Leicestershire County Council

Meeting: **Health Overview and Scrutiny Committee**

Date/Time: **Wednesday, 31 August 2022 at 2.00 pm**

Location: **Sparkenhoe Committee Room, County Hall, Glenfield**

Contact: **Mr. E. Walters (0116 3052583)**

Email: **Euan.Walters@leics.gov.uk**

Membership

Mr. J. Morgan CC (Chairman)

Mr. M. H. Charlesworth CC
Mr. K. Ghattoraya CC
Mr. D. Harrison CC
Mr. R. Hills CC
Mr. P. King CC
Ms. Betty Newton CC

Please note: this meeting will be filmed for live or subsequent broadcast via the Council's web site at http://www.leicestershire.gov.uk

AGENDA

Item		Report by
1.	Minutes of the meeting held on 15 June 2022.	(Pages 5 - 14)
2.	Question Time.	
3.	Questions asked by members under Standing Order 7(3) and 7(5).	
4.	To advise of any other items which the Chairman has decided to take as urgent elsewhere on the agenda.	
5.	Declarations of interest in respect of items on the agenda.	
6.	Declarations of the Party Whip in accordance with Overview and Scrutiny Procedure Rule 16.	
7.	Presentation of Petitions under Standing Order 35.	

8.	Urgent and Emergency Care System.	University Hospitals of Leicester NHS Trust	(Pages 15 - 62)
9.	Learning from Deaths of People with Learning Disability and Autistic People Review Programme Annual Report.	Leicestershire County Council	(Pages 63 - 112)
10.	Alcohol Misuse and Trading Standards.	Director of Public Health	(Pages 113 - 132)

11. Date of next meeting.

    The next meeting of the Committee is scheduled to take place on 2 November 2022 at 2.00pm.

12. Any other items which the Chairman has decided to take as urgent.

QUESTIONING BY MEMBERS OF OVERVIEW AND SCRUTINY

The ability to ask good, pertinent questions lies at the heart of successful and effective scrutiny. To support members with this, a range of resources, including guides to questioning, are available via the Centre for Governance and Scrutiny website www.cfgs.org.uk. The following questions have been agreed by Scrutiny members as a good starting point for developing questions:

- Who was consulted and what were they consulted on? What is the process for and quality of the consultation?
- How have the voices of local people and frontline staff been heard?
- What does success look like?
- What is the history of the service and what will be different this time?
- What happens once the money is spent?
- If the service model is changing, has the previous service model been evaluated?
- What evaluation arrangements are in place – will there be an annual review?

Members are reminded that, to ensure questioning during meetings remains appropriately focused that:

(a) they can use the officer contact details at the bottom of each report to ask questions of clarification or raise any related patch issues which might not be best addressed through the formal meeting;

(b) they must speak only as a County Councillor and not on behalf of any other local authority when considering matters which also affect district or parish/town councils (see Articles 2.03(b) of the Council's Constitution).

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Agenda Item 1

Minutes of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Glenfield on Wednesday, 15 June 2022.

PRESENT

Mr. M. H. Charlesworth CC
Mr. K. Ghattoraya CC
Mr. D. Harrison CC
Mr. R. Hills CC
Mr. J. Morgan CC
Ms. Betty Newton CC
Mrs. R. Page CC

In attendance
David Giffard - Senior Public Health Commissioning Manager at NHS England and NHS Improvement (minute 10 refers).
Stephanie Cook - Senior Public Health Commissioning Manager at NHS England and NHS Improvement (minute 10 refers).
Yasmin Sidyot - Deputy Director Integration & Transformation (City), Leicester, Leicestershire and Rutland CCGs (minute 11 refers).
Fay Bayliss - Deputy Director of Integration and Transformation, Leicester, Leicestershire and Rutland CCGs (minute 11 refers).
Helen Thompson - Director of FYPC and LD Services, Leicestershire Partnership NHS Trust (minute 12 refers).
Colin Cross - Service Group Manager for Healthy Together (minute 12 refers).
Kate Allardyce, Senior Performance Manager (Leicestershire CCGs), NHS Midlands and Lancashire Commissioning Support Unit (minute 14 refers).

1. Appointment of Chairman.

RESOLVED:

That Mr. J. Morgan CC be appointed Chairman of the Health Overview and Scrutiny Committee for the period ending with the date of the Annual Meeting of the County Council in 2023.

Mr. J. Morgan CC in the Chair

2. Election of Deputy-Chairman.

RESOLVED:

That Mr. P. King CC be appointed Deputy Chairman of the Health Overview and Scrutiny Committee for the period ending with the date of the Annual Meeting of the County Council in 2023.

3. Minutes of the previous meeting.

The minutes of the meeting held on 2 March 2022 were taken as read, confirmed and signed.

4. Question Time.

The Chief Executive reported that one question had been received under Standing Order 34:

1. Question by Giuliana Foster

What actions will the Scrutiny Committee and CCG/ICS leads be taking to improve performance of the South Leicestershire Medical Groups GP practices following patient complaints and the CQC report?

Reply by the Chairman:

Health Scrutiny Committees do not have the power to take direct action regarding health services such as GP Practices, however, the Committee can try and influence health providers and make suggestions for improvements. The Committee uses Care Quality Commission (CQC) reports to aid scrutiny of particular services and identify areas of concern. The Committee can request that the providers of those services attend public Committee meetings and answer questions. For example, today's meeting has an agenda item relating to Primary Medical Care in Leicestershire and a representative from the Clinical Commissioning Groups (CCGs) will be attending to explain what is being done to improve Primary Care in Leicestershire. I expect there will be further agenda items on Primary Care in the future.

With regards to the particular issue of the South Leicestershire Medical Group I have sought information from the CCG in relation to this and they have provided me with the following response:

"The practice has taken on board the concerns raised by its patients and areas of improvement as identified in the Care Quality Commission report. Both the practice and the CCG, which is committed to supporting the practice, are pleased to note that the CQC report rated the practice as good in the caring domain and that staff treated people with kindness respect and compassion, while recognising that there are still further improvements to be made.

The practice has developed a robust improvement plan based on the CQC findings, which demonstrates a clear commitment by them to address the issues raised. It is recognised by all parties that that the plan will take some time to fully complete and for the actions to become embedded, although there are some areas which will require quicker action. The CCG, our Clinical Lead and our Quality team will continue working proactively with the practice to help them deliver the plan and, once delivered, support them further to ensure improvements are sustained.

Telephone access and general appointment availability are particular concerns that have been clearly highlighted by patients. The CQC did note that improvements had started in these areas, whilst recognising that there remains scope for further work.

Meanwhile, the CCG engagement team is providing additional support to the practice, including through with its Patient Participation Group, to ensure that patients remain involved in the improvement journey."

5. Questions asked by members.

The Chief Executive reported that no questions had been received under Standing Order 7(3) and 7(5).

6. Urgent items.

There were no urgent items for consideration.

7. Declarations of interest.

The Chairman invited members who wished to do so to declare any interest in respect of items on the agenda for the meeting.

There were no formal declarations in relation to any of the agenda items however it was noted that Mrs. M. E. Newton CC had several relatives that worked for the NHS and Mr. R. Hills CC worked as a dentist.

8. Declarations of the Party Whip.

There were no declarations of the party whip in accordance with Overview and Scrutiny Procedure Rule 16.

9. Presentation of Petitions.

The Chief Executive reported that no petitions had been received under Standing Order 35.

10. National Screening Programmes.

The Committee considered a report of NHS England and NHS Improvement -Midlands which informed of the impact of the Covid-19 Pandemic on the National Screening Programmes in Leicestershire and the steps that had been undertaken to support recovery. A copy of the report, marked 'Agenda Item 10', is filed with these minutes.

The Committee welcomed to the meeting for this item David Giffard and Stephanie Cook, Senior Public Health Commissioning Managers at NHS England and NHS Improvement.

Arising from discussions the following points were noted:

(i) The Antenatal and Newborn screening programme, along with the Cervical programme, had continued as normal throughout the Covid-19 pandemic with only minor disruption. The Abdominal Aortic Aneurysm screening service had been

paused in March 2020 in response to the pandemic but had now been fully recovered. The Bowel Cancer Screening programme was recovered however an additional cohort was being introduced into the programme which now meant the introduction of screening for 56-year olds. The Diabetic Eye Screening Programme was expected to be recovered by mid-July 2022 and the Breast Screening Programme would be recovered in a similar timescale.

(ii) Members welcomed the progress that had been made in recovering the Screening Programmes and reported that few concerns had been raised by local residents in relation to screening.

(iii) In response to a question from a member regarding the Breast Screening Mobile Unit which had visited Lutterworth prior to the Covid-19 pandemic it was explained that during the pandemic prioritisation decisions had to be made on the sites that the Mobile Unit visited and there were access problems with some of the sites. It was expected that the Breast Screening Mobile Units would resume their normal service, and after the meeting further details would be provided to the Committee in relation to the service in Lutterworth.

(iv) Some demographics were less likely to come forward for screening and the Covid-19 pandemic had exacerbated health inequalities. NHS England was keen to work with stakeholders to tackle the problem and partnership groups had been put together.

(v) The reduction in screening during the Covid-19 pandemic had an impact on detection rates and it was known that some cancers had been missed.

RESOLVED:

That the update regarding the impact of the Covid-19 Pandemic on the National Screening Programmes in Leicestershire be noted and the steps that had been taken to support recovery be welcomed.

11. Primary Care Improvement Plan.

The Committee considered a report of Leicester, Leicestershire and Rutland Clinical Commissioning Groups (CCGs) which provided an overview of Primary Medical Care in Leicestershire including the current priorities, issues and challenges. A copy of the report, marked ‘Agenda Item 11’, is filed with these minutes.

The Committee welcomed to the meeting for this item Yasmin Sidyot, Deputy Director Integration & Transformation (City), and Fay Bayliss, Deputy Director of Integration and Transformation, Leicester, Leicestershire and Rutland CCGs.

Arising from discussions the following points were noted:

(i) Concerns were raised by members that the plans for Primary Care were focused on how the workload of doctors could be reduced rather than how the experience of patients could be improved. Some members were of the view that as doctors were working from home they were distancing themselves from patients, and overall GP’s were less accessible than they had been in previous years. In response the

concerns were acknowledged by the CCG and reassurance was given that it was not intended that doctors carry out less work but it was more about ensuring their time was spent carrying out work that GPs were intended to do. The way GP Practices operated had to change because there were currently less doctors available than previously and there would be less in the future so the best use of doctors' time had to be made. Therefore, there was a move away from GP Practices being focused on the doctor towards making use of a wider healthcare team. Patients were living longer and had more long term conditions which required a broader range of health professionals to deal with them. In response to a suggestion from a member it was confirmed that a document would be produced which explained to patients the roles of all the healthcare professionals at GP Practices and how they fitted together. One of the new staff roles in Primary Care Networks would be paramedics to help triage patients and treat minor injuries.

(ii) Particular concerns were raised about Care Home residents who were unable to see a GP and the CCG agreed that this should not be the case and agreed to look into it further.

(iii) There had been recent media coverage regarding greater use being made of chemists to make referrals for medical appointments and a member raised concerns about privacy at chemists, but it was noted that most chemists had a private consulting room. Other members were of the view that chemists should be utilised more.

(iv) Where the report referred to 'appointments' this referred to a consultation with either a GP or another Healthcare professional and this could be either in person face to face, via a video call or a telephone call and included appointments booked in advance or on the same day. Currently in the County 68.3% of all appointments delivered were face to face i.e the patient was in the same room as the practitioner.

(v) In response to concerns raised by members about the difficulties in obtaining an appointment with a GP Practice it was explained that various options were being considered to improve the process of booking an appointment. Cloud based telephony was being introduced but this would not help where delays were being caused by a lack of call handlers. Therefore, trials were taking place where admin staff across GP Practices worked collectively and answered calls for more than one Practice. Consideration was also being given to releasing appointments gradually throughout the day rather than making them all available for booking early in the morning. All GP Practices had the facility for appointments to be booked online but not all practices had resumed using this facility since the Covid-19 pandemic and work was taking place to encourage all GP Practices to offer this facility.

(vi) A member suggested that Facebook and other social media were useful tools for GP Practices to get messages to patients such as when the practice was closed or phone lines were not working.

(vii) Members were of the view that patients would have more confidence with a video appointment than a telephone appointment and GP Practices should invest in the technology required for video appointments. In response it was explained that GP Practices began providing video appointments during the Covid-19 pandemic but the implementation was piecemeal due to the urgency at the time. Going forward consideration was being given to how video technology could be implemented in a more joined up manner across GP Practices. Though it was noted that one style of

offering video appointments would not suit all practices and there would have to be some bespoke procedures in place.

(viii) Leicestershire County GP Practices delivered 388,894 appointments in March 2022 and in response to questions from members it was agreed that further information would be provided after the meeting regarding the number of GP appointments where the patient failed to attend including telephone and videocalls, and the breakdown of whether the appointments were with a GP, nurse or other health professional.

(ix) Every single GP Practice was part of a Primary Care Network (PCN) and in response to a request from a member it was agreed to provide details of the Lutterworth PCN after the meeting.

(x) A member raised concerns about poor people skills shown by staff at GP Practices in the Harborough area.

(xi) Reassurance was given that quality assessments of GP Practices took place and work was ongoing to reduce variation in the way practices delivered services. The LLR CCGs had commissioned a support programme for all LLR Practices from the Royal College of General Practitioners.

(xii) There were 7 County GP practices with active Care Quality Commission and/or Risk improvement plans in place. It was agreed to provide information to members after the meeting on the percentage of GP Practices across Leicestershire that were on the improvement list.

(xiii) GP Practices were using Care Navigators to signpost patients to the most appropriate source of advice and support and the care navigators were working together with the Local Area Co-ordinators (LACs) as part of Integrated Neighbourhood Teams rather than duplicating the roles of LACs.

(xiv) In response to a request from members the CCG agreed to provide a report to the Committee for later in the year regarding the actions being taken to improve Primary Care and timescales, who was responsible for carrying out the actions and how success would be monitored. It was also agreed that this report would cover the Next Steps for Improving Primary Care: Fuller Stocktake report.

RESOLVED:

(a) That the overview of Primary Medical Care in Leicestershire including the current priorities, issues and challenges be noted with concern;

(b) That officers be requested to provide a further report regarding Primary Care for a future meeting later in the year.

12. <u>Recovery of 0-5 Health Visiting Contacts and Transition.</u>

The Committee considered a joint report of Leicestershire Partnership NHS Trust and the Public Health department at Leicestershire County Council which set out the current

position in relation to the restoration and recovery of the Healthy Child Programme (HCP) universal contacts for children and families in Leicestershire, following the Covid-19 pandemic. A copy of the report, marked 'Agenda Item 12', is filed with these minutes.

The Committee welcomed to the meeting for this item Helen Thompson, Director of FYPC and LD Services, Leicestershire Partnership NHS Trust and Colin Cross Service Group Manager for Healthy Together.

Arising from discussions the following points were noted:

(i) Members welcomed the progress that had been made with recovering the Healthy Child Programme since the Covid-19 pandemic and the plans that were in place for sustaining the service going forward.

(ii) Concerns were raised by members that the full recovery of the service was reliant on recruitment challenges being resolved and the successful implementation of the workforce plan. In response it was explained that the programme had been very reliant on the Public Health nurse and so the model had been changed to reduce that reliance and make more use of a workforce that was available in Leicestershire. For example greater use could be made of nursery nurses as they had the skills in child development and upskilling them so they could carry out assessments on children. It was a case of getting the skill mix right and using the skills that were available.

RESOLVED:

That the update in relation to the restoration and recovery of the Healthy Child Programme (HCP) universal contacts for children and families in Leicestershire be welcomed.

13. Public Health Strategy 2022-2027.

The Committee considered a report of the Director of Public Health which advised on the development of the Public Health Strategy 2022-27 ahead of the Cabinet meeting on 24 June 2022, where approval for the Strategy would be sought. A copy of the report, marked 'Agenda Item 13', is filed with these minutes.

In introducing the report the Director explained that this was the first Public Health Strategy since the Department had transferred to the County Council from the NHS in 2013. Up until now the Health and Wellbeing Strategy had been the main Strategy document along with individual strategies for areas such as sexual health and substance misuse. The aim was to include Public Health aspirations in all of the County Council's strategies, not just those of the Public Health Department.

Arising from discussions the following points were noted:

(i) Members welcomed the Strategy, particularly the emphasis on communities and putting residents' needs at its heart, and praised the initiatives that were proposed.

(ii) A member noted that the Public Health Strategy 2022-27 made no reference to tackling drug problems. In response the Director explained that the Department carried out a lot of work in this area particularly in partnership with the NHS and agreed that it should be better reflected in the Strategy.

(iii) A member suggested that current programmes being delivered in schools for tackling terrorism and knife crime could also be used for teaching about the dangers of drugs. In response the Director explained that there were strong links between the Public Health Department and colleagues working in Community Safety and one member of the Department specialised in community safety.

(iv) The community asset based approach involved viewing people in communities as assets and taking advantage of particular skills and knowledge they may have.

(v) Concerns were raised by members that only 30% of adult carers in Leicestershire had as much social contact as they would have liked (the national average was 35.5%) and it was questioned what impact the Covid-19 pandemic had on these figures. In response it was explained that the 30% figure was taken as the pandemic began and therefore was likely to be much worse now, however reassurance was given that the Public Health Department was working with colleagues in Adult Social Care to tackle the problem. Community Recovery Workers were looking at the affects of the Covid-19 pandemic and trying to encourage individuals to come out of their homes.

RESOLVED:

(a) That the Public Health Strategy 2022-27 be supported;

(b) That the comments now made be forwarded for consideration by Cabinet at the meeting on 24 June 2022.

14. Health Performance Update.

The Committee considered a joint report of the Chief Executive at Leicestershire County Council and the CCG Performance Service which provided an update on public health and health system performance in Leicestershire based on the available data on 17 May 2022 and an update on Health Inequalities as per the Leicester, Leicestershire and Rutland Health Inequalities Framework. A copy of the report, marked 'Agenda Item 14' is filed with these minutes.

The Committee welcomed to the meeting for this item Kate Allardyce, Senior Performance Manager (Leicestershire CCGs), NHS Midlands and Lancashire Commissioning Support Unit.

Arising from discussions the following points were noted:

(i) With regards to the metric '% of patients seen within 2 weeks for an urgent referral for breast symptoms' the report gave the figures for March 2022 which were 66.67% for East Leicestershire and Rutland CCG and 31.25% for West Leicestershire CCG. The figures for April 2022 were now available and there had been a great improvement.

(ii) It was noted that performance against most of the cancer targets was below the national target and therefore those metrics were rag rated as red. Much of this was due to the increase in referrals that was being received as patients began visiting their GP more after the Covid-19 pandemic. It was suggested that the Committee

could consider this matter in more detail at a future meeting and in particular how Leicestershire was performing compared to the rest of the country.

(iii) In response to a suggestion from the Chairman regarding the usefulness of regional targets as well as national targets it was explained that benchmarking did take place against other organisations in the midlands and NHS England had set up peer groups of areas with similar population and demographics which the Leicestershire CCGs could be compared against.

(iv) With regards to the Better Care For All Framework a member raised the following points:

- The Social Model of Health at page 108 made no mention of Mental Health.
- The Strategic Actions to reduce health inequalities at the ICS level at page 114 made no mention of improving patient experience and access.
- Figure 2 at page 107 which demonstrated the difference in health indicators between the most and least deprived local areas of LLR made reference to alcohol related hospital admissions but did not refer to drug related admissions.

In response it was explained that the document had been created by the Health Inequalities team at the CCG and the member's comments would be forwarded onto that team.

RESOLVED:

(a) That the update on public health and health system performance in Leicestershire and health inequalities be noted;

(b) That officers be requested to provide a report for a future meeting of the Committee regarding performance against the cancer metrics.

15. Date of next meeting.

RESOLVED:

That the next meeting of the Committee take place on Wednesday 31 August 2022 at 2.00pm.

2.00 - 3.56 pm CHAIRMAN
15 June 2022

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Agenda Item 8

University Hospitals of Leicester NHS
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NHS Leicester, Leicestershire and Rutland is the operating name of Leicester, Leicestershire and Rutland Integrated Care Board

HEALTH OVERVIEW AND SCRUTINY COMMITTEE – 31 AUGUST 2022

URGENT AND EMERGENCY CARE SYSTEM

REPORT OF THE INTEGRATED CARE SYSTEM AND UNIVERSITY HOSPITALS OF LEICESTER

Purpose of the Report

1. The purpose of this report is to provide the Committee with an update on the performance of the Leicester, Leicestershire and Rutland Urgent and Emergency Care System including the findings of a Care Quality Commission (CQC) report into the system dated 8 July 2022.

Background

2. The CQC undertook system reviews of urgent and emergency care services across England in spring 2022, as services had been and continue to be under sustained pressure. During these visits the CQC carried out a series of coordinated inspections to a range of acute, community, primary and social care services. During these they monitored calls, observed services in action and analysed data to identify how services in a local area work together to ensure patients receive safe, effective, and timely care.

Leicester, Leicestershire and Rutland CQC Inspection

3. The CQC inspected the Leicester, Leicestershire and Rutland urgent and emergency care services in April 2022 and the summary of findings report is attached as Appendix A. In summary, the report identified that the provision of urgent and emergency care in Leicester, Leicestershire and Rutland was supported by services, stakeholders, commissioners and the local authority. It recognised

that staff are working very hard under difficult circumstances. However, it also noted issues around access, demand, staffing and a high volume of admission avoidance pilot schemes may be exacerbating challenges. More details on these are included later in this report.

4. In addition, the inspection of the Emergency Department (ED) at the Leicester Royal Infirmary resulted in a Warning Notice being served, under Section 29A of the Health and Social Care Act 2008 to the University Hospitals of Leicester NHS Trust (UHL). This specific action was in relation to the care they observed for the regulated activity of 'Treatment of Disease, Disorder or Injury' in Urgent and Emergency Services.

Summary of findings and system response to the report

5. Overall, the inspection did not identify anything that system partners were not already aware of or were not already proactively trying to respond to. Health and care partners across Leicester, Leicestershire and Rutland welcomed the review by the CQC and fully accepted its findings.

6. The report acknowledges the challenges we face and recognises the hard work of health and care staff and those in care homes and other services in response to significantly increased levels of demand faced by urgent and emergency care services. Importantly it emphasises the need for a system response with all organisations involved in urgent and emergency needing to play their part to make the necessary improvements.

7. One area of note was the provision of psychiatric liaison services which were found to be well run and designed to meet people's needs. Staff demonstrated effective partnership working with a person-centred approach and good use of alternative pathways to avoid admission into acute or social care services.

8. Specific feedback included:

    a. Staff reported that they had seen an increase in people coming to their services for care and/or treatment;
    b. Some people reported difficulties when trying to see or speak to their GP;
    c. Poor patient flow across health and social care has increased the significant pressure in the emergency department, resulting in long delays in care and treatment;
    d. High number of patients remain in hospital who are medically fit for discharge but remained in acute services;

e. Long delays in ambulance handovers and the impact this has to services further increased the significant pressure on the emergency department;
f. Staff with advance skills didn't always feel empowered, or able to make referrals to alternative pathways;
g. Some staff raised concerns about having enough time to maintain their knowledge and skills.

9. The warning notice issued to UHL indicated that significant improvement was required in the emergency department and across the Trust to ensure service users receive safe and timely care. It specifically set out that improvements were needed in the following areas:

h. medical in-reach and clarity about specialities responsibilities;
i. bed availability;
j. triage;
k. privacy and dignity;
l. staffing levels.

10. Again, whilst undoubtedly disappointed, UHL accepted the warning notice as a fair assessment of a hospital which has been caring for patients with Covid for two years, has very high levels of emergency activity for this time of year, has high waits for elective care and colleagues who are tired.

11. UHL will respond to the CQC directly about some of the points they have raised – particularly in regard to the relationship between safe timely patient discharge from UHL and the Trust's ability to provide timely care to patients in the Clinical Decisions Unit (CDU) at Glenfield and the Emergency Department at the Leicester Royal Infirmary.

12. All partners have an action plan in place which focuses on reducing unnecessary attendances; improving patient flow across the system; and enabling patients to be seen in the right place first time, which we have further strengthened to address the recommendations in the CQC report.

13. Patients rightly expect high standards and quality of care and we, as a system, are fully aware of the need to drive the necessary improvements for patients. Our priority is that local people should be confident that their journey through the services should be as smooth as possible from the moment they access them.

Assurance and actions being taken in response to the report

14. System partners continue to work together to improve the urgent and emergency care pathway, and leaders are driving the change at both executive and operational meetings.

15. In addition, Leicester Leicestershire and Rutland is being supported by national leaders and regional teams who have undertaken visits and continue to provide guidance on the work underway. These visits have acknowledged the challenge the system faces and the steps being taken to address difficult and complex issues, whilst at the same time identifying areas that require further focus to improve the pathway for patients that access them.

16. Some of the multi-agency improvement work underway will:

    m. provide a more consistent care offer of short-term support for people in the community;
    n. establish criteria-led-discharge to enable more timely discharges from the wards;
    o. enable more co-ordinated discharge teams, to include, adult social care;
    p. facilitate adult social care and specialist nurses to support appropriate discharge of people that need a step-down placement.

17. UHL has undertaken additional specific actions in response to the warning notice. These include:

    q. an increase in medical in reach provision to the emergency department
    r. refresh and relaunch of the UHL Interprofessional standards, with training on e-referrals;
    s. clarification of medical responsibility for patients accepted by a speciality but awaiting a bed;
    t. revised triage process with simple streaming to the onsite Minor Injuries and Minor Illnesses (MIaMI) unit.

18. Specific examples of actions being taken across the system include:

- We have opened Urgent Treatment Centres (UTCs) across LLR, some with walk-in access. UTCs are GP-led, open at least 12 hours a day, every day, offer appointments that can be booked through 111 or through a GP referral, and are equipped to diagnose and deal with many of the most common ailments people attend A&E for. UTCs help ease the pressure on hospitals, leaving other parts of the system free to treat the most serious cases.

- Initiatives to reduce, where medically appropriate, ambulance conveyance to the emergency department. EMAS has a clinical assessment team in the 999-control room consisting of nurses, mental health professionals and paramedics who conduct further clinical

assessments of patients over the phone to help identify the best place for them to receive medical help, without requiring an ambulance

- Maximise the use of community-based alternatives where these are the right place for patients. The Integrated Care Response service is an innovative partnership between health and social care partners which is dramatically reducing the level of unscheduled hospital admissions amongst frail and older people, many of whom have suffered a fall at home. The service offers a 24/7, 365-day solution that responds to patients within two hours of a call from a home or referral by a GP.

- Expansion of the Pre-transfer Clinical Discussion and assessment scheme (PTCDA): Led by geriatricians and GPs, a discussion takes place between all relevant parties when a care home resident is at risk of hospitalisation to explore safer alternatives and a package of support

- Detailed focus on improvements to discharge processes to ensure all support is in place to support safe and timely discharge for patients. This includes the use of integrated discharge teams which bring together people from different services to plan and manage the discharge of individual patients.

- Same Day Emergency Care (SDEC) is the provision of same day care for emergency patients who would otherwise be admitted to hospital. Patients presenting at hospital with relevant conditions are rapidly assessed, diagnosed, and treated without being admitted to a ward, and if clinically safe to do so, will go home the same day their care is provided.

Quality and Safety monitoring

19. The impact of poor experience and/or harm to people who access the urgent and emergency care pathway is monitored through clinical incidents, complaints and harm reviews alongside performance data.

20. One of the biggest, most immediate and most visible indicators for an urgent and emergency care system in distress is long delays for ambulance handovers. Partners in the Leicester, Leicestershire and Rutland system continue to work to achieve improved ambulance handover times and stop people waiting on the backs of ambulances with an agreed objective of zero handovers over 30 minutes by 1st September 2022. This is deemed an important step in decreasing unacceptable risks across the pathway.

