, consistent changes in management and a lack of senior management presence throughout the organisation.
- Generally, ambulance staff we spoke with told us that relationships with the transport booking and call handling teams was fractious and there were difficult relationships between front line and office staff. Ambulance staff said that workloads often led to them not getting breaks or correct information about patients.
- Generally, staff told us that staff morale was low at the ambulance stations we visited. Staff said they had no contact with the senior team and that managerial posts had changed so much they were unsure who was in managerial roles.

However, we also found:

- The provider had recruited a fleet manager, we noted an improvement from our last inspection in terms of fleet management and the provider had detailed records of vehicle maintenance and scheduling.
- Staff we spoke with across the providers teams, demonstrated caring attitudes towards patients and a will to provide them with the right level of care and support.

Patient transport services (PTS)

- The complaints team had increased in size and the provider now had a system to log and respond to complaints formally.
- The provider had implemented a corporate risk register, strategic plan, vision and business plan.
- The provider had introduced a quality team and was beginning to review some areas of performance data.
- The provider had increased the number of staff trained to safeguarding level 3 and 4.

Are patient transport services safe?

Inadequate

Incidents

- **The service did not manage patient safety incidents well. Although staff recognised incidents these were not always reported or learnt from appropriately.**
- We were not assured that managers investigated all incidents and lessons learned were not always shared with the whole team and the wider service. However, we did see examples of when things went wrong, and staff apologised and gave patients honest information and suitable support.
- We had concerns about incident reporting and learning from incidents. At the Lincoln location, staff could tell us what the process was (an incident report form), but were not always reporting incidents. For example, we were told by staff that patients could sometimes bang their heads on vehicle ceilings because they were not the appropriate vehicle but this would not be reported as an incident unless it was 'serious' such as a fall. The providers incident policy did give guidance to staff on reporting incidents, staff could not give examples of recent incidents and where learning was shared.
- At the Grimsby location we found a box where staff placed completed incident forms. We found two incident reports dated September 2018, which had not been scanned or sent to the managerial team, which meant the incident reporting system was not being followed or tracked. Incident reporting was not embedded with staff reporting that they did not bother as they never got any feedback and told us about incidents that should have been reported but were not.
- Data supplied by the provider post inspection showed that from April 2018 to September 2018 they reported 282 incidents. The provider rated ten incidents as severe, 99 moderate, 103 low and 70 with no harm.
- The provider had implemented a Rapid Review Panel (RRP) to review incidents when they occurred and make a judgement on how the incident should be managed.

We reviewed three serious incident reports and two safeguarding reports which had been through this process. Actions were clearly documented along with timescales for completion of any ongoing actions.

- Incident data showed that the three main categories of incident related to injury, accident or ill health of a patient, the inappropriate planning of a journey and aggressive, abusive or inappropriate behaviour towards TASL staff.
- Staff we spoke with routinely told us they did not get feedback on incidents and that they could not remember when their last management meeting was to discuss any events that had occurred. Staff were supposed to receive information such as newsletters through their PDAs, however often these did not connect properly and staff could not access the internet.
- The provider had a serious incident (SI) handbook, designed for staff, which explained the SI process, the types of SI and impact, the staff members responsibilities and how the serious incident would be dealt with by the provider. We were unable to establish if this had been shared with the staff team and staff did not refer to this guidance when speaking with the inspectors. The SI Handbook is included in the TASL policy and procedure suite accessed via the staff intranet. The provider told us they had passed communications to all staff via the internal internet site, stating the SI handbook had been rolled out in 2017. The provider also told us staff have signed workbook sheets evidencing that they had read and understood the document.
- The provider told us that if any incidents resulted in a change of policy, procedure or practice, it would be fed back via the providers intranet.
- The provider had a formal policy for the duty of candour, operational managers we spoke with understood their role in being open, honest and transparent when dealing with complaints. We noted in the minutes from the RRP that the provider had liaised with complainants when things had gone wrong and sought feedback to improve the service. The duty of candour is a regulatory duty that relates to openness and transparency and requires the providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- The provider had an up to date incident management policy and procedure implemented in June 2018 and due for review in June 2019, this was an improvement from our last inspection. If an incident occurred staff were expected to complete a form, give this to their manager who then scanned and submitted the form electronically for review by the providers management team. Incidents were the reviewed by the quality and clinical governance group who had access to incident reports as soon as they were submitted.

Mandatory training

- **The service did not provide consistent mandatory training in key skills to all staff and make sure everyone completed it.**
- The provider did not ensure that staff achieved the required levels of mandatory training to support the safe delivery of the service. Mandatory training included first aid, basic life support, manual handling, health and safety, infection prevention, whistleblowing, dementia awareness, equality and diversity, mental capacity, do not attempt cardiopulmonary resuscitation (DNACPR), end of life, information governance, PREVENT and conflict resolution.
- Following our inspection, we asked the provider to provide additional training data. Training compliance varied greatly from location to location. We were not assured that all staff had the appropriate level of training to safely carry out their role and support patients. Data showed the Scunthorpe location staff compliance for all areas of mandatory training was 28%, Kettering 29% and planning and control 33%. Eleven of the providers locations achieved compliance levels of between 52% and 85%. Data for the Loughborough location showed 28% compliance for seven of the mandatory training fields, with the remaining eight showing 100% compliance. The Sussex, Leicester, Canvey Island achieved 100% compliance with mandatory training. The provider had a training plan in place to address this shortfall,
- Managers at the locations we visited were unable to tell us staff training compliance and had no oversight of the

training process. A manager we spoke with at the Grimsby location had not completed mandatory training since July 2017. We also asked the senior team for reassurances of the training figures, but were told on the day of our inspection that they could not provide these accurately.

- The provider had a training schedule for 2018, this was to cover all mandatory training, including safeguarding. The training manager told us it was difficult for ambulance staff to be released from their day-to-day duties to attend training due to the demands on the services.
- Staff at Lincoln told us they had not had any mandatory training since July 2017 but that training was now starting to be offered. Staff were unsure if training in relation to supporting the transportation of children was offered to them. Four members of staff we spoke with told us that they did not have any training to ensure they were competent for their role. This included not having manual handling training, safeguarding training, first aid or infection prevention and control training.
- Ambulance staff gave examples of being taken off training due to the workload and not having opportunities to update their skills. One staff member told us they attended a training session, but this was cancelled on the day of training as only three staff attended the session.
- TASL had transferred some staff from a previous provider to their employee workforce during organisational changes. Staff we spoke with told us that these transfers had led to discrepancies in training allocation.
- Staff who had been though a Transfer of Undertakings (Protection of Employment) regulations (TUPE) process from a previous NHS service in July 2017 had not had any mandatory training with TASL and were reliant on their previous employer's training. TUPE staff also felt that they had to train TASL staff 'on the job' because their training was insufficient for them to carry out the role properly, for example showing them how to use equipment,
- Call handling and control staff we spoke with said they had access to training in their respective role. Usually in the form of on the job coaching and support, including shadowing other staff to observe how the role was performed. Training included dealing with abusive calls, equal access and IT.
- We were told of one example of a bariatric patient who regularly used the service, who lived upstairs and required four members of staff to bring them downstairs and into a vehicle. Staff did not have up to date training in moving and handling or specialist bariatric training and the staff said there was a risk of injury to themselves or the patient.
- The manager at the Spalding location did not have information on staff safeguarding training rates, mandatory training rates, driver competencies and licence checks. All this information was stored centrally and not shared with leadership teams at the sites.
- At the Grimsby location, the manager told us the service had removed all ownership of local monitoring of mandatory, safeguarding training and competencies such as driving, to a central location. This meant that the team leader and area contracts manager did not have oversight of staff competency and training and personnel records.

Safeguarding

- **Staff had not received training on how to recognise and report abuse, and there were inconsistencies amongst staff on how they would report a safeguarding concern.**
- Safeguarding systems and processes were not fully embedded and staff did not reach compliance with the providers requirements for safeguarding training.
- Following our inspection, we asked the provider for up to date safeguarding training for all staff. Data showed that compliance amongst operational staff was varied across locations with Canvey Island, Leicester, Loughborough and Sussex achieving 100% compliance with adult safeguarding training.
- Fourteen of the providers other locations were below 75% compliance with safeguarding adults training, with most locations achieving between 27% and 51% compliance.

