Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING SCRUTINY COMMISSION

Held: THURSDAY, 29 AUGUST 2019 at 5:30 pm

P R E S E N T :

Councillor Kitterick (Chair)
Councillor Fonseca (Vice-Chair)

Councillor Chamund Councillor Dr Sangster
Councillor March

In Attendance:

Councillor Dempster, Assistant City Mayor - Health

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17. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Aldred and Councillor Westley.

18. DECLARATIONS OF INTEREST

No declarations were made.

19. MINUTES OF PREVIOUS MEETING

Further to minute 10, “Primary Care Hub Access at the Merlyn Vaz Health and Social Care Centre”, it was noted that the discussions on how an analysis of patient experiences following the introduction of a hybrid system for accessing services at the Merlyn Vaz Centre could be undertaken had not been held yet.

Further to minute 15, “Work Programme”, it was noted that scrutiny of issues such as education Health Care Plans for children, childhood obesity and

children's mental health services would be undertaken with the Children, Young People and Schools Scrutiny Commission at he January meeting of the Health and Wellbeing Scrutiny Commission.

AGREED:

that the minutes of the meeting of the Health and Wellbeing Scrutiny Commission held on 4 July 2019 be confirmed as a correct record, subject to the first line of paragraph 12 of minute 10, "Primary Care Hub Access at the Merlyn Vaz Health and Social Care Centre", being amended as follows (new wording in italics):

"~~Sarah Prema~~ *Harsha Kotecha*, *Chair of* Healthwatch, advised that Healthwatch had visited two hubs …"

20. CHAIR'S ANNOUNCEMENTS

No announcements were made.

21. PETITIONS

The Monitoring Officer reported that no petitions had been received.

22. QUESTIONS, REPRESENTATIONS AND STATEMENTS OF CASE

Ms Lucy Chaplin submitted the following representation:

"Are health providers aware that by offering mental health support through mainly telephone-based services that phone companies - particularly mobile phone companies - do not inform users that they may have used up contracted minutes and accumulated large phone bills in accessing the support they need?

While it is very helpful to be able to call the crisis team, and other services, it is very difficult to keep track of time. Indeed why should someone who is already so unwell that they need these services have the additional burden of thinking about their phone bill?

Has any part of the NHS looked into this, or discussed the issue with mobile phone companies, as many patients with severe mental health problems are already on reduced income, indeed many are classed as homeless, and cannot afford huge phone bills. When people can't pay the bill their phones are barred by companies, which actually cuts patients off from ALL the support networks they have.

This is like an additional tax, and additional stress, on those who are ill with poor mental health, as is discriminatory.

Responses from the CCG and LPT would be welcome.

I would also ask that the Leicester City Council Health and Wellbeing scrutiny commission agrees to take this up with NHS England and asks that there are agreements with phone companies about making those telephone services COMPLETELY freephone - in order that already vulnerable people are not faced with huge bills just for accessing the services they need.

Is Leicestershire the only place where this happens?

I've also copied in Keith Vaz as my local MP and Jon Ashworth MP as the shadow Health secretary as they could also take this up nationally.

It is a scandal that while society tries to breakdown the stigma of poor mental health, the telephone companies are making a lot of money from people accessing help, especially when that help is mostly available only via telephone."

On behalf of Leicester City Clinical Commissioning Group, Richard Morris (Director of Corporate Affairs) gave the following response:

"We would like to thank Ms Chaplin for raising these issues. We have spoken with Leicestershire Partnership NHS Trust who have provided the following response:

'Where phone-based support is offered to our patients and service users we want to ensure it is accessible and affordable. Our 24-hour mental health crisis support line, commissioned from our partners at Turning Point, is free to call from landlines and most mobile networks and a call-back service is also offered via email request. Similarly, our suite of ChatHealth support services provide confidential support via a secure text messaging service.

Where individuals are given landline numbers we also aim to ensure they have information about the other options open to them. However, if there is more we can do we will certainly consider it and we are grateful for this helpful feedback. We will be reviewing it as part of our plans to develop of a single central access point as part of our All-Age Transformation programme to transform our mental health and learning disabilities services.'

The local clinical commissioning groups are working with LPT to support them in their plans to transform local services.

We also believe that Ms Chaplin's feedback raises national challenges relating to accessibility and cost of phone lines. This in turn raises potential issues with availability of funding, patient confidentiality and the need to work with phone companies to bring about change. This issue is therefore wider than Leicester, Leicestershire and Rutland and may also

affect a broader range of health services. As such we will be raising the matter with NHS England for their consideration."

AGREED:

That the Leicester City Clinical Commissioning Group be asked to circulate the letter sent to NHS England in relation to this matter, and any response received, to the members of this Commission for information.

23. LEICESTERSHIRE PARTNERSHIP NHS TRUST: UPDATE ON STEPS TAKEN IN RESPONSE TO REGULATORY INSPECTIONS

Angela Hillery, Chief Executive Officer, and Anne-Maria Newham, Director of Nursing (AHPs & Quality), from the Leicestershire Partnership NHS Trust (LPT) gave a presentation providing the Commission with details on the current Care Quality Commission (CQC) position for LPT, assurance around actions that had been taken following recent inspections and the Trust's approach to monitoring and embedding these actions. A copy of this presentation is attached at the end of these minutes for information.