21. During periods when the system is under greatest pressure the Clinical Executive meet to provide oversight and consideration of the level of clinical risk. In doing so it risk assesses solutions put forward to mitigate patient flow issues and patient harm, and the group considers and takes responsibility for supporting less palatable solutions and positive risk taking when required.

22. A multi-agency Patient Safety Risk Summit is planned for September 2022 will provide clinicians and professionals a chance to look again for the greatest opportunities to improve the services for local people.

Conclusion

23. System partners continue to work together to improve the urgent and emergency care pathway for the people of Leicester Leicestershire and Rutland. The impact of the changes continues to be monitored closely by the System Flow Partnership and Integrated Care Board.

24. The UEC pathway and the system has support and oversight at a local, regional, and national level, and finding solutions remains a key priority. The next steps include

- Focus on practical actions that will have most impact;
- The UEC Pathway Patient Safety and Risk Summit in September 2022;
- Updating and aligning pathway improvement UEC plans;
- Continue to work with and accept support from NHS England.

Appendices

Appendix A – Summary of Care Quality Commission Inspection Report dated 8 July 2022

Appendix B – Full Care Quality Commission Inspection Report dated 8 July 2022

Officers to Contact

Rachna Vyas – Chief Operating Officer, NHS Leicester, Leicestershire and Rutland Integrated Care Board.
rachna.vyas@nhs.net

Julie Hogg, Chief Nurse, University Hospitals of Leicester NHS Trust
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A summary of CQC findings on urgent and emergency care services in Leicester, Leicestershire and Rutland.

Urgent and emergency care services across England have been and continue to be under sustained pressure. In response, CQC is undertaking a series of coordinated inspections, monitoring calls and analysis of data to identify how services in a local area work together to ensure patients receive safe, effective and timely care. We have summarised our findings for Leicester, Leicestershire and Rutland below:

Leicester, Leicestershire and Rutland

Provision of urgent and emergency care in Leicester, Leicestershire and Rutland was supported by services, stakeholders, commissioners and the local authority.

We spoke with staff in services across primary care, integrated urgent care, acute care, mental health services, ambulance services and adult social care. Staff had worked very hard under sustained pressure across health and social care services.

People reported difficulties when trying to see or speak to their GP. Some GP practices had invested in new technology to improve telephone access. Staff working in GP practices signposted patients to extended and out of hours services to prevent people attending emergency department whenever possible.

Staff working in urgent care reported an increase in demand and an increase in acuity of patients presenting to their services. Some staff reported frustrations in relation to urgent care pathways; staff working in advanced clinical practice were not always empowered to make referrals into alternative pathways.

Staff working in urgent care services reported challenges due to the volume of pilots focused on admissions avoidance running across Leicester, Leicestershire and Rutland. Many pilots ran for relatively short periods of time and were often impacted by staffing issues. This made it difficult to maintain oversight of pathways available to avoid acute services. However, some pilots had proved successful and prevented ambulance responses and hospital admissions.

Staff working across urgent and emergency care services raised concerns about their skills set. Some ambulance staff feared the shift from dealing with multiple emergencies to providing longer term care for one patient in a shift, in combination with having less time for training, impacted on their competency. Some staff in urgent care services felt they needed additional training to meet the needs of patients presenting with higher acuity.

Patients seeking advice from NHS111 in Leicester, Leicestershire and Rutland experienced some delays getting through to the service, when compared against national targets. However, at the time of our inspection, performance was better than England averages for key indicators including the percentage of calls answered within 60 seconds, and call abandonment rates. Staffing continued to be a challenge across NHS111, however recruitment was on-going.

Out of hours care had been challenging throughout the pandemic as staff were redeployed to other key services, this had particularly impacted on home visiting services.

The emergency department serving Leicester, Leicestershire and Rutland is within a large, city centre hospital. and poor patient flow across health and social care has further increased the significant pressure on the emergency department. This pressure has resulted in long delays in care and treatment. Long delays in ambulance handovers have, in turn, resulted in a high number of hours lost to the ambulance service whilst their crews wait outside hospital. This causes further delays in responding to 999 calls to patients in the community with serious conditions.

Ambulance crews reported an increase in the volume of patients calling 999 who told them they had been unable to see their GP and crews often signposted patients back into primary care.

We found psychiatric liaison services at the city centre hospital were well run and designed to meet people's needs. Staff demonstrated effective partnership working with a person-centred approach and good use of alternative pathways to avoid admission into acute or social care services.

We found that staff working across specialisms in acute services did not always provide sufficient in-reach into the emergency department to improve patient flow and the care received. This was particularly apparent at night. Beds were not allocated to patients until they had been accepted by specialists, this meant some patients spent additional time waiting in ED. During our inspection, between 45 and 60 beds were needed for new patients waiting in ED. Some patient transfers to other hospitals in Leicester, Leicestershire and Rutland stopped at 8pm, this restricted patient flow out of the city centre hospital.

Some staff reported frustrations with escalation processes across health and social care in Leicester, Leicestershire and Rutland. At times when the city centre hospital and the ambulance service was under significant pressure, staff felt there was a lack of diverts available to other sites or services and that system partners were slow to respond. There was a rapid ambulance handover process when services were in escalation; however, staff reported these were not effective.

There was a high number of patients in hospital who were medically fit for discharge but remained in acute services. System stakeholders worked together to consider discharge pathways; however, at the time of our inspections the number of patients awaiting discharge remained very high. Delays were still commonplace and capacity in community and social care services impacted on the ability of staff to safely discharge patients. Communication about discharge and discharge processes were impacting on the quality of transfers of care to social care services.

People living in social care setting experienced long delays, particularly when accessing 111 or 999 services. Although advice was provided, this had resulted in significant waits and poor outcome, especially for people who had fallen and

remained on the floor. Staff working in social care services told us they had limited access to support and advice and relied on GPs, 111 or 999.

System wide collaboration, accountability and risk sharing needs to improve to alleviate pressure on key services in Leicester, Leicestershire and Rutland.

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Appendix B

University Hospitals of Leicester NHS Trust

Leicester Royal Infirmary

Inspection report

Infirmary Square
Leicester
LE1 5WW
Tel: 03003031573
www.uhl-tr.nhs.uk

Date of inspection visit: 12 and 13 April 2022
Date of publication: 08/07/2022

Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at Leicester Royal Infirmary

Requires Improvement 

We carried out this unannounced focused inspection of both the urgent and emergency care and medical care core service because we had concerns about the quality of services in these core services. These concerns included waiting times for patients, delays in their care and treatment, delayed discharges, and delays in being able to hand over patents waiting in ambulances. We also checked the quality of services in response to a warning notice we issued following our inspection of urgent and emergency care in January 2020.

During this inspection we inspected the urgent and emergency care and medical care core services using our focused inspection methodology. We did not cover all key lines of enquiry; however, we have re-rated some key questions based on the findings from our inspection. We rated both these core services as requires improvement. Overall, we rated safe and responsive as requires improvement in both urgent and emergency care and medical care services. We did not rate the effective, caring or well led domains.

Our rating of urgent and emergency care services stayed the same. We rated it as requires improvement and have taken enforcement action as a result of this inspection to promote patient safety. We served a warning notice to the trust requiring them to make improvements to their urgent and emergency care services, to address safety concerns in respect of staff deployment, flow in, through and out of the emergency department, timely and consistent medical in-reach processes, privacy and dignity, clarity in respect of clinical responsibility when patients were referred to speciality services and triage processes.

We did not inspect surgery, services for children and young people, outpatients or diagnostic imaging previously rated requires improvement. We are monitoring the progress of improvements to services and will re-inspect them as appropriate.

We had an additional focus on the urgent and emergency care pathway across Leicester, Leicestershire and Rutland and carried out a number of inspections of regulated services across a few weeks. This was to assess how patient risks were being managed across health and social care services during increased and extreme capacity pressures.

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System wide collaboration, accountability and risk sharing needs to improve to alleviate pressure on key services in Leicester, Leicestershire and Rutland

Our rating of services stayed the same. We rated them as requires improvement because:

- The service did not always have enough staff to care for patients and keep them safe. Patients risks were not always assessed, and medicine administration was not always carried out in a timely manner which had the potential to cause patient harm.
- Patient care, treatment and access was impacted by the lack of medical review processes within urgent and emergency care services.

However:

- Local leaders and managers had the right skills and abilities to run the service and were visible to staff. They supported staff to develop their skills and take on more senior roles.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service controlled infection risk well. Staff used equipment to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

How we carried out the inspection

During our inspection we spoke with 70 staff, of various specialty and profession including consultants, doctors, nurses, pharmacists, healthcare support staff, matrons, and senior managers. This included interviews conducted after the inspection visit on site.

Our findings

During our inspection we visited the GP assessment unit, acute frailty unit, Acute Medical Unit (AMU), discharge lounge, the stroke ward 26, older people's wards 23 and 29, wards 33 and 34 and ambulatory care. We visited all areas of the emergency department.

We spoke with 24 patients and reviewed 48 patient records, including additional electronic versions.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Urgent and emergency services

Requires Improvement ➔➔

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

- There were delays in moving patients off ambulances into the ED and in triage when the department was full. This resulted in delays in assessment and treatment for some patients. Patients admitted to the department had some of their risks assessed and updated.
- People could not always access the service when they needed it and did not always receive care promptly. Specialists did not always review their patients in ED within agreed timescales which increased blockages in the department and delays to treatment. Poor hospital flow led to delays in accessing hospital beds for patients who required an admission.
- There were nurse vacancies in the emergency department (ED) and on some days, not all services operated fully due to staffing shortages. During our inspection the risks associated with gaps in the rota had some mitigation. The ED did not always have enough nursing staff with the right qualifications, skills, training and experience which increased the risk of patients suffering avoidable harm.
- There were not enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care at all times. More consultants were required to run the department safely when it was overcrowded. Patients waited a long time to see a senior decision maker.
- Due to high demands on the service, and excessive capacity pressures, the premises did not always keep people safe. There was insufficient space to accommodate all the patients in the department and some rooms were unsuitable for the purpose they were being used.

However:

- Local leaders and managers had the right skills and abilities to run the service and were visible to staff in the emergency department (ED). They supported staff to develop their skills and take on more senior roles.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service controlled infection risk well. Staff used equipment to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Is the service safe?

Requires Improvement ➔➔

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

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
Staff knew how to identify adults and children at risk of or suffering significant harm and worked with other agencies to protect them. Staff knew how to make safeguarding referrals and who to contact if they had concerns about patients. Children identified as being at risk while in the emergency department (ED) were referred to the trust safeguarding team and to the local authority appropriately. There was a system to flag up known concerns about children and families.

Urgent and emergency services

Children and adults who left without being seen were reviewed and if necessary, followed up by GP notifications.

Staff had training on how to recognise and report abuse and they knew how to apply it. All staff we spoke with said they had received safeguarding training at a level appropriate to their role. Most nurses were trained to level two adult safeguarding and level three children safeguarding. This was in line with national guidance for nursing staff in emergency departments.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. Some areas of the department included non COVID-19 patients and possible COVID-19 patients in close proximity.

Once patients were admitted to the department, staff took appropriate actions to prevent the transmission of COVID-19 and other infections. There was a designated area for patients who presented with COVID-19 symptoms or had tested positive for COVID-19. Most patients were treated in single cubicles with glass fronted doors, except in the ambulatory area and the resuscitation rooms which were fully enclosed. Suspected COVID-19 Patients who arrived by ambulance were taken to a designated waiting area until an appropriate space in the emergency department (ED) became available.

The waiting area for walk in patients was separated by portable screens which attempted to keep patients who may have COVID-19 or other infections, separate from those who were unlikely to have COVID-19. Throughout our inspection, these screens had been pushed aside by patients and their relatives who wanted more space. It was difficult for staff to always supervise the screens.

Confirmed COVID-19 cases and those with other highly infectious conditions, or highly vulnerable patients were allocated to a cubical on arrival, subject to availability. This was on the service risk register.

All areas within the ED were visibly clean and had suitable furnishings which were mostly well maintained. Furnishings, such as chairs and flooring were wipeable and easy to clean.

Managers audited staff compliance with infection control practices including hand hygiene, use of personal protective equipment (PPE) and cleaning. Compliance was reported to the infection prevention and control team and reported in the matron's quality reports. Audit results showed staff were following infection prevention and control guidance and that the ED environment was kept clean and tidy.

Staff mostly followed infection control principles including the use of PPE. Staff were bare below elbows for effective handwashing and always wore surgical masks. Staff wore disposable gloves and aprons, most of the time when required, for example when assisting patients with personal care. Not all staff wore aprons when cleaning bed spaces and some staff wore aprons for multiple tasks without changing them. Hand hygiene sinks, hand gel and PPE were available throughout the department.

Staff cleaned patient equipment after each patient use. Equipment not in use was stored cleanly. Some equipment was stored in patient bed areas and was assessible to patients. There was a risk this equipment could become contaminated between patient use. Some equipment had stickers with cleaning dates recorded.

Urgent and emergency services

Most staff had in date infection prevention and control training and all staff told us they had received updated training in donning and doffing PPE during the COVID-19 pandemic. Staff compliance with IPC training was monitored across the ED.

Rapid tests were available for COVID-19 and all patients were asked screening questions on arrival to ED. There was a policy for staff to test themselves for COVID-19 twice a week. This was not recorded by the hospital although matrons were assured guidance was followed as COVID-19 positive staff were routinely identified during this process. All staff had been offered COVID-19 vaccinations and boosters in line with national guidance.

Environment and equipment

Due to high demands on the service, and excessive capacity pressures, the premises did not always keep people safe. There was insufficient space to accommodate all the patients in the department and some rooms were unsuitable for the purpose they were being used.

The design of the environment mainly followed national guidance but the size and layout of the department did not meet the needs of all of the patients requiring access to the service. Guidance contained within the Health Building Note 15-01; Accident and Emergency Departments planning and design and the 2018 Royal College of Paediatrics and Child Health (RCPCH) guidance, Facing the Future: Standards for children in emergency care was largely followed. However, due to the reconfigurations carried out as a result of COVID-19, some areas of the ED were not suitable for the purpose they were being used.

The adult and children's emergency departments (ED) were physically separate departments and were purpose built in 2017. Since this time several reconfigurations had taken place. The environment inside the ED was light and spacious and most patient cubicles were fully enclosed single rooms.

We inspected two rooms where more than one patient received care at the same time. One room was used to monitor cardiac patients and contained two beds, separated by curtains. The room was used for both male and female patients at the same time and was located away from the nurses' station and out of view from the main area. The room also contained open shelving with lots of equipment, including neck braces and walking frames, which could get dirty or cause a trip hazard.

A small room in the ambulatory area was used to sit up to four patients on reclining chairs. This room was not designed for overnight use. During our inspection, three patients were always in the room and patients stayed there for excessive periods of time and overnight if necessary. During our inspection one patient had been in one of the reclining chairs for 18 hours. The room also contained storage cupboards and patients told us nurses had accessed these frequently during the night. Patients were on different treatments while in the room, including oxygen and intravenous (IV) therapies. Patients told us about the increased noise levels, including IV machines bleeping and nebuliser therapy. However, the patients we spoke with all told us they would rather be treated in the room than kept waiting out in the main ED waiting area. There was a standard operating procedure (SOP) for the use of this room which contained admissions criterion for patients allocated here. However, this was under review at the time of our inspection and had had not been ratified, we were therefore unable to review it.

There were insufficient treatment and assessment areas to accommodate all the patients attending the department. Patients were frequently held on the back of ambulances until a bed became available. However, no patients were cared for in the ED corridors. There were not always enough triage rooms to triage patients at a rate the staff wanted, or within guideline timeframes.

Urgent and emergency services

When the waiting area was busy, it was difficult to follow social distancing, including for patients sitting in the 'possible COVID-19 area'. Patients were asked to attend alone if possible, however family members were permitted to accompany patients when necessary.

Walk in patients were booked in at the main reception area. There were several reception staff on duty day and night. The reception desk was an oval space with seating for booking in staff and a visual assessment clinician (VAC nurse). Patients queued prior to presentation at the reception desk. Patients were advised to stand back and footprints on the floor guided patients to where they were required to stand to improve privacy.

After booking in, patients saw the VAC nurse and were asked more details about their condition. Due to the layout of the department, it was possible these conversations were overhead by other patients waiting. However, attempts had been made to limit this since our last inspection and more space was allocated behind patients while they received their VAC assessment. Privacy at the front desk and during the VAC assessment had been raised in the two previous inspections of the department and it remained on the ED risk register.

The injuries area was in a different area to the main ED. Patients who attended with suspected minor injuries were sent to the minor injury's unit. The signposts to and from injuries area were difficult to follow. The injuries area was not purpose built and lacked piped oxygen and wall suction, although portable versions were both available in the department. The patient trolleys were spread out over several rooms, which were difficult to observe and most of which also contained large amounts of storage including sterile dressings and equipment cupboards. These were not locked and were open to tampering or theft.

There was enough suitable equipment in the emergency department to help staff safely care for patients. Staff had access to emergency resuscitation trolleys for adults and children and knew where the nearest one was in the emergency department. Daily safety checks of specialist equipment had been carried out on most days.

Clinical waste was disposed of safely using separate designated waste bins for general and clinical waste and sharps buckets for sharp instruments were available throughout the department.

Assessing and responding to patient risk

There were delays in moving patients off ambulances into the ED and in triage when the department was full. This resulted in delays in assessment and treatment for some patients. Patients admitted to the department had some of their risks assessed and updated.

Patients who arrived by ambulance when the ambulance assessment area was full remained in the care of the ambulance service until they were handed over to the emergency department (ED) staff. The hospital had clinical responsibility for these patients. Patients waiting more than 30 minutes in an ambulance were assessed by an advanced care practitioner (ACP) and monitored regularly by ambulance staff.

ACPs did not always have the necessary skills and experience to appropriately assess the seriousness of every patient presenting in an ambulance. ACP's told us they had concerns about doing their assessments in the back of an ambulance, and consultants told us they had concerns that some seriously ill patients may not be allocated the correct priority score without a review by a senior decision maker on arrival. There was a concern amongst ED consultants there may be missed opportunities to identify deteriorating patients rapidly without a senior ED medical review. The ACP had access to medical staff working in the department if they were concerned about a patient. Senior medical staff were not

Urgent and emergency services

allocated to assess patients on ambulances due to a lack of senior medical staff in the ED. ED doctors told us they were concerned about the safety for patients waiting in ambulances a long time and this was on the service risk register. Mortality and morbidity meeting minutes discussed a case where the patient assessment on the ambulance had been done by an ACP and where a senior decision maker may have prioritised the patient differently.

Guidance from Royal College of Emergency Medicine (RCEM) recommends patients should be offloaded from ambulances within 15 minutes of their arrival at ED. Trust board papers from February 2022 reported that 24% of ambulances waited more than an hour to offload in December 2021. On 8 April 2022, 57% of ambulances waited over an hour to offload and from 21 March to 18 April 2022,1548 patients waited more than an hour in an ambulance. On 11 April 2022, at 8pm, the longest ambulance delay was four hours and six minutes. The average time for patients to stay on an ambulance when arriving at this ED in April 2022 was 112 minutes. It had been over 70 minutes every month since October 2021.

ED staff previously conducted harm reviews for patients delayed on an ambulance for more than 30 minutes and later adjusted this to delays of 120 minutes. They concluded there had been no incidence of significant patient harm for these patients and consequently, harm reviews were stopped for this group of patients. Instead, harm reviews were undertaken on all patients in the ED who had been waiting a 'long time'. Senior nurses told us they had identified several harms to patients in this group, including an increase in the number of patients that have sustained level 2 or 4 harm as a result of a fall in ED. Actions instigated to address this included: Booking healthcare staff to care for vulnerable patients on a one to one basis; the introduction of ward based matrons to the ED to ensure the ongoing needs of individual patients were identified quickly; and new patient chairs in each area which allowed patients to sit out of bed to prevent deconditioning and maintain patient strength.

Concerns regarding long delays in ambulance turnaround times were raised with the trust in November 2019 and the trust produced an action plan to improve flow in ED. However, this had little impact, and long delays were still a problem for many patients. Trust board minutes from February 2022 identified hospital flow and delays in discharging medically fit patients as a key issue in preventing improvements to ED performance. On 11 April 2022 at 9pm, 55 patients were waiting in ED for a bed to become available within the hospital. At the time, there were no beds available although senior managers told us some of these patients would be admitted to a bed that night.

Walk in patients were not always assessed or given treatment in a timely manner. Standards set by the RCEM state an initial clinical assessment should take place within 15 minutes of a patient's arrival at hospital. From 22 March to 18 April 2022, between 64% and 23% of patients were triaged within 15 minutes of arrival. On most days, less than 40% of patients were triaged within 15 minutes of arrival.

During our inspection we saw some delays to triage. The longest wait on 11 April 2022 at 9.15pm was two hours. Children triages were also delayed. For example; on 1 January 2022, 135 children's assessments were carried out, and only 39% were carried out within 15 minutes of arrival and on 15 March 2022, 196 assessments were done and only 26% were within guidance. Compliance on most days from 1 January 2022 to 25 April 2022 was between 50 and 60%. A lack of nursing staff and not enough clinical triage rooms had been identified as a cause of the increasing delays to triage. Delays to triage was on the service risk register.

Some of the risks associated with delays to triage and assessment of walk in patients in the ED were slightly reduced by checks undertaken by the visual assessment clinician (VAC nurse). The VAC nurse had the first point of clinical contact with patients and were responsible for assessing the patient appropriately and streaming them to the correct area for a full assessment and treatment, according to their presenting complaint. Patients were streamed to the ambulatory care area, or minor injuries clinic for example.

Urgent and emergency services

The VAC nurse allocated each patient a dynamic priority score (DPS). DPS scores were one, two or three, with one being the most urgent. Most walk-in patients were categorised as DPS two or three, and were seen in order of DPS priority, and time of arrival. However, the DPS score did not mitigate the risks of delayed triage, especially when there were insufficient nurses to offer timely triage to all patients trying to access the service. Some patients had delays in their VAC assessment. For example, on 28 March 2022, 117 patients waited more than 30 minutes and a further 47 waited more than 47 minutes which accounted for 21% of all patients awaiting a VAC assessment. Patients whose condition worsened while waiting may not be seen quickly enough because they had been allocated a lower priority DPS score. Delays to immediate treatment may lead to a rapid deterioration in some patient's conditions leading to poorer outcomes for patients. ED staff were aware of this risk which had been discussed in relation to a patient death highlighted in the mortality and morbidity meeting minutes in March 2022.

To reduce the risks of patients waiting for triage after their VAC assessment, most patients had a full set of observations undertaken in the waiting room by another healthcare professional and following which they had an early warning score calculated. During our inspection, there was a member of staff allocated to carrying out patient observations in the waiting room some of the day.

Senior staff reduced the risks associated with delays to triage by allocating only senior (band six and above) nurses to the VAC role, and also by having experienced senior nurses working in triage. This helped identify the sickest patients, or those most at risk of rapid deterioration, as soon as possible. However, this had been recognised as a risk to staffing in other areas of the ED, where experienced nurses were also required for their skills in looking after seriously ill patients.

Adult patients were assessed using the National Early Warning Score (NEWS2) as recommended in guidance from the National Institute of Health and Care Excellence (NICE), Clinical Guidance (CG) 50: 'Acutely ill adults in hospital: recognising and responding to deterioration' (2017). The NEWS2 determined the degree of illness and was based on the patient's vital signs, including respiratory rate, oxygen saturation level, blood pressure and heart rate. The score was highlighted on the initial assessment as an early warning score (EWS) which helped to identify patients most at risk of deterioration or sepsis. Sepsis is a life-threatening condition that arises when the body's response to infection injures its own tissues and organs and action is required quickly.

Patient observations were recorded electronically in all areas of the department. The electronic track and trigger system (e-observations) calculated the EWS scores and set frequency of observations and any escalation response. Most patients had their repeated early warning score carried out appropriately and in line with frequency guidance, however we saw some patients whose repeat monitoring was delayed. This included a patient with an EWS of 10 waiting more than hour before the next set of observation were recorded, and another patient with an EWS of nine, waiting nearly 90minutes before the next set of observations were recorded. Higher EWS required more frequent recordings. For example, an EWS above seven required repeat observations every 15 minutes. Staff said the risks to these patients were minimised due to their high visibility in the department, and that despite delays in recording observations for some patients, patients were regularly being checked and monitored by staff.

A large visual display unit listed each patient's EWS along with the time the next set of observations were due. Any delayed observations were highlighted in red for all staff to see. Senior nursing staff were aware there had been some delays in repeat observations and had increased the number of healthcare staff to reduce delays. There had been no incidents of harm reported as a result of delayed observations and failures to recognise deteriorating patients. Medical staff were aware of EWS and nurses escalated changes appropriately. Audits on timeliness of EWS were not undertaken in the ED.

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Nurses and medical staff were aware of recognising sepsis and we saw no delays to treatment for suspected sepsis patients during our inspection. Sepsis treatment and recognition was audited in ED. Results for March 2022 showed 21 patients out of 226 patients, waited more than three hours for their antibiotics. Compliance with antibiotic administration within one hour for March 2022 was 62%. This was similar to the monthly compliance from April 2021 to February 2022. The trust shared three incidents from January 2022 to April 2022, including one resulting in moderate harm, where patients in ED had not received sepsis care in line with trust policy or national guidance. Reasons for this were recorded as lack of review by speciality team, and/or an overcrowded ED.

The trust had a policy which required venous thrombus embolism assessments (VTE) to be carried on all patients in the ED if they had been there for more than 14 hours from their time of arrival. We did not see any VTE assessments undertaken in the patient records we looked at when patients had been in the department for over 14 hours. The trust were aware of low compliance with VTE assessments and had carried out a risk assessment on the likelihood of harm for patients of not getting an assessment. The assessment concluded the likelihood of harm was low and this was listed as a moderate risk on the trust risk register. From January to March 2022, trust data showed an average of 350 patients per week met the trust's criteria for a VTE assessment in ED. During most weeks, only one patient had received a VTE assessment and some weeks, no patients received one. VTE assessments were the responsibility of the speciality teams who had accepted the patient. There was an action plan to improve this. Actions included adding the VTE assessment to the Inter-Speciality Professional Standards document and setting up a medical in reach team plus adding VTE assessments to electronic prescribing. These actions were not in place at the time of our inspection.

Other assessments undertaken included falls assessments, pressure risk assessments and care rounding, which recorded care interventions, for example the times patients were offered food, or repositioned. We did not find any omissions in these assessments during our inspection. Matrons told us they audited patient assessments and documentation and that no areas of concern had been identified as a result of these audits.

Emergency nurse practitioners were responsible for the care of patients in the injuries area which was open from 7.30am to 2am. There was a doctor present in MIU from 8am to 5pm and occasionally from 6pm to 10pm. When the ED was short staffed, ENP's were moved from the injuries area to cover the main department. This meant on some days the skill level in injuries area was not optimised. The injuries area was located away from the main ED leading to potential delays in accessing immediate senior support for deteriorating patients.

Some patients were streamed to an on-site urgent treatment centre (UTC) operated by another healthcare provider, which did not form part of this inspection. Patients were also directed to the UTC following full triage, or alternatively, the UTC accessed the ED waiting list, and actively chose patients to treat. There was a standard operating procedure (SOP) for this service which listed inclusion and exclusion criteria. Trust and UTC staff audited patients which were sent back to the ED following a referral to the UTC. Audit results showed an average of 5% of patients returned to the ED each week for a variety of reasons, including deteriorating conditions, alternative diagnosis, further tests or inappropriate referrals. Each case was examined for learning, and if required, extra training for referring clinicians was organised. The current UTC arrangement was temporary and trust leaders told us it was due to be relocated and redesigned by late Spring 2022, although longer term funding had not been agreed.

In the children's ED, not all nurses undertaking triage had received specific children's triage training, but the trust's triage training module was a combined programme covering both adult and children's triage skills. Adult nurses working in the children's department had completed paediatric competency training. There was a clinical sign off after nurses had been supervised in assessing both adults and children.