- Combined compliance with safeguarding adults training amongst operational staff across all locations was 65% and 73% across administration teams, including the executive team, patient experience team, and other admin staff.
- Two of the providers locations achieved below 33% compliance with safeguarding children training, this included Kettering 29%, Scunthorpe 28% and planning and control. Four locations achieved 100% compliance with most locations achieving between 52% and 85% compliance.
- The provider had a training plan in place to address this short fall, we were not assured that all staff had the appropriate level of training to safely carry out their role and support patients.
- The provider had eight managers or directors trained in level 4 safeguarding and a further 14 trained at level 3. The executive team were 100% compliant with safeguarding adults training.
- The provider had up to date policies for safeguarding children and adults, which reflected current requirements in legislation and policy. The policies provided staff with detailed information in relation to the types of abuse they may encounter during their day-to-day work activities.
- The safeguarding policies stated that all staff were responsible for referring a safeguarding alert to the local authority or police. Staff did this via social service contact details provided in the policy, which varied dependent on which local authority the patient transport was contracted in.
- Staff reported and recorded safeguarding referrals on the providers incident reporting system once a referral had been made, the same way that staff reported incidents. One member of staff gave an example of making a safeguarding referral, and said they hadn't received feedback once the referral had been made. TASL senior team members told us that information is seldom received from the safeguarding board to provide feedback to staff members who have raised the referrals.
- We asked one of the senior management team at head office what the correct process was for staff to escalate a safeguarding concern and they said it would be internal, the staff would fill out a safeguarding concern form which would then be sent to the safeguarding team, who would review the details and then refer to the local authority. But when asked if staff could contact the local authority themselves this manager said, 'they can if they want'. This showed a lack of understanding of the policy guidance and safeguarding implementation.
- Generally, ambulance staff we spoke with knew how to recognise and respond to safeguarding concerns, however we were unable to establish if this was from specific training or just word of mouth, or the information packs in ambulances. At the Grimsby location, we were not assured that staff had received appropriate safeguarding training as there were no training records to view and managers were not aware of staff training compliance. Staff were not aware of any clear process or pathway in the event of a safeguarding concern.
- We asked managers at various locations about safeguarding. One manager said that staff may be level one or two trained in safeguarding adults, but they did not know if children were covered in any training. Another manager said they had not received safeguarding training since July 2017.
- Vehicles contained a vehicle pack that included the safeguarding pathway with contact numbers and details for staff to follow in the case of a safeguarding alert.
- Staff at the Lincoln location knew that the provider had safeguarding policies, what constituted abuse and how to refer this using the phone details provided. One member of staff told us that safeguarding was skipped on their training.
- Staff confirmed they were transporting children but had not had any specific paediatric safeguarding training.

Cleanliness, infection control and hygiene

- **The service did not control infection risk well. Staff did not keep equipment and the premises clean or routinely use control measures to prevent the spread of infection.**
- The provider had policies and audits to monitor and promote infection, prevention and control. However, we

found the provider was not ensuring that staff followed this guidance and numerous occasions where infection control and prevention was not implemented effectively to limit risks to patients and staff.

- At the Spalding location ambulance staff told us they had a 15-minute window for checking vehicles before leaving the ambulance station. Two of the wheelchair accessible vehicles (WAV) had not been cleaned prior to use.
- A deep cleaning team was supposed to clean all vehicles every six to eight weeks. At the Spalding location records showed that seven of the 13 vehicles had not been deep cleaned since the 24 and 25 July 2018, some three months. Staff told us that the deep clean team had come on the 2 October 2018, but they had not updated their schedule to reflect this, and staff could not access records to show the deep cleans had taken place.
- The garage floor at the Grimsby location, vehicles and equipment were contaminated with bird faeces due to pigeon ingress whenever the garage door was opened. This had been highlighted at previous inspections but not improved and represented an infection risk. There were also many desk equipment items stored in the garage including fabric chairs which were all contaminated with bird faeces.
- Thames ambulance staff were responsible for laundering their own uniforms.
- Staff we spoke with explained that the provider did carry out uniform audits, but they never saw the results of these. Staff told us they were concerned they did not have enough uniform to wear and some of the uniforms were starting to look faded.
- Ambulance care assistants were responsible for cleaning their vehicles (inside and outside) before and after shifts but this was not always done if staff had finished late, and it relied on staff coming in early to clean them if they hadn't been cleaned the night before. It was not clear how the service was assuring themselves a vehicle clean had been done between shifts.
- At the Lincoln location we noted that staff responsible for deep cleaning vehicles did not complete the vehicle cleaning records completely or accurately. The staff had simply placed a line through all the sections that needed completion. Many of the vehicle checks had been documented as June 2018, but then crossed out to July 2018. We were unable to tell from the records we reviewed if the any of the vehicles had been deep cleaned appropriately.
- At the Spalding location, staff did not have adequate cleaning facilities. The site didn't have access to an outside hose or tap to clean the inside or outside of the vehicles. Staff were not allowed to carry buckets of water or hoovers down the steep steps at the base. This meant the vehicles were not ever being cleaned with water or hoovered. Staff used dustpan and brushes and an antibacterial spray to clean their vehicles.
- The issues in relation to vehicle cleaning at the Spalding location were identified at the clinical and quality group meeting in June 2018. Notes from the meeting showed that vehicle cleaning, the option to install an outside tap and use petty cash at a nearby garage for a jet wash had been explored. Staff told inspectors during our inspection they were using their own money to pay for jet washers, and no action to resolve the concerns had been taken by the provider.
- Staff at the Spalding location told us that they no longer were given the opportunity to come back to base to clean their vehicles after carrying infectious patients and that they would just give a wipe down with what they had onboard (bacterial spray and wipes) and be on their way to their next transfer.
- Offensive waste was not securely stored at the Grimsby location, with unlocked pedal bins only in the garage area (collected monthly) and four plastic bags of dirty linen on the floor waiting for staff to transport back to the local NHS trust hospital. The bins had an offensive odour and staff could not provide any assurance about what was in the bins or how long it had been there.
- At the Lincoln base we found a bin for offensive non-infectious waste, stored next to a standard waste bin. The station used a colour coded system for cleaning equipment, and we found the sink in the ambulance station visibly dirty. We spoke to one member of staff who told us they were responsible for cleaning the vehicle inside each morning, and if they had time they would clean the outside of the vehicle at the end of the

day, but this didn't always happen. The staff member explained that they didn't always clean the vehicle with detergents, but if there was an infection risk they would be more careful.

- At the Grimsby location staff completed a combined hand hygiene and uniform audit. This included choosing five staff per week, and checking these staff three times per day as a minimum. From 23 April to 8 October 2018, we found the provider had completed nine checks. We also found that vehicle spot checks were not consistent, as we found two vehicle that had not been checked for the week prior to our inspection on 23 October 2018.
- At the Spalding location we reviewed five weeks of hand hygiene audits, all areas were compliant except for one week where a staff member didn't comply with guidance on wearing earrings as part of infection control.
- We spoke with a cleaner at the Grimsby location and reviewed housekeeping audits in relation to office spaces and kitchen areas, from July and October 2018 which showed daily cleaning was completed as required.
- At the Spalding location, staff told us they had not received infection prevention control or deep clean training.
- Cleaning equipment and chemicals were not stored securely at the Grimsby location in a locked cupboard but were kept on open shelves in the garage area which meant that they did not comply with the Control of Substances Hazardous to Health Regulations (2002). Items were at risk of contamination from bird excrement, or stored in the stock room along with patient transport supplies such as masks, gloves and incontinence sheets.
- We observed TASL staff using hand sanitizer and washing their hands between patient contact during a patient handover at a local hospital.
- At the Spalding location staff told us that they did not have wipe clean cushions for wheelchairs which meant that when a patient soiled themselves, which happened occasionally, they would just have to wipe down the wheelchair and use spray. There was no formal method of deep-cleaning wheelchairs or taking them out of service when this happened. Staff told us that they would spray down the wheelchairs, they would be wet as a result and they would still then have to use them for another patient.

Environment and equipment

- **The service did not have suitable premises and equipment for the range of services it provided.**
- The provider delivered its services from dedicated ambulance stations in locations across the UK. We inspected at Lincoln Head Office and its Lincoln, Grimsby and Spalding ambulance locations.
- Ambulance staff used a personal digital assistant (PDA) to receive bookings and transport details from the control centre teams. This included all details relevant to the journey, including destinations, time of departure, arrival and drop off. At the Grimsby location nine out of 20 PDA were out of use which meant that staff had to use their own mobile phones to contact the control centre and receive patient information.
- Staff told us that issues with the PDA's were normal in the service and it often led to confusion over journeys and affected the patient transport times. When PDA's did not work, staff were manually recording details, and handing these to managers, this led to further issues as details in relation to transport were not always accurate or available.
- TASL operated approximately 400 non-emergency patient transport vehicles, including ambulances, cars and wheelchair accessible vehicles. The provider employed a full time fleet manager, responsible for oversight of the vehicles.
- The provider had effective central systems for monitoring vehicle servicing, tax and MOT certification. The system informed the provider of when vehicle servicing was required, the number of vehicle breakdowns and vehicles were not available.
- At the Lincolnshire location we found that staff kept vehicle keys in a staff room and during our inspection the door to this room and the main ambulance station door were open, posing a security risk and an opportunity for the vehicle keys to be taken.
- At the Grimsby location we reviewed records and found staff did not complete daily vehicle checks consistently.