During the presentation, Ms Hillery drew particular attention to the following:

- Full information on the results of the CQC regulatory inspections was available on the LPT's website (www.leicspart.nhs.uk);

- The STEP up to GREAT strategy was the focus for the whole Trust. A director had been assigned to each area of the strategy, and these directors had responsibility and accountability for taking their areas forward. The Programme Management office supported them in doing this;

- Nationally, the use of dormitory accommodation in mental health units was considered unacceptable. The LPT endorsed this view and was trying to find capital funding to eliminate it in the Trust's facilities;

- Staff were at the heart of change, so a number of Change Champions had been recruited across the organisation. Approximately 80 people had volunteered for this role and had provided useful insights in to the organisation culture, what worked and what did not work;

- The CQC had undertaken an unannounced inspection in June 2019 and had identified some encouraging improvements. For example, improvements had been made in recording patients' physical healthcare and monitoring patients with ongoing physical healthcare problems, so mental health services did not just focus on mental health. Fire safety also was much improved, part of which was enforcement of the 'No Smoking' policy. However, most mental health units nationally found this difficult to implement, as people attending these units often were in distress and smoking provided them some relief from this;

- As the waiting list of children and young people waiting for treatment had increased and the demand for neurodevelopment assessment remained high, work needed to be undertaken with the Trust's commissioning partners to improve access to these services and ensure they were appropriate;

- An intensive support team from NHS England had looked at the commissioning and provision of Child and Adolescent Mental Health Services (CAMHS);

- Awarding a rating was not part of the process of the inspection undertaken in June, but the Warning Notice was removed following that inspection; and

- The LPT would have a re-inspection sometime from October or November 2019 onwards, when it was hoped that some improvement would be seen.

Ms Newham assured the Commission that the LPT was not being complacent about this work. It was recognised that the Trust had not worked well co-operatively in the past, but this had been addressed. It also was recognised that the Trust had not provided good responses to complaints in the past, particularly telephone complaints, and this also was being addressed.

Rachel Bilsborough, Divisional Director Community Health with the LPT, stressed that staff on the ground were being fully supported to understand the continual cycle of improvement being undertaken, to ensure that they were aware that these were not one-off improvements and needed to be embedded in the organisation. This was a new approach for the Trust.

Ms Hillery recognised that the Trust had a lot of priorities and it could be hard for staff to navigate through them in order to contribute to the improvements being made. The priorities therefore needed to be simplified, so that all contributions also were clearer. To facilitate this, the complexities of management structures also needed to be made clearer, as did the way in which the various parts of the organisation worked together. There had been some separate attempts to explain individual elements of this, but these had not made it clear how those elements affected the Trust as a whole. The Change Champions therefore were now working with the directors leading change to remedy this.

Mark Farmer, Healthwatch, enquired how patient experience was captured and understood pro-actively by the Trust. In reply, Ms Hillery noted that Mr Farmer, was on the LPT Board, which helped improve the Trust's understanding of patient experience. In addition, patient involvement teams from the Trust were visiting communities and trying to ensure that 'harder to see' patients were identified and their experiences captured. This work was ongoing. Ms Newham stressed that this needed to be done throughout the Trust, as it was a core area to which the Trust needed to give attention.

In response to an enquiry regarding whether district nursing was a stress area, Ms Bilsborough explained that district nursing services had been inspected by

the CQC in 2018 and had been categorised as a Good component of community services.

Members expressed some concern that ligature risks had been highlighted as an area needing attention for a number of years. Ms Newham and Ms Hillery explained that the service was not necessarily missing ligature risks, but as environments changed, (for example, through works to buildings), patients found different ways in which to use fixed and non-fixed ligatures. There had been no fixed ligature incidents in the Trust for a number of years, but continual audits of premises were undertaken and external advice taken, including from other trusts. The CQC had identified some potential ligature points, such as radiators positioned away from walls, but welcomed the plans that had been produced for each ward identifying all points of concern.

Members raised concerns that problems at the Bradgate Unit had been known about for some time, but did not appear to have been addressed before now. It therefore was questioned whether the LPT could be confident of getting funding needed and improving the service rating. Ms Hillery explained that the Sustainability and Transformation Partnership and the Better Care Together programme agreed priorities for the population, but the LPT had to develop the business case for this expenditure. This then had to receive system support for the work to be identified as a priority, followed by approval from the system partners. This funding bid would be separate from bids for other projects or programmes.

The business case for funding for improvements to the Bradgate Unit was being prepared and it was anticipated that the LPT would consider it in September, following which it could be shared with other partners. Other trusts had reduced the number of beds available in order to create single accommodation, but beds in Leicestershire already were under significant pressure, which was an important consideration. It was noted that it could take some time to acquire the necessary funding, so clear plans also were needed for the interim period.

The Commission enquired how the Trust approached equalities, particularly for women. In reply, Ms Hillery explained that the LPT had a very good champion and lead on this, who was assessing what work was being done in this area. Work also was being done with NHS national teams, such as the Race Equality team, to identify any further action that could be taken. An update on progress with this could be given to the Commission in due course.

The Commission noted that the LPT was working in partnership with Northamptonshire Healthcare NHS Foundation Trust (NHFT), having a shared Chief Executive. Ms Hillery explained that this was a “buddy” relationship. When NHS Improvement (NHSI) felt that a trust needed support, a near-by trust with a Good or Outstanding rating was asked to provide “buddy” support. The LPT had been approached before the support was put in place to ensure that it was comfortable with the arrangement.