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A patient management screen displayed an overview of patients in the ED. It showed the length of time each patient had been in the department, or on an ambulance, or were waiting for triage, or treatment. Managers saw where the greatest risks were and moved staff and resources around accordingly. Senior trust staff outside of the ED had access to the screen and viewed live information. A bed flow manager was based in the department every day and liaised with site managers, matrons and doctors to access beds for patients as soon as possible.

Risks were discussed at regular bed meetings every day. This included capacity in the department and the hospital, and staffing across all services. Staff were moved around the hospital to reduce risks in each area. Concerns and risks were shared and discussed at daily ED huddles and there was good oversight of daily issues by the senior ED team.

The service had 24-hour access to mental health liaison and specialist mental health support. Mental health support was available 24 hours a day. ED staff were aware of caring for patients with specific mental health needs, including carrying out risk assessments, and had received training on how to do so. ED staff referred patients to appropriate support services in batches of four or five, rather than individually on arrival and there were delays from 90 minutes to two hours during our inspection. The local commissioning groups had not set targets for wait times.

Staff shared key information to keep patients safe when care was handed over to other departments. However, for some patients who were in the department for more than 24 hours, this meant repeated handovers between several different ED teams. Some patients were handed over three times to both nursing and medical staff. There was a risk key information about a patient's care and treatment may get missed or delayed.

Nurse staffing

There were nurse vacancies in the emergency department (ED) and on some days, not all services operated fully due to staffing shortages. During our inspection the risks associated with gaps in the rota had some mitigation. The ED did not always have enough nursing staff with the right qualifications, skills, training and experience which increased the risk of patients suffering avoidable harm.

Managers regularly reviewed staffing levels and skill mix and moved staff to keep patients safe**.** Nurse staffing in the ED had been established as 34 nurses per day however, we were told the department had contingencies to function safely with 28 nurses. This included reducing the number of nurses taking triage, and the number of nurses working in the children's department. Children's nurses told us the department often closed beds, or areas, in the children's short stay unit due to inadequate staffing to keep patients safe. The children's department staffing establishment was nine per day shift, four of whom were required to be paediatric trained. Nurses told us this was not always achievable and there were occasions when only one paediatric nurse was on duty. During our inspection, there were two advance care practitioners and one emergency nurse practitioner, who were all registered children's nurses working in the paediatric emergency department. The 'Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings' document titled, "Standards for Children and Young People in Emergency Care Settings" (2012) recommends that EDs should have a minimum of two paediatric trained nurses per shift. Nurses working in the paediatric ED had completed children's nursing competencies including recognition of the sick or injured child, paediatric life support skills, and the ability to initiate appropriate treatment.

The ED rota from 14 March to 10 April 2022 showed nurse staffing gaps on most days. For example, on 14 March 2022, there should have been 34 adult nurses on the late shift, plus four twilight shift nurses. However, only 25 nurses were on the late shift and there were no twilight nurses. This meant at peak time in the early evening, the department was 13 nurses short. However, on some days, more staff had been on duty than planned. Senior nurses told us this enabled the department to flex staff across the whole of the service and place nurses wherever they were most needed.

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The nurse vacancy rate was 20% for adult nurses and 25% for paediatric nurses. New nurses attended a trust induction and a local induction and were given competency booklets along with a full programme of mandatory training. Bank and agency staff were used and nurses from other wards or departments were moved to the ED if necessary, to keep patients safe. Agency staff used were regular staff who knew the department and were experienced ED nurses. New bank and agency staff underwent a local induction in the department.

Incidents relating to nurse staffing shortages had been reported across all areas of the ED. This included the paediatric ED, majors, and the ambulatory and ambulance assessment areas. The incidents demonstrated the extra delays patients experienced while waiting to access the service. There had been no serious harms reported as a direct result of staff shortages.

Nurse staffing was on the service risk register. Senior nurses continually recruited nurses and had recently appointed a group from oversees who were awaiting their conversion training. There were some mitigation to cover staffing shortages which included daily ED safety huddles and twice daily nurse staffing meetings across the trust. Nurses were moved across the emergency floor to where the risk was greatest. Other actions included opening and closing areas as necessary, including the GP assessment unit and asking matrons and senior nurses to cover clinical shifts.

Medical staffing

There were not enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care at all times. More consultants were required to run the department safely when it was overcrowded. Patients waited a long time to see a senior decision maker.

Consultants were in the ED 8am to 1am every day which met the Royal College of Emergency Medicine (RCEM) recommendation of 16 hours consultant presence every day. Consultants stayed longer in the department at night if required. An on-call consultant covered the out of hours period seven days a week.

During our inspection, consultants told us there were not enough of them to cover the whole of the department safely, all of the time. This had been mitigated to some extent by increasing the number of registrar grades working each day. Nevertheless, consultants said they felt under enormous pressure in the department due to the demands of the service.

There were 30 whole time equivalent (WTE) consultants working in the ED against a target of 31 WTE. Consultants told us they believed more than 45 consultants were required for this department due to the number of patients using the service. We did not see any evidence of direct harm to patients due to consultant shortages, however, many adults and children waited a long time to be seen, treated and admitted or discharged. Consultant meeting minutes recorded that even having a full complement of staff, the daily staffing did not allow for safe effective care for all patients.

Eight paediatric consultants worked in the paediatric ED. Consultants from the adult department provided cross cover for paediatric ED when required. Paediatric consultants worked from 8am to 1am and registrars with specialist training in paediatric medicine covered out of hours. Senior paediatric support was available from the children's ward if required in an emergency.

Junior doctors told us they felt supported while working in the department and had been exposed to some good learning opportunities. Trust leaders told us the junior doctor survey gave largely positive feedback. Registrar staff said they often worked outside of their specialist area to meet the demands of the service.

Medicines

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Staff did not always follow systems and processes when safely prescribing and administering medicines. However, medicines were stored securely.

The process for enabling patients' timely access to their regular time critical medicines whilst they were held in the ambulance awaiting access to the department was not always safe. When patients were identified as having a time critical medicine, they were prioritised for admission. If a space was not available in the ED there was no process to enable patients to have access to these medicines whilst they remained on the ambulance. Once patients were in the department, they had timely access to their medicines.

The trust used a paper-based prescribing and medicines administration system in the department. We looked at seven prescription records and saw that drug histories and allergies were recorded to allow for safe prescribing of medicines. Initial venous thromboembolism (VTE) risk assessments had not been completed for any of these patients, despite patients being in the department for between 18 and 23 hours.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines.

A clinical pharmacist was based in the department Monday to Thursday as part of the frailty team. They reviewed patient's medicines, spoke to patients about their medicines and liaised with care homes if required. No pharmacist support was available to the wider department to provide regular clinical support to staff, but staff did know how to contact a pharmacist when they needed them.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy. Medicines, including controlled drugs and IV fluids, were stored securely. Prescription pads were stored securely and there was an audit trail to monitor use of these forms. Prescription charts where kept outside the individual patient bays, in an area accessed only by hospital staff.

Staff followed current national practice to check patients had the correct medicines. Patients drug allergies and regular medicines were recorded by the assessing doctor. Staff had access to summary care records to support this process.

Is the service responsive?

Requires Improvement 

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

Access and flow

People could not always access the service when they needed it and did not always receive care promptly. Specialists did not always review their patients in ED within agreed timescales which increased blockages in the department and delays to treatment. Poor hospital flow led to delays in accessing hospital beds for patients who required an admission.

Waiting times and treatment times were monitored and compared to national standards. There were systems to manage the flow of patients through the emergency department (ED) and to discharge or to admit patients to the hospital. Senior managers could view the length of time each patient had been in the department, and what they were

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waiting for, including speciality reviews or bed admissions. The system displayed the number of patients arriving at ED from ambulances and by walk ins. The data was discussed at bed meetings during the day. However, due to the number of people using the service, and capacity issues within the rest of the hospital, there were long delays in accessing assessment, treatment and admission or discharge, and national targets for ED care were not met.

The inability to review and admit patients in a timely way increased overcrowding and reduced flow in the department. The Department of Health and Social Care standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department. This is known as the Emergency Access Standard (EAS). The England average EAS is 75%. The trust's February 2022 board papers reported the EAS for December2021 as 69%. During our inspection, on 10 April 2022 the EAS was 46% and on 11 April 2022 it was 55%. On 1 April 2022, the average waiting time for a decision to admit, discharge or transfer was over five and a half hours. From 21 March to 18 April 2022 the trust failed to achieve an EAS greater than 61% on any day.

Some patients waited more than 12 hours before a decision about their care was made and waited even longer for a hospital bed to become available. In December 2021 the trust reported 582 breaches for 12 hour trolley waits. During our inspection on 12 April 2022, 42 patients waited more than 12 hours and from 21 March to 18 April 2022, 853 patients waited more than 12 hours. On 11 April at 9pm, the longest wait in ED for a hospital bed was 24 hours and 46 minutes.

There were delays in specialists reviewing their patients in ED. The Inter-Speciality Professional Standards document required specialities to review their patients in ED within 30 minutes of receiving the referral. This standard was not upheld by clinical leaders across specialties which directly impacted on patient care in the department. ED staff had done a one off audit which demonstrated a clear deviation from the 30-minute rule. Senior managers across the trust were aware of this and repeatedly failed to enforce the standard, which had been raised as an issue since 2010. This was highlighted as a concern during our last inspection in December 2019, and except for some surgical specialities where improvements had been made, it still remained a serious concern.

Some speciality teams were based offsite and carried out virtual reviews. Medical patient reviews were not undertaken out of hours and patients arriving in ED after 10pm waited until the following day for a medical opinion. There was no in reach medical services in the department, although leaders told us they were making plans to introduce it. We were not told of a date when this service would be implemented.

The lack of medical doctors in ED led to many patients waiting in the ED longer than necessary resulting in delays in decisions about their care, and delays in commencing specialist treatment. Senior ED doctors were concerned that some patients deteriorated without early intervention from specialists and said that some patients were admitted to a hospital bed unnecessarily due to a lack of face to face specialist reviews in ED.

There were insufficient beds available in the rest of the hospital to accommodate all the patients in ED who needed admitting. Throughout most of our inspection, there were more than 50 patients waiting for a bed in the trust. ED doctors were frustrated by a lack of progress in addressing the trust flow issues and poor hospital flow was identified as having a major impact on the care of their patients.

Surgical in reach was available 9am to 5pm along with the same day emergency care (SDEC).

ED escalation levels were determined by the regional health economy Operational Pressures Escalation Levels (OPEL) management system. OPEL levels were graded one to four. OPEL one was normal working, and four was the department was under severe pressure, and unable to sustain business as usual. The ED had been operating at OPEL four for several weeks prior to our inspection. The trust had activated their 'Capacity and Flow Escalation Policy and Whole Hospital

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Response to Emergency Care Demand' which included steps to be taken during OPEL four. During our inspection the trust told us it was carrying out the actions listed in the policy including identifying patients suitable for discharge as soon as possible and allowing discharges up to 11pm at night. When necessary, patients who were waiting on a ward for an admission to a hospital bed were bedded in areas and on beds which were not properly configured. The trust did have a standard operating procedure which staff followed when this was required. The OPEL level was regularly communicated within the trust and to stakeholders to ensure the wider health and social care systems were aware of the current access and flow status.

In January 2022, 9% of patients left the department without being seen. This had increased from the previous year when 2% of patients left without being seen. Nearly 8% of patients who attended the ED in January 2022 reattended within seven days, compared with less than 1% in January 2021.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs. When the department was working above capacity, not all individual needs could be accommodated all of the time.

Staff were discreet and responsive when caring for patients admitted to the unit. Staff interacted with patients in a respectful and friendly way. However, due to the volume of patients using the service, and overcrowding in some areas, some patients had their conversations overheard by others and it was difficult to share confidential information privately.

Some areas of the ED provided mixed sex accommodation overnight. This was permitted and within national guidance on mixed sex rules in emergency care but it was difficult for staff to always respect the individual personal, cultural, social and religious needs of each patient cared for in these areas.

When the department was full, some patients individual care needs were not met. For example, patients who had been in the department for many hours told us they had not been offered assistance or facilities to wash. However, as the department was established for emergency care, and not intended for long stay patients, it was not staffed or built to facilitate one to one personal care for lots of patients. Senior nurses had recognised this and had recruited more healthcare assistants to help provide hands on nursing care, which was more akin to traditional inpatient ward-based care. They had also facilitated increased access to one to one care for individual patients when this was required. Nursing care rounds had been completed on most patients in a timely way.

Most patients were aware what they were waiting for in ED. Some patients admitted to the ED were unaware of the next stage of their ED journey and this was particularly noticeable in patients who were told they were waiting for a bed to become available in the hospital, but they had no idea where or when this would be.

Is the service well-led?

Inspected but not rated

Leadership

Local leaders and managers had the right skills and abilities to run the service and were visible to staff in the emergency department (ED). They supported staff to develop their skills and take on more senior roles.

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The senior leadership team for emergency care was led by a head of nursing, an operations director and a clinical director who were all experienced leaders with strong decision making abilities and had the appropriate levels of operational knowledge to lead the department in pressurised circumstances. Both directors were responsible for care across the emergency department service and the medicine service. There was an emergency care consultant who was responsible for clinical care in the department, and who worked alongside the head of nursing to provide local leadership direct to the ED team.

The clinical leadership team were very visible in the department. Staff knew who they were and how to contact them if they needed support. Leadership was clear, positive and collaborative. It was clear from all staff we spoke with that leaders were supportive of their staff and passionate about their service. They were aware of how the ED environment and pressures in the workplace affected the welfare of their staff. They worked hard to ease the pressures of working in such a busy environment.

A senior nurse oversaw care in each clinical area. It was not always possible for us to identify who that person was, however, junior staff told us they knew who to ask if they had queries or concerns about patients.

The nurse in charge of the shift had responsibility for overseeing the smooth running of the whole department, including monitoring waiting times and moving staff around the department to cope with demand and capacity. They escalated patient concerns to medical staff or senior managers when and if appropriate.

Senior staff in the department were fully aware of the challenges they faced and felt the full responsibility of delivering a safe service for all. The medical team and the nursing team worked well together and spoke highly of each other's abilities and support.

ED consultants were represented up to executive level by a medical consultant who was not trained in emergency medicine and who also represented the medicine team. This was raised by staff as a concern as it meant the ED leadership team did not have direct and independent access to the board. It also represented a potential conflict of interest between medical doctors and emergency care doctors. There was additional concern that decisions may be made at board meetings about the department without independent ED presentation being present. This was raised during our previous inspection in December 2019. Consultants told us they were able to approach any of the senior leadership team freely and discuss any concerns they had, however, formal representation and feedback to the senior leadership team was via a doctor from the medical speciality.

Since our last inspection, the trust had established an urgent and emergency care strategic board (UEC board) which included ED physicians along with other healthcare providers including GP's, ambulance services and clinical commissioning teams and which fed into the trust board.

Staff development was encouraged at all levels and senior staff told us they were proud of the department's ability to 'grow their own' senior staff. Nurses told us they were encouraged to apply for more senior roles within the department and registrars were supported to apply for consultant grade status. This enabled staff to develop their clinical and leadership skills in an area where they already had a good working knowledge and the support of good teamworking.

Management of risk, issues and performance

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The service had systems to monitor performance. Relevant risks were identified and escalated, and some actions were taken to reduce their impact, other actions were not effectively implemented or monitored. Performance in the emergency department (ED) was not in line with the national average, and patients waited a long time to be seen, treated, and admitted or discharged. A lack of patient flow in the hospital hindered the department's ability to make progress.

The department risk register listed several high-level risks, most of which were lowered to some degree by mitigating actions. For example, children's triage times had a risk score of 16 (high risk), which was reduced to 12 (medium risk) by the introduction of visual assessment clinicians (VAC nurses), which prioritised those waiting for triage.

Medical and nursing workforce capacity in the major's area was risk rated 20 (high risk) in November 2020 and remained so even after controls were put in place. It was due for review in April 2022. The risk record stated that the department sometimes functioned at 200% capacity. One of the control measures in place was the maintenance of the Inter-Speciality Professional standards which required admitting specialities to review their patients with 30 minutes. Staff of all grades told us that this standard was continually not met and posed a risk to patients using the service.

ED consultants audited speciality response times and shared the findings with senior trust leaders. The audit demonstrated long delays and showed that the Inter-Speciality Professional standards were not being adhered to. Senior leaders told us they were making plans to address this and to remove unnecessary delays. However, delays in speciality reviews had been a concern in the department since 2010 and ED staff told us very little had been done to improve the situation. Delays were seen particularly for medical patients requiring cardiology and respiratory reviews, along with oncology patient reviews. Trust plans to address the issue included an in-reach medical team based in the ED 24 hours a day, seven days per week and having cardiology and respiratory physicians based in ED, although there was not date when this was expected to start.

Some specialities had improved their response times since our last inspection, and staff in ED highlighted that most of the surgical division were now very supportive.

Risks remained for patients who were waiting a long time in the ED. The senior leadership team had committed to look for harms as a result of patients waiting in the department for 'a long time' and had instigated some plans to reduce the risks for these patients. However, for some areas of concern, the risks remained unmitigated. For example, not all patients who required a VTE assessment had received one, and not all patients suspected of sepsis were treated within the appropriate timescales.

It was difficult to establish who had clinical ownership of patients who were waiting in ED for a hospital admission. While the trust medical director's position was patients in ED who had been accepted by speciality teams, were the responsibility of the speciality team, clinical directors had failed to enforce it. This was evidenced in minutes from a meeting between the trust medical director and ED consultants in April 2022.

It was not possible to mitigate all the risks associated with running a department at 200% capacity, and when there were more than 200 patients in the department it was difficult to have thorough oversight of every patient. Opportunities existed for patients to deteriorate rapidly without being detected. For example, in majors, not all patients had their early warning scores reassessed in line with guidelines, and some walk-in patients were in the department for more than an hour before a set of observations were recorded.

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Hospital flow was recognised by the senior leadership team as a serious risk to the department's ability to provide safe care and treatment and achieve the performance standards required by both the royal colleges and NHS England. There was an action plan which focussed on improving this. The plan was updated regularly, and the key interventions were priorities by the trust.

The action plan had been developed with colleagues across the trust and the urgent and emergency care pathway and was aligned with the system urgent and emergency care (UEC) plan. The action plan was monitored through the trust UEC steering group who reported to the Executive Finance and Quality Board, and the Operational Performance Committee.

The largest group of actions were designed to either manage the flow in, manage the flow through, or manage the flow out. It included:

- Increasing the urgent treatment centre capacity;
- Working with primary care to prevent unnecessary ED attendances;
- Reviewing trust discharge process;
- Increasing medical in reach into ED;
- Having some cardiology and respiratory doctors based in the ED;
- Changing patient pathways;
- Virtual ward expansion; and
- Completing capacity reviews with the system.

Flow in, and flow through actions were dated Spring and Summer 2022. Most flow out actions were later in the year. Other key actions included improving live data visibility, with regular reporting on speciality review times and more medical input direct in ED.

One of the actions, to be completed by June 2022, was to set up speciality level review meetings to define response times and the actions speciality teams needed to undertake to ensure swift response to ED. The actions required were to be defined by the individual speciality. However, an acceptable response time already existed, in the form of the Inter-Speciality Professional standards document, which considered 30 minutes to be acceptable. It was therefore difficult to see what impact this action would have.

Some actions to ease pressure in the ED had centred around increasing ED capacity, for example by moving the injuries area away from the main ED. However, this had not improved patient flow in the department, as the main disruptor to the service was the lack of flow out of the department.

Some patients from the ED required an admission to hospital to receive a specialist review. However, if specialist reviews had been done in the ED, some patients may not require an overnight admission to a hospital bed and could be discharged straight from ED. This would potentially have a positive impact on flow. NHSEI were supporting the trust with patient discharges to improve flow.

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ED mortality and morbidity meetings took place to discuss any deaths which had occurred unexpectedly in the ED and were used to identify learning and reduce risks to patients. The reports from March to April 2022 showed several cases had been discussed which highlighted the 'busyness' of the department, the 'lack of available cubicles for sick patients' and, 'seeing so many patients in one day'.

The risks of running the department without sufficient staffing were recognised, and recruitment attempts were ongoing, particularly to nursing roles. Further risks of running the department without always having the necessary skills were also recognised. For example, the lack of senior medical staff meant there were no regular reviews for patients delayed on the back of ambulances, which had led to potential missed diagnosis, and the lack of available experienced nursing staff to triage and carry out the VAC role meant some minor injuries clinics ran without sufficient seniority.

Senior clinical staff told us about the pressure they felt working in the department faced with the everyday overcrowding and capacity risks. The trust were aware of this pressure, and had tried to assure staff these risks belonged to the trust and the system and not to individual ED staff. Trust board papers from February 2022 report that the ED Friends and Family Test indicated higher levels of dissatisfaction around waiting times and delays and recorded that work was being undertaken to improve the communication with patients who were waiting.

Culture

Staff and managers working in the emergency department (ED) promoted a positive culture that supported and valued one and other. Staff were respectful of each other and demonstrated an understanding the pressures they each faced.

Nurses and doctors in the ED spoke very highly of each other and worked well as a team. There was a good understanding between staff in different roles and the pressures they each faced. All staff spoke highly of the local team. ED nurses and doctors worked well together.

Nursing staff said they knew who to approach if they had concerns and some told us they had raised issues with line managers or matrons in the past and that they had been supported and encouraged in this process. Staff told us they felt comfortable in reporting incidents, although some said they did not always receive feedback.

Clinical leaders were highly visible in the department and it was clear they were respected by their teams. Matrons and other senior staff worked clinical shifts in the department regularly to cover staff shortages and help teams deal with the workload. There were team meetings and daily huddles where staff could raise issues.

Junior doctors spoke highly of their training experiences in the department and said their consultants were very approachable.

There was a disconnect between the culture of supportiveness within the ED, and that felt by staff working in ED from other areas of the hospital. Staff said many of the problems within the ED were the result of other services within the trust not taking responsibility for their patients, yet it was perceived that the onus was on ED staff to solve the issues.

The trust senior leadership team (SLT) told us about their regular department walkabouts and drop-in sessions, plus their open-door policy. ED consultants and senior nurses confirmed they had access to trust leaders. However, some

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staff said they had not seen the SLT in the department, and that they were not aware of the walkabouts. Some staff told us about personal welfare issues which they believed were the result of the ED workload and daily pressure in the department. They believed not enough was being done to address these issues and were concerned about 'good' staff leaving the service due to unsustainable levels of pressure.

Areas for improvement

Action the trust MUST take to improve:

- The trust must ensure that patients arriving by ambulance are handed over to trust staff in a timely way. They must reduce the length of time and the number of, patients who are cared for in the back of an ambulance Regulation 12 (2) (a) (b) (i)
- The trust must ensure that all patients are triaged and assessed in a timely manner and ensure that patients receive assessment and treatment in appropriate environments.
- Safety measures to protect patients must be implemented to ensure all environments are safe for all patients using them. Regulation 12 (2) (a) (b) (i)
- The trust must ensure that patients receive medical and speciality reviews in a timely manner. Regulation 12 (2) (a) (b) (i)
- The trust must ensure all patients delayed on the back of an ambulance have an assessment carried out by an appropriately skilled and experienced decision maker. Regulation12 (2) (a) (b) (i)
- The trust must ensure that the ED environment is established in a way which always protects the dignity of all patients using the service. Regulation 12 (a)
- The trust must ensure that there are enough consultants working in the department to keep patient safe when even in times of overcrowding. Regulation 18 (1)
- The trust must ensure that there are always enough nurses working in the department every day in order to keep patients safe. Regulation 18 (1)

Action the trust SHOULD take to improve:

- The trust should ensure that governance processes are sufficiently robust. Actions from action plans and other improvement initiatives should be verified to ensure they have been effectively implemented and where appropriate, change audits undertaken to demonstrate sufficient improvements have been made.
- The trust should consider improving emergency department consultant representation at executive level.
- The trust should ensure all staff wear and change their personal protective equipment in line with local and national guidance.
- The trust should ensure all patients waiting on the back of an ambulance receive their critical medicines in a timely way.

Medical care (including older people's care)

Requires Improvement 

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

- Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service managed infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service mostly managed safety incidents well and learned lessons from them.
- Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- The service did not always have enough staff to care for patients and keep them safe. Falls related incidents remain a concern with over 60% of reported serious incidents, relating to falls.
- Key services were not always available seven days a week.
- In-reach services to ED were not always available.
- Staff told us that the reduced staffing levels impacted on their wellbeing at times.

Is the service safe?

Requires Improvement 

Mandatory training

The service provided mandatory training in key skills, which included the highest level of life support training, to all staff and made sure everyone completed it.

Systems were in place to monitor staff training and highlight areas for improvement. We saw that the electronic system recorded mandatory training for each member of staff and could be used to identify any noncompliance. On all wards we visited, staff had a 100% completion rate for mandatory training, which was clearly linked to staff appraisals.

Staff told us that they had completed the mandatory training but found it difficult to access some of the supplementary training, to develop in their roles.

Cleanliness, infection control and hygiene

Medical care (including older people's care)

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves, and others from infection. They kept equipment and the premises visibly clean.

The service performed well for cleanliness. Ward areas and equipment were clean and well-maintained. Staff completed safe cleaning processes on all wards visited. This was in accordance to the trust policy for Infection Prevention and Control (IPC).

Signs describing the procedures for good hand hygiene and use of protective equipment, were located appropriately in all areas.

Staff used the relevant protective equipment and followed hand hygiene processes, when caring for patients. There was good access to face masks, hand gel and equipment cleaning materials.

Patients that had been identified as having an infection, such as COVID 19, were isolated to prevent further spread of infections. Patients and the areas they were admitted to, were managed safely.

We saw doctors cleaning stethoscopes with sterile wipes between uses.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.

Staff completed daily safety checks of specialist equipment such as resuscitation trolleys, hoists, and beds. All wards and departments we visited had emergency resuscitation trolleys available. These were locked and secure. We found all checks were completed daily with the name of the staff member, date, and their signature.

Patients could reach call bells to alert staff if they required assistance. We saw that staff reacted to the call for assistance in a timely manner. However, one patient told us that at night the staff did not always respond quickly. We observed that some patients did not use the call bells and routinely shouted the staff for assistance. All patients we spoke with told us that they knew how to use the call bell system and that they were available to use.

Due to the impact of COVID 19 pandemic, some wards had stopped using communal areas, such as day rooms, to reduce the risk of infection. Wards had not reintroduced access these areas to patients. On the wards we visited these areas were maintained well and remained part of the cleaning schedule. Some rooms had been re-purposed to suit the needs of the ward.

All areas within wards were part of a daily cleaning schedule which was checked and signed for by staff to ensure a good level of cleanliness. Areas could be cleaned on request outside of the cleaning schedule.

Staff disposed of clinical waste safely. Staff used separate and designated waste bins for general and clinical waste disposal.

Staff gained access to wards and clinical areas with electronic cards or a security code, to ensure controlled access to wards.

Medical care (including older people's care)

Visitors accessed the ward using a call bell, which enabled staff to monitor visitors and patients entering the wards. We saw examples where staff challenged visitors to ensure only appropriate access was gained, when visitors had followed staff into wards.

Assessing and responding to patient risk

Staff completed risk assessments for each patient. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration. However, falls related incidents remain high.

Staff completed risk assessments, in line with policy, for each patient on admission or arrival, using a recognised tool, and reviewed this regularly. Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The National Early Warning Score (NEWS2) was used to identify patients at risk of deterioration.

All areas had a screen to display information electronically, a dashboard for review of relevant risk assessments, such as NEWS2, with colour coding to aid in recognising patients at risk. The use of an electronic system meant senior nursing staff and medical staff had an oversight of the clinical risk of unwell patients. Patients identified as deteriorating were escalated to senior clinicians for re-assessment. Review by a specialist consultant could be facilitated to ensure appropriate care was given to the patient. However, cardiac, and respiratory patients could experience delays in respect of face to face specialist consultant input.