- At the Lincoln location staff used a white board to show vehicle details including MOT and servicing details.
- Staff told us at the Lincoln location that equipment for children was not available on any vehicles and they would expect that a request for children's transport would include the child coming with their own equipment. The provider carried out patient transport service that included children, this raised a significant concern as we weren't assured that children had access to equipment appropriate to their needs whilst being transported, for example seating and harnesses.
- At the Grimsby location staff had access to two paediatric car seats, however we were unable to locate any children's harnesses or restraints on vehicles we inspected and staff told us they had not received training in this type of equipment.
- At the Lincoln location we checked one of the store rooms and found due to the level of stock, the store room was over cluttered and boxes placed on the floor. All the consumables we checked were within manufacturer use by dates.
- At the Grimsby location we found items of equipment not labelled to say they had been safety checked, for example a wheel chair and walking frame. We also found multiple pieces of broken equipment, chairs and other items stored against a wall inside the ambulance station.
- We found old style oxygen regulator spares mixed within new oxygen regulator spares at the Lincoln location. We informed the manager at that location that next test dates on some of the regulators dated back as far as February 2015, we were not assured these were safe for use.
- At the Spalding location, staff and equipment was on a first-floor level. This meant staff had no access to hoovers, or running water to clean vehicles. The location as accessed by steep stairs, making carrying equipment difficult.
- At the Grimsby location some staff had not received training for items of equipment and relied on colleagues who had previously been trained in another organisation to show them how to use equipment.
- The provider reported an incident in relation to a bariatric patient (morbidly obese) who needed transferral from an upstairs room for their transport to hospital. We spoke with a manager in relation to staff concerns due to the weight of the patient and taking them down stairs and the risks this presented. The manager told us that training was about to be implemented in the use of bariatric equipment to support the patient and staff. Staff we spoke with were unaware of the training being planned or its implementation date.

Assessing and responding to patient risk

- **The process in place for assessing the risk to patients using the service was not effective. The eligibility criteria and booking process did not allow the provider to make a holistic assessment of the patient's needs.**
- The provider used a dedicated check list as part of their booking process as the assessment of patient risk and to exclude patients when the transfer was not safe or staff could not meet the patient's needs.
- Following our inspection, we asked the provider to provide additional training data on first aid compliance. Training compliance varied greatly from location to location. For example out of the 16 bases, four were 100% compliant with training six were at 75% and the others were all below 75%, with two bases with less than 51% compliance
- We asked the provider for staff compliance with basic life support (BLS). Data supplied by the provider showed out of the 16 bases, four were 100% compliant with training six were at 75% and the others were all below 75%, with two bases with less than 51% compliance The provider had a training plan in place to address this shortfall, we were not assured that all staff had the appropriate level of training to safely carry out their role and support patients.
- We spoke to a member of call handling staff at the control centre who told us usually patients with mental health needs had an escort with them and TASL provided two ambulance staff based on what section of the mental health act the patient was on. We were unable to establish how staff understood the relevant section of the mental health act or what risk assessment would be completed to support the transfer.

- We observed a patient transfer from hospital to home. The patient had mental health needs and staff had not completed any risk assessment of the patient's mental health needs prior to the journey. Staff made up excuses to manage the patient, for example to refuse a cigarette and stop the patient leaving the vehicle. There was no appropriate care plan in place to address the patient mental health needs or risks associated with this, for example absconding.
- Staff at the Lincoln location told us they undertook journeys for patients with mental health needs, they would speak to the control centre to discuss actions that may be required, for example the risk to the driver, wellbeing of patients. Staff gave an example of a patient being locked in a vehicle by staff who left the vehicle due to their aggressive behaviour, we were not assured that the assessment of risk was routinely carried out for this group of patients, posing a risk to the patient, staff and members of the public.
- We spoke with a call handler who told us there was a substantial amount of eligibility criteria they had to follow and that it was difficult to remember all the details. We observed call handlers using the eligibility criteria, which did require a great deal of detail. Staff contacted other members of the team if they needed advice or guidance on the eligibility criteria.
- One of the call handlers showed us a script they had adopted to speak with patients, this was not standard. All the call handlers had their own way of going through the eligibility criteria, there was no consistent approach. We were concerned as there was a lack of consistency in call handling processes and this could lead to issues regarding the quality of the booking.
- Staff told us the provider transports children, and one member of staff told us these included babies and that usually these patients have an escort provided. Staff explained they had not received any training in supporting children and were unsure of any protocols for meeting their needs.
- Ambulance staff we spoke with knew how to escalate a deteriorating patient and the provider had a process to support staff, this was an improvement since our last inspection.
- The provider had a policy for supporting patients transported who had an active do not attempt cardiopulmonary resuscitation order (DNACPR) in place. Staff who transported patients with a DNACPR were required to make the patient comfortable and call 999 for emergency services.

Staffing

- **The service did not have enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**
- The provider had various staff groups starting at different times across its location based on the needs of the service and operated 24 hours a day 365 day a year. Ambulance staff worked shifts between eight and ten-hour shifts which started at various times of the day, dependent the needs of the service and followed an eleven-week rolling shift rota.
- Staff were assigned to vehicles by the providers control and planning staff team, as either single or double crew dependent on the needs of the patient.
- At the locations we visited we were not assured that staffing levels met the providers obligations to provide the service. We were not assured that managers understood or had oversight of the staff skill mix to ensure the right members of staff were providing the right levels of care and support during journeys.
- Data supplied by the provider showed they tracked vacancy rates across the various locations, this was an improvement on the last inspection. From August 2017 to August 2018, 316 staff left the organisation and 249 staff were recruited, showing a 6.5% reduction in the work force over 12 months.
- The provider collated sickness absence data, based on hours lost due to staff sickness. Sickness data supplied by the provider showed the contact centre had the highest level of staff sickness across its staff groups from August 2017 to July 2018.
- At the Grimsby location staff rotas were displayed on the wall. The rota showed gaps and the manager told us that most staff usually work extra shifts, even staff from other locations to cover any shortfall in staff.
- Ambulance staff told us that they regularly worked long shifts, sometimes without breaks and single staffed.

Patient transport services (PTS)

- The Grimsby location had four whole time equivalent (WTE) vacancies with another two-staff due to go on maternity leave imminently. The contract with a local taxi company to convey renal patients was also due to end in January 2019, which meant that there will be increased demand. We observed the rotas which showed gaps in cover and the team leader struggling to cover shifts.
- The service at Spalding had four WTE vacancies and the team leader told us they struggled to cover shifts.
- Staff at the Lincoln location told us they were frequently unable to take breaks, including staff who were doing a single-crew 12-hour night shift due to demand on the service. The area manager acknowledged this was an issue but still said staffing levels were appropriate, however ambulance care assistants told us they felt understaffed routinely.
- Staff had access to on call duty managers out of hours for escalation and management support in case of staffing issues

Records

- **Staff did not always have access to detailed records of patients' care and treatment.**
- Staff accessed patient records securely via the PDA's. We found routinely that staff did not have access to a working PDA and that staff universally acknowledged there was an issue with connection and often did not get to see documents in a timely fashion. This impacted on staff ability to meet the needs of the service, due to late transfers, or scheduling of wrong vehicles.
- Call handlers used the eligibility criteria in the form of check lists on a desk top PC to record patient information.

Medicines

- **Medicines were not always managed or stored appropriately at the sites we inspected.**
- Patients own medicines were transported with the patient. The ambulance staff did not take any responsibility for controlled drugs (CDs) carried by patients. If CDs accompanied a patient they were the responsibility of the patient or carer.
- At the Grimsby location we found oxygen stored correctly, with full and empty canisters clearly labelled.
- At the Spalding location, the site had an oxygen cage which was lockable however the staff were storing oxygen cylinders, unsecured in an internal cupboard as the service did not want staff carrying heavy objects down the steep set of stairs to access the building.

Are patient transport services effective?