Although a shared Chief Executive role provided the infrastructure for support

for the LPT, but care was taken to ensure that this was not to the detriment of the NHFT. Ms Hillery stressed that the "buddy" arrangement was not a take-over by NHFT or a merger of the two trusts, although it was a formal arrangement. NHSI provided some resource towards backfilling time in relation to the joint Chief Executive role if needed and the regulators would require reasons to be given if either party withdrew from the arrangement.

As an example of the type of work now being undertaken, Ms Newham noted that the LPT and the NHFT had worked together on nursing, enabling ideas to be shared without having to go through development processes already undertaken by either trust.

It was noted that the current "buddy" arrangement was for 12 months. Monthly monitoring was undertaken to ensure that learning was happening and a yearly review, based on the financial year, would be undertaken to ensure that the arrangement was making a difference. During this time, work with other trusts would continue, such as that on reducing CAMHS waiting lists, and a CQC inspection was anticipated during the partnership period.

Ms Hillery explained that the LPT needed more robust governance. Her experience from other organisations was that it took approximately three years to move to an Outstanding rating, although a Good rating could be achieved in the interim. As this involved a change in culture, it would not be an easy change to make, but the Board had been very receptive to changes and suggestions made.

Tim Sacks, Chief Operating Officer at East Leicestershire and Rutland Clinical Commissioning Group, emphasised that change would take time, but he also noted that very real change and engagement already had taken place, which was a welcome start to the process. Tamsin Hooton, CCG Director Lead for Community Services Redesign, agreed with this, noting that work with nurses was key to the process and had started straight away.

AGREED:

1) That the presentation be received and noted;

2) That the improvements made to date be welcomed;

3) That the Leicestershire Partnership Trust be asked to provide:

    a) an update on its work on equalities at an appropriate time;

    b) a report at the end of 2019 on progress with the redevelopment of the Bradgate Unit, this report to include the design of accommodation at the Unit and the business case for, and progress with, the acquisition of the funding required; and

    c) information on why some service areas had not been rated during Care Quality Commission regulatory inspections.

4) That the Leicestershire Partnership Trust be asked to present for scrutiny by this Commission at the appropriate time details of any further changes and/or improvements made in response to Care Quality Commission regulatory inspections.

24. LEICESTER, LEICESTERSHIRE AND RUTLAND 2019/20-2023/24 PRIMARY CARE STRATEGY

The Leicester, Leicestershire and Rutland 2019/20-2023/24 Primary Care Strategy was submitted by the Leicester City, West Leicestershire and East Leicestershire & Rutland Clinical Commissioning Groups (CCGs).

Tim Sacks, Chief Operating Officer at East Leicestershire and Rutland Clinical Commissioning Group, explained that the CCGs had been asked to produce the Strategy, to show how primary care practice would be driven forward, including how it was envisaged Primary Care Networks (PCNs) would work together and impact on the functions of CCGs. This therefore was a high-level plan, from which an operational plan would be developed.

The Strategy would be delivered through the PCNs, but meetings to discuss how this would be achieved had only just started, so it was anticipated that it would take time to implement the Strategy. Directors across the three organisations were taking the lead on portfolios within the Strategy to ensure their delivery.

To facilitate this, new funding was being provided, which included funding for the PCNs and for 12 or 13 additional clinical staff. Initial funding was for five years and it was hoped that during the first year funding would have been accessed, staff appointed and trained, and patients would be seeing improvements in access and care. Government guidance indicated that funding would only be released when the additional clinical staff had been employed. There also had been an increase in funding for GP practices this year, with an additional 1.5% being provided for core practice services.

The Commission expressed some concern that structures were being funded, not services. In reply, Mr Sacks explained that the roles in PCNs were very specific, so with the additional staff delivering other services more time was available in practices for providing core services.

It was stressed that the differences between PCNs, (for example, in demographics and resources), needed to be taken in to account. Services therefore needed to be locally responsive and to address the concerns of patients in each area, so would be commissioned accordingly. Practices could ask to move between PCNs, or they could be expelled from a PCN, which could change the resources and demographics of those PCNs and it was anticipated that there would be some movement over time.

Improvements in primary care would be determined through analysis of data by

NHS England and the establishment of local benchmarks. The three basic aims of improving care, access and outcomes had been set by the CCGs and would be achieved through delivery in the seven key contract areas. At present, performance indicators for these had not been created, so work was underway to establish the base line. Risk stratification scores and national standards of care also would be used to direct service delivery and improvement. Progress with the Strategy was monitored through the national workforce survey, which was held every three months and to which all practices were required to respond.

This structure meant that it was possible that improvements would not be reflected in patient surveys during the first year, but it would be disappointing if improvements were not seen in the second year.

Michael Smith, Healthwatch, stressed that patients' experience of visiting GPs was an important part of this and Healthwatch would know quickly if improvements were being made, (for example, if greater, and more timely, access to GPs was available). He suggested that monitoring the use of primary care hubs could be an indicator of such improvements, as the improvements described should reduce the need for people to use the hubs.

Concern was expressed that as the number of PCNs increased, so did the possibility of privatising services if users' needs were not being met. In reply, Mr Sacks explained that GP practices in PCNs still had their own independent contracts with the NHS. The PCN contract was an addition to this, but could mean that service delivery had to change to enable the practices to work together in different ways through the PCNs.

During discussion on the Strategy, the Commission noted that social prescribing was a way of supporting GPs in relation to patients' non-clinical needs through prescribing things such as swimming sessions. In order to maximise opportunities for this, consideration needed to be given to how health organisations and local authorities worked together.