An electronic system was used to help manage patient risk and provide clear and up to date information to staff. The system provides flags linked to risk, along with information on referrals. Multi-disciplinary teams had access to the system and information was clearly available to show which staff were caring for the patient, levels of risk and referrals to specialist services.

We saw the use of Glasgow admission prediction score (GAPS) to aid in identifying patients for ambulatory care pathways. This supported the admission process and did not rely on clinical decisions alone.

Wards had daily safety huddles to discuss risks and care plans for the individual patients on wards. A record was kept ensuring all staff had access to the information discussed in safety huddles. Safety huddles were done several times a day to discuss changes in risk or to keep staff informed of relevant information.

We observed safety huddles and reviewed notes taken on wards. A multi-disciplinary approach was taken, and staff discussed, patient care, risks of falls, pressure area care, sepsis, and other patient related care plans. Equipment issues and staffing levels were also discussed and escalated appropriately.

Although assessments were managed well using the electronic system, of three assessments we looked at, we found that a venous thromboembolism (VTE) assessment had not been re-assessed in the appropriate time frame.

There had been an improvement in the recording and management of falls since July 2021. Assessment and management of the risk of falls was completed by staff, with the support falls lead nurses, and flagged appropriately. We saw six patient falls assessments completed correctly and appropriate follow up assessments. These were available electronically and in paper notes. However, falls related incidents remained a concern with over 60% of reported serious incidents relating to falls.

National audits for falls indicate that the trust meet all the required standards and practices for falls management.

Medical care (including older people's care)

Staffing

The service did not always have enough staff across the medical care services which had been identified as a risk, by the trust. Most areas did not have enough staff to meet the planned commitment and that sickness levels had impacted on the availability of staff to be redeployed. However, there were systems that allowed twice daily reviews of staffing levels and senior managers were able to prioritise where staff were needed.

Nurse staffing

The service did not always have enough nursing staff and support staff with the right qualifications, skills, training, and experience to meet planned levels. However, managers regularly reviewed staffing levels and skill mix, and escalated concerns appropriately.

There was a vacancy rate of 25% and a 10.4% sickness rate across the nursing staff in medical specialties at the time of our inspection. This caused some wards to be short staffed. These issues were escalated, and nurses were often re-deployed to other areas during their shift.

Managers calculated and reviewed the number of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance, but this was not always achievable due to vacancies and sickness.

Bank and agency staff were used to fill gaps in rotas. These staff had an induction and were trained appropriately. Some substantive trust staff decided to work as bank nurses during the COVID pandemic. However, many of the bank and agency staff return to the same wards regularly to ensure consistency.

The recruitment of overseas nurses has resumed, following a pause due to the COVID pandemic, to help address the issues with staff shortages. The trust has also recruited nurse associates to support nurses and have implemented pathways for them to progress to registered nurse training. There had been an increase of 3% in staff employed by the trust in medical care services in 2021.

On the day of our inspection, the actual nurse staffing did not meet planned nurse staffing levels on five wards visited. These issues were escalated at twice daily meetings and with the manager on call.

Staff were shared within and across each of the three main hospital sites, within the trust, to manage staffing levels and prioritise care for patients. We saw an example where a nurse had been moved from ward 33 to AMU to cover.

The trust used a safe care electronic tool to monitor staffing levels and ensure staff were utilised across the service. This could be accessed by all on call managers and by ward staff to see the staffing in their area.

We saw matrons working with senior sisters to coordinate staffing levels to help support areas with lower staffing and higher patient acuity. On occasions matrons became part of the nursing team to support with patient care. Discharge co-ordinators, when available, and housekeepers (who cover nutrition and hydration), were also used to help free up nurses from some tasks.

Medical staffing

Medical care (including older people's care)

The service did not always have enough medical staff with the right qualifications, skills, training, and experience to meet planned levels. Managers regularly reviewed staffing levels and skill mix and gave new and locum staff a full induction.

Up to December 2021 there had been a 4% increase in medical staffing in the trust, compared with the previous 12 months, which equated to a 1% increase across medical care services.

We saw data that indicated a rise in sickness rates from 1.9% in November 2021 to a 3.6% in January 2022. The fluctuation in rates compares to the increase and decrease of COVID 19 infection rates and is within a similar range of national variations.

We found medical staffing was an improving picture within some areas, such as stroke, actively recruiting to registrar posts. Some doctors were moved from one area to another during their shifts, to cover priority areas. We saw an example of doctors being deployed in other areas and then returned to the ward for the rest of the day. However, a junior doctor being moved from the stroke ward to cover in the AMU, had caused a shortfall of medic cover on the ward.

Recruitment of consultants that have an interest across general medicine had increased. This was an initiative to provide a wider range of care across medical wards to support the needs of patients.

Records

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

We reviewed 18 sets of notes, which included written records and electronic records. In most cases, there were written risk assessments along with an electronic copy. In 16 out of 18 records we found they had been completed appropriately, with information available to staff. Electronic records were clear and easy to use. Assessments and flags were in place to warn staff of any patient needs, such as risk of falls. In all but one, paper assessments were completed appropriately and linked to the electronic notes systems.

Medicines

Staff followed systems and processes to safely prescribe and administer medicines. The service had systems and processes to safely prescribe, record and store medicines securely. However, in two cases we observed medicines had been given to patients later than prescribed.

Staff stored and managed all medicines and prescribing documents in line with the trust policy. The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Staff received information about safety alerts and learning from medicines incidents through regular 'Insight' bulletins on the intranet. Medicine incidents were reported and investigated appropriately.

Electronic devices used when prescribing and administering medicines were secured when not used by staff. On the GP assessment unit, prescription pads were stored securely and there was an audit trail to monitor use of them.

Medical care (including older people's care)

An electronic system allowed pharmacy staff to prioritise new patients and complete medicines reconciliation (the process of accurately listing a patient's medicines they were taking at home and comparing it to what is prescribed whilst they are in hospital) in a timely manner. Staff had access to summary care records to support this process.

Patients on an older people's ward did not always receive their medicines on time due to staff shortages on the ward. We saw two patients received their morning medicines, which included medicines for pain relief, over three hours late. This caused subsequent doses to be delayed, with patients receiving them late in the evening.

Staff reviewed patient's medicines regularly but did not always provide specific advice to patients and carers about their medicines. A patient told us they had been prescribed a new medicine but was not sure what it was for.

We saw evidence of effective communication of medicines issues between pharmacists and other healthcare professionals. Medicines were reviewed regularly on ward rounds on the older people's wards and general medical wards. A clinical pharmacist visited the medical care wards, Monday to Friday, reviewed patient's medicines and would speak to patients about their medicines if required.

Is the service effective?

Inspected but not rated

Competent staff

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

We saw that wards had achieved appraisal rates of 90% or over. On three wards we visited there was a 100% of nurses had completed appraisals. Staff told us that senior nurses had discussed progression opportunities and supported nurses in changing roles to gain experience in other areas. Supervision records formed part of the appraisals for staff. The appraisal rate was 100% on the wards we visited.

Link nurses were available on wards to support specific care needs of patients. For example, wards we visited had falls link nurses, that had been trained in assessing and managing patient falls.

Multidisciplinary working

Doctors, nurses, and other healthcare professionals on the medical care wards, worked together as a team to benefit patients. They supported each other to provide good care. However, this was not always achieved within the emergency department.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Senior staff held risk management meetings four times daily to discuss key issues relating to patient care, staffing and patient flow. These included non-clinical staff, senior clinical managers and on call managers. During inspection we attended a meeting and observed issues that had been escalated. We saw examples where staff had been moved from one ward to assist a patient that required one to one support.

Medical care (including older people's care)

Clinical staff reviewed each patient on a ward, called a board round. These reviews involved medical staff, nursing staff and allied health professionals to ensure a multidisciplinary approach to patient care, was achieved. Often discharge coordinators were involved in these reviews to support appropriate discharge of patients.

Seven-day services

Key services were not always available seven days a week to support timely patient care.

Reduced access to discharge coordinators at weekends and at other times, contributed to issues with patient flow. However, following COVID restrictions being lifted, care agencies have been permitted to reintroduce dedicated staff to support with discharges and support with discharge processes.

Some services were not available at weekends and this caused some delays for patients. For example, there were no occupational therapist services available to support discharges at the weekends. We were told that a patient on ward 29 was delayed due to the ward not being able to fulfil agreed care plans and potentially could have been discharged earlier.

In some cases, we were told access to imaging services could be delayed for patients that moved from the emergency department into medical care areas. Access to these services were sometimes difficult after 5pm and at weekends. We were told that in most cases staffing levels were the factor that caused delays.

Is the service caring?

Inspected but not rated

Compassionate care

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

Staff took time to interact with patients and those close to them in a respectful and considerate way. During the inspection, on all wards, we witnessed staff interacting positively with patients.

Patients said staff treated them well and were very caring. However, we were told that staff were often “very busy” and this could cause frustration to some patients when requiring support at peak times.

We observed staff interact with patients living with dementia in a calm and caring manner. On several occasions we saw staff helping patients make telephone calls to loved ones.

Understanding and involvement of patients and those close to them

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

Medical care (including older people's care)

Staff made sure patients and those close to them understood their care and treatment. We saw in patient records that staff had spoken with patients' families to provide information relating to their care. We saw staff talking with family members to inform them of their loved one's wellbeing.

Staff talked with patients, families, and carers in a way they could understand, using communication aids where necessary. Specialist support staff would visit the older people's wards to help with improving communication and support for vulnerable patients.

All patients and visitors we spoke with felt confident to raise concerns with staff. There was information displayed on the wards that informed patients and visitors of the process for concerns to be discussed or escalated.

Patients gave positive feedback about the service. We saw patient feedback information displayed on wards, with cards from families, thanking staff.

Is the service responsive?

Requires Improvement 

Service delivery to meet the needs of local people

The service did not always plan and provide care in a way that met the needs of local people and the communities served. Some specialty medical services could not always provide an in-reach service into ED. However, it worked with others in the wider system and local organisations to plan care.

We saw the introduction of care pathways for older patients. There was an in-reach pathway into ED that currently provided a service five days a week with consultant support in the morning and afternoon. This team were known as the "Frailty Emergency Squad" (FES) and they focused on admission avoidance by signposting or referring to more appropriate services instead of the acute hospital. In-reach services were not available for any speciality, after 8pm.

We saw a system wide approach to caring for older people. A process has been set up to include the local NHS ambulance provider to prevent admission to hospital when more appropriate care can be found in the health system. This was applicable to care homes and includes patients living at their own home.

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. Processes were in place within medical care services, to ensure cardiac and respiratory patients were directed to a different hospital within the same trust for more specific care, when needed.

The use of electronic patient record systems helped ensure that the most up to date information was available to those caring for patients. Staff could see referrals, make referrals, and follow the progress of patient care from specialist teams or other allied healthcare professionals. Assessments were updated and staff had access to the bed status for those being admitted to wards.

Medical care (including older people's care)

There was limited in-reach clinician availability to assess patients awaiting a medical bed. For example, patients waiting in the emergency department for a specialist medical bed were delayed in seeing a specialist clinician. In some specialties, such as stroke care, availability of a specialist clinician to provide in-reach into ED had improved due to recent employment.

We saw the use of daily clinics in the GP assessment unit area, known as “hot clinics”, to enable patients to be seen by specialist clinicians. Neurology clinicians were available three times a week and diabetes and nutritional nurses, were available Monday to Friday. However, there was no input from cardiology and respiratory clinicians as these were based at a different hospital site. However, access to specialist cardiology and respiratory care advice was regularly conducted by remote access and telephone, for those admitted through ED and awaiting assessment for a variety of conditions.

Access and flow

People could not always access the service when they needed it. Waiting times from referral to treatment were not always in line with national standards. Although there was a reduction in elective admissions during the COVID pandemic, the medical care services saw a 4% increase in emergency admissions and a 14% increase in day case admissions.

The flow of patients into the medical wards often came from a primary care referral and then into the emergency department (ED). Patients were then transferred through the admissions unit to a specialist medical ward. This resulted in long waits for patients within ED for patients waiting for appropriate admission to wards.

The discharge lounge was not used effectively and could not take patients, whose discharge arrangements were complex. These discharges could include patients living with dementia or those that were vulnerable due to learning difficulties.

Between 1st January 2022 and the Inspection on 14th April 2022 the highest overall number of medical optimised for discharge (MOFD) patients was 256 on 12th January 2022 and the lowest was 156 on 31st January 2022. Delays were seen due to a variety of issues. On inspection in medical care services, we saw some patients were awaiting coordination from social care agencies to provide appropriate care packages, allowing appropriate discharge. Patients with complex needs were often those that waited longest for an appropriate discharge. We were told that patients’ discharges could also be delayed whilst awaiting diagnostic or imaging procedures to be completed. Staffing issues also contributed to delays; for example, when the availability of discharge coordinators and nursing staff was reduced this would impact discharge processes.

Patients with complex needs could not be discharged from the discharge lounge and so this disrupted the admission process for other patients. On occasions the patient being admitted would require safer placement within the ward area to wait for a discharge to occur. These patients were reviewed to assess risks and aid in prioritising admission to wards.

We saw on one day that only six patients were in the discharge lounge waiting for discharge. This was a reduced number, compared to the full capacity of the discharge lounge and potentially impacted on those patients that might be requiring a safer placement.

Medical care (including older people's care)

When patients' discharges were delayed this impacted on medical specialities ability to free up capacity and flow through the ED and medical care wards. Managers and staff worked to make sure patients did not stay longer than they needed to. Clinicians worked together to review the electronic patient records and other electronic systems, to update risks and patient needs to improve progress of care and patient flow. Staff discussed patient discharge plans daily to support the process and to update availability of beds on wards.

Areas, such as the GP assessment unit used the electronic system to manage the process for admitting patients to wards. This meant patients waiting to be admitted, could be managed according to individual needs, as it was based on risk, priority, and urgency. This reduced the number of patients waiting in the emergency department areas. Although the aim was to not have patients staying overnight, the unit had appropriate facilities and staffing to manage patients overnight, if required. On the day of the inspection there were seven patients that had been waiting overnight for admission to a ward. A process was in place to assess patients that may need to stay overnight.

Processes had been introduced and were monitored by staff to improve patient care. For example, falls assessment processes included reviews when changes in patient presentation occurred, and post fall reviews to help reduce future risk. Specialist nurses supported the process to ensure consistency and that learning was shared. Falls safety letters were produced to increase staff awareness.

Is the service well-led?

Inspected but not rated

Leadership

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

The service had a clear management structure. We saw competent leaders that had the right level of experience to manage teams across the service. They were present to guide and support staff at difficult periods and demonstrated a range of skills to ensure care was provided appropriately. They supported staff to improve and encouraged them to take on more responsibility, where appropriate. There were no vacancies in senior posts, and we saw that some had been filled by staff that had been developed into the roles.

Medical divisions were divided into clinical management groups (CMG's) which incorporated some services on other hospital sites, within the trust. CMG's had lead consultants and senior nursing staff providing clinical leadership across the areas. Each CMG had a clinical director, assistant director, and a head of nursing. There were also heads of operations to support the CMG. Specialties within the CMG also had a head of service and a general manager to have oversight of each specialist service. Leaders told us that risk was discussed across different specialities to encourage joint solutions and support a learning environment.

Senior leaders were visible, and staff told us there were regular visits by the chief executive officer (CEO) to areas across the site. Other senior staff were available to support across the service and could be contacted for advice and support. Staff told us that other senior clinical leaders were available to support staff and areas across the sites. Matrons were visible and approachable across their areas, and an on-call system or bleep system was available for staff to escalate issues to.

Medical care (including older people's care)

A weekly message was sent out to all staff by the CEO to update on issues concerning the trust and invite questions from staff. Staff told us about one issue that was raised to the CEO and the situation was resolved within a week. Staff complimented the senior team for being involved in matters that they cared about and providing an avenue for issues to be raised. This was qualified by the notable increase in freedom to speak up contacts that the trust had received over the last six months. The head of nursing produced a weekly briefing that was communicated at the daily staff huddles to ensure information was shared.

Staff told us that they could easily escalate concerns to the head of service at CMG meetings. Staff on the stroke ward told us that the head of service was easily approached and supportive of staff and patient needs.

Matrons were visible in the ward areas and we saw on two occasions where a matron supported nurses in performing clinical duties due to a shortage in staff. We saw a matron supporting a patient that had got out of bed and assisted them in returning safely, spending several minutes talking to the patient. First names were used, and the matron had a good knowledge of the patient's history.

Staff told us matrons were supportive, but nurse staffing issues often meant that they were utilised across other wards, to support and this could reduce the availability and visibility of matrons in some areas.

Staff told us that they were supported in developing their careers and were supported by managers to do this. However, due to pressure within the service, staff morale was low, particularly around the lower levels of nursing staff. Ward managers seemed to have accepted the reduced staff levels as "normal".

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service had a risk register that included risks identified across the clinical management group (CMG). Risks were discussed and escalated appropriately at regular risk meetings and mitigations discussed. For example, nurse staffing issues had short term and longer-term solutions to mitigate risk. The reintroduction of employing staff from overseas formed part of the long-term solutions, along with the introduction of staff retention initiatives.

We found several ways in which risks could be escalated. Longer term risk was managed through the regular monthly meetings. Risk was reviewed and managed by the senior team at monthly executive board meetings and weekly senior clinical cabinet meetings. These reviews linked into other risk meetings to encourage shared learning across CMG's within the trust. There were also tactical meetings four times a day, with the operations team, which included the senior nurse manager of the day, to consider capacity, flow, clinical risk, elective risks and emergency department and ambulance waits. Any immediate risk could be escalated through a process where a matron or senior nurse could be contacted on a "bleep" or telephone call.

Reduced staffing levels had been included on the risk register and was being mitigated with the use of a priority staffing process to use staff in higher risk areas. Senior nurses were also used to support areas with highest risk. Although there was no data linking staffing levels to a direct increase in incidents, staff told us that they reported staffing issues and that the risk to patient safety had increased.

Medical care (including older people's care)

A longer term plan is being implemented to introduce a single point of access system, with a medical team available to assess and care for patients on their arrival at hospital and move them to an appropriate ward, rather than go via the emergency department (ED). This has not been embedded but progress was being made in developing this system.

Senior staff discussed with us about a plan to develop a general medicine department, with several wards, to enable a better level of overall care for patients. The purpose of this being to improve patient experience and reduce complications of referring to specialist wards or clinicians. The department will have full time consultants and general medicine registrar trainees. This is an initiative being piloted at the trust, with a view to rolling it out nationally. This has started with the employment of a consultant to support and oversee the development of the idea. Staff talked about the differences that the initiative would make and although at early stages, there was a forward momentum being seen across medical care services.

Medical staff were encouraged to take part in quality improvement initiatives and regular clinical audits. We saw that there had been a recent initiative across the trust around delirium and its effects. As part of development, junior doctors told us they had been involved in clinical audits and were encouraged to contribute to new ideas. For example, one doctor told us that they were encouraged to participate in the development of the general medical care model being introduced.

Areas for improvement

MUSTS

Action the trust MUST take to improve:

- The trust must review staffing levels across medical care services to ensure staffing levels are safe and reduce impact on patient safety and staff wellbeing. Regulation 18 - staffing
- The trust must review and provide an action plan for the improvement in providing a consistent and timely in-reach service for the emergency department. Regulation 12 – safe care and treatment

SHOULDS

Action the trust SHOULD take to improve:

- The trust should ensure staff re-assess patient’s venous thromboembolism (VTE) risk after 48-72 hours, as indicated in trust policy. Regulation 12 – safe care and treatment
- The trust should ensure that patients are administered medicines on time and ensure pain relief is monitored to avoid delays in administering. Regulation 12 – safe care and treatment
- The trust should consider reviewing staff availability to provide occupational therapist support at weekends. Regulation 12 – safe care and treatment
- The trust should review the process and staffing of the discharge lounge to improve efficiency in discharging patients and considering patients that require a complex discharge package. Regulation 12 – safe care and treatment
- The trust should review resources and maximise them to support and facilitate timely discharges from wards.

Our inspection team

The team that inspected urgent and emergency care and medical care core services comprised two CQC lead inspectors, two CQC medicines inspectors, and two CQC mental health inspectors. The inspection team also included four specialist advisors who were consultants in emergency care, a registrar in general medicine, a senior emergency care nurse and general medical nurse. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

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

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

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Agenda Item 9

Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 31 AUGUST 2022

LEARNING FROM DEATHS OF PEOPLE WITH LEARNING DISABILITY AND AUTISTIC PEOPLE REVIEW PROGRAMME ANNUAL REPORT

REPORT OF THE JOINT SENIOR RESPONSIBLE OFFICERS FOR THE LEDER WORK (Heather Pick, LCC & David Williams, LPT)

Purpose of the Report

1. The purpose of this report is to update the Committee on progress and achievement within the Leicester, Leicestershire and Rutland (LLR) LeDeR (Learning from lives and deaths of people with learning disability and autistic people) programme in 2021/22.

Policy Framework and Previous Decisions

2. The report does not implicate any change to current policy or plans. We ask the committee to receive the report, as provided to stakeholders.

Background

3. LeDeR is a national service improvement programme directed by NHS England and Improvement, managed in LLR by the Integrated Care Board for the Integrated Care System. Originating from the Transforming Care work carried out by the former CCGs in partnership with LLR Health and Social Care Services, the programme reviews the lives and deaths of people with a learning disability or autism, or both, to extract and disseminate learning into action.

4. The two main aims of the programme are

   - To support improvements in the quality of health and social care service delivery for people with learning disabilities and people with autism;
   - To help reduce premature mortality and health inequalities for people with learning disabilities and people with autism.

5. Learning from reviews is taken through a Governance Panel to formulate SMART actions which advise and enable services to make improvements.

This in turn increases quality of life and care for people and helps prevent premature death.

6. There are two types of review:

7. **Focused** (in-depth): it is expected that approximately 35% will be of this type. Focused reviews are automatically given for automatically for and death of a person
    - With autism only (no learning disability);
    - From an ethnic minority;
    - Who had mental health restrictions in the last 5 years of life;
    - If family request a focused review.

   Additionally, focused review is allocated locally if a priority analysis area in LLR, e.g. respiratory or COVID deaths. LLR is currently running at 45% focused.

8. **Initial** (light-touch) for all other cases.

9. Learning from reviews in year has resulted in actions for LLR services including Primary Care, Secondary Care and Community Care.

10. Primary care is asked to

    - Read the weekly e-newsletter that is sent to all GP practices, it now includes a Learning Disability section, with all the key information;
    - Designate a Clinical Lead GP for Learning Disabilities in every Practice. Support and advice for this person is available from ICB Clinical Leads for LD;
    - Ensure individuals are included on the LD QOF Register* this is the gatekeeper to being invited to LD AHC, awareness of reasonable adjustments, safeguarding and referrals to secondary care;
    - Instigate RESPECT forms when the person is well enough to ensure their wishes are heard, in primary healthcare. People with a LD, their family and carers should be supported to understand about RESPECT forms and they differ from a DNACPR;
    - Ensure use of regular appropriate Mental Capacity Act Assessment;
    - Promote hospital passports for people with LD and to promote at consultation/LD AHC*;
    - Increase knowledge and awareness of the “Adult not brought to appointment;Y2de1” (Was not brought) read code and safeguarding policy, especially for GP Receptionist teams;

      https://vimeo.com/392944939

11. The ICB is working on:

- Wheelchair scales; update the GP Annual Health Check and LD Newsletter with guidance on accessing them.
- Improving and simplifying the AHC template;
- Clarifying the blood-letting pathway, designating a Co-Ordinator and will share this with Primary Care.

12. Secondary Care is asked to:

- Effectively plan, identify and consider people at the end of their life through timely commencement of End of Life care pathway;
- Communicate with and remind Care Providers they are welcome to support people with a learning disability in hospital and advocate for them;
- Review process of community follow up after discharge, e.g. CLDT discharge coordinator in LPT could feed into LPT long term plan;
- Establish and communicate as early as possible, the funding required when someone with an LD goes into hospital;
- Establish early dialogue with family and carers so their needs are taken into account when giving information;
- Use of regular appropriate MCA Assessment;
- Promote use of Hospital Passport;
- SALT to consider leading a REFLUX campaign for people with LD in partnership with LeDeR team;
- Where a hospital has been informed that a person has a LD, this is to be communicated to other staff early. Any information about the person/resources to also be circulated amongst staff supporting the patient at admission.
- Inform Acute Liaison Nurses immediately of any hospital admission of a person with LD and give ALN contact details for family and carers.
- Pursue wider training for other staff around supporting a patient with LD in an acute setting, so the ALNs are not pressurised with the support required to be provided.

13. Community Care is asked to

- Support people to live where they choose and enable them to make decisions in a timely manner. *Funding should not be a barrier.*
- Ensure that all care providers have access to current, wider learning disability services and know who to contact.
- Ensure all care providers clearly understand when a RESPECT form is to be instigated by all everyone including people with a learning disability, family, carers, health and social care staff.
- Use of regular appropriate MCA Assessment

- Promote training and education around the use of tools to help staff recognise the deteriorating patient.
- Ensure care providers are appropriately risk assessed and safeguarding is assured
- Ensure that when sourcing residential care placements that an individual's culture, language, preferences and communication needs are take into account.
- Put steps into place to ensure that these needs can be met at all times by the identified care provider.

Engagement

14. Every review of a death includes involvement of any family and carers of the person who died. They are informed in writing of the review, invited to contribute to the review itself, request a focused review if this is not already set, and receive a copy of the final submitted review. The review is carried out whether the family participate or not, in line with national policy.

Resource Implications

15. There a no resource implications.

Timetable for Decisions

16. No decisions are required.

Conclusions

17. The report is submitted for information. It shows progress made against the two main aims of the LeDeR Programme, notably in reducing premature deaths of people with learning disability and/or autism.

    In the two previous years (2018/19 and 2019/20), the median age at death for people a learning disability was 59 years. This report shows an improvement in median age at death to 64 years in 2021/22. Additionally, more children and young people reached the age at which they transition into adult services.

Background papers

Presentation slides from Health Overview and Scrutiny Committee meeting on 5 September 2018: https://politics.leics.gov.uk/documents/s140050/LEDER%20Information%20pack.pdf

Circulation under the Local Issues Alert Procedure

18. None

Equality and Human Rights Implications

19. There are no equality or human rights implications arising from the recommendations in this report. The LeDeR programme supports and advises on actions to improve services for people and so influences positive change for people with learning disability and/or autism.

Appendices

20. Appendix A - LLR LeDeR Annual Report 2021/22
    Appendix B - Summary presentation of the annual report

Officer to Contact

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APPENDIX A

Leicester, Leicestershire and Rutland LeDeR Annual Report June 2022

This report covers the period from 1 April 2021 to 31 March 2022

Leicester City Council

NHS
Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

Leicestershire County Council

NHS
Leicestershire Partnership NHS Trust

Rutland County Council

NHS
University Hospitals of Leicester NHS Trust

Contents

"He loved being with his family and would often enjoy family trips to the theatre, cultural music events, shopping and trips to Blackpool which he particularly enjoyed"

Executive Summary

The primary purpose of the Learning from Deaths of people with Learning Disability (LD) and autistic people review programme (LeDeR) is to review the care each person has received leading up to their death and make recommendations that could help improve the care for other people and reduce premature deaths. Recommendations from each review are intended to highlight best practice and thereby support health and social care professionals and policy makers to implement positive change for people to have better experience of their care.

The core principles and values of the LeDeR programme are as follows:

- The programme overall must effect change and make an identifiable difference to the lives of people with learning disabilities and autistic people and their families.
- We value the on-going contribution of people with learning disabilities and autistic people and their families to all aspects of our work and see this as central to the development and delivery of everything we do.
- We take a holistic approach, looking at the circumstances leading to deaths of people with learning disabilities and autistic people and don't prioritise any one source of information over any other.
- The key principles of communication, cooperation and independence are upheld when working alongside other investigation or review processes.
- The programme overall strives to ensure that reviews of deaths lead to reflective learning which will result in improved health and social care service delivery.