Inadequate

Evidence-based care and treatment

- **The provider had policies and guidance in place to support evidence based care and treatment, for example staff use of oxygen. However, we were not assured that all staff had access to up to date policies.**
- We were not assured that all bases had up to date polices available for staff and the lack of working personal digital assistants (PDA) at the Grimsby location hindered staff ability to access policies electronically.
- At the Lincoln base we found policies and procedures that were out of date. This included a copy of the staff sickness policy, corporate dress code policy and we also found a copy of a policy for another provider which did not relate to the current service.

Response times / Patient outcomes

- **The provider monitored response times and used these to improve the service. However, the provider was failing to meet a number of key response times within the service.**
- The call handling team had a key performance project running at the time of our inspection., This was to address issues regarding consistency in call handling times. At the time of our inspection call handlers were expected to answer 85% of calls within one minute. The display screen showed 25% compliance against this target on 23 October 2018. Data supplied by the provider showed that from October 2017 to June 2018 the provider achieved a 67.4% average against the 85% compliance target.

- The provider monitored response times across its locations and provided data to commissioners against set key performance indicators (KPI). Data supplied for Lincolnshire from July 2017 to May 2018 showed that the provider achieved an average 83% compliance with same day journey collections within 150 minutes, against a 95% compliance target. For the same period compliance against collecting renal patients within 30 minutes was 57% and none-renal patients within 60 minutes was 65%.
- From July 2017 to May 2018 the provider did not achieve compliance with any of the KPI's in relation to Lincolnshire contracts. This included 64% of journeys arriving on time, against a compliance target of 85%, and the patients time on vehicle should be less than 60 minutes which showed 61% compliance.
- From October 2017 to June 2018 data in relation to the providers Leicester contract showed on average 69% of patients arrived on time for their outpatient appointment against a compliance target of 100%. The provider achieved 58% compliance against a 90% compliance target with collection within 60 minutes of patient appointment.
- At the time of our inspection the provider told us they were implementing fixed route planning and auto planning to improve planning and efficient use of resources.

Competent staff

- **The provider did not have effective processes in place to ensure staff competencies after their employment started, however new starters told us that the initial induction supplied them with enough information to start their roles.**
- Ambulance staff routinely told us that appraisals were either out of date or had not happened for over a year, in some cases staff told us they had not had an appraisal at all. None of the staff we spoke with at the Grimsby location had received an appraisal within the last 12 months and some had not had one since staff who had been though a Transfer of Undertakings (Protection of Employment) regulations (TUPE) over from another organisation in 2016.
- Data supplied by the provider showed poor compliance in all locations with appraisal completion with most of locations achieving below 17% compliance. After our inspection, the provider told us that they had a plan to improve appraisals completion rates which was due to start in January 2019.
- In the control centre two staff told us they had received regular appraisals and found these useful in terms of discussing their performance and plans for development.
- The provider checked driving licences annually, for issues that may affect an employee's day to day activities, for example, speeding fines, driving whilst intoxicated. We asked the provider to provide evidence of compliance with driving license checks, which showed 100% compliance with checks.
- Drivers must be over 18 years of age, with a clean driving license. Staff undergo a two-day training programme that includes a driver assessment from a qualified driving assessor, competency is signed off and placed on the employees personnel file.
- Data supplied by the provider following our inspection showed 652 frontline staff should have Disclosure and Barring Service (DBS) checks in place. The provider had assurance that 642 staff had a DBS Clearance number with date on file and had been viewed and checked by its human resource department. The provider had ten staff where they knew a check had been completed, but did not have a DBS Clearance number and date on file at the time of our inspection.
- All new staff entering employment were required to complete an initial induction. Staff we spoke with felt the induction was good and covered the areas they needed to carry out their roles.
- At the Lincoln location, staff who had been TUPE'd in July 2017 said they had not had a formal appraisal since being with the service.
- At the time of our inspection the provider told us they were in the process of updating their IT systems to ensure that managers could access this information to support staff with their mandatory training needs.

Multi-disciplinary working

Patient transport services (PTS)

- **Front line staff worked together well to support the needs of the patients however there was often poor communication with managers to achieve effective MDT working.**
- Patient transport service bookings were coordinated through control centres where staff selected available transport for each booking. Call handlers and control room staff worked with ambulance care assistants and managers to plan and monitor journeys.
- Call handlers contacted hospitals and other health care providers to discuss individual patient needs and reflect these in the eligibility checklists and record additional data for ambulance staff to meet patient needs, for example if a patient lived upstairs or required specific mobility equipment.
- Since our last inspection the provider had taken steps to ensure that contract managers had regular contract monitoring meetings with commissioners. We noted that where appropriate other healthcare providers such as NHS hospitals were engaged with as part of these meetings to discuss service provision.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **Staff did not always understand how and when to assess whether a patient had the capacity to make decisions about their care or understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.**
- Staff we spoke with showed there was genuine confusion on the providers stance on supporting patients with mental health needs.
- The provider had an up to date policy on mental capacity and staff roles and responsibilities.
- Training data supplied by the provider following our inspection showed that only four of its sixteen locations achieved 100% compliance with Mental Capacity Act (2005) training.
- Training rates in Scunthorpe and Kettering were 28% and 29% respectively, with the other eleven locations ranging between 52% and 85% compliance. The provider had a training plan in place to address this short fall, however we were not assured that all staff had the appropriate level of training to safely carry out their role and support patients.

Are patient transport services caring?

Good

Compassionate care

- **Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness**.
- During our inspection, we observed patient care and reviewed 15 patient feedback records.
- We observed ambulance staff supporting a patient at a local hospital. Staff showed compassionate care, and a gentle approach, giving additional time and comfort to ensure the patient was comfortable.
- A family member feedback said, “The male crew member was very kind and caring”, another said “I want to thank the ambulance crew who took my father from the hospital to the nursing home last Wednesday. Dad was not well and we were upset. The crew was extremely kind as well as very professional. So please pass on our gratitude”.

Emotional support

- **Staff provided emotional support to patients to minimise their distress**.
- A family member feedback said “I just wanted to say a big thank you to the two guys that transported my dad from home to the care home. They took great care with my dad, making him laugh during the move”.
- We observed ambulance staff supporting a patient at care home. The patient became upset during a physical transfer, the staff stopped the transfer, gave the patient additional reassurance to make them feel safe and provide additional reassurance.

Understanding and involvement of patients and those close to them

- **Staff involved patients and those close to them in decisions about their care and treatment.**

Patient transport services (PTS)

- We observed staff engaging with a patient at a local hospital, the staff encouraged the family to participate in the patient handover, to keep the patient calm and provide reassurance.
- Hospital staff supporting end of life patients gave an example of ambulance staff taking a patient home on an end of life plan. On the journey home, the ambulance passed the farm where the patient had worked. The staff stopped the ambulance and sat the patient up so they could see the farm and surrounding fields, the patient and his family were extremely grateful for the support and care provided by the staff.
- A family member feedback said, "A few months ago I made a complaint to your department as my father waited long durations on return journeys back to his home after hospital appointments. This has now been resolved. Today my father used your transport to attend an x-ray appointment at hospital. The transport came in good time which meant my father arrived early. As the department was not busy he had his x-ray early and the return transport was there waiting to take my father back home. The transport picked my father up at approximately 11am and he was back home approximately 12.30pm. This was the best experience my father and I have had of you and proves you listen and take action to improve your service. Thank you."
- Staff gave an example of an end of life patient who was discharged to a property in the wrong vehicle, the patient couldn't stand to get into the wheel chair and their partner got distressed. Due to the time taken, the patient was not well enough to go home and had to go back into hospital. This was reported as incident by the provider but had a negative impact on the patient experience.

Are patient transport services responsive to people's needs?

Inadequate

Service delivery to meet the needs of local people

- **The service did not plan and provide services in a way that met the needs of local people.**
- We were concerned that the provider was not meeting the needs of local people due to lack of appropriate specialist equipment, for example for children and staff understanding the needs of patients with mental health conditions.
- We spoke with an area manager who told us they had built good relationships with a local contactor, and held regular meetings to discuss the service provision.
- At the Grimsby location managers told us they had quarterly contacts meetings with commissioners, monthly operations meetings and daily emails in terms of planning the service.
- The provider was introducing a commissioners' information online self-service portal to enable commissioners to log in and access up to date information in relation to their contract. The quality, finance and operations teams will also have a presence at contract management meetings to improve information sharing and increase awareness of the needs of the local population.