The Commission noted that, although a priority in relation to personal health budgets was to work with people with frailties, these people could be reticent to take up these budgets. In reply, Mr Sacks explained that there were defined markers for frailty, but a personal health budget was a choice, so people did not have to have one and did not receive a lesser service if they chose not to have one.

Members also expressed concern that the target of recruiting 30 GPs from overseas in the next five years appeared to lack ambition. It was noted by Mr Sacks that reference to this in the Strategy related to relocation costs for 30 GPs, not pay, and funding was only for 30, so any more would have to be funded by the CCGs. However, Richard Morris, Director of Corporate Affairs at Leicester City Clinical Commissioning Group, noted that the increase in GPs from abroad coming to Leicester in recent years was higher than the national average, as a result of ongoing work to encourage GPs to consider moving to the city. Mr Sacks also advised that more newly qualified GPs who trained in

Leicester, Leicestershire and Rutland stayed in the area than the national average, but many GPs working in these areas were doing fewer clinical sessions.

Mr Smith asked that consideration be given to consulting on the different parts of the Strategy whenever possible, as this helped to build public trust. Mr Sacks advised that this was done, and would continue, as engagement was considered to be very important.

Members were reminded that information on attendance statistics at hospital Accident and Emergency services had been circulated following the last meeting of the Commission, (minute 10, "Primary Care Hub Access at the Merlyn Vaz Health and Social Care Centre", referred). These statistics are attached at the end of these minutes for information.

Mr Morris noted that the number of attendances at the Accident and Emergency department by people aged 21-25 were consistent with expectations in a city like Leicester. Tamsin Hooton, CCG Director Lead for Community Services Redesign, explained that these numbers partly reflected the number of young people in the city due to it having two universities, but they also were partly due to people choosing to go to Accident and Emergency services, rather than seeking alternative assistance. Work therefore needed to be done on encouraging them to deflect to other services where appropriate.

Some GP practices had low presentation rates, with more of their patients using Accident and Emergency services. This could be for a number of reasons. For example, it was known that one practice in the city with low presentation rates had the highest number of registered patients living in care homes in the city and these residents often were taken to the hospital Accident and Emergency department as a first choice destination.

It was noted that homeless people could register with a GP practice, but nationally there were problems in encouraging them to do so. Homeless people therefore tended to present in high numbers at Accident and Emergency services, but locally Inclusion Healthcare was rated excellent and was very pro-active, including walking round the streets with clinical staff and having conversations with homeless people about their health.

AGREED:

1) That the Leicester City, West Leicestershire and East Leicestershire & Rutland Clinical Commissioning Groups be asked to provide the Commission with:

    a) a review of progress with implementing the Leicester, Leicestershire and Rutland 2019/20-2023/24 Primary Care Strategy early in 2020, this review to include information on funding and expenditure; and

    b) information on the work being done to deflect people from using hospital Accident and Emergency services when

appropriate; and

2) That Healthwatch be asked to provide the Commission with a review of progress it identifies in the implementation of the Leicester, Leicestershire and Rutland 2019/20-2023/24 Primary Care at the same time as the review requested under 1a) above is presented to the Commission.

Councillor Dr Sangster left the meeting during discussion on this item.

25. COMMUNITY SERVICES REDESIGN - FUTURE MODEL OF CARE, IMPLEMENTATION AND NEXT STEPS

The Leicester, Leicestershire and Rutland Clinical Commissioning Groups (CCGs) submitted a report describing the Community Services Redesign project to date. The report set out the future model that the CCGs would commission, describing what impact that would have on the care people received and what that would mean to other parts of the health and care system in Leicester, Leicestershire and Rutland. The report also outlined the next steps in the CCGs' work on community health services.

Tamsin Hooton, CCG Director Lead for Community Services Redesign, introduced the report, making the following points:

- Adult community health services in Leicester, Leicestershire and Rutland were being reviewed as they had not been commissioned to work with other health care providers in a way that was consistent with how health care would be provided in the future;

- Some of the perceived deficits it was hoped to address included services for people in crisis and the capacity of community nursing services;

- A new model of care had been developed, based on feedback, which showed that a lot of services were not seen as being joined up;

- A new model of home-based care had been designed, comprising of three parts: neighbourhood community nursing and therapy services, Home First services and Locality Decision units;

- As part of this, investment was being made in greater GP capacity through Primary Care Networks;

- The key change in the first phase of introducing the new model would be the reorganisation of teams within the Leicestershire Partnership NHS Trust (LPT) by the end of 2019 and increasing capacity through to early 2020;

- A system transformation working group had been established and included

various partners, such as University Hospitals of Leicester NHS Trust (UHL); and

- The success of the redesign would be assessed by a steering group comprised of various partners looking at the impact that the redesign had on people's experiences, including whether they were able to stay at home, and the impact on community hospitals.

Rachel Bilsborough, Divisional Director Community Health with LPT, advised the Commission that the redesign was being co-produced by health care professionals, Healthwatch and patients, carers and users. Service users would be the same people as previously and they would have the same needs, but the care received would be changing under the redesign. The LPT Board would consider the proposals on 30 August 2019.

Members noted that the service already had a strong relationship with the City Council and this would be built on through the redesign, but Council staff would remain working for the Council. Ms Hooton also noted that the City Council's Adult Social Care service had been very engaged in the redesign of Community Services, helping with things such as the testing of new models.

The Commission noted that a significant workforce challenge would be in the number of therapy staff employed, as this currently was lower than national averages. In addition, integrating therapy services and acute social care could be problematic, as people were being discharged to go home for assessment to be undertaken there, but therapy services had not yet moved to that model.