Therefore, the LeDeR programme is so important. It represents a real opportunity to improve the lives of people with learning disabilities and autistic people. Implementation in Leicester, Leicestershire and Rutland has been difficult, but much progress has been made; we are now able to make evidence-based SMART recommendations as to how the quality of health and social care services for people with learning disabilities can be improved.

There are two sets of people that deserve special recognition.

- Our LeDeR reviewers. Without their expertise, experience and passion we would not be where we are.
- The families, friends, carers and health and social care professionals who have provided critical contributions to each LeDeR review. Their support has been invaluable.

We must not rest upon the contents of this report. Instead all partners across the Leicester, Leicestershire and Rutland health and social care sector must embrace the initial findings of this report, everyone has a role to play. Only then will we ensure that every person with a

learning disability and autistic people receive the high quality of care that they deserve. Only then will we address health inequality.

Caroline Trevithick, Chief Nurse & Executive Director, West Leicestershire CCG.

Heather Pick, Assistant Director (Adults & Communities), Leicestershire County Council.

David Williams, Director of Strategy and Business Development, Leicestershire Partnership NHS Trust.

Good practice checklist

We can make a real difference to people in the following ways;

Listen to people with learning disabilities and autistic people and their families and carers	✓
Ensure everyone is fully up to date with training	✓
Everyone having a clear understanding of the difference between learning disability and learning difficulties	✓
Carry out Mental Capacity Assessments in every relevant case	✓
Ensure patient records are fully accurate and changes are recorded correctly	✓
Communicate more effectively, in particular • with people with LD and autistic people • across providers about Care Plans • discharge planning • advocacy • decision making • end of life • DNACPR	✓
Make no assumptions, particularly about LD or autism being related to cause of death	✓
Check procedures to ensure nothing is missed in any process	✓
Ensure annual health checks are provided for every eligible person	✓
Support people to attend appointments, especially for annual health checks and screening programmes	✓
Ensure the correct versions of documents are used and completed accurately, including death certificates	✓

Acknowledgements

Leicester, Leicestershire and Rutland Clinical Commissioning Groups would like to acknowledge the support provided to the LeDeR programme by the following organisations, groups and individuals:

NHS England and Improvement National Team (NHSE/I)

NHS England and Improvement Regional Team

All our Reviewers and Clinical Leads

All family members' contributions

Leicestershire Partnership Trust

North-East Commissioning Support (NECS)

University Hospitals of Leicester

Primary Care

Insight Training and Consultancy

Leicester City Council

Leicestershire County Council

Rutland County Council

Leicester, Leicestershire and Rutland Child Death Overview Panel (CDOP)

LPT Talk and Listen Group

LLR LeDeR Expert by Experience

Introduction

This is the third Annual Report for Leicester, Leicestershire and Rutland (LLR) Learning from Deaths Review Programme and describes progress from the previous year's report.

The aims of the LeDeR programme are:

- **To support improvements in the quality of health and social care service delivery for people with learning disabilities and people with autism**
- **To help reduce premature mortality and health inequalities for people with learning disabilities and people with autism**

The programme is funded by NHS England at a national level with responsibility devolved to Clinical Commissioning Groups. However, the programme is delivered through local partnerships across health and social care organisations in LLR.

The LeDeR process is summarised below

Anyone with a diagnosed learning disability who has died over the age of 4 years old since 1 October 2017 can and should be referred to the programme. The more people who are referred the stronger an evidence base for change can be developed.

Since 1 January 2022, people diagnosed with autism and no diagnosis of a learning disability have been included in the notification of deaths to enable a review to be carried out.

Each LeDeR referral is allocated to a LeDeR reviewer. In LLR these are trained health and social care professionals experienced in working with people with learning disabilities and autism. Allocation of reviews ensures that a review is not allocated to someone that has previously cared for the person who has died.

The purpose of the 'Initial Review' is to identify key learnings and recommendations to improve local health and social care services. To do this the LeDeR reviewer will consider relevant case records and speak to family, friends and carers to form a 'pen portrait' of the individual and a coherent narrative of their care in the lead up to their death.

Where there were significant concerns about the person's health and social care service delivery further information can be gathered to undertake a 'focused review'. A family can request a focus review if they have concerns about the care delivery.

Focused reviews have also been undertaken if the death has been caused by a priority area. Respiratory related deaths have been an area of focus in LLR during 2021/22.

Before each review is approved and submitted, it undergoes a quality assurance process. LLR has set high standards that every review must meet.

Areas to explore are identified in every review. Initial reviews are locally analysed by clinical leads. Focused reviews are taken to governance panel for multi professionals to identify actions and recommendations required. In both circumstances thematic review is undertaken.

LLR have trialled governance panel ahead of the policy requirement and have been using this process during quarters 3 and 4.

Deaths for children with a learning disability are reviewed as part of the Child Death Overview Panel (CDOP) process. In LLR this is achieved through 'themed' panels where the exclusive focus is on learning disability or autism related deaths. The learnings and recommendations are then fed into LLR LeDeR Programme and implementation of 'Learning into Action'.

Statement of Purpose

The LLR Learning Disability and Autism Partnership is committed to the ongoing delivery of the LeDeR Programme. This means that:

- LeDeR reviews are allocated and completed to a high standard within the stipulated programme timescales.
- Identified learnings and recommendations become 'Learning into Action'.
- 'Learning into Action' improves the quality of health and social care services and reduces the health inequality faced by people with learning disabilities and autistic people.
- All stakeholders, including people with learning disabilities and their family, friends and carers, feel an equal partner in the LeDeR programme.

These ambitions sit within the broader LLR system-wide Person-Centred Leadership Framework.

"How lucky we are to have someone that made saying goodbye so hard.

Thursday was bright and beautiful, just like you"

Local Progress and Performance

The LeDeR Programme was initially led by the University of Bristol including policy, direction of reviews, the operation of the web based platform and data analysis. However, the contract ended in May 2021. This resulted in the closure to the web platform and notifications for reviews were held centrally by NHS England during this time. As per the LeDeR Policy (2021) there was an acknowledgement that the main focus so far has been on the completion of reviews. We must now improve our reporting and recording of issues and concerns and act upon those findings. Therefore the LLR LeDeR team have spent the past year synthesizing the evidence from reviews already conducted, creating a sophisticated model of analysis. Whilst also committing to meeting the timescales and quality of reviews on an ongoing basis.

Thematic analysis has been a priority for LLR LeDeR team during the past year. Lincoln and Guba's (1985) criteria for trustworthiness during each phase of thematic analysis is widely used and often viewed as the "gold standard" for qualitative research. This framework has been adopted in LLR for the purposes of the LeDeR Learning into Action and demonstrates the systematic structure of thematic analysis undertaken for the LeDeR reviews in LLR.

LLR LeDeR team have committed to a Quality Improvement model, supported by LPT's WeImproveQ. LLR LeDeR is working with research colleagues and following a nationally recognised Plan, Do, Study, Act (PDSA) cycle of quality, service improvement and redesign. LLR LeDeR strives to ensure the programme is well-governed, produces high standards and ensures patient involvement and engagement. The PDSA cycle highlighted some areas to focus the programme which are outlined below.

Following its launch in June 2021, the web based LeDeR platform remains in beta format. NHS England has been clear in the expectation for local areas to use it, however this means there are limitations to the programme's ability to produce sophisticated reporting.

To overcome these barriers early on LLR LeDeR Team proactively engaged in all offered LeDeR web platform feedback sessions and actively participated in user groups.

LLR LeDeR team took the opportunity to develop local reporting systems, therefore ensuring LLR can give assurance and reporting of the LeDeR programme. For 2022/23 these locally developed methodologies will be shared with the LeDeR User Research Group and the LeDeR system design team.

It is worth noting that the new reporting platform can only receive the reviews and does not include a facility to generate reports from the reviews. Any datasets and subsequent reports have been created from a central dashboard created and maintained by the LLR LeDeR

team[1]. Therefore, data presented in this report may not be comparable with that presented by other LeDeR programmes.

There was an additional problem between 21st December and 8th February when the LLR LeDeR programme received no notifications of death thereby causing a cumulation of unallocated reviews; no allowance regarding the completion deadline has been made for this. Consequently, 15 cases were outsourced from the CCG to achieve the six month completion date.

The ongoing pandemic outbreak of COVID-19 has continued to have a significant impact on reviewers, especially those working within the University Hospitals of Leicester NHS Trust, Leicestershire Partnership Trust and local authorities due to the redeployment of the clinical lead and some reviewers' activity to focus on clinical roles.

An addition to the LeDeR programme has been the inclusion of reviews of the death of people aged 18 years and over with a confirmed diagnosis of autism with no LD. This was delayed by the national programme and the academic partner from September 2021 to January 2022. This was further hampered because, unlike people with a learning disability, there exists no formal register of people with a diagnosis of autism. During 2021-22, one such death was referred to LLR LeDeR, the review is ongoing at the time of writing.

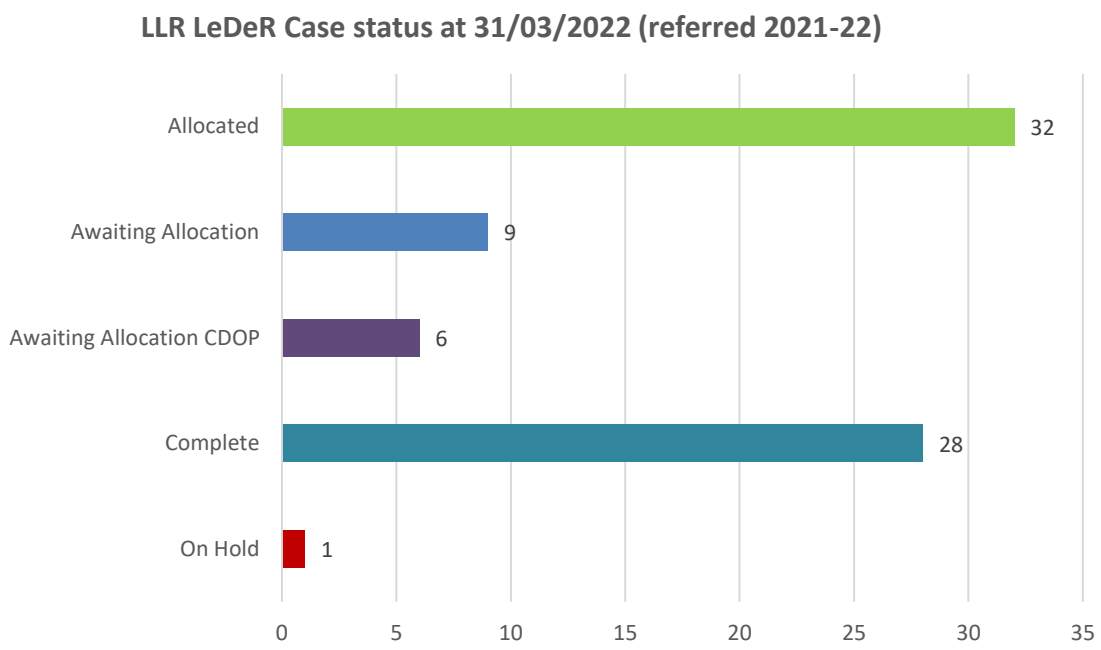
The number of cases on hold has been greatly reduced during the last twelve months, with only one case remaining on hold at end of year. This is largely due to the Team's active participation in and sharing of reports from Safeguarding and CDOP Panels. Additionally, no further CDOP cases were placed on hold, in compliance with new guidance.

All deaths of children are reviewed by the Child Death Oversight Panel (CDOP) that operates to its own timeframes. The LLR LeDeR clinical team have forged links with the CDOP team to ensure that all required reports are included in the LeDeR programme.

The chart in Figure 1 shows the status on 31 March 2022 of all cases referred to LLR LeDeR in 2021/22.

[1] It should be noted that all cases received during LeDeR system shutdown (1 March 2021 to 1 June 2021) were outsourced by NHSE/I to NECS for completion. Data on these cases was therefore not recorded in the same amount of detail as cases managed locally, as the new LeDeR system does not yet allow download of any data.

Figure 1



N.B. In 2021-22, LLR received 77 referrals and completed 65 reviews. Unless specified, all charts in this report refer to reviews *completed* within the 2021-22 year.

Quality

The LLR LeDeR team's PDSA has enabled quality improvements to the programme. These are detailed in Table 1 below.

Table 1

Area to explore	What could we do better	Where are we now	Cycle 2 of PDSA
As soon as a safeguarding concern is raised from a LeDeR Review it is being placed on hold.	Work in conjunction with local authority safeguarding teams and the safeguarding adults board (SAB) to share relevant information to allow reviews to be conducted simultaneously instead of waiting for outcomes of safeguarding reviews. This will also reduce reviews being placed on hold and support more timely outcomes.	Working relationships are much stronger with local authority safeguarding and the SAB. A lead practitioner for safeguarding has taken up a local area contact role for LLR LeDeR. The SAB invite LeDeR to all Safeguarding adult reviews associated with LeDeR.	
Families and loved ones being contacted repeated times from different services who are undertaking a review on the death of their loved one.	Work together with all partner agencies to ensure family are contacted once and informed of all the reviews that are being undertaken by one identified main contact on behalf of all reviews.	LeDeR works closely with the SAB and a single point of contact is identified for family liaison. As the SAB already have family liaison well established, this person now centralises all questions from SAB and LeDeR in one conversation and gives detail should family wish to contact LeDeR separately.	

Area to explore	What could we do better	Where are we now	Cycle 2 of PDSA
NHS England are only allowing 6 x reviewers to be able to conduct reviews at any one time. LLR LeDeR Programme uses bank staff.	Work towards employed reviewers and in the interim contract out reviews to individuals who have capacity to undertake multiple reviews at a time.	Recruitment completed in May 2022.	
Inconsistent and time-consuming retrieval of records made by individual reviewers.	Centralise record retrieval and work with other agencies to ensure where information has already been retrieved so it can be shared with the LeDeR Team, for example coroner's report.	LLR LeDeR has set up a flowchart of record retrieval which is led by LeDeR Senior Administrator. This includes all partner agencies, with regular review and checks to ensure this process remains efficient. This has also increased productivity of reviewers due to less time spent retrieving records and improved the integrity of the programme by professional, consistent record request working in collaboration with partners.	
Supporting multiple reviewers through a change process and new web platform.	Regular peer support and formalised clear process of working through a LeDeR Review.	LeDeR Clinical leads and senior administrator hold a weekly LeDeR Reviewer peer support drop-in session. A Reviewer toolkit has been developed, this has been shared with NHS England and disseminated to other regions for them to adapt and use. (See appendix)	
LeDeR Policy (2021) requires Governance Panels to be established. Plan by 30th Sept 2021 and operational by 1st April 2022.	Implement multiagency professionals to form LLR LeDeR Governance Panel, with the function of developing SMART actions for LeDeR Steering Group.	Governance panels were trialled between Sept 2021 and March 2022. The LLR LeDeR Team have a fully operational multiagency governance panel as of 1st April 2022.	
No engagement of experts by experience.	Involvement of people with a learning disability, people with autism and family and carers.	LLR LeDeR has been successful in recruiting on a voluntary basis an expert by experience to represent people with a learning disability in March 2022. A family carer has been identified and keen to work with the team, formalities to recruit on a voluntary basis into the team are being undertaken.	Recruit further experts by experience and ensure autism is included and representation of ethnic minority is included.

Area to explore	What could we do better	Where are we now	Cycle 2 of PDSA
Is LLR LeDeR programme clearly representative of its population, including the population of people from ethnic minority background.	Understand if our local population is clearly represented by the LLR LeDeR programme to demonstrate if any further work is needed in this area, based on locally understanding Leicester City, County and Rutland's diverse populations.	Collaborative work with De Montfort University has been agreed. The demographic population reporting has been requested through Leicestershire Health Informatics Service.	Population reporting to be undertaken as a clinical audit. De Montfort University research colleagues to analyse the data and feedback to LeDeR Clinical leads for synthesis.
Thematic Analysis: • **Respiratory Deaths**	Set up and define thematic analysis process for LLR LeDeR and conduct on respiratory deaths based on past reviews undertaken where the individual died from a respiratory death.	Respiratory Death Thematic Analysis conducted on deaths from LLR LeDeR pre-2021, presented to governance panel and SMART actions created.	Clearer and more structured reporting functions would support easier thematic analysis for future. In the absence of the LeDeR web platform holding a reporting function this will need to be developed locally.

The LLR LeDeR team has an agreement with local authorities that cases reported as safeguarding can share any relevant information and reviews conducted simultaneously instead of waiting for the outcome of the safeguarding review. This should enable a reduction of cases 'on hold'. Other cases currently 'on hold' are either undergoing a police investigation or are waiting for the outcome of a coroner's report.

The LLR LeDeR programme has worked closely with the regional and national teams to embrace the changes whilst continuing to undertake the reviews. During this time, the LLR LeDeR team has laid the foundations for identifying and implementing learning.

The achievements made by the LLR LeDeR programme include the profile of the LeDeR programme being raised using effective communication tools resulting in more consistent notification of deaths and strengthening across all partners, including Primary Care, to obtain and upload patient records for reviewers to access.

All reviews allocated to reviewers (79.53%) were completed within the timeframe. There remained 23 reviews that could not be completed because they had been referred into statutory processes e.g., coroner's inquest, CDOP, police or safeguarding investigations and waiting for the outcomes from those. These, along with reviews referred to LeDeR between 1 March and 1 June 2021 (LeDeR online system shutdown), comprised the remaining 20.47%.

"She enjoyed having some pamper sessions and would often relax when her hair was being washed or her nails were being painted. She always took pride in her appearance."

Governance Arrangements

Clinical Lead

The LeDeR programme leadership team in LLR consists of 1.8 WTE senior Clinical Leads who support the reviewers, undertake quality assurance of reviews and carry out thematic analysis of completed reviews. The Clinical Lead roles incorporate the Senior Reviewer role as specified in the 2021 LeDeR Policy. They lead a governance panel of representatives from a full range of providers to identify the SMART actions.

Local Area Contact

The Local Area Contact role (LAC) is shared between four people, who provide expertise from both the health and social care sectors. They approve and submit the reviews and are a direct link to the Regional NHSE/I LeDeR team.

Administration

The LeDeR Team is supported by the LeDeR Senior Assistant, who manages all meetings and performs administrative duties, including recording case information, progress and data input and analysis the LLR LeDeR 'Masterbook', a secure file with controlled access. Several requests for data from the programme are requested regularly, facilitated by the Senior Assistant and LACs, with regular verbal updates at various meetings.

Steering Group

The Steering group meets on a monthly basis. A LAC has stood in as Chair of the group, which has oversight of the activity taking place within the programme, since April 2021. This was due to the original Chair, CCG Head of Mental Health and Learning Disability, going on secondment and not being replaced for the duration of that secondment. This should be rectified in 2022/23 with a new appointment.

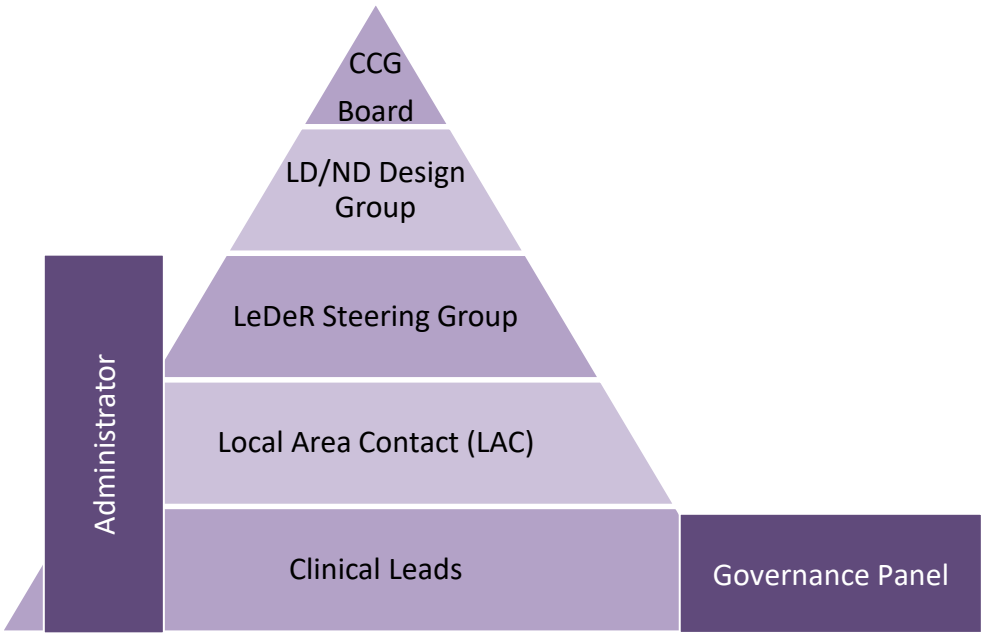
Membership of this group consists of senior managers from partner organisations including local authorities and both acute Trusts. The Steering Group has had representation from Primary Care/ethnic minority community.

Information from the Steering Group is shared monthly with the Learning Disability and Neurodevelopmental Design Group to either escalate concerns or promote achievements, which informs the CCG Board. Additionally periodic updates are provided for LLR Safeguarding Boards, CDOP and other stakeholders.

To ensure the LLR LeDeR programme has met its responsibilities under the Equalities Act, the Steering Group has endeavoured to engage with people with Learning Disability, their families and carers as well as voluntary groups, community and faith organisations to ensure views from a range of ages, demographic groups and cultures are captured. The Leicester City Council LD Partnership Board has a representative on the LeDeR Steering Group, who has lived experience and another person with lived experience began with the LeDeR leadership team on a regular basis as LeDeR EBE.

Governance arrangements are illustrated in Figure 2.

Figure 2



Equality Impact & Demographic Data

Age

Analysis of data from the local LeDeR system shows the mean age of death for people, both male and female with LD in LLR who died in 2019-20 was 58 years.

For adults only (18+) in that year the median age (used in NHSE National LeDeR Report) was 59. In 2020-21 this remained unchanged.

Median age of death for adults has increased by five years to 64

For cases completed in 2021-22, the median age at death of adults was 64, a significant improvement. This includes case that were referred before April 2021 and comprises 27% of deaths due to COVID-19. Many cases referred during 2021-22 are still ongoing and therefore the mean age for those people could not be confirmed at the time of writing.

Disability

The national data reports that of people with a disability 9.3% reported that their day-to-day activities were limited a little, and a further 8.3% reported that their day-to-day activities were limited significantly. LLR data showed that the activities of 9.1% of people with a disability were only a little limited whilst a further 7.1% of people with a disability were restricted a lot.

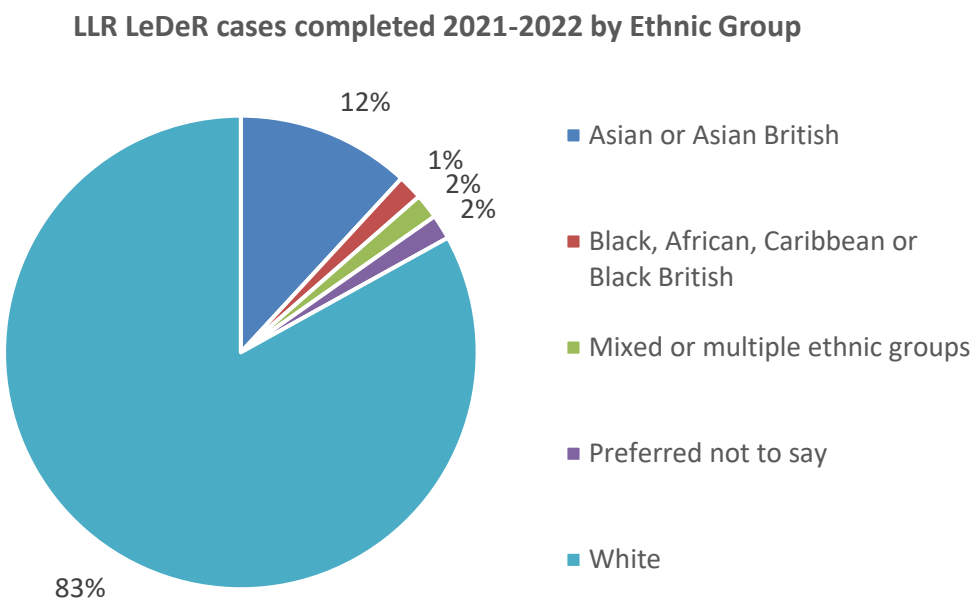
First Language

Compared to the England benchmark, Leicester, Leicestershire, and Rutland had a lower proportion of people who spoke English as their first language. In Leicester, Leicestershire, and Rutland the most widely spoken first language was English (88.7%), followed by Gujarati (4.3%), Punjabi (1.0%), Polish (1.0%), and Urdu (0.4%). These languages covered over 95% of the population of Leicester, Leicestershire, and Rutland.

Ethnicity

Compared to the England benchmark, LLR has a higher proportion of people from an Asian or other ethnic group background. However, this is more focused within the boundaries of Leicester city as Leicestershire and Rutland counties had a lower proportion of people from an Asian or other ethnic group than Leicester city or the England benchmark. Figure 3 shows 83% of cases were 'White' and 12% 'Asian or Asian British'. 'Mixed or multiple ethnic groups' comprised 2% and 'Black, African, Caribbean or Black British' at 1%. 2% had no ethnicity recorded.

Figure 3

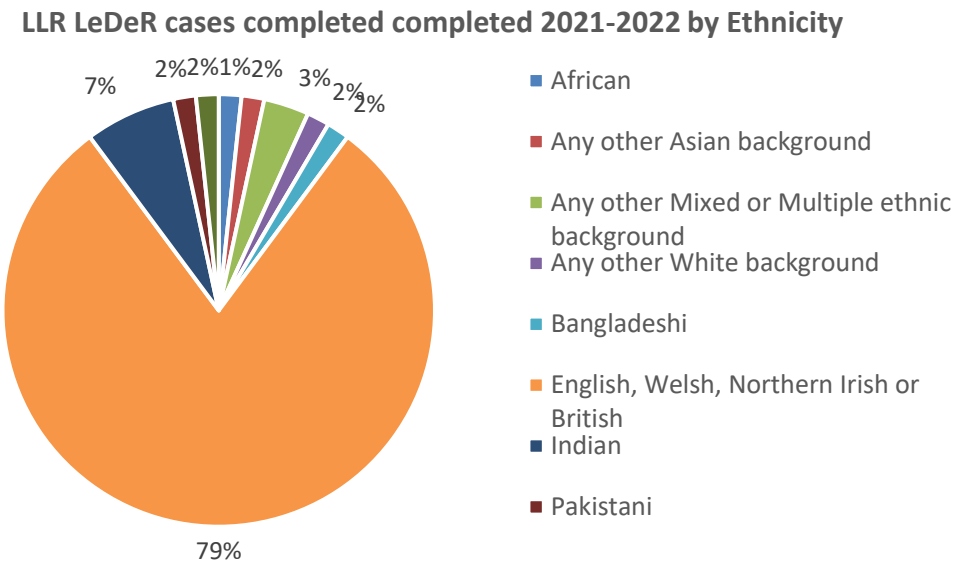


Looking at those wider groups broken down into individual ethnicities, Figure 4 shows that of all deaths referred to LLR in 2021-22, the majority, 79% were 'British' (White) 7% were 'Indian', 3% were 'Any other Mixed or Multiple Ethnic background''.

"Staff still regularly talk about him very fondly and he is greatly missed.

They were glad to be able to support him during the end of his life at home."

Figure 4



Ethnic Minorities

Looking at ethnic minorities only, with the 'English, Welsh, Northern Irish or British' group removed, it is easier to see distribution of deaths within those communities. These correlate with the overall composition of the LLR population.