Meeting people's individual needs

- **The service did not always take into account patients' individual needs.**
- As part of the patient eligibility criteria checks carried out by call handlers, staff established if the patient required a translation services. The call handler explained if the patient required a translation service, the patient would have to arrange this for themselves. However, the provider told us they used a language line service to support translation, staff were not clear on this process during our inspection.
- The provider had two vehicles specifically for supporting bariatric patients (morbidly obese). However, staff gave examples of not being trained in correct handling and moving techniques, or not having appropriate equipment to meet the needs of this group of patients.
- Staff we spoke with told the inspection team that they provided ambulance transfers for patients with mental health needs and those living with dementia who required additional escorts. However, we were unable to establish with the provider the eligibility criteria for patients with mental health and staff we spoke with gave us conflicting information on this process. For example, we spoke to a member of call handling staff at

the control centre who told us usually patients with mental health needs had an escort with them and provide two ambulance staff based on what section of the mental health act the patient was on.

- Staff gave several examples where patients had become violent or aggressive on journeys, and they felt unequipped to deal with the level of aggression towards them. Staff gave an example of a patient being locked in a vehicle by staff who left the vehicle due to their aggressive behaviour, we were not assured that the assessment of risk was routinely carried out for this group of patients, posing a risk to the patient, staff and members of the public.
- The provider transported children, we found limited equipment to support this activity and staff we spoke with had not received training in respect of supporting children.
- Staff had access on vehicles to pictorial signage to support patients with additional communication needs.

Access and flow

- **Waiting times were not always in line with good practice.**
- Staff we spoke with at the Lincoln location told us that the control centre and planning of journeys was poor, this was affecting their ability to offer a service. They gave examples of multiple overlapping bookings in various locations, making it impossible to travel between the locations on time.
- The service ran contracts awarded from commissioning groups and other healthcare providers. Patients were booked for transport against a set of eligibility criteria by the call handling staff and control room staff then passed these details on to the ambulance staff teams to carry out the journeys.
- We observed call handling staff supporting patients and their carers when making bookings via telephone, call handlers were available 24 hours a day 365 day a year. The call handling staff used eligibility criteria to identify any patients who may need more immediate support, for example length of time on a vehicle following treatment, and tried where possible to arrange transport that met their needs. However, the call handlers and control team had to maximise journeys and often patients were on a multi drop vehicle, with other patients so it was difficult to prioritise needs.
- The provider informed us that the eligibility questions may alter between contracts, dependant on the criteria set by the commissioners. The script may alter in the dialogue used by the call taker to ask the question, but the criteria is not amended from that set by the commissioner. The provider said that if the same questions were applied to each booking the patients may know the questions and how to respond to try and achieve eligibility when they shouldn't.
- Call handling staff were very clear with patients and their carers when making a booking and explained the limitations of the service. Where a patient did not meet eligibility criteria, staff explained this clearly and offered alternative options, for example contacting a relative, friend or independent taxi service.
- We observed call handlers dealing with questions from patients in relation to late pickups. Staff contacted the appropriate health care provider to establish if patients had been seen, checked where the vehicle was in terms of location and fed this back to patients so they had an estimated time of arrival.
- During our inspection staff gave us examples where they had been tasked to carry out journeys, but were unable to complete these as they had been sent in the wrong vehicle. This increased waiting times and delays as well as affecting the patient experience. The provider was implementing fixed route planning and auto planning to improve planning and efficient use of resources.

Learning from complaints and concerns

- **The service treated concerns and complaints seriously and investigated them. However, lessons learned from the results were not shared with all staff.**
- Since our last inspection the provider had increased the size of its complaints handling team. In March 2018 the provider had a back log of 700 complaints, at the time of our inspection the provided told us the this had reduced to eight complaints outside of the 25-day response key performance indicator.

Patient transport services (PTS)

- The provider risk rated complaints for impact and rated them from low impact, to moderate and high impact. We asked the provider for 12 months data in relation to its complaints handling. The provider supplied us with five months data from June 2018 to October 2018, showing 37 complaints over seven locations. Ten of the complaints were over the 25-day performance indicator set by the provider for handling and closing complaints.
- The complaints handling team told us they shared complaint learning via the providers intranet site or via emails. Staff we spoke to at the ambulance stations said they had limited feedback from complaints, and that often the personal digital devices didn't work, restricting their access to the providers intranet.
- The service did not benchmark itself against other providers in relation to the complaints it received which meant it could not assess how effective it was within the sector with providing positive experiences for people using the service.
- Two ambulance care assistants said they did not know how to deal with patient complaints, or if the provider had a process for this.
- Managers we spoke with at locations did not have oversight of complaints, they were unaware of the number of complaints received or actions taken to minimise risks to patients or staff from issues reoccurring. Managers told us they did not routinely receive feedback from complaints.
- At the Spalding location, staff told us that they were not aware of how to collect patient feedback or to advise patients how to complain. The service included complaint forms in their ambulance packs but staff said that the complaint forms were not given out and they were not encouraged to collect patient views.

Are patient transport services well-led?

Inadequate

Leadership of service

- **Leadership and management of the service had been through a number of changes, and at the time of our inspection we found staff uncertainty and a lack of understanding of managerial roles within the service.**
- Thames ambulance service was led by an executive management team (EMT) led by the chief operating officer (CEO), supported by an executive assistant. A team of directors supported the CEO including a finance director, director of work force, director of operations, director of quality and clinical governance and an assistant director of corporate services.
- Locally patient transport services were managed by contracts managers who oversaw area managers. At the time of our inspection, the provider did not have a registered manager in post for the service.
- In October 2018 we wrote to the registered provider in respect of a criminal offence of failure to comply with conditions of registration (section 33 of the Health and Social Care Act 2008). We also issued the provider with two fixed penalty notices in relation to failure to comply with conditions of registration in February 2018 which were paid in full. Since the inspection, the provider has made some improvements in this area.
- Ambulance stations at each location were led by team leaders, the provider was in the process of restructuring this role at the time of our inspection to have an ambulance station manager at each location.
- Staff at the Lincolnshire location said that the local manager was better than predecessors and the restructure had been a 'bumpy road'. Staff felt like things may be picking up and that the manager now called them to say thank you for their work.
- Staff we spoke with routinely told us they did not have meetings or engagement with managers, many of them did not know any of the senior management team, citing continual changes in the managerial structure.
- At the Spalding site, staff told us there was a disconnect between management and the local leadership teams. Staff told us that no management meetings were currently happening as these had fallen by the wayside with the current management restructure. As a result, there was not an effective system in place for the local leadership to escalate concerns to senior management.

- Staff at the Lincoln location told us there had been lots of management changes and restructuring and they were not clear what the current structure was, so there was not an effective system in place for the local leadership to escalate concerns to senior management.

Vision and strategy for this service

- **The service had a vision for what it wanted to achieve and plans to turn it into action, however this was new and at the time of our inspection in the process of being shared with the staff team.**
- Since our last inspection the provider had developed a vision for the services, linked to performance outcomes in its annual business plan 2018-2019 and its strategic plan 2018-2021.
- Managers we spoke with at the ambulance stations did not know the providers vision or strategy. Staff we spoke with were also unsure on the providers vision and strategy, although this was displayed on some of the ambulance station notice boards.

Culture within the service

- **Due to the significant managerial changes and staff contractual requirements, managers across the service struggled to promote a positive culture that supported and valued staff, and to create a sense of common purpose based on shared values.**
- Staff we spoke with said there was friction between control room staff and ambulance staff. This led to poor relationships between them when communicating transport requirements and created an air of bad feeling within the staff team.
- Thames Ambulance Service Limited (TASL) had transferred some staff from a previous provider to their employee workforce during organisational changes. Staff we spoke with told us that these transfers had led to discrepancies in earnings and working hours and created 'bad feeling' amongst employees. Under Transfer of Undertakings (Protection of Employment) regulations (TUPE) staff transferring from an alternative provider still adhere to their previous employment contracts and pay until such time as they transfer across to a TASL contract. TASL were working alongside the union to support that staff within the scope of employment laws.
- Staff felt senior managers did not listen to their concerns, saying that even though they do voice their opinions, they fell on deaf ears.
- We heard routine concerns in relation to staff not taking breaks, or not having allocated rest periods. This was leading to poor morale and staff felt undervalued by the provider.
- At the Lincoln location staff told us there was a disconnect between management and the local leadership teams. Staff could not tell us the names of the senior management team apart from one person and said they had never seen them come to visit the site, even though the site was about five minutes from head office. There were newsletters but staff felt these were insufficient to engage them and share learning.