Retention of staff was a problem in some parts of the city. This also was affected by the national shortage of Band 5 registered nurses and problems regarding the supply of newly qualified nurses, the latter relating at least in part to changes in the number of training places available and the availability of bursaries. Suggestions of how people could be incentivised to work in the city, or assistance with doing this, therefore would be welcome.

It was noted that District Nurses often had problems parking near homes they were visiting. This could be problematic, as they often had to carry equipment in to the homes. The Commission noted that a scheme allowing parking in restricted areas for people in this situation had been tried previously, but had not been successful. However, it was suggested that discussions on possible options for such a scheme could be held.

Members noted that consultancy support had been provided by Deloitte. This had been sourced by NHS England and offered as a support package to work on some areas of the service redesign. Funding also was provided by NHS England. Deloitte's involvement in this work had now ended.

The Commission recognised that this was an evolving service model, but queried how it would be assessed whether the new service design was successful. In reply, Mr Sacks explained that a set of outcomes had been identified, but some of these were reliant on other organisations, such as social

care performance indicators.

AGREED:

1) That the Scrutiny Policy Officer be asked to liaise with members of this Commission to establish a small “task and finish” group to consider how parking problems being experienced by Community Services providers can be addressed; and

2) That the Leicester, Leicestershire and Rutland Clinical Commissioning Groups be asked to report back to this Commission in one year on how the redesigned Community Services are evolving.

26. WORK PROGRAMME

AGREED:

The work programme for the Commission be received and noted.

27. CLOSE OF MEETING

The meeting closed at 8.15 pm

Leicestershire Partnership NHS Trust

Health & Wellbeing Scrutiny Commission

LPT: Update on steps taken in response to regulatory inspections

Minute Item 23

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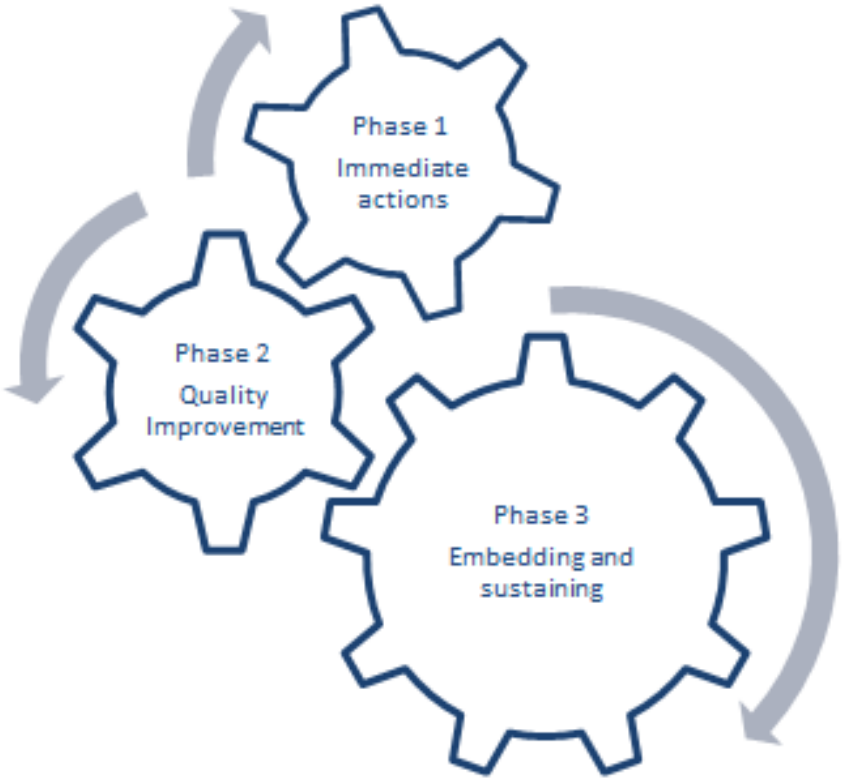
Approach for responding to regulatory inspections



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CQC Warning Notice – Key Areas

1. Access to services – waits for CAMHS
2. Mixed sex accommodation issues
3. Environment including ligatures
4. Fire safety including smoking
5. Medicines management
6. Seclusion
7. Care planning – physical care/risk assessments
8. Governance / Learning

	Safe	Effective	Caring	Responsive	Well led	Overall
Long stay or rehabilitation mental health wards for working age adults	Inadequate	Inadequate	Requires improvement	Good	Inadequate	Inadequate
Community-based mental health services for older people	Good	Good	Good	Good	Good	Good
Wards for people with a learning disability or autism	Requires improvement	Good	Good	Good	Not rated	Requires improvement
Acute wards for adults of working age and psychiatric intensive care units	Inadequate	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate
Specialist community mental health services for children and young people	Requires improvement	Good	Good	Inadequate	Requires improvement	Requires improvement
Community health services for adults	Good	Good	Good	Good	Requires improvement	Good
Mental health crisis services and health-based places of safety	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Community-based mental health services for adults of working age	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Wards for older people with mental health problems	Good	Requires improvement	Good	Good	Good	Good
Community health services for children, young people and families	Good	Good	Outstanding ☆	Good	Good	Good
	Safe	Effective	Caring	Responsive	Well led	Overall
Community health inpatient services	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Child and adolescent mental health wards	Good	Good	Good	Good	Good	Good
End of life care	Good	Requires improvement	Good	Good	Good	Good
Forensic inpatient/secure wards	Good	Requires improvement	Good	Good	Good	Good
Community mental health services with learning disabilities or autism	Good	Good	Good	Requires improvement	Good	Good