Cases by Ethnicity

Figure 5

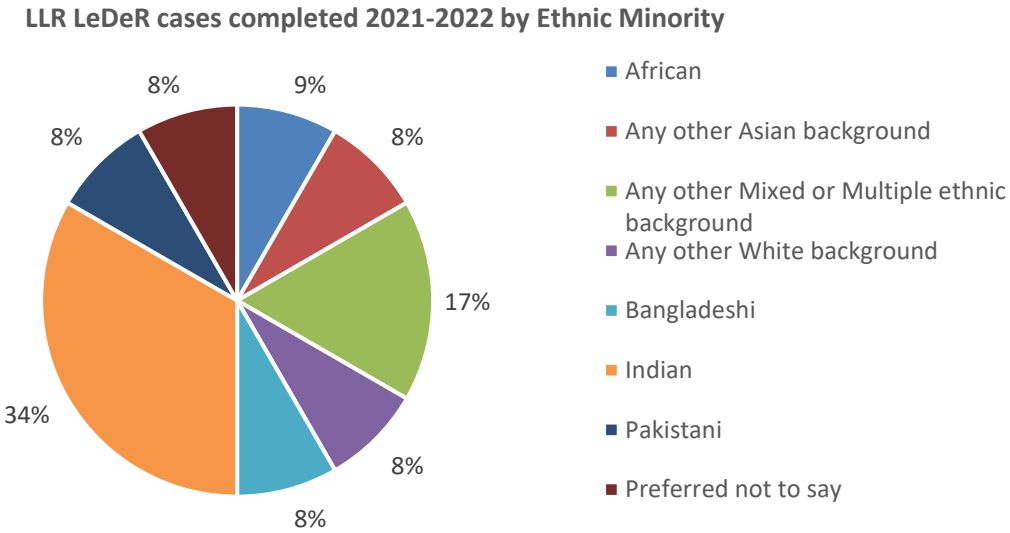


Figure 5 shows that the largest ethnic minority groups were 'Indian' at 34% and 'Any other Mixed or Multiple Ethnic background' at 17%. The remainder were fairly evenly distributed; 9% 'African', 8% 'Any other Asian background', 8% 'Any other White background', 8% 'Bangladeshi and 8% 'Pakistani'. 8% had no ethnicity stated.

Leicester, Leicestershire and Rutland has a very diverse population of mixed ethnic groups, especially within the boundaries of Leicester city. However, it has been a concern that the notifications of deaths amongst the LD/A population does not reflect this. As highlighted in the PDSA plan a clinical audit between LLR LeDeR and De Montfort University colleagues is being undertaken to determine reasons for this.

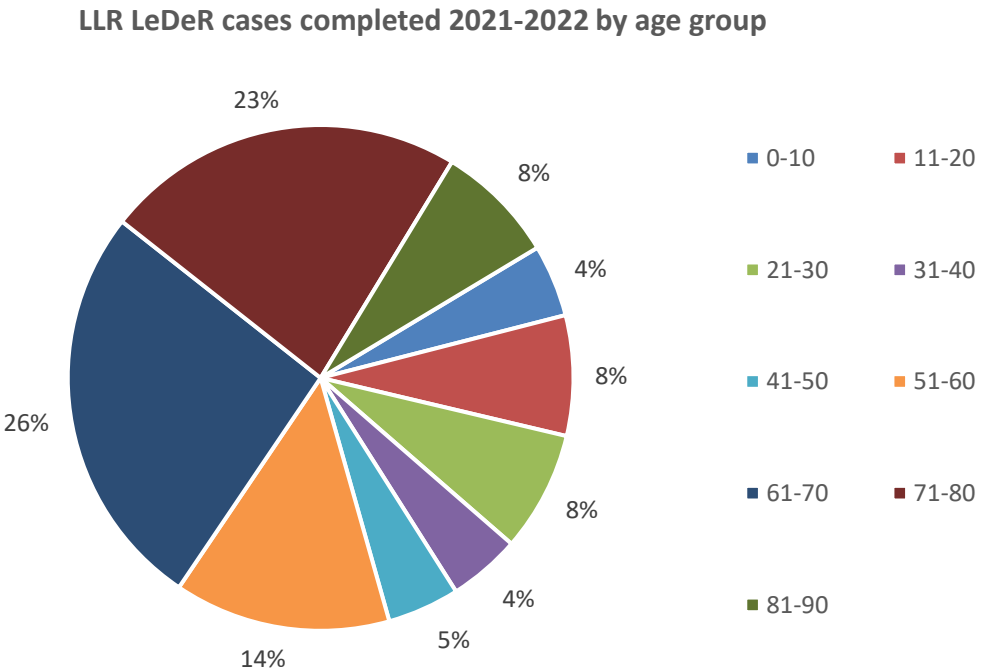
Cases by age group

Cases completed in 2021-22 are broken down into age groups in Figure 6. A total of 57% of cases were aged 61 or older (26% 61-70, 23% 71-80 and 8% aged 81 or older). 14% were aged 51-60. 41-50 and 31-40 age groups comprised 5% and 4% respectively, while 11-20 year olds were 8% and under 0-10 4%.

It is worth noting that 12% of all reviews completed within 2021-22 were of CDOP cases (Child Death Overview Panel). Some of these had been on hold for a significant amount of time and as a result, the average age at death for the year was artificially lowered (56).

Looking at adults only (18 and older), the mean age at death was 62. LeDeR nationally however has traditionally reported the median age. In 2020-21 in LLR, the median age was 59. In 2021-22, it has risen to 64.

Figure 6



Cause of Death

Of all case reviews completed in 2021-22, the two most prevalent causes of death were COVID-19 and Respiratory illness (each at 27%). Taken together, these represent 54% of all LLR LD deaths reviewed within the year.

54% of deaths were from COVID-19 or Respiratory causes

Respiratory deaths

A thematic analysis of Respiratory Deaths was conducted on earlier deaths to the programme (Deaths notified to LeDeR on or before 31st March 2021).

The top two areas of focus around the quality of the lives and deaths of those dying from Respiratory related deaths were:

1. Advanced care planning is not happening early enough; or in a multiagency manner and plans of how to support avoidance of hospital admissions for those with known readmissions are not being instigated.
2. The Mental Capacity Act (MCA) is not being applied and the decision making framework is not being operated. This is in relation to both preventative healthcare and ongoing treatment decisions related to respiratory illness [such as a requirement for a Percutaneous Endoscopic Gastrostomy (PEG)]. Consensus in the reviews found that there appears to be a general lack of instigation and enquiry regarding the MCA in the health and social care of the person during their life and death.

Positive experiences highlighted compassionate, person centred care and collaborative working to be of a particularly high standard within both health and social care. The support from the Learning Disability Acute Liaison Nurses during hospital admissions demonstrated noticeable improvements in the care and treatment people received. Timely support from GP practices and individuals were supported to die at home, supporting their wishes, signifying dignity and respect at the end of life.

This analysis has prompted a deep dive into those deaths from Aspiration Pneumonia, early findings indicate:

- Aspiration Pneumonia appears to be being used as an overarching cause of death for people with a learning disability, even though reviews do not demonstrate this to be the case.
- Aspiration Pneumonia diagnosis during treatment appears to also be used as an overarching diagnosis for repeated chest infections.
- Identification of the deteriorating patient requires improvements, where aspiration pneumonia is present.

- An aspiration pneumonia workstream to be convened.

Two actions have been developed

Aim:

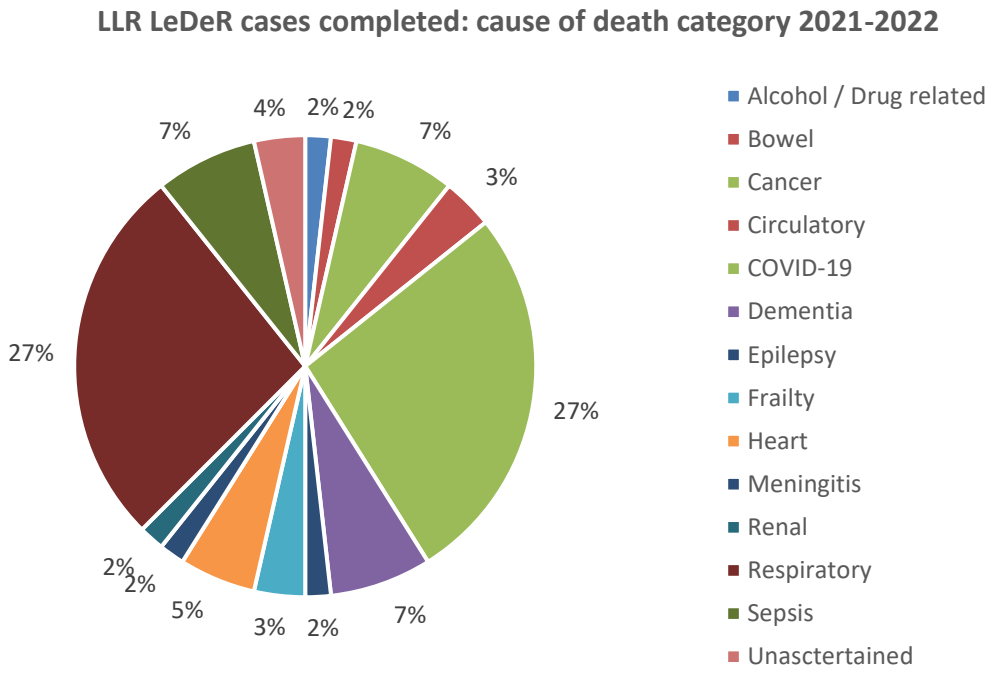
1) To improve the holistic care of people with a learning disability when diagnosed with aspiration pneumonia.

2) To ensure National policy and recommendations are followed locally in LLR in the care and management of Aspiration Pneumonia diagnosis in people with a learning disability.

Other deaths

Other Causes of death from completed cases were 'Cancer' 'Dementia' and 'Sepsis' (each at 8%), followed by 'Heart' conditions 'Alcohol/drug related', 'Circulatory', 'Frailty' and 'Meningitis'. 2 Causes of death were unascertained (see Figure 7).

Figure 7



The percentage of deaths related to respiratory causes has reduced from 46% in 2020/21 to 27% in 2021/22, which is closer to national averages. However, this in part due to COVID-19 related deaths not being separated from other respiratory deaths in 2020/21. The combination of respiratory and COVID-19 related deaths in 2021/22 is 54%.

Thematic analysis was undertaken of all reviews completed before 1 April 2021. Only respiratory deaths were analysed, this included but was not limited to:

- Aspiration Pneumonia
- Respiratory Failure
- Pneumonia
- Bronchiectasis
- Community Acquired Pneumonia
- Lower Respiratory Tract Infection

Areas of positive practice found:

- Many people died at home, which was their wish
- Compassion and honesty (UHL)
- Successful personal health budgets (LA)
- Health and social care services working in a person-centred way and listening to families
- Best interest decisions conducted well
- Collaborative working (GP UHL and LPT)
- GP's visiting in a proactive and timely manner on several occasions.
- Support from the LD Acute Liaison Nursing team was evidently consistently beneficial for high quality care

Top two themes to explore further:

- Advanced Care Planning
- Mental Capacity Act

"They had been best friends for around 18 years and social services recognised this, moving them to different care agencies together when needed allowing their friendships to continue."

Specific actions (objectives) resulting from this analysis are shown in Table 2.

Table 2

Aim	Objective

Respiratory Deaths Thematic Analysis 1) End of Life Care Aim: To improve the end of life care of people with a learning disability (LD) in line with national policy and recommendation	• Launch and embed Accessible Advance Care Plan
	• Establish a working group to
	  ○ identify systemic barriers for people with a LD in end of life care
	  ○ create an action plan for presentation at LeDeR Steering Group
	Achievement will be demonstrated when the Reduction in the number of Recommendation on improving EoL are noted from LeDeR Deaths.

Respiratory Deaths Thematic Analysis 2) Mental Capacity Act (MCA) Aim: To improve the use of the MCA including knowing when to instigate, in health and social care professionals when working with people with a LD.	All members of LeDeR Steering Group to • escalate to their organisational MCA lead (or individual responsible for MCA such as safeguarding lead or principle social worker) the lack of undertaking of the MCA in the health and social care treatment of people with a LD in LLR • bring to the LeDeR Steering Group an action plan as to how to address this to enable a wider cross organisational action plan to be produced and shared plans There is a specific gap to be highlighted which is professionals knowing about MCA but not instigating it in practice.
1) To improve the holistic care of people with a learning disability when diagnosed with aspiration pneumonia. 2) To ensure National policy and recommendations are followed locally in LLR in the care and management of Aspiration Pneumonia diagnosis in people with a learning disability.	• Clear understanding from the literature on the evidence base of reflux and aspiration pneumonia diagnosis. • SALT to undertake a Literature review on the evidence base of reflux specific to people with a learning disability on 18th Feb 2022. • To ensure the responsibility to manage aspiration pneumonia is a multi-disciplinary responsibility • Define who's role is it to manage secretions (excess or poor control) and reflux • Patients being referred to UHL in a timely manner • LD Physio to undertake a literature review to establish requirement for specialist LD Chest physio in adults with LD. If not required, specify where adults with a learning disability can access chest physio after childhood. • Plans of care to evidence consideration of aspiration pneumonia when the patient has this diagnosis (all professionals) and where ceiling of care has been reached. • Consideration of differential diagnosis to be recorded. Potential aspiration pneumonia management flow chart.

This thematic analysis requires further scrutiny and LLR LeDeR intends to understand the death from aspiration pneumonia in further detail to understand why this cause of death remains so high.

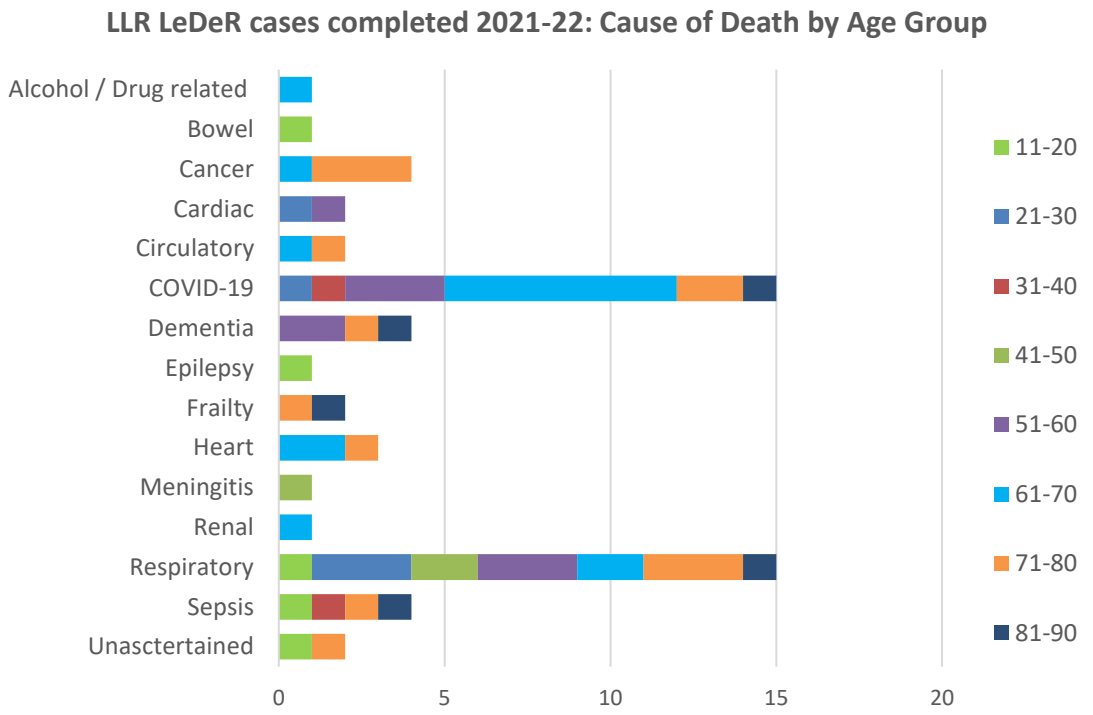
The respiratory deaths thematic analysis has prompted a deep dive into those who have died from aspiration pneumonia, this will be commenced in the coming year as part 2 of respiratory deaths thematic analysis is formulated. Early findings into those who have died from aspiration pneumonia is indicating there may be a potential for people with a learning disability to be experiencing diagnostic overshadowing at the end of their life, with aspiration pneumonia being used as a universal diagnosis at death in some instances.

This has implications for the recommendations that LeDeR can make therefore, it is imperative to further evaluate those deaths. LeDeR will be leading a multi-agency work stream focusing on aspiration pneumonia and people with a learning disability. The workstream will be evaluating the evidence base, research and NICE Guidelines around the diagnosis and care of people with dysphagia and aspiration pneumonia and deliberate local practice for improved care and outcomes for people with a learning disability in LLR.

Cause of death by age group

Cause of death is broken down by age group in Figure 8. It is clear that the main causes of death, COVID-19 and Respiratory, were most prevalent in the 61-70 and 51-60 age groups respectively. COVID-19 was in fact the most common cause of death in the 61-70 age group. Respiratory illness was more prevalent in the younger age groups than COVID-19.

Figure 8

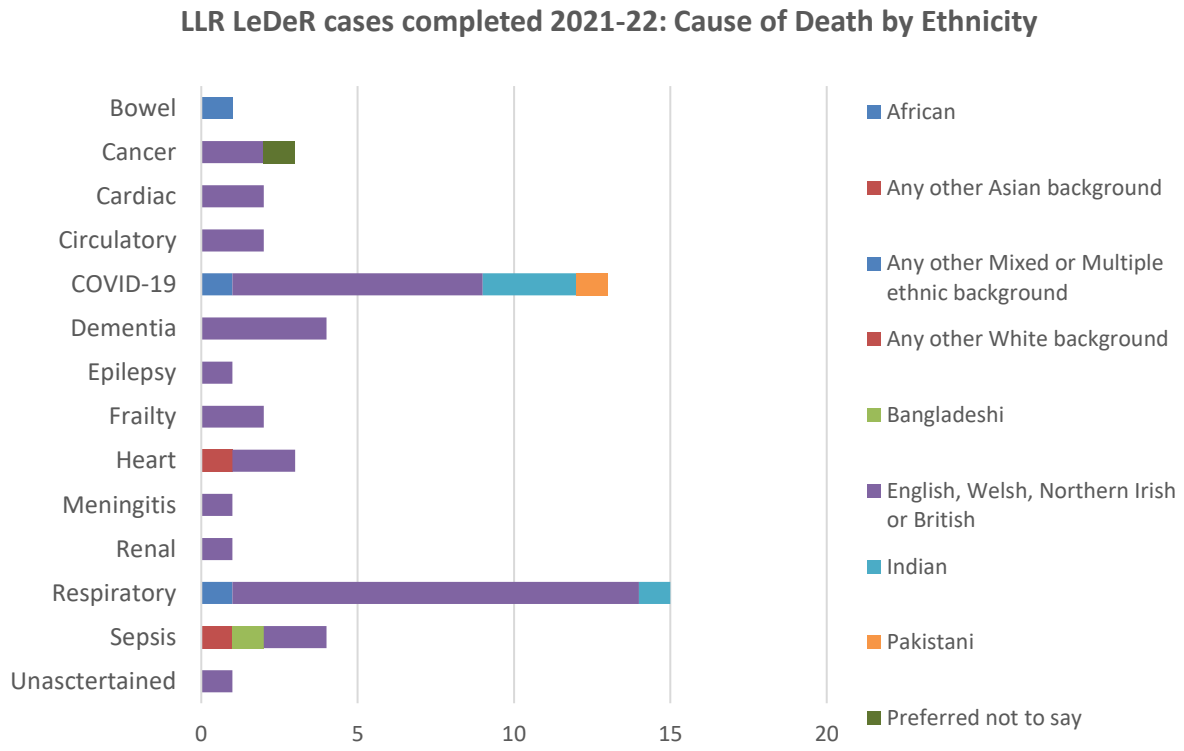


"She loved animals and thoroughly enjoyed when the care home would have the animal interactions, cats were her favourite!"

Cause of Death by Ethnicity

Looking at Figure 9, cause of death prevalence is proportionately spread across the ethnicities, though the proportion of 'Indian' deaths due to COVID-19 appears more significant than other ethnicities.

Figure 9



COVID-19

The continued absence of any reporting or analysis facility in the LeDeR online system meant that all data management and analysis was carried out externally to that system, and this was true for COVID-19 cases.

Thematic Analysis on Covid-19 deaths is a priority for LLR LeDeR. At time of writing this was in the process of being conducted with results and analysis available later in 2022.

As shown earlier in Figure 7, just over a quarter of all deaths (27%) were from COVID-19.

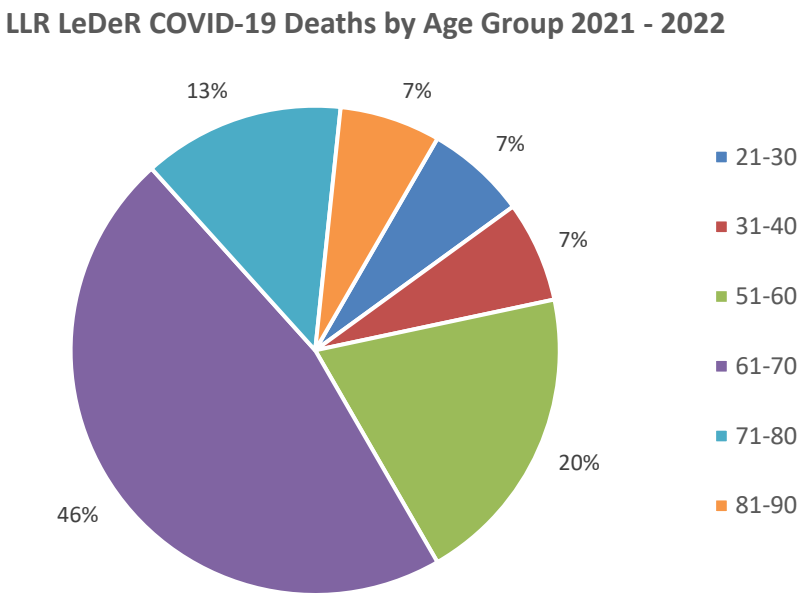
COVID-19 deaths by age group

In the UK, the average (mean) age of death due to COVID-19 in 2021/22 was 76 [ONS, 27 April 2022, www.ons.gov.uk]. In LLR LeDeR cases, the mean age of COVID-19 deaths was 62; 14 years younger than national average. However, it is interesting to note that other causes of death occurred at a younger age, a mean age of 54. Some of this is due to several CDOP

cases being completed that were outstanding and on hold from the previous year and which have biased the mean age overall downwards to 56 years.

It is clear to see from Figure 10 that almost half of all deaths from COVID-19 (46%) were of people aged 61-70. 20% were aged 71-80 13% were 51-60. The youngest COVID-19 death was in the 21-30 age group.

Figure 10



COVID-19 and ethnicity

Of the 15 cases in which COVID-19 was named the primary cause of death, ethnicity recorded in 13 of those. Figure 11 shows a contrast to deaths overall, as originally shown in Figure 3; 83% of all deaths were 'White English, Welsh, Northern Irish or British', but only 69% of COVID-19 deaths were of this ethnicity. Only 12% of all deaths were 'Asian or Asian British', but this group comprised 31%. Overall, only 15 deaths were due to COVID-19 so it is not necessarily significant statistically but is still of concern and will be examined in thematic analysis. Comparison data table is shown in Table 3.

Figure 11

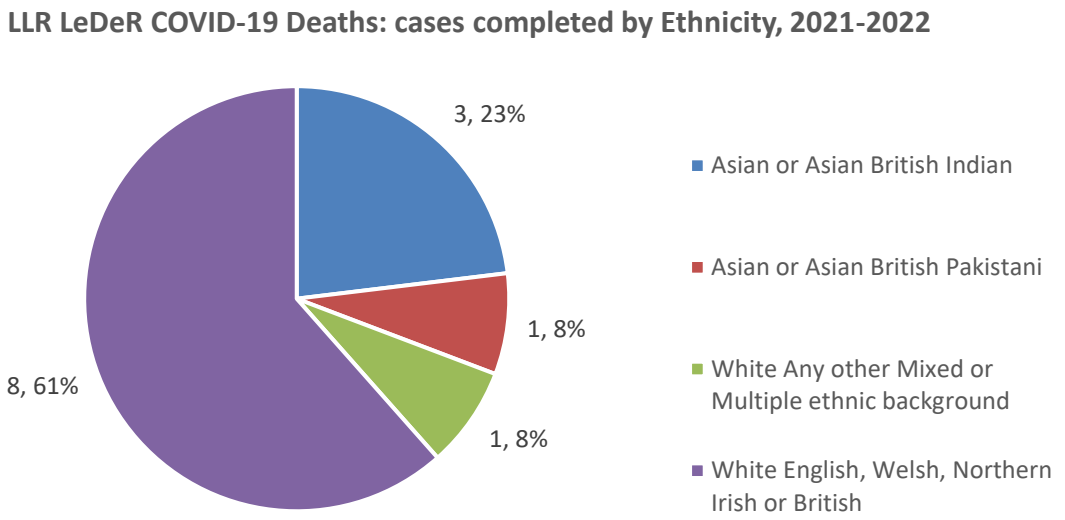


Table 3

Ethnicity	All Deaths	COVID-19 Deaths
Asian or Asian British	12%	31%
Black, African, Caribbean, or Black British	2%	0%
Mixed or Multiple Ethnic Groups	2%	0%
White	83%	69%
No ethnicity recorded	1%	0%

"They enjoyed making homemade cards and used to sell them to raise funds for charity"

Service Improvement achievements

A wide range of improvements have been achieved within the year.

LPT has introduced a range of service improvements supporting the LeDeR programme:

- The Families, Young Person and Children / Learning Disability Directorate (FYPC/LD) has implemented a learning from deaths forum which welcomes clinicians to review the care and treatment provided by LPT and identify lessons to be learnt locally in a timely manner.
- LeDeR clinical leads are engaged with LPT's governance process allowing for robust information sharing and influencing lessons learned.
- LPT LD Community have identified progression of a complex physical health pathway to incorporate deteriorating patients and end of life care.

- LPT LD services have improved access to services and mobilised a new access to service pathway and team which has improved its assessment process, responsiveness and utilised the learning from LeDeR to inform the implementation of this pathway, e.g., introduced physical health observations at core assessment, purchased accessible scales to ensure all patients accessing the community LD Team have baseline weight and ongoing monitoring if required as part of their treatment and care plan.
- The service has also employed a practice development nurse who will be given set projects across LD services to improve clinical skills in relation to physical health, recognising the deteriorating patient and end of life.
- LPT is also engaging in the Learning Disability and Autism (LD/A) Collaborative Meeting ensuring a LLR approach to learning lessons from LeDeR is embedded in the 3 year plan.

UHL has undertaken a variety of improvements to enhance the experience of people admitted to hospital. These include:

- LD Lead Nurse has liaised with the Lead for the hospital post-pandemic recovery programme to identify and prioritise those patients who have had long waits for appointments or procedures due to the pandemic.
- The team has worked with the Surgical Pathway Lead to produce easy read leaflets regarding pre-operative assessment.
- LD Liaison Nurses are attending Mortality & Morbidity meetings across different Clinical Management Groups where a structured judgement review (SJR) for a patient with a learning disability is being discussed to identify any specific learning related to their care. (There are plans for this to be further developed in 2022 with the acute liaison team supporting the completion of the LD specific slides prior to the Mortality and Morbidity meetings and jointly presenting them with the Doctors.)
- Identified LD Champions across UHL with a passion to 'get it right' for patients with learning disabilities and provided them with some online resources and training with a plan to meet in 2022 to further explore the role to enhance patient care

- Designed and produced a Traffic Light Lanyard Pin Badge to be awarded to hospital staff who consistently go the 'extra mile' to support patients with learning disabilities.
- Continued to provide direct support to the wards, departments and all areas of the hospital to identify and implement reasonable adjustments for patients despite current pressures and a reduced team.
- Produced and presented an annual report to the Mortality Review Committee regarding the deaths of patients with a learning disability.