Governance

- **The service did not systematically improve service quality and safeguard high standards of care to create an environment for excellent care to flourish.**
- The provider had a quality and clinical governance group who aimed to provide the executive board with assurances against contract performance, CQC standards, Health and Safety Executive regulations and information governance standards.
- We reviewed notes from the clinical quality group meetings, where various issues like the providers complaints policy update, vehicle cleanliness and intranet were discussed amongst other quality issues. Action notes were provided in the minutes, with clear ownership of each action, but not all actions were dated and not shared with local teams to encourage engagement and improvement.
- We reviewed monthly quality reports which contained key data in relation to contact provision and audits across the providers locations. These were well written and contained a broad range of data that could be used to track quality and give assurance to commissioners. The provider told us that relevant actions and outcomes from meetings are shared as applicable on their internal website and notices placed on boards in all bases, but

not the full minutes due to the confidentiality of items discussed at the meeting. The quality and governance group invited representation from a pool of contract Managers who feed back to staff at base.

- Prior to our inspection we received anonymous concerns that the prior had lost confidential data and staff personnel files. During our inspection the provider confirmed they were in dispute with another provider who was withholding the data and the provider was considering seeking legal advice to obtain the data required.
- The provider undertook a range of audits across its locations including hand hygiene, vehicle spot checks and uniforms. Staff knowledge of audit was limited across the locations we visited. One manager told us that key performance data was sent to head office by station managers, but they did not know about these or what the provider did with them.
- No team meetings had occurred at the Grimsby location, despite this being highlighted at the previous inspection as a cause for concern. The team leader indicated that they planned to start these monthly in November 2018.
- Staff we spoke with across the various locations we visited told us that management meetings were infrequent and irregular. This meant staff did not get routine feedback from managers on areas of risk or performance.
- One manager at the Lincolnshire location had a management folder of meetings to show the inspector, this was out of date. The folder contained minutes from December 2017, a pension grievance letter and a sign off sheet for staff understanding wheel chair seating.
- At the Spalding location, the manager said they were having team meetings and felt these were more effective than previously. These had recently been put in place for the month prior to our inspection in October 2018.
- Audits were carried out at the Spalding site which included vehicle cleanliness, uniform and hand hygiene and the environment audits however once completed these were saved onto the shared drive and staff told us no feedback was given to the local teams about them. Learning was not identified or shared from them locally or centrally. If a poor result was given, no action was taken to improve the service.
- At the Lincoln location, audits were carried out at site level for vehicle cleanliness, uniform and hand hygiene, however the person who had responsibility for this was off work and no arrangements had been made for this to be completed in their absence. There was no system, such as meetings, in place to share audit feedback with the wider staff group.
- Audits were performed at the Grimsby location and included vehicle cleanliness, uniform and hand hygiene, however staff were unaware of the results of the audit results to enable them to improve.

Management of risk, issues and performance

- **The service did not have good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.**
- The provider had a corporate risk register, with centralised risks in relation to the delivery of the services which was reviewed in August 2018. Risks were rated in terms of impact and likelihood and related to the organisations strategic plan, this was an improvement on our last inspection. Risks included poor performance, failure to engage with commissioners, and failure to deliver mandatory staff training, amongst other risks.
- The provider recognised that failure to comply with staff mandatory training requirements was a significant risk to its operations, this was identified on its corporate risk register. Actions to address the issues included the provider conducting a training needs analysis to identify gaps in knowledge and understanding, full implementation of an IT based training data base to provide centralised training records, implement new bespoken training course developed by Thames Ambulance Service Limited (TASL) and recruiting a work based assessor for each location.
- Each of the providers locations was meant to have a local risk register that also reflected the wider risks associated with the safe operating of the business. We found knowledge of local risks and the use of local risk registers were not consistent.

- The manager at the Lincolnshire base did not know the provider had a risk register or the risks associated with that location. There was a risk register but the area manager could not access it when asked and told us the team leader had responsibility for this, which was not consistent with what we were told at other sites. The manager told us it was 'in the team leaders emails' and could not access it (the team leader was on annual leave). The manager could not tell us about specific risks and mitigation of risk management plans when prompted and did not seem to consider the risks we had identified such as training, communication with staff, learning from incidents.
- At the Grimsby location we reviewed the risk register, which included ten risks. The highest rated risk from February 2018 was the bird faeces inside and around the ambulance station. We saw no updates to the risk register in relation to this risk or individual ownership to deal with the issues.
- The Spalding location had a risk register which did reflect the local risks however staff who were assigned to be responsible for the risks were not aware and the team leader was not aware that the risk register existed. As a result, the risk register was not being frequently reviewed, updated and risks were not being progressed.
- The leadership team at the Spalding location were not aware of any performance data against the providers key performance indicators (KPI's). The area manager told us that they had not seen any KPI data against the contract since April 2018.

Information Management

- **Information was shared with staff however, the approach to this was inconsistent.**
- The ambulance station at Lincoln had a notice board for staff including report forms for patients refusing transport, staff behaviour and complaints policies and a notice reminding all staff that vehicle damages must be reported.
- Vehicles contained a vehicle pack. This included daily report forms for example if staff missed a break, incident report forms, safeguarding pathway with contact numbers, a medical gases policy, vehicle accident and collision documents amongst other key documents.
- We found a policies folder in the staff room at the Lincoln base, but the ambulance staff were unaware this was in the room, and had not pointed this out when we asked them how they accessed policies and procedures.

Public and staff engagement

- **The service did not always engage well with patients, staff, the public and local organisations to plan and manage appropriate services.**
- The provider had launched a speak out meeting planned to occur every Friday from January 2018, where staff could nominate a chair person to take feedback from staff on any issues arising in the speak out meetings. We were unable to assess the impact of this process as the provider had not submitted any evidence in support of this process and none of the staff we spoke with mentioned this process during our inspection.
- The provider negotiated an agreement with a trade union to support its ongoing discussions with staff in relation to terms and conditions, benefits and other key areas of the business.
- The providers main method of measuring patient satisfaction was using on-board surveys available on each vehicle, the form features a space for comments. We reviewed 15 patient feedback records supplied by the provider.
- At the Spalding location the manager told us they did not receive encouragement to seek patient feedback.

Innovation, improvement and sustainability

- **The service had a number of new initiatives which were due to commence or had just commenced at the time of our inspection.**
- At the time of our inspection the provider was implementing fixed route planning and auto planning to improve planning and efficient use of resources.
- The provider is introducing a commissioners' information online self-service portal to enable commissioners to log in and access up to date information in relation to their contract. The quality, finance and operations teams have a presence at contract management meetings to improve information sharing and increase awareness of the needs of the local population.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

The provider must manage patient safety incidents appropriately and lessons learned are shared with the whole team and the wider service.

The provider must ensure all staff complete all mandatory training including how to recognise and report abuse, and promote consistency amongst staff on how to report a safeguarding concern.

The service must ensure infection prevention and promotion is manged well and staff keep equipment and the premises clean using control measures to prevent the spread of infection.

The provider must ensure that its premises and equipment are appropriate for the range of services it provided.

The provider must ensure that its processes for assessing the risk to patients is effective and the eligibility criteria and booking process enables the provider to make a holistic assessment of the patient's needs.

The provider must ensure that it has enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

The provider must ensure that staff have access to detailed records of patients' care and treatment and electronic equipment used for this purpose is fit for purpose and in good working order at all times.

The provider must take appropriate action to improve its performance in relation to meeting key response times within the service.

The provider must ensure that all staff have the required training and competency to understand how and when to assess whether a patient had the capacity to make decisions about their care and understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

The provider must ensure that all staff take into account patients' individual needs.

The provider must ensure that complaints and lessons learned from complaints are shared with all staff.

The provider must ensure that all managers in the service have the right skills and abilities to run a service providing high-quality sustainable care.

The provider must ensure that all staff understand and implement its vision and promote a positive culture to create a sense of common purpose based on shared values.

The provider must ensure that it has effective systems to improve service quality and safeguard high standards of care to create an environment for excellent care to flourish.

The provider must ensure that it has effective systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment .