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Identified essentials for success

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Bradgate Unit

New flooring, windows and lighting

Improvements to medication disposal, labelling and the management of controlled drugs

Staff and patient involvement

Change Champions

Freedom to speak up partners

Involvement Centre

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Our progress to date

CQC re-inspection report (9th August 2019)

Unannounced inspection in June 2019 to follow up on enforcement action issued after the last core service inspection dated November 2018

Key identified improvements;

- Significant improvement has been made to the environments at most wards.
- There were improvements in ligature risk assessments.
- Improvement in recording patient's physical healthcare, monitored patients with ongoing physical healthcare problems, and maintained privacy and dignity.
- Improved medicines management, this includes the labelling, disposal, reconciliation and ward level audit.
- Some improvements addressing no smoking policy at the Bradgate Mental Health Unit.
- Fire safety is much improved.
- Some improvement in seclusion documentation and new paperwork introduced.
- Significantly reduced waiting times for children and young people waiting for assessment.

Our progress to date

Actions still to do

- Further improvement to environments at Bradgate Mental Health Unit needed.
- Pharmacy oversight in medicines management needs strengthening.
- Quality of recording seclusion requires further improvement.
- Waiting list of children and young people waiting for treatment has increased. Demand for neurodevelopment assessment remains high.

Support and Scrutiny

Buddy Relationship with NHFT

Infection Prevention Visit

External Reviews

1. Governance

2. Learning from SIs

Intensive Support Team from NHSEI

Questions?

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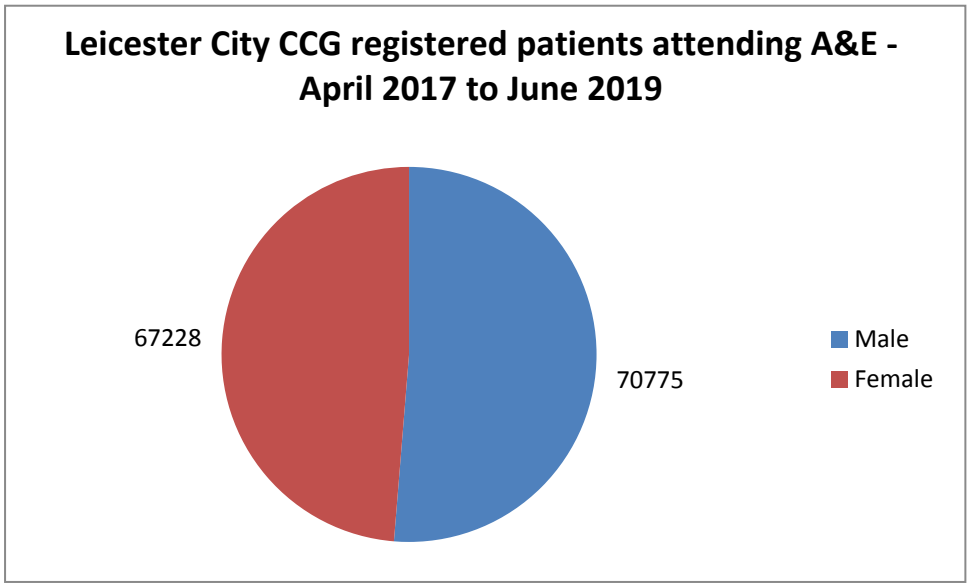
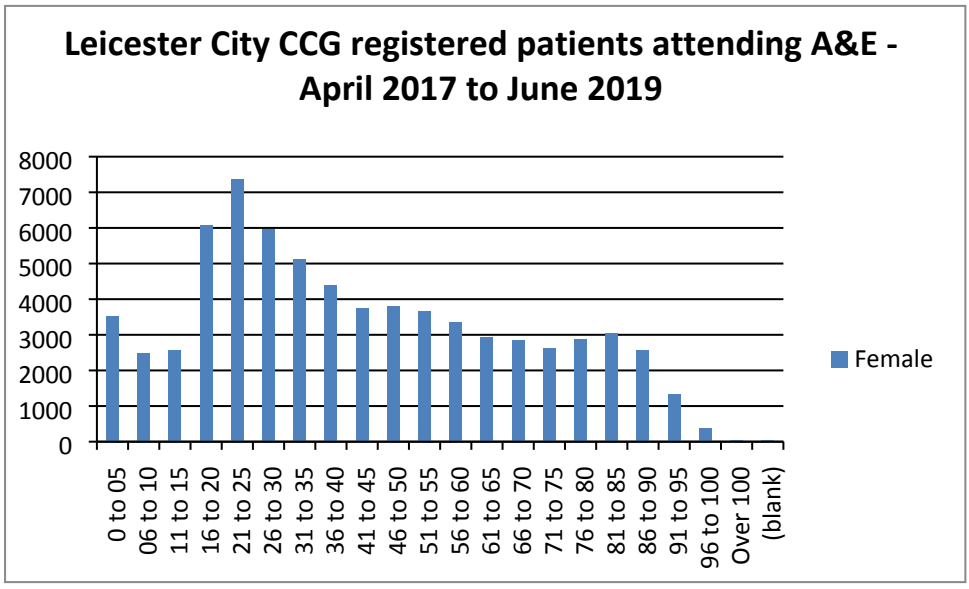
Minute Item 24