Leicestershire County Council has undertaken Continuous Professional Development learning sessions with all Social Workers and Occupational Therapists, this involved learning from the life and death of someone with a learning disability, who was also part of a safeguarding enquiry. This case study enabled professionals to explore the challenges faced by people with learning disabilities, in relation to health inequalities. Through the session they were able to reflect on their practice and consider how this learning transitions into their professional practice. In addition to this, all newly appointed staff that work within the Learning Disability and Autism Teams are provided with comprehensive learning development training, that explains the importance of the LeDeR programme and how learning from deaths and lives of people with learning disabilities and autism can support professional development and our work with people across Leicestershire.

Rutland County Council has maintained a monthly Continuing Professional Development session delivered to all our Adult Social Care (ASC) teams including therapy and housing. At least one of these sessions is scheduled annually to deliver a learning session on LeDeR as well as information shared at team meetings across ASC especially those with a high staff turnover.

Leicester City Council continues to develop its internal review group process and quality assurance mechanisms where learning into actions from LeDeR reviews, in relation to care and support providers or care management process, can be embedded.

In addition, representation from both contracts and assurance and care management teams

"He enjoyed slapstick humour and had a very dedicated staff team who learned how to communicate with his non-verbal signs."

steering group where action plans are approved and monitored. There have been several engagement sessions from LeDeR Clinical Leads and Local Area Coordinators at management sessions, team meetings and provider forums including the shared lives teams. This has enabled the reinforcement of the message that LeDeR is a system wide responsibility and as such we will continue to ensure that there is a process for supporting the implementation of learning into action.

Future Plans

2021-22 has been a year of significant change and development for the LeDeR programme and the LLR LeDeR team has effectively coalesced into a proactive team with some strong plans for the forthcoming year. It is important to highlight that the new reporting platform can only receive the reviews and does not include a facility to generate any reporting from the reviews. Any datasets and subsequent reports have been designed from a dashboard formulated by the LLR LeDeR team. Therefore, data presented in this report may not be comparable with information presented by other LeDeR programmes.

It is hoped that comparable information will be generated by improvements to the national reporting platform through improved liaison with NHSE/I. One member of the LLR LeDeR Senior Team has enrolled onto the national Technical User Research Group to encourage and support this work.

The role of the person with lived experience will be developed as the individual gains confidence and experience. Initially, attendance and support at the LeDeR Steering Group will be the priority with a progression to advising on the actions required to implement recommendations from the reviews.

To comply with directions in the national policy, the LLR LeDeR programme has recruited 1.6 WTE and retained 2 supplementary reviewers. Their role will be to support the programme by undertaking reviews, monitor progress of reviews, support the administrative assistant to update and cleanse data and support the implementation of recommendations from reviews.

The substantive Clinical Lead posts commenced in June 2021 and together with the administrative assistant developed an in-house data set to monitor review progression and produce reports. This will be refined on an 'as and when' basis during the coming year.

There has been a suggestion to link with another CCG/ICS to 'share' reviewers and this will be explored in more detail over the coming months. A toolkit for reviewers has been developed by the Clinical Leads that has been widely shared across the Midlands LeDeR network. This will be regularly revised as required by the clinical leads and new substantive reviewers to ensure consistency in the approach to reviews.

The regional NHSE/I, to comply with the national policy, has requested support to quality assure completed reviews. Following discussion with NHSE/I and other LeDeR programmes, a system of peer review has been suggested, which will be developed further in partnership with NHSE/I and other area programme leads.

The LLR Clinical Leads have completed an in depth thematic review of respiratory associated deaths and identified SMART actions as outcomes from the review.

The team has identified a need for further thematic reviews of:

- Second thematic analysis of respiratory deaths post April 2021
- COVID 19 related deaths
- Deaths those associated with nutritional status, particularly weight loss or gain in the months leading up to death
- Constipation and continence issues as contributing factors

The Clinical Lead roles have specific responsibility to embed learning into action and support a cycle of learning, positive change, monitoring and evaluation throughout each year. The outcomes from the reviews and the in depth thematic reviews will be periodically reported from the Governance Panel to the LeDeR Steering Group; LD and Autism Collaborative meeting; the ICS Board and NHSE/I.

The thematic reviews will take place during the forthcoming year creating links with clinical specialists outside of the LeDeR programme such as Physiotherapists, Occupational

Therapists, Speech and Language Therapists and expert nutritional clinicians. Whenever possible experts from social care and care providers will be consulted and included in developing the improvements in care provision. The intention is to raise the profile of LeDeR as a collaborative and inclusive quality improvement programme across all areas of care and that it is not a 'stand-alone' programme.

In addition to the proposed improvements in the quality of care and improved experience of people and their families, the LLR LeDeR programme is participating in the national Learning Disability week in June aimed at raising the profile of learning disability in the community as well as that of the LeDeR programme. We have liaised with three third sector organisations and individuals, their families and carers during the month of June will be invited to create video clips, audio clips, artwork, prose or poetry of their experiences, whether positive or negative, that will be shown during events held in LD week in June.

Strengthened links, formalised and streamlined partnership working with Safeguarding Adults and Child Death Overview Panels CDOP, resulting in several outstanding CDOP cases being completed in-year.

The LLR LeDeR programme senior team has identified that the cause of death is not always easily accessible at the time of notification. This has been known to be a cause of difficulty for reviewers when speaking directly with families. To overcome this, the LLR team intends to work with the city and county registrars to develop a system to access death certificates in a timelier way.

Conclusion

In conclusion, the LLR LeDeR team has worked tirelessly and in collaboration with partners and stakeholders to progress the LeDeR programme against a backdrop of significant change within the national programme and local organisational changes.

Reflecting on the principles of the LeDeR programme, the LLR team has effected change and is beginning to make differences to the lives of people with LD and autism, their families and carers who have been enabled to contribute to reviews. Together with other sources of information, a rounded approach to identifying learning has been accomplished, the outcome is the increased recognition of the programme as a force for constructive service improvements and enhanced quality of care for those people with LD and autism, their families and carers.

Appendix I: LLR LeDeR PDSA Cycle 2

1st April 2022

Area to explore	What could we do better	Where are we now	Cycle 3 of PDSA
Recruit further experts by experience and ensure autism is included and representation of ethnic minority is included.			
Population reporting to be undertaken as a clinical audit. DeMontfort University research colleagues to analyse the data and feedback to LeDeR Clinical leads for synthesis.			
Communication Plan is ad hoc.	A clear, strengthened and organised communication plan that is well structured, factual, empathetic and ignites change.		
Recruitment of LeDeR Reviewers on fixed term contract.	Permanent roles would ensure the widest range of suitable candidates and	Funding in place only for 2022/23.	
A LLR LeDeR Vision	LLR LeDeR Programme must ensure its independence whilst equally collaborating with partner agencies. A clear vision to be defined based on LPT, CCG, Local Authority, UHL and national LeDeR visions.		
Yearly planning calendar for LLR LeDeR	Understand, outline and define the input and output for LLR LeDeR to prevent duplication and improve efficiency and professionalism.		
Process for obtaining death certificates is unclear.			
Thematic Analysis: • **Respiratory Deaths** • **COVID-19** • **Weight**			
Clearer and more structured reporting functions would support easier thematic	The Masterbook of all reviews was developed and implemented in 2021/22.		

Area to explore	What could we do better	Where are we now	Cycle 3 of PDSA
analysis for future. In the absence of any data download or reporting functionality from the LeDeR web platform, this will need to be developed locally.	For 2022/23 a qualitative data analysis tool would prove beneficial.		
Sharing of LLR LeDeR Areas to Explore and actions (not Steering Group SMART Actions) are not regularly shared in a timely manner to relevant service.	Set up a quarterly communication out to share those actions with the relevant authority.		

APPENDIX B

NHS
Leicester, Leicestershire and Rutland

LeDeR Annual Report 2021/22

Learning from Deaths of people with a Learning Disability and autistic people: review programme

NHS Leicester, Leicestershire and Rutland is the operating name of
Leicester, Leicestershire and Rutland Integrated Care Board

Improving outcomes – Primary Care

- Read the **weekly e-newsletter that is sent to all GP practices**, it now includes a Learning Disability section, with all the key information
- **Designate a Clinical Lead GP for Learning Disabilities in every Practice. S**upport and advice for this person is available from ICB Clinical Leads for LD
  - Dr Graham Johnson graham.johnson2@nhs.net and
  - Dr Archana Anandaram a.anandaram@nhs.net
- Ensure individuals are included on the **LD QOF Register*** this is the gatekeeper to being invited to LD AHC, awareness of reasonable adjustments, safeguarding and referrals to secondary care.
- **Instigate RESPECT forms** when the person is well enough to ensure their wishes are heard, in primary healthcare. People with a LD, their family and carers should be supported to understand about RESPECT forms and they differ from a DNACPR.
- Use of **regular appropriate MCA Assessment**
- Promote **hospital passports** for people with LD and to promote at consultation/LD AHC*
- Please increase knowledge and awareness of the **"Adult not brought to appointment;Y2de1**" (Was not brought) read code and safeguarding policy, especially for GP Receptionist teams. https://vimeo.com/392944939

*Use the support of our Primary Care Liaison Nurse Team lpt.pcln@nhs.net

We are working on

- **Wheelchair scales**; once we have them we'll update the GP Annual Health Check and LD Newsletter with guidance on accessing them.
- Improving and simplifying the AHC template
- **Clarifying the blood letting pathway**, designating a Co-Ordinator and will share this with you also.

Improving outcomes – Secondary Care

- Effective planning, identification, and consideration for people at the end of their life through timely commencement of **End of Life care pathway**
- **Communicate with and remind Care Providers** they are welcome to support people with a learning disability in hospital and advocate for them
- Review process of **community follow up after discharge**. E.g. CLDT discharge coordinator in LPT could feed into LPT long term plan
- Establish and communicate as early as possible, the **funding** required when someone with an LD goes into hospital
- Establish early dialogue with **family and carers** so their needs are taken into account when giving information
- Use of **regular appropriate MCA Assessment**
- Promote use of **Hospital Passport**
- **SALT to consider leading a REFLUX campaign** for people with LD in partnership with LeDeR team. Contact us at llrlederadmin@nhs.net
- Where a hospital has been informed that a person has a LD, this is to be communicated to other staff early. Any information about the person/resources to also be circulated amongst staff supporting the patient at admission.
- **Inform Acute Liaison Nurses** immediately of any hospital admission of a person with LD and give ALN contact details for family and carers.
- Pursue wider training for other staff around supporting a patient with LD in an acute setting, so the ALNs are not pressurised with the support required to be provided.

Improving outcomes – Community Care

- **Support people to live where they choose**, and enable them to make decisions in a timely manner. *Funding should not be a barrier.*
- Ensure that **all care providers have access to current, wider learning disability services** and know who to contact.
- **Ensure all care providers clearly understand when a RESPECT form is to be instigated** by all everyone including people with a learning disability, family, carers, health and social care staff
- Use of **regular appropriate MCA Assessment**
- Promote training and education around the u**se of tools to help staff recognise the deteriorating patient**.
- Ensure care providers are **appropriately risk assessed and safeguarding** is assured
- Ensure that when sourcing residential care placements that an individual's **culture, language, preferences and communication needs** are take into account.
    - Put steps into place to **ensure that these needs can be met at all times** by the identified care provider.

LeDeR aims

- To support improvements in the quality of health and social care service delivery for people with learning disabilities and people with autism
- To help reduce premature mortality and health inequalities for people with learning disabilities and people with autism

Two types of review

- Focused (expected 35%) automatically for
- Autism-only
- Ethnic minority
- MH restrictions in last 5 years of life
- If family request
- Allocated locally if a priority area in LLR

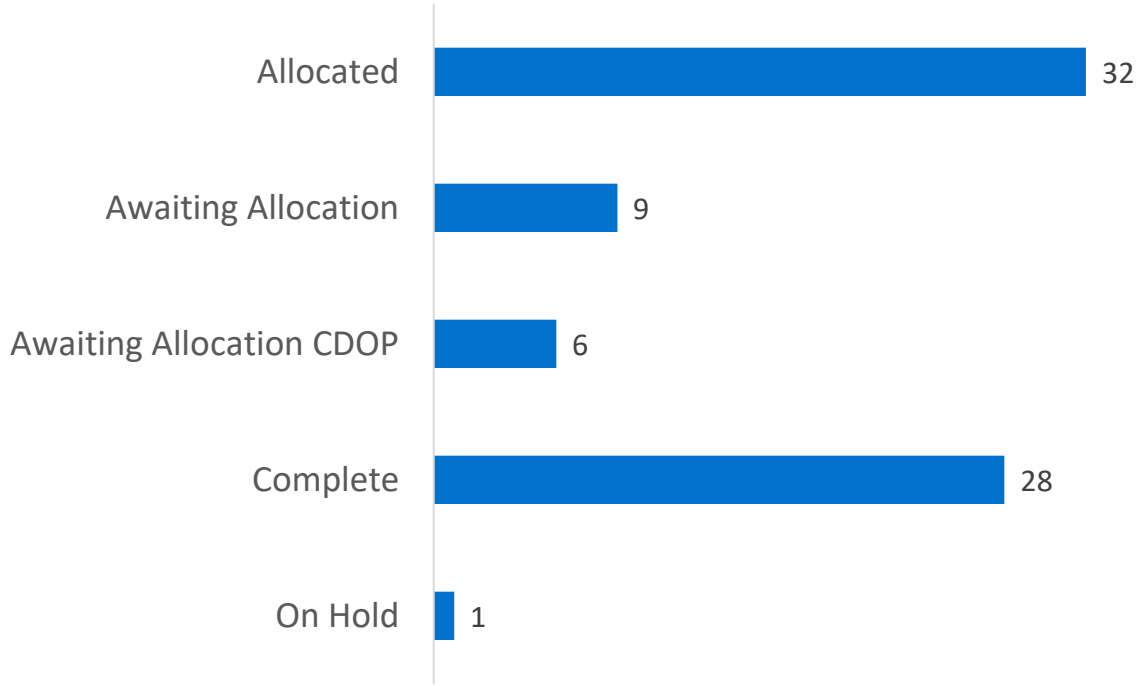
- Initial all other cases

Programme progress

This year we…

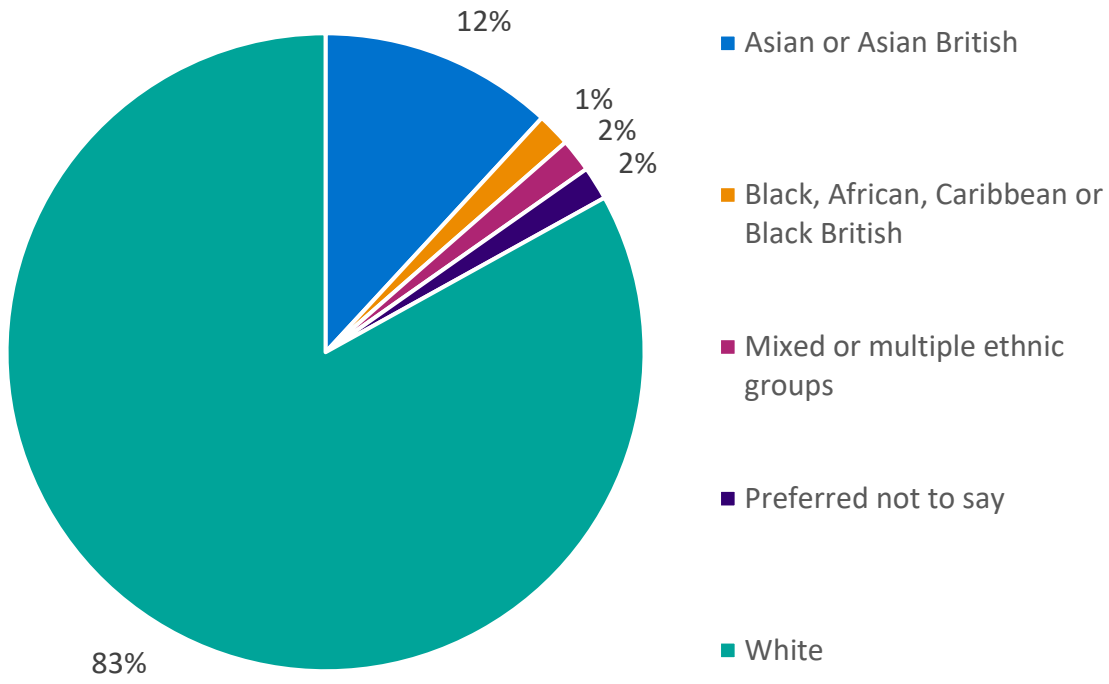
- Received 77 referrals of death
- Completed 65 reviews
- Appointed a new team, with some permanent roles
- Set up governance panels to agree actions from learning
- Refreshed our Steering Group

Case status at year end

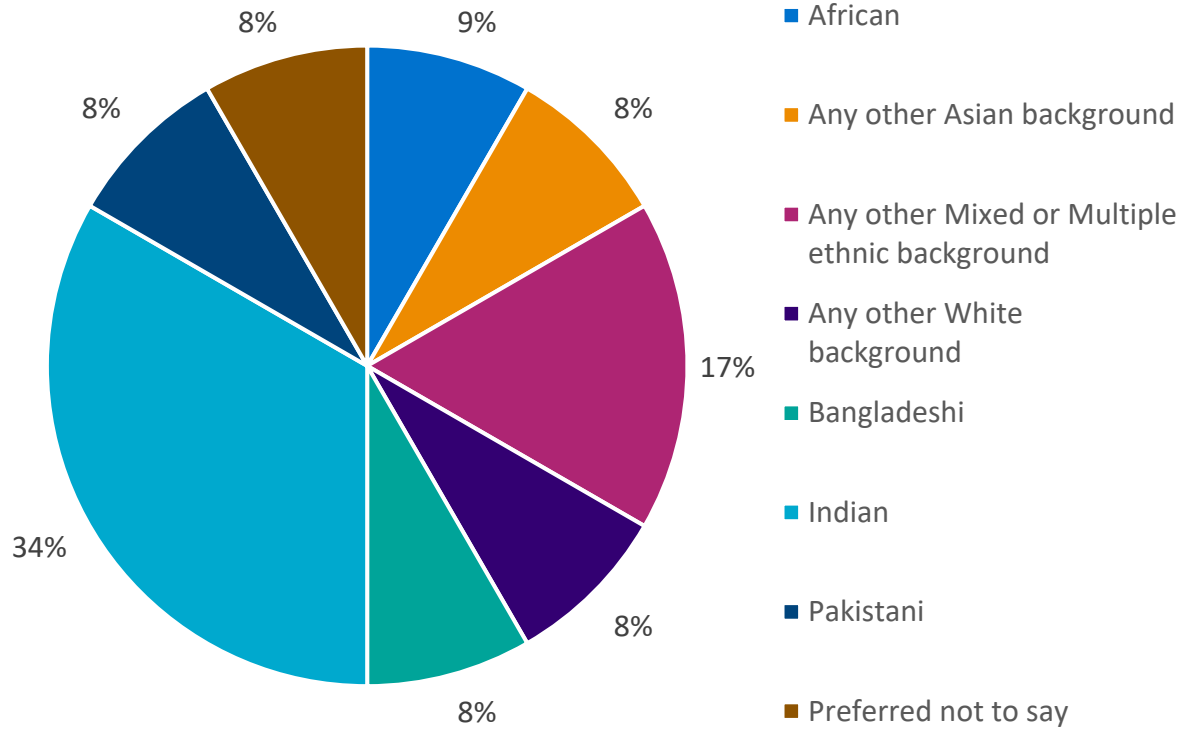


Cases completed in year - ethnicity

Ethnic Group



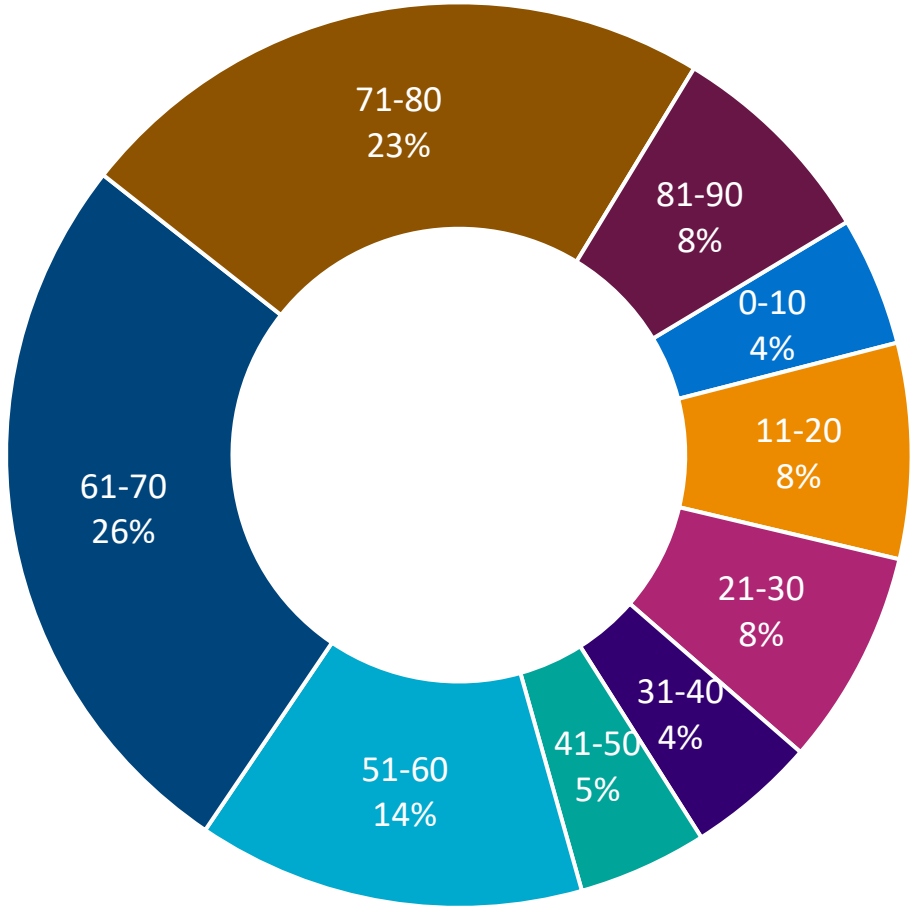
Ethnic Minority



Cases completed in year – age groups

- The majority of people died aged 61 or older (57%) and more than half of those were over 70
- 14% were 51-60
- Among the younger age groups (Under 51) 11-20 and 21-30 each comprised 8%

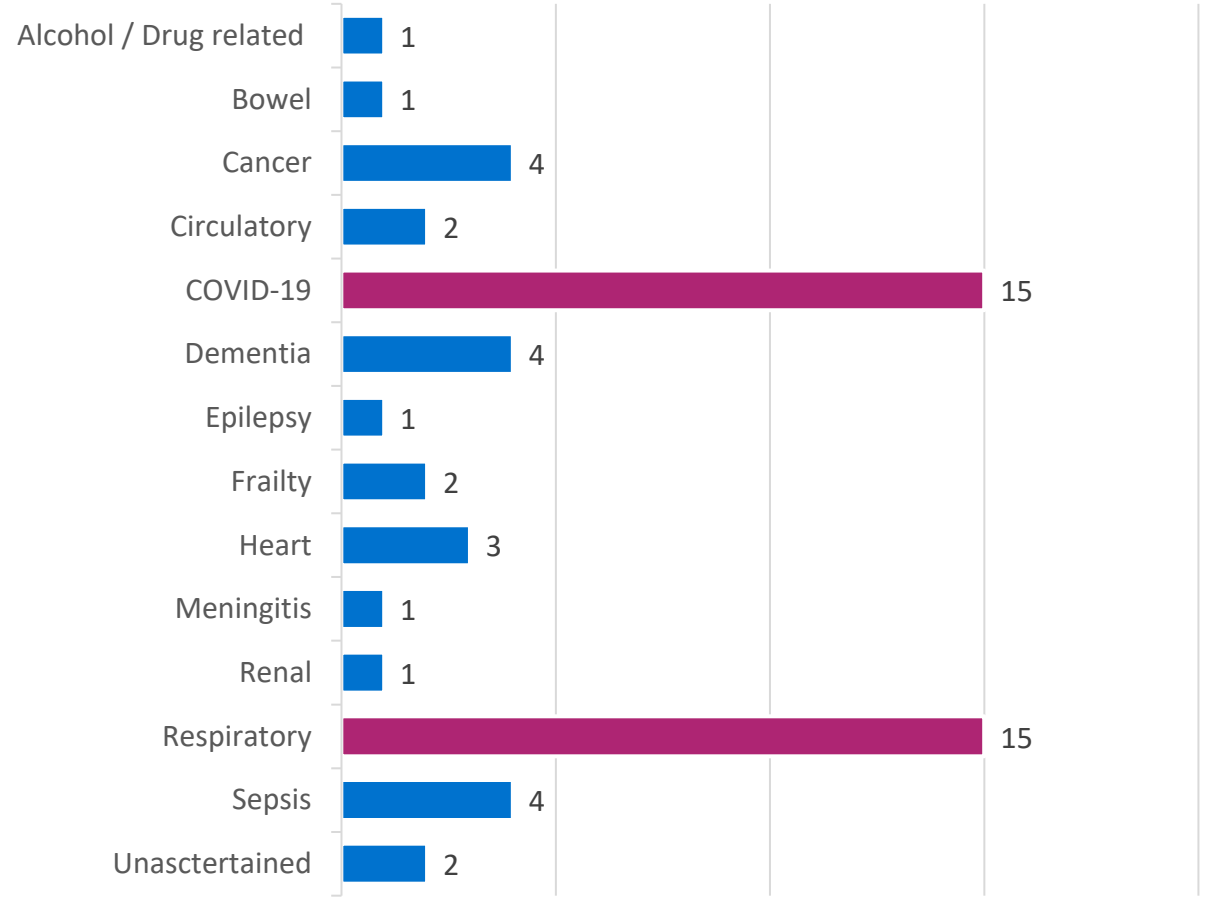
- Median age at death nationally was 62
- **In LLR, it was 64 for adults**
- **Children with life-limiting conditions now transitioning into adulthood**
- In the previous 2 years, it was 59