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
Failing to comply with Regulation 12, (1) (2)(a)(b)(c)(d)(e)(f) (h)of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment. Failing to comply with Regulation 13, (2) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safeguarding service users from abuse and improper treatment. Failing to comply with Regulation 17, (1) (2)(a)(b)(d)(e)(f) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance. Failing to comply with Regulation 18 (1)(2)(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing. The provider is required to become compliant with Regulations 12, 13, 17, and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 above by 1 February 2019.	Thames Ambulance Service Limited Danwood House, Harrisson Place, Whisby Road, Lincolnshire. LN6 3DG. Thames Ambulance Service Limited Grimsby (hub of North Registered Office) Unit 5 Omega Business Park, Estate road, Grimsby. DN31 2TG Thames Ambulance Service Limited Lincoln (Main) Units 5/6 Sadler Park, Earlsfield Close, Sadler Road, Lincolnshire. LN6 3RS Thames Ambulance Service Limited Spalding (hub station of Lincoln main) Yard & 1st Floor Suite, Unit 3 Mayden House, Wardentree Lane, Pinchbeck, Spalding, Lincolnshire. PE11 3UG

NHS
Camden
Clinical Commissioning Group

Monday 25th February 2019

Sent via email:

To: CCG Chief Operating Officer/Managing Director

CC: STP Accountable Officers

14th Floor, Euston Tower
286 Euston Road
London
NW1 3DP
www.camdenccg.nhs.uk

Dear CCG Chief Operating Officer/Managing Director

RE: Proposed move of site for Moorfields Eye Hospital (City Road, London)

Background and introduction

Moorfields Eye Hospital NHS Foundation Trust is proposing to relocate all the services currently provided at Moorfields' City Road site in Islington, London (along with the UCL Institute of Ophthalmology and Moorfields Eye Charity) to a brand new integrated, purpose-built site on the St Pancras hospital site in Camden, London, subject to public consultation.

The Trust's ability to provide modern, efficient and effective treatment pathways is compromised on the current site due to the physical limitations of the historic building in City Road. The buildings at City Road, some of which are over 125 years old, are impacting negatively on patients and their experience at the hospital.

A new integrated site would enable the design and development of a purpose-built building that could enhance and improve patients' experience and staff satisfaction, and support integration of clinical care, research and education; facilitating the development of new practice, new technologies and new models of care, which in turn could improve outcomes for patients, attract and empower staff, and accelerate scientific research and discoveries. Additionally, the St Pancras hospital site could offer better access for patients travelling from outside London, and improved transport links across the capital.

Services provided at Moorfields City Road site are commissioned by 77 NHS Clinical Commissioning Groups (CCGs) and by NHS England Specialised Commissioning across 188 CCG areas (see Appendix 1). Of the 77 CCGs, 14 in London and Hertfordshire hold contracts with a material value (defined as >£2m per annum) with Moorfields for activity at the City Road site.

These 14 CCGs, which comprise Barnet, Camden, City & Hackney, Ealing, Enfield, Haringey, Havering, Islington, Newham, Redbridge, Tower Hamlets, East & North Herts and Herts Valley, will be undertaking a consultation process on the proposal to change the base of Moorfields' operations from the listed buildings, which have been its long-term home on City Road.

It has been agreed that Camden CCG, on behalf of Islington CCG, will lead the consultation process, in partnership with NHS England London Region Specialised Commissioning. In order to oversee the consultation and subsequently reach commissioning decisions, a Committee-In-Common has been established whose membership is taken from these 14 CCGs.

Any move of this kind is a long process, with many stages of formal assurance and approval, and these proposals have been in development for several years. Engagement has been ongoing during this time with patients, staff and stakeholders, helping to shape the plans for the future.

Moorfields is now at the stage where it has more details to share with you and your partners about the proposals and future timelines, and we want to engage you and your partner organisations, your residents and their representatives, including all those who could be affected by the proposed changes, in discussing the developing proposals and plans for consultation later this year.

Further information on the proposals and processes will follow at the beginning of March, with a request for feedback.

Legislative drivers

As you will be aware, NHS trusts and commissioners have a duty to involve people in service planning, including consultation on significant changes to services, Guidance on this is set out by NHS England in ***Planning, assuring and delivering service change for patients,*** March 2018. We expect to bring change proposals to patients and the public formally during the Spring of 2019/20.

The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 also require NHS commissioners to consult local authorities on proposed substantial variations to health services; requiring each CCG to notify its local authority partners when it has such proposals under consideration.

We are therefore asking CCGs to inform their partner Local Authority via the Health Overview and Scrutiny Committee, to determine if a formal item on the proposed relocation is required at the next local scrutiny committee and the extent to which the local area would wish to participate in the public consultation to inform the relocation proposal. As you will be aware, this could result in local authorities being asked to convene a joint scrutiny arrangement under section 30(5) of the regulations, to represent the national catchment population that Moorfields serves.

To date, we have engaged with the 14 Local Authorities, whose CCGs commission services from Moorfields a value greater than £2 million, and we are keen to ensure that the interests of all relevant local authorities are represented in this process.

As an indicator of how Moorfields' services are provided to people across the country, contract values and numbers of patients are detailed in Appendix 1, noting that specialised services are commissioned for the whole of England across 188 CCG areas.

We are therefore writing to confirm your CCG/LA area's requirements for support to engaging your Local Authority Health Overview and Scrutiny Committee to inform them about the proposals and plans for public consultation.

Immediate action to set up joint scrutiny arrangements

We would like to hear from your CCG, STP and local authorities on how best to involve local scrutiny in your area in an effective joint scrutiny arrangement.

Please could you advise us of the following:

1. Will you engage your local authority directly, with support from us in the form of materials and templates?

2. Will you arrange joint scrutiny arrangements across your STP area, with support from us in the form of materials and templates?

3. Should we liaise directly with your scrutiny officers on a joint scrutiny arrangement?

4. If so, please could you send us details of health overview and scrutiny committee (or similar scrutiny function)

5. Please tell us what further support you might need?

We would appreciate your feedback by Friday 8 March 2019. If we do not hear from you by 8th March, we will write directly to your Local Authority regarding the proposal and public consultation processes.

Should you require any further information, please contact Programme Director, Denise Tyrrell on 07818 291387 or denise.tyrrell@nhs.net.

Yours faithfully,

Sarah Mansuralli
Senior Responsible Officer – Moorfields Consultation Programme
Chief Operating Officer, NHS Camden Clinical Commissioning Group

BREAKDOWN OF PATIENT NUMBERS & SPEND FOR CCG AREAS IN ENGLAND				
CCG Area (2017/2018 data)	**SpecComm Spend**	**SC Patient Nos**	**CCG Spend**	**CCG Patient Nos**
London Region				
Barking and Dagenham	£233,842	1,036	£1,557,353	8,064
Barnet	£338,752	1,378	£3,771,449	20,011
Bexley	£158,292	662	£846,158	4,680
Brent	£483,835	2,849	£1,574,384	8,064
Bromley	£195,714	712	£1,477,237	7,002
Camden	£218,268	1,048	£2,651,058	18,823
Central London (Westminster)	£75,351	305	£870,450	5,069
City and Hackney	£677,839	3,179	£5,682,412	30,290
Croydon	£1,174,323	7,036	£873,489	5,145
Ealing	£612,058	3,843	£2,337,389	10,180
Enfield	£440,059	1,561	£3,515,121	18,103
Greenwich	£270,877	1,160	£1,701,723	9,186
Hammersmith & Fulham	£54,683	333	£545,998	2,829
Haringey	£356,893	1,339	£2,918,271	17,220
Harrow	£667,452	4,559	£978,673	8,752
Havering	£302,236	1,039	£2,036,798	9,529
Hillingdon	£126,238	730	£724,441	3,636
Hounslow	£183,664	721	£1,021,038	4,908
Islington	£456,826	2,279	£4,135,886	22,765
Kingston	£88,694	306	£562,357	2,250
Lambeth	£211,567	932	£1,315,098	7,218
Lewisham	£215,588	648	£1,519,010	8,478
Merton	£406,241	2,119	£416,552	2,487
Newham	£580,861	2,436	£3,787,005	19,867
Redbridge	£509,221	1,911	£3,039,622	16,342
Richmond	£112,954	436	£604,947	3,135
Southwark	£130,001	457	£1,327,533	7,656
Sutton	£132,390	500	£346,515	1,576
Tower Hamlets	£390,978	1,790	£3,795,769	18,864
Waltham Forest	£328,000	1,351	£2,365,141	12,607
Wandsworth	£677,959	4,021	£1,212,720	5,814
West London	£99,737	412	£931,993	4,932
Total	**£10,911,293**	**53,106**	**£60,443,590**	**325,482**