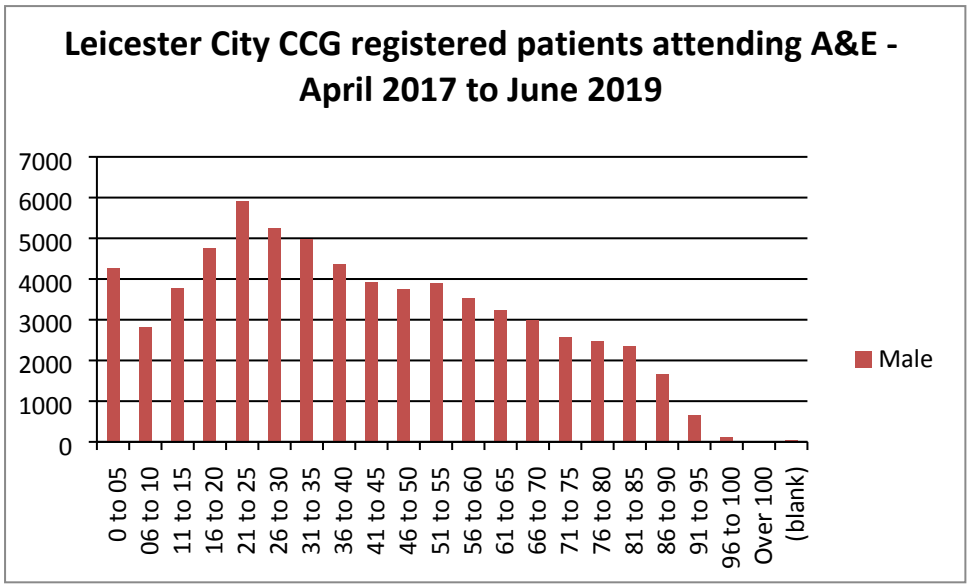
UPDATE ON ACTIONS FROM LEICESTER CITY HEALTH SCRUTINY COMMISSION

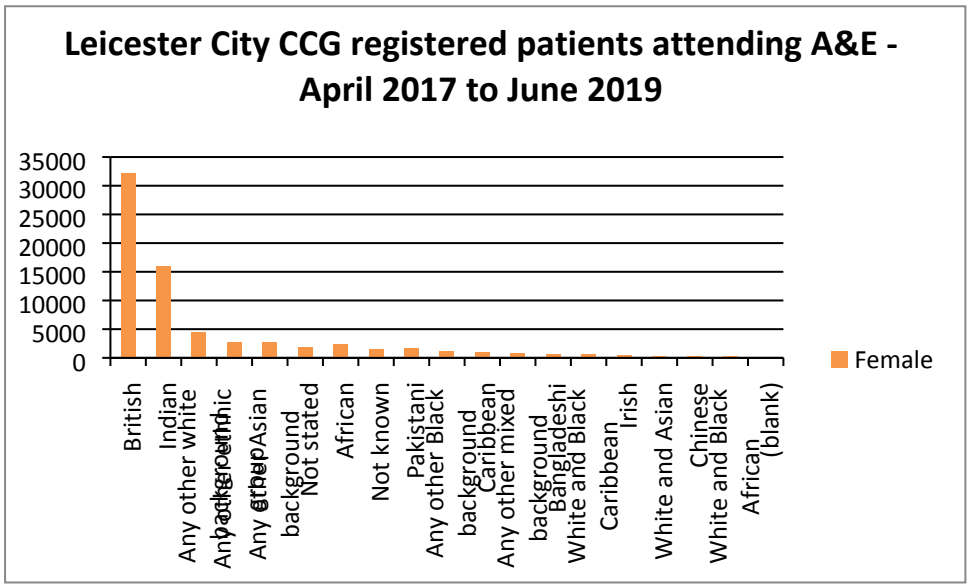
PRIMARY CARE HUB ACCESS AT THE MERLYN VAZ HEALTH AND SOCIAL CARE CENTRE

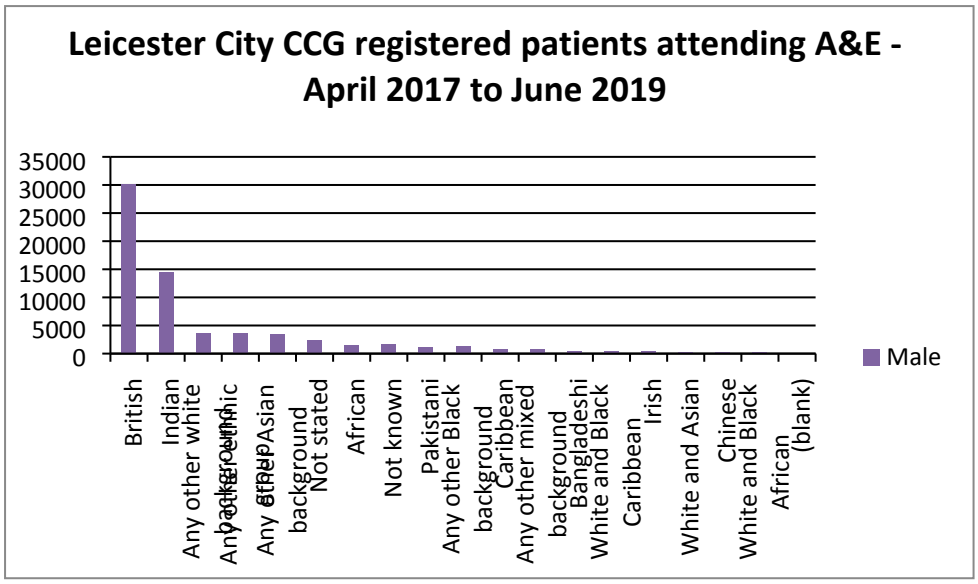
1. **Demographic profiling of Leicester City CCG registered patients attending A&E – April 2017 to June 2019**






Leicester City CCG registered patients attending A&E - April 2017 to June 2019
7000
6000
5000
4000
3000
2000
1000
0
0 to 05
06 to 10
11 to 15
16 to 20
21 to 25
26 to 30
31 to 35
36 to 40
41 to 45
46 to 50
51 to 55
56 to 60
61 to 65
66 to 70
71 to 75
76 to 80
81 to 85
86 to 90
91 to 95
96 to 100
Over 100
(blank)
Male


Leicester City CCG registered patients attending A&E - April 2017 to June 2019
35000
30000
25000
20000
15000
10000
5000
0
British
Indian
Any other white background
Any other ethnic background
Any other Asian background
Not stated
African
Not known
Pakistani
Any other Black background
Caribbean
Any other mixed background
Bangladeshi
White and Black Caribbean
Irish
White and Asian
Chinese
White and Black African
(blank)
Female



Leicester City CCG registered patients attending A&E - Weighted attendance (12 month average) per 1000 patients

Attendance at A&E	Average weighting
GP Practice	
INCLUSION HEALTHCARE	126.72
LEICESTER CITY ASSIST PRACTICE	40.68
THE PRACTICE BEAUMONT LEYS	40.57
BOWLING GREEN STREET SURGERY	38.22
THE HEDGES MEDICAL CENTRE (SA BAILEY)	34.03
THE SURGERY @ AYLESTONE	33.73
HOCKLEY FARM MED PRACT (A NANA)	33.42
WESTCOTES GP SURGERY (ONE)	32.95
PASLEY ROAD HEALTH CENTRE (G SINGH)	31.59
WESTCOTES GP SURGERY (TWO)	31.20
THE PARKS MEDICAL CENTRE (B HAINSWORTH)	31.19
PARKER DRIVE SURGERY	30.97
SAFFRON GROUP PRACTICE	30.96
BEAUMONT LODGE MEDICAL PRACTICE	30.37
WESTCOTES MEDICAL CENTRE	30.28
ST PETER'S MED CENTRE (MANSINGH & MEHRA)	30.27
THE WILLOWS MEDICAL CENTRE	30.11
HERON GP PRACTICE	29.55
ST ELIZABETH'S MEDICAL CENTRE (JA WOOD)	29.25
ASQUITH SURGERY	28.81
WILLOWBROOK MEDICAL CENTRE (JG ASTLES)	28.04
EAST LEICESTER MED PRACT(S LONGWORTH)	27.88
GROBY ROAD MEDICAL CENTRE (ID PATCHETT)	27.85

PASLEY ROAD HEALTH CENTRE (TK KHONG)	27.62
OAKMEADOW SURGERY (RA LEACH)	27.31
MERRIDALE MEDICAL CENTRE (RP TEW)	27.19
SHEFA MEDICAL PRACTICE	27.01
RUSHEY MEAD HEALTH CENTRE	26.89
BRANDON STREET SURGERY	26.75
COMMUNITY HEALTH CENTRE (ZS OSAMA)	26.55
HUMBERSTONE MEDICAL CENTRE (IP JONES)	26.12
FOSSE FAMILY	26.03
HIGHFIELDS SURGERY (R WADHWA)	25.84
FOSSE MEDICAL CENTRE (GK SHARMA)	25.55
DR S SHAFI	25.48
AL-WAQAS MEDICAL CENTRE	25.26
AYLESTONE HEALTH CENTRE	24.66
HEATHERBROOK SURGERY (RP ARCHER)	24.19
THE PRACTICE-SAYEED	24.19
THE CHARNWOOD PRACTICE	24.11
WALNUT ST MED CTR (LEICESTER MED GROUP)	23.94
WESTCOTES HEALTH CENTRE (RL HAZELDINE)	23.82
JOHNSON MEDICAL PRACTICE	23.63
HIGHFIELDS MEDICAL CENTRE	23.51
NARBOROUGH ROAD SURGERY	23.49
EVINGTON MEDICAL CENTRE (C KUMAR)	23.39
DE MONTFORT SURGERY	21.30
CLARENDON PARK ROAD HEALTH CENTRE	21.11
AR-RAZI MEDICAL CENTRE	19.64
EAST PARK MEDICAL CENTRE (RP PANDYA)	19.57
SPINNEY HILL MEDICAL CENTRE	19.28
BROADHURST ST MED PRACT (KS MORJARIA)	19.11
DOWNING DRIVE SURGERY (AJJ BENTLEY)	19.07
DR B MODI	18.25
DR R KAPUR & PARTNERS	18.05
DR GANDECHA & PARTNER	17.62
VICTORIA PARK HEALTH CENTRE	16.18

A note of caution should be applied when interpreting the above data, with the following caveats noted:

(i) Patient demographics vary across each practice

(ii) Practices with a high proportion of patients with multiple complex long term conditions, or care home patients, may expect to see higher A&E attendances

(iii) Practices which are closer to A&E tend to be slightly higher users of the service

(iv) The two practices with the highest use of A&E services are managed by Inclusion Healthcare - which look after homeless and the asylum seeker patients.