Midlands & East of England Region				
NHS Basildon and Brentwood	£110,059	326	£773,788	3,650
NHS Bedfordshire	£180,824	430	£859,291	3,626
NHS Birmingham Crosscity	£28,846	63		
NHS Birmingham S. & Central	£8,177	24		
NHS Cambs & Peterborough	£84,837	181	£411,355	1,860
NHS Cannock Chase	£4,686	5		
NHS Castle Point & Rochford	£69,539	158	£284,355	1,252
NHS Corby	£17,198	13		
NHS Coventry and Rugby	£12,282	35		
NHS Dudley	£11,676	23		
NHS East & North Hertfordshire	£335,412	1033	£3,089,293	13,275
E. Leicestershire & Rutland	£22,510	46		
NHS Erewash	£159	2		
Great Yarmouth and Waveney	£9,966	34		
NHS Herefordshire	£1,952	2		
NHS Herts Valleys	£389,243	1217	£2,835,261	13,368
NHS Ipswich & East Suffolk	£42,449	96		
NHS Leicester City	£30,600	50		
NHS Lincolnshire East	£32,959	54		
NHS Lincolnshire West	£12,133	15		
NHS Luton	£96,098	280	£310,023	1,563
NHS Mansfield and Ashfield	£4,522	3		
NHS Mid Essex	£193,780	377	£1,186,499	4,827
NHS Milton Keynes CCG	£84,760	204	£250,386	1,232
NHS Nene	£46,758	139		
NHS Newark & Sherwood	£1,195	3		
NHS North Derbyshire	£634	8		
NHS North East Essex	£88,382	224	£460,754	2,116
NHS North Norfolk	£6,168	15		
NHS North Staffordshire	£305	3		
NHS Norwich	£17,631	34	£37,944	227
NHS Nottingham City	£6,186	32		
Nottingham North and East	£335	3		
Redditch and Bromsgrove	£319	4		
NHS Rushcliffe	£1,052	6		
Sandwell and West Birmingham	£16,215	46		
NHS Shropshire	£2,996	5		
NHS Solihull	£24,133	53		
SE Staffordshire & Seisdon	£3,837	3		
NHS South Lincolnshire	£28,264	40		
NHS South Norfolk	£10,511	27	£61,164	264
NHS South Warwickshire	£17,016	27		
NHS South West Lincolnshire	£7,205	21		
NHS South Worcestershire	£8,370	31		
NHS Southend	£43,456	101	£213,936	1,207
NHS Southern Derbyshire CCG	£18,977	27		
NHS Stafford and Surrounds	£80	1		
NHS Stoke on Trent	£159	2		
NHS Telford and Wrekin CCG	£11,072	17		
NHS Thurrock	£49,571	286	£453,296	2,101
NHS Walsall	£159	2		
NHS Warwickshire North	£8,197	9		
NHS West Essex	£227,957	797	£1,345,930	6,541
NHS West Leicestershire	£26,478	32		
NHS West Norfolk	£19,133	28		
NHS West Suffolk	£10,517	15		
NHS Wolverhampton	£3,707	6		
Grand Total	**£2,491,641**	**6718**	**£12,573,275**	**57,109**

South of England Region				
NHS Ashford CCG	£24,457	76		
NHS Aylesbury Vale CCG	£32,656	73	£108,049	581
NHS Bath and North East Somerset CCG	£16,929	31		
NHS Bracknell and Ascot CCG	£17,526	65	£73,369	377
NHS Brighton and Hove CCG	£15,446	69		
NHS Bristol CCG	£14,062	39		
NHS Canterbury and Coastal CCG	£67,850	108		
NHS Chiltern CCG	£60,441	244	£340,507	1,850
NHS Coastal West Sussex CCG	£52,278	186	£245,469	1,273
NHS Crawley CCG	£27,605	96	£119,567	476
NHS Dartford, Gravesham and Swanley CCG	£216,742	1020	£625,918	3,278
NHS Dorset CCG	£49,430	93	£167,588	838
NHS East Surrey CCG	£51,194	206	£244,613	1,131
NHS Eastbourne, Hailsham and Seaford CCG	£13,986	42	£84,041	420
NHS Fareham and Gosport CCG	£9,331	22	£36,014	169
NHS Gloucestershire CCG	£8,038	21		
NHS Guildford and Waverley CCG	£93,563	169	£153,893	824
NHS Hastings and Rother CCG	£37,169	90	£129,857	678
NHS High Weald Lewes Havens CCG	£6,569	45		
NHS Horsham and Mid Sussex CCG	£55,147	106	£163,968	768
NHS Isle of Wight CCG	£31,172	61		
NHS Kernow CCG	£26,861	56		
NHS Medway CCG	£49,663	203		
NHS Newbury and District CCG	£6,753	26	£46,621	181
NHS North and West Reading CCG	£8,113	25	£32,629	198
NHS North East Hampshire and Farnham CCG	£37,937	99	£130,409	634
NHS North Hampshire CCG	£30,878	69	£90,004	464
NHS North Somerset CCG	£7,945	19		
NHS North West Surrey CCG	£97,537	281	£426,525	2,067
NHS N, E, and Western Devon CCG	£32,059	65		
NHS Oxfordshire CCG	£36,205	95	£174,630	890
NHS Portsmouth CCG	£22,993	38	£27,258	200
NHS Slough CCG	£61,882	161	£129,203	663
NHS Somerset CCG	£43,043	72		
NHS South Devon and Torbay CCG	£9,745	34		
NHS South Eastern Hampshire CCG	£17,393	46	£48,680	255
NHS South Gloucestershire CCG	£5,909	20		
NHS South Kent Coast CCG	£44,196	89		
NHS South Reading CCG	£21,026	34	£63,572	356
NHS Southampton CCG	£33,218	45	£28,189	216
NHS Surrey Downs CCG	£124,792	380	£458,969	2,367
NHS Surrey Heath CCG	£8,864	27		
NHS Swale CCG	£32,706	78	£59,869	352
NHS Swindon CCG	£13,582	38		
NHS Thanet CCG	£24,188	44		
NHS West Hampshire CCG	£23,930	87	£114,329	581
NHS West Kent CCG	£115,369	266	£550,450	2,742
NHS Wiltshire CCG	£27,272	73		
NHS Windsor, Ascot and Maidenhead CCG	£15,321	65	£131,598	575
NHS Wokingham CCG	£26,502	57	£78,989	449
Grand Total	**£1,907,474**	**5454**	**£5,084,777**	**25853**

North of England Region				
NHS Airedale, Wharfedale and Craven CCG	£3,121	9	**No**	
NHS Barnsley CCG	£9,087	36	**CCG**	
NHS Bassetlaw CCG	£402	4	**Commissioning**	
NHS Blackburn with Darwen CCG	£13,660	26		
NHS Bolton CCG	£2,918	3		
NHS Bradford Districts CCG	£2,725	9		
NHS Darlington CCG	£9,842	10		
NHS Doncaster CCG	£20,584	46		
NHS Durham Dales, Easington and Sedgefield CCG	£15,535	21		
NHS East Lancashire CCG	£5,875	18		
NHS East Riding of Yorkshire CCG	£6,794	10		
NHS Eastern Cheshire CCG	£8,689	8		
NHS Fylde and Wyre CCG	£4,928	1		
NHS Greater Huddersfield CCG	£2,471	3		
NHS Greater Preston CCG	£255	2		
NHS Halton CCG	£80	1		
NHS Hambleton, Richmondshire and Whitby CCG	£750	7		
NHS Harrogate and Rural District CCG	£80	1		
NHS Hartlepool and Stockton-on-Tees CCG	£4,535	3		
NHS Heywood, Middleton and Rochdale CCG	£1,115	2		
NHS Hull CCG	£23,491	27		
NHS Knowsley CCG	£80	1		
NHS Leeds North CCG	£4,030	7		
NHS Leeds West CCG	£1,297	6		
NHS Liverpool CCG	£11,242	16		
NHS Manchester CCG	£357	3		
NHS Morecambe Bay CCG	£1,359	8		
NHS Newcastle Gateshead CCG	£832	8		
NHS North Cumbria CCG	£2,627	2		
NHS North Durham CCG	£6,689	7		
NHS North East Lincolnshire CCG	£4,108	11		
NHS North Kirklees CCG	£2,512	10		
NHS North Lincolnshire CCG	£80	1		
NHS North Tyneside CCG	£3,534	3		
NHS Northumberland CCG	£535	6		
NHS Rotherham CCG	£3,343	8		
NHS Salford CCG	£2,419	10		
NHS Scarborough and Ryedale CCG	£3,047	1		
NHS Sheffield CCG	£17,681	34		
NHS South Sefton CCG	£176	1		
NHS South Tees CCG	£5,352	6		
NHS St Helens CCG	£637	8		
NHS Sunderland CCG	£594	4		
NHS Trafford CCG	£159	2		
NHS Vale of York CCG	£7,527	8		
NHS Wakefield CCG	£5,399	4		
NHS Warrington CCG	£4,578	13		
NHS West Cheshire CCG	£3,274	22		
NHS Wigan Borough CCG	£319	4		
Grand Total	**£240,522**	**492**		
Source: CCG data and NHSE Specialised Commissioning data				