Causes of death

54% of all deaths were from 2 causes

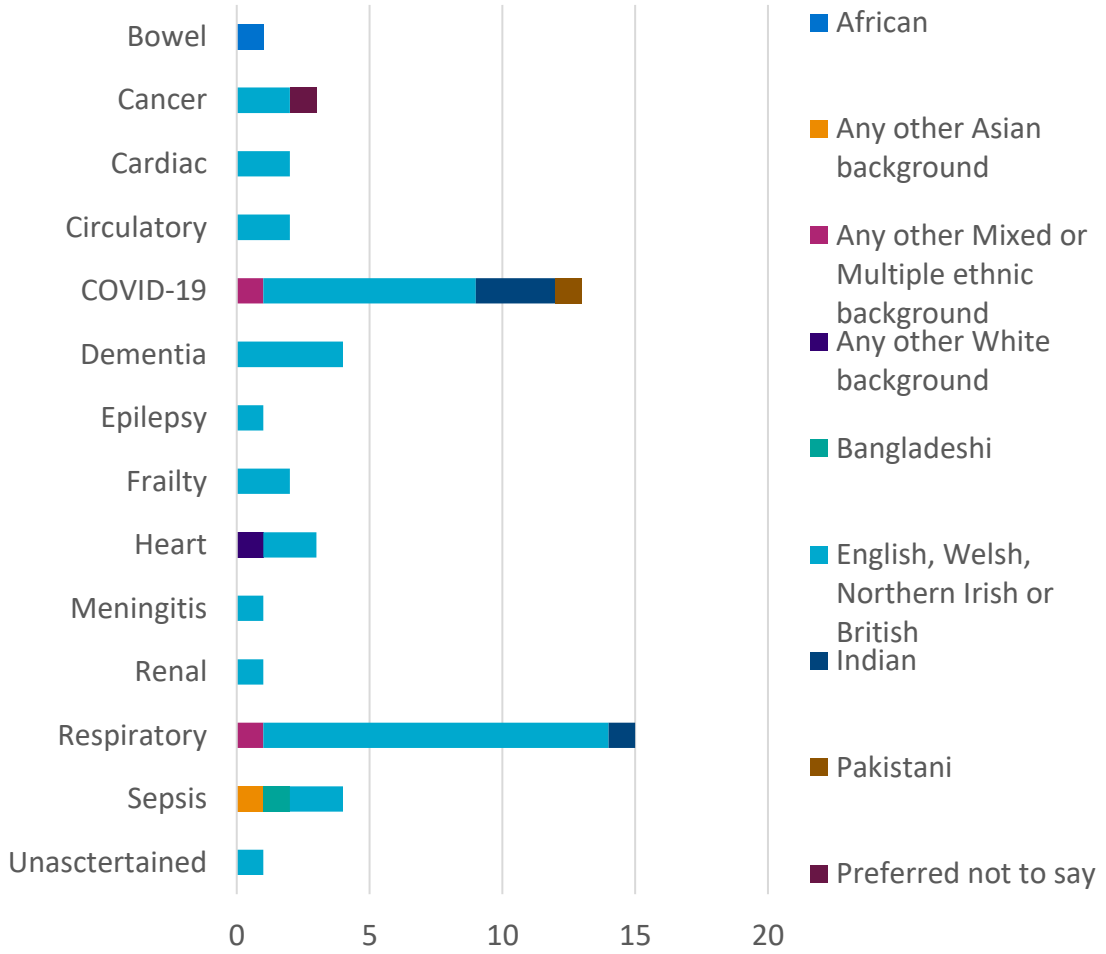
- COVID-19 (15 deaths)
- Respiratory illness (15 deaths) including
  - Aspiration Pneumonia*
  - Respiratory Failure
  - Pneumonia
  - Bronchiectasis
  - Community Acquired Pneumonia
  - Lower Respiratory Tract Infection



Cause of death by Ethnicity

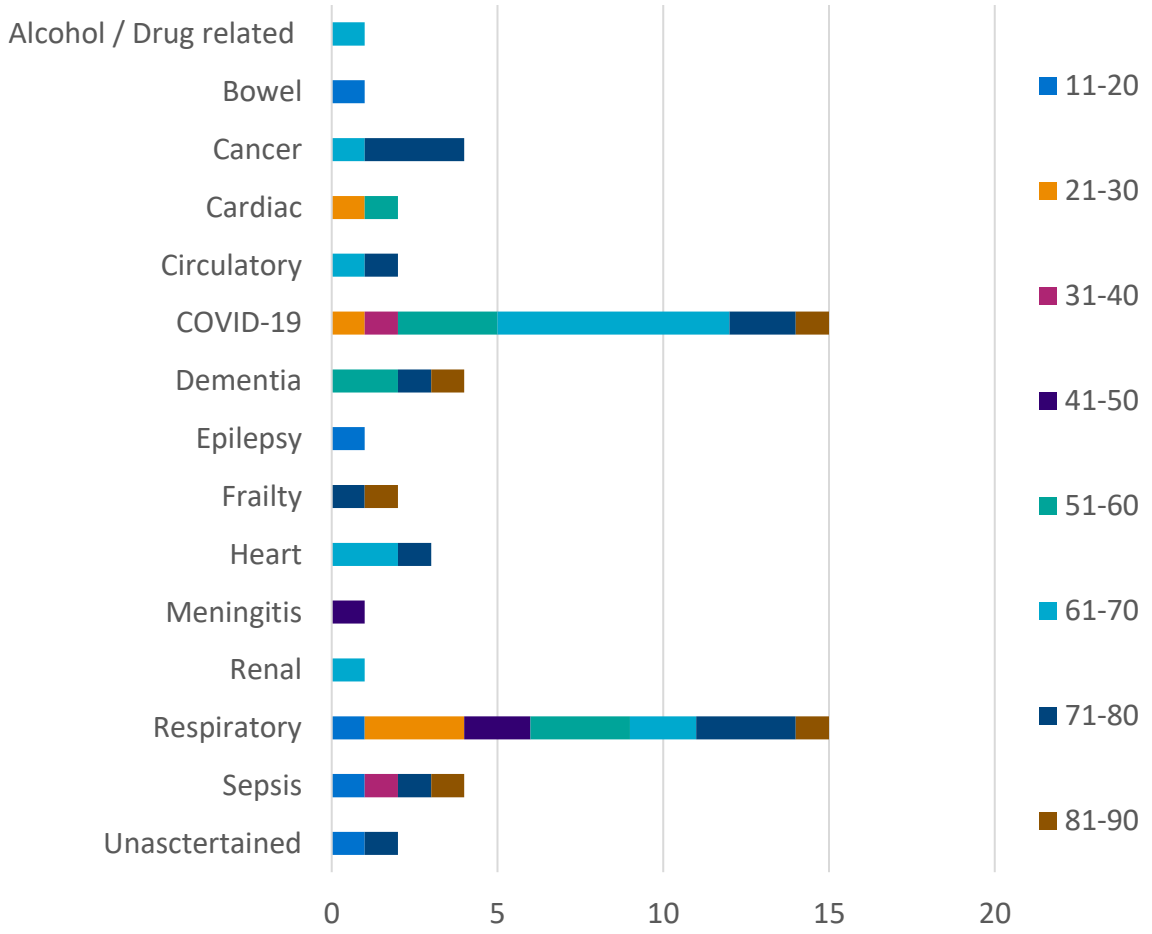
Ethnicity	All Deaths	COVID-19 Deaths
Asian or Asian British	12%	31%
Black, African, Caribbean, or Black British	2%	<1%
Mixed or Multiple Ethnic Groups	2%	<1%
White	83%	69%
No ethnicity recorded	1%	0%

- COVID-19 disproportionately affected Asian or Asian British people
- Respiratory deaths were proportionate across ethnic groups



Cause of death by age group

- COVID-19 caused more deaths in the 61-70s than any other group; this is what we would expect
  - Vaccination data was required only for ‘focused’ reviews
- Respiratory deaths occurred relatively evenly across age groups in comparison



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Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 31 AUGUST 2022

ALCOHOL MISUSE INCLUDING THE WORK OF TRADING STANDARDS

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

Purpose of the Report

1. The purpose of this report is to provide the Health Overview and Scrutiny Committee with an overview of the Public Health response to alcohol misuse, including the remit of the Trading Standards Department.

Policy Framework and Previous Decisions

2. The County Council's Substance Misuse Strategy 2020 – 2023 approved at Cabinet in November 2019 attached at Appendix A, outlines the following key priorities:

    a. Raise awareness and prevent the harms of drug and alcohol misuse particularly for those at greatest risk;
    b. Develop a coordinated approach to early identification of individuals exposed to the harmful effects of drug and/or alcohol misuse;
    c. Develop an approach to the provision of treatment and recovery services that is responsive to the changing trends in drug and alcohol addiction among residents of Leicestershire;
    d. Reduce ill health and deaths as a result of alcohol and drug misuse;
    e. Ensure a joined up and timely response to changing patterns of substance misuse and emerging issues relating to substance misuse.

3. The above priorities align with the 'Safe and Well' strategic outcome of the County Council's Strategic Plan 2022-26 approved by the County Council on 18th May 2022, the 'Staying Healthy, Safe and Well' strategic priority of the Leicestershire Joint Health and Wellbeing Strategy 2022-2032 approved by the Health and Wellbeing Board on 24th February 2022, and the 'Protect' priority in the Public Health Strategy 2022 – 2027 approved by Cabinet on 24th June 2022.

4. In December 2019, Cabinet agreed a model for the delivery of substance misuse treatment and recovery services. This was presented to the Health Overview and Scrutiny Committee in January 2021. The new service commenced on 1st April 2022 across Leicestershire and Rutland.

Background

5. Alcohol misuse is the biggest risk factor for death, ill-health, and disability among 15-49 year olds in the UK, yet evidence suggests that only 20% of dependent drinkers are currently accessing treatment.

6. Research suggests that those most susceptible to developing problematic substance misuse problems are from vulnerable groups such as children in care, persistent absentees from school, young offenders, the homeless, and children affected by parental substance misuse.

7. Drinking patterns in England changed during the COVID-19 pandemic with an increase in the number of higher risk drinkers, and the heaviest drinkers having increased their consumption the most, which brings a risk of more alcohol-related health problems. These changes in alcohol consumption have continued beyond the national lockdowns of 2020 and 2021. In addition, there was a 20% increase in alcohol-specific deaths in England in 2020 compared with 2019, and this trend persisted through 2021.

8. The economic burden of alcohol is estimated between 1.3% and 2.7% of annual UK GDP. Nationally, estimates suggest that the social and economic impact of alcohol-related harm amounts to £21.5 billion. These include costs associated with lost productivity, crime, health and social care and deaths.

9. Evidence indicates that when engaged in treatment, people consume less alcohol, commit less crime, improve their health, and manage their lives better. This correlates with the economic argument that for every £1 spent on alcohol treatment, there is a social return of £3.

10. Data for Leicestershire for 2020 shows the following:

    a. Deaths specifically caused by alcohol use are similar to regional and national averages (Leicestershire - 10.9/100,000, East Midlands - 12.9/1000,000, England - 13.0/100,000);
    b. Hospital admissions for alcohol specific conditions are significantly lower than regional and national averages (Leicestershire - 399/100,000, East Midlands - 510/1000,000, England - 587/100,000);
    c. Proportion of individuals successfully completing alcohol treatment is significantly better than regional and national

averages (Leicestershire (including Rutland) – 42.1%, East Midlands – 34.0%, England – 35.3%);

11. Additional data for Leicestershire shows:
    a. 30% of individuals in treatment report smoking tobacco and 68% report a mental health need;
    b. Only 44% of individuals in treatment report being in regular employment;
    c. 5% of domestic abuse victims report substance misuse issues.

Current provision

12. Local Authorities are required to provide an accessible drug and alcohol treatment and recovery system while having regard to reducing health inequalities. This is a condition of the Public Health grant.

13. Recommissioning of the Integrated Substance Misuse Community Treatment Service took place last year with the new service commencing on 1st April 2022 across Leicestershire and Rutland. The new service is provided by Turning Point. The service works in partnership with Dear Albert, Falcon Homeless and Community Support and Age UK to provide the following offer:

    a. **My Turning Point** - a digital treatment tool that provides 24/7 access to a range of guided and self-help sessions that can help with drug and alcohol use, as well as emotional health and other wellbeing issues.
    b. **Alcohol and wellbeing programmes** – designed to help individuals cut down or stop drinking.
    c. **Young People's Service** – A dedicated Young People's team that works with all under 18s (and those aged up to 25 where required) at a location suited to the young person. The team supports young people to make changes to their drug and alcohol use. The team also supports young people affected by someone else's substance use.
    d. **Family and Friends Support** - Offers support to family and friends even if the individual with a drug or alcohol problem isn't accessing treatment services.
    e. **Last Orders Project** – This project helps those over 50 to learn more about their drinking and how it affects their life and provides support to make positive changes.
    f. **Community detoxification service**
    g. **Access to inpatient detoxification services**
    h. **Access to residential rehabilitation services**
    i. **Harm reduction support** via district wide drop-in sessions in partnership with Falcon Support Services.
    j. **Access to recovery support**

14. Activity from the service shows:

a. In Quarter 1, there were 186 new presentations involving alcohol misuse. This represents 70% of all new presentations to the service.
b. Over a rolling 12 month period, there were 1,347 individuals in treatment for alcohol misuse. This represents 51% of all individuals in treatment.
c. Over a rolling 12 month period, 37% (505 individuals) of individuals successful completed treatment for alcohol misuse.

15. Turning Point also deliver a dual diagnosis service through additional funding from the Clinical Commissioning Groups. This service provides specialist and intensive support to individuals with co-occurring mental health and substance misuse issues. In Quarter 1 22/23, the service supported 117 individuals, of which 68 (58%) were County residents. This is a pilot service that will run until 31st March 2023. Following changes to NHS structures, it is unclear whether funding for this service will continue beyond March 2023.

16. The Public Health department funds Alcohol Brief Intervention training for any staff that are linked to Leicestershire County Council. There are two training sessions on offer. The first training session focuses on general alcohol awareness including understanding the short-term and long-term effects of alcohol misuse. To date 186 members of staff have received this training. The second training session focuses on providing low level/initial support to individuals who are consuming alcohol at levels likely to cause harm. To date 26 members of staff have received this training.

17. Turning Point are currently piloting a service (commenced July 2022) aimed at reducing the number of individuals at risk of long-term effects from alcohol misuse. The offer involves a non-invasive procedure to assess liver health and spot early signs of liver damage. One of the many strengths of this offer is an outreach provision within primary care services to support dependant drinkers who not yet managed to reduce their alcohol consumption.

18. The Public Health department funds and provides a Healthy Schools Programme which supports all schools in Leicestershire (and Rutland) to create a positive environment that improves the health and wellbeing of pupils, staff, and the wider school community. A component of the offer is the provision of free resources to support schools in offering drug and alcohol education.

19. Leicestershire Police have a Substance Misuse Team that is dedicated to reducing the demand for substances, supporting recovery, and working to reduce related harms. Their offer includes:

a. Working alongside Turning Point when a young person's offending behaviour is linked to substance use including alcohol.

Since February 2022 100% of those individuals have engaged with Turning Point.

b. Carrying out checks on those coming through Police custody to identify any substance misuse issues particularly those previously 'hidden'. Since January 2022, 37% of the 731 individuals identified have had alcohol as their main substance of concern with only 15% of this cohort actively engaged in support.
c. Delivering the Police Substance Misuse Educational Offer in education settings, facilitating tailored workshops utilising local information and case studies. Working alongside Turning Point and the Violence Reduction Network, the offer is delivered to over 16,000 young people each year.
d. Co-management (alongside Turning Point) of a new Drug Alert Protocol (including alcohol), ensuring that more information regarding local trends and emerging substance misuse issues is shared with a wider range of partners more effectively.

20. Turning Point and Leicestershire Police jointly chair the LLR Substance Misuse Community Safety Partnership Meeting. The purpose of this meeting is to coordinate partnership activity relating to substance misuse across LLR, increasing collaboration, intelligence sharing, dissemination of key information, and targeted partnership activities.

The role of Trading Standards

21. The Licensing Act 2003 introduced a scheme, administered by local authorities which covers the retail sale of alcohol, the supply of alcohol, the provision of various forms of entertainment and the provision of late-night refreshment.

22. The objectives of the Act include: the prevention of crime and disorder; public safety; the prevention of public nuisance and the protection of children from harm.

23. Under the Act, a range of public bodies (responsible authorities) must be notified of applications and are entitled to make representations on those applications to the licensing authority. Since 2013, directors of public health in England have been included in the Act as responsible authorities.

24. The Trading Standards Department receive a small number of complaints regarding alcohol and underage sales. While this is not an area of concern currently, there is an increase in complaints regarding children using vapes.

25. On receiving complaints from either Public Health, schools or specific shops regarding underage sales, the Trading Standards Department make use of the following options:

a. Visiting shops to provide advice about how to avoid selling alcohol to children.
b. Test purchasing businesses who, following a visit, it is believed are selling to those underage
c. A licence review could be considered if the business does not follow advice and, if successful, would prevent the business from being able to sell alcohol.
d. There are other remedies available such as prosecution, caution and/or warning letter.

26. Trading Standards respond to complaints, or intelligence received, when it concerns counterfeit alcohol due to the potential danger to life or health, along with statutory duties under the Trade Marks Act 1994 and Food Safety Act 1990. Counterfeit alcohol remains a concern to the Trading Standards Department. It is not always the case that non genuine brands are cheaper and more accessible, and a recent Court case focussed on counterfeit wine labelled with a well-known brand, found not to have an obvious price reduction.

Future Developments

27. As part of the NHS Long Term Plan 2019, national funding has been made available to set up hospital Alcohol Care Teams in areas with highest need. Locally, Leicester City Council are leading on behalf of University Hospitals of Leicester NHS Trust (UHL) and on behalf of LLR. The aim of the provision is to reduce demand on NHS services as a consequence of alcohol. The offer involves the provision of specialist interventions to alcohol dependent patients admitted to hospital, and to liaise with community substance misuse treatment services to facilitate ongoing management following discharge from hospital. Once the service has commenced, it will run for 3 years.

28. The Public Health department is leading on the implementation of an LLR Drug and Alcohol Related Deaths Review Panel. The panel is a multi-agency panel whose primary aim is to prevent and/or reduce future drug and alcohol related deaths by:

    a. Reviewing drug and alcohol related deaths as well as near misses;
    b. Determining any modifiable risk factors which may have contributed to the death;
    c. Identifying patterns or trends;
    d. Identifying and sharing learning across agencies;
    e. Identifying, advocating, and actioning changes.

    It is anticipated that the panel will go live in Autumn 2022.

29. The Office for Health Improvement and Disparities (OHID) have provided supplemental funding to all local authorities across the country to enhance substance misuse service provision over the next 3 years. For

Leicestershire, the maximum allocation is just under £2m. The proposal for Year 1 (2022/23) has been approved by OHID and comprises of:

a. Enhanced work with underserved communities – understanding unmet need and putting in place recommendations for action;
b. Enhanced capacity to support police and court custody assessments to improve pathways into treatment;
c. Complex case/vulnerability team within the treatment service to support individuals with complex needs;
d. Enhancing the volunteer and peer mentor scheme;
e. Additional substance misuse recovery workers.

30. The Public Health department is currently reviewing its role in the review and input into alcohol licensing applications to ensure the objectives of the Licensing Act continue to be met.

31. The Public Health department is working jointly with the Children & Family Services department to implement the adolescent (11-19 years) public health service which is due to commence in September 2022. An element of the offer is to support children and young people to make healthier choices with a particular focus on reducing substance misuse and reducing the impact of substance misuse.

32. Dame Carol Black was commissioned by the Home Office and the Department of Health and Social Care to undertake an independent review of drugs to inform the government's thinking on what more can be done to tackle the harm that drugs cause. This led to the development of a 10-year national drug strategy – 'From Harm to Hope' and a requirement for local systems to set up a 'Combating Drugs Partnership'. The focus of the national work is geared towards illicit drugs with very little mention of alcohol even though these quite often go hand in hand. As such, the local direction of travel is to continue to focus on substance misuse as a whole and to utilise existing partnerships to strengthen our work rather than creating new standalone ones.

Background papers

Report to Cabinet 22nd November 2019: Leicestershire Substance Misuse Strategy 2020 – 2023: https://politics.leics.gov.uk/documents/s149616/Leicestershire%20Substance%20Misuse%20Strategy%202020-23%20FINAL.pdf

Report to Cabinet 17th December 2019: Recommissioning of Substance Misuse Treatment and Recovery Services: https://politics.leics.gov.uk/documents/s150182/Substance%20Misuse%20Recommissioning%20report%20final.pdf

Report to County Council 18th May 2022: Leicestershire County Council's Strategic Plan 2022 – 2026:

https://politics.leics.gov.uk/documents/s168908/Strategic%20Plan%202022-26.pdf

Report to the Health and Wellbeing Board 24th February 2022: Leicestershire Joint Health and Wellbeing Strategy 2022 – 2032: https://politics.leics.gov.uk/documents/s166706/HWB%2024th%20February%20JHWS.pdf

Report to Cabinet 24th June 2022: Public Health Strategy 2022 – 2027 Delivering Good Health and Prevention Services: https://politics.leics.gov.uk/documents/s169676/Public%20Health%20Strategy%202022%20-%202027.pdf

Circulation under the Local Issues Alert Procedure

33. None

Crime and Disorder Implications

34. Substance misuse has far reaching impacts on individual health, families, and communities. There are clear links between substance misuse, crime, and community safety. Meeting the needs of people with alcohol problems can help to achieve reductions in crime, reduce reoffending, and improve an individual's health.

Appendices

Leicestershire Substance Misuse Strategy 2020 – 2023 https://www.leicestershire.gov.uk/sites/default/files/field/pdf/2019/7/8/substance-misuse-strategy%20.pdf

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Leicestershire County Council

Substance Misuse Strategy 2020 - 2023

Introduction

Drug and alcohol misuse impacts on people's lives in many ways. Providing treatment and support to people with alcohol and/or drug problems can have a significant beneficial impact not just for the individual, but for their families and their community. Preventing people from developing alcohol and drug problems and reducing their dependency on alcohol and drugs not only improves their individual health and wellbeing but also reduces the burden on health and social care services.

There are around 600,000 dependent drinkers in England and around 200,00 children living with an alcohol dependent parent or carer. We know that growing up in an environment where there is substance misuse is a significant factor impacting on childhood adversity and trauma, which itself leads to a higher risk of those children developing alcohol and drug problems and engaging in health harming behaviours in adulthood.

These issues are not bound by geography, individual circumstances or age, and therefore at the heart of our strategy is the need to take a coordinated, whole system, life-course approach.

National evidence suggests that specialist drug and alcohol interventions for young people contribute to improvement in health and wellbeing, educational attainment, attendance at school and reduces risky behaviour. In monetary terms, young people's drug and alcohol interventions result in annual savings of £4.3m for health services and £100m for crime. If a 10% reduction in the number of young people continuing their dependency into adults is achieved, the lifetime societal benefit of treatment is estimated to be £159m which equates to £8 benefit for every £1 invested.

For Leicestershire, it is estimated that investment in treatment services for individuals with drug misuse reduces crime by 23% and for alcohol misuse is 48%, with total financial benefits to social care of £1.3million per annum and economic benefits of £7.5million per annum. Alcohol treatment provides a return on investment of £3 for every £1 invested. Drug treatment provides a return on investment of £4 for every £1 invested.

We have made considerable progress over recent years in reducing the harm caused by drug and alcohol misuse in Leicestershire. However, the changing landscape of substance misuse needs in the local population coupled with increasing financial pressures faced by the County Council and partner organisations means there is a need to review the existing approach to substance misuse service provision to ensure we continue to provide appropriate, accessible and equitable services to our local population.

This strategy takes stock of achievements made thus far and outlines the key priorities for the next 3 years to further reduce the harm caused by substance misuse in Leicestershire. These priorities align with the following outcomes from the Leicestershire County Council's Strategic Plan 2018-22 which has a focus on making life better for people in Leicestershire:

- **Wellbeing and opportunity:** The people of Leicestershire have the opportunities and support they need to take control of their health and wellbeing.
- **Keeping people safe:** People in Leicestershire are safe and protected from harm.
- **Great communities:** Leicestershire communities are thriving and integrated places where people help and support each other and take pride in their area.

Vision

People of Leicestershire are able to make informed healthy lifestyle choices to reduce the harms caused by alcohol and drug misuse and improve their wellbeing.

Priorities for Leicestershire

This strategy outlines a partnership approach to tackling the problems associated with drug and alcohol misuse in Leicestershire. The priorities identified within this strategy have been developed based on an understanding of needs in relation to substance misuse and following widespread consultation with stakeholders.

Priority 1:

Raise awareness and prevent the harms of drug and alcohol misuse particularly for those at greatest risk.

Where are we now?

Leicestershire has a significantly higher proportion of adults who drink more than 14 units per week, compared to England (29.8% and 25.7% respectively). A significantly higher proportion locally also reported binge drinking compared to the national average (21% and 16.5% respectively).

The Modern Crime Prevention Strategy 2016 refers to evidence that:

- Good quality Personal, Social and Health Education (PSHE) and school-based interventions designed to improve behaviour (e.g. by building confidence, resilience and effective decision-making skills) can have a preventative impact on substance misuse.
- Brief interventions (including motivational interviewing techniques) at early contact points with health, criminal justice and social care services can help prevent escalation for those in the early stages of substance misuse.

Evidence also indicates that identification and brief advice can reduce weekly drinking by between 13% and 34% which reduces the risk of alcohol-related conditions by approximately 14%, and risk of lifetime alcohol related death by approximately 20%.

Within Leicestershire County Council, the Public Health department provides a robust prevention offer centred around a social prescribing model. The offer focuses on developing community capacity, and on providing information, advice and referral through Local Area Coordinators and First Contact Plus.

Public Health also funds and supports the Leicestershire Healthy Schools Programme. One of the four key themes within the programme is the delivery of Personal, Social and Health Education (PSHE) which includes an emphasis on drugs and alcohol education. All 285 schools within Leicestershire participate in the programme.

Public Health also commissions the evidence-based 'Alcohol Risk Reduction Scheme' which is delivered by over 75 GP practices and 35 pharmacies across the county. It is an evidence-based preventative approach aimed at identifying individuals whose drinking might impact their health, now or in the future. Staff from these primary care services are trained to deliver a simple structured intervention based on an assessment using a validated alcohol screening tool, followed by brief advice, information on the harm of alcohol, and written information on reducing the risk from drinking alcohol. A similar approach is also delivered in the local hospitals via hospital liaison workers. Currently these are the only formal setups for assessment of alcohol intake and delivery of alcohol brief interventions. This limits the reach of this evidence-based prevention intervention.

What do we want to achieve?

- Empower young people to make positive choices when it comes to alcohol and drug use.
- Increase the number of adults receiving brief interventions and harm minimisation advice for drug and alcohol misuse.
- Clear and consistent communication messages in relation to drugs and alcohol to ensure people receive the right messages at the right time. This includes local implementation of national campaigns.

How will we get there?

- Utilise a partnership approach to provide a sustainable prevention offer to schools in relation to drug and alcohol misuse.
- Review the Alcohol Risk Reduction Scheme and its outcomes and utilise the findings to develop a revised offer that has a greater reach.
- Develop a coordinated and consistent approach across relevant partners to communications relating to drugs and alcohol.

Priority 2:

Develop a coordinated approach to early identification of individuals exposed to the harmful effects of drug and/or alcohol misuse.

Where we are now?

Adverse Childhood Experiences (ACEs) are events that have a traumatic and lasting effect on the physical and/or mental health of young people which subsequently impact on the health and wellbeing of these individuals in adulthood. Examples include abuse, neglect, substance misuse within the household and bereavement. The evidence suggests that 4 or more adverse childhood experiences results in a 4-fold increase in the likelihood that a person will use illicit drugs and a 7-fold increase in the probability that a person will develop an alcohol addiction. Locally, over half (54%) of adults in treatment have and/or live with children. The Leicestershire Children and Families Partnership Plan (2018-21) focuses on 5 priorities, one of which is to keep children safe and another is to enable children to have good physical and mental health with an emphasis on developing an approach to ACEs.

In recognition that support is better delivered by considering the needs of the whole family, the Children and Family Services Department provides early help support through the Children and Family Wellbeing Service. The Services delivers a range of support to families including group work and one to one support according to the assessed needs of the family.

Alongside this, Public Health commissions the 0-19 Healthy Child Programme which includes the provision of support through Public Health Nurses (Health Visitors and School Nurses) and through digital communications (text messaging service and a website of information for parents and young people). A range of support is provided based on the level of need. This includes a multi-agency approach to support children and young people and their families where substance misuse is identified.

There is clear evidence that a large amount of work is taking place to support children, young people and their families during the early stages of difficulties, including drug and alcohol misuse. Further work is required to ensure join up between these different offers to ensure our residents receive the right support at the right time from the right professionals, and to minimise duplication of provision.

The evidence shows that 85% of individuals within Leicestershire who may benefit from specialist treatment for alcohol misuse are not in treatment and 51% of opiate users and 68% of crack users are not in treatment. This evidence indicates a gap in identifying individuals with alcohol and/or drug dependency and a gap in referring these individuals into treatment services. For many individuals misusing drugs and/or alcohol, engaging in treatment can be the catalyst for getting the help they need to address other issues such as their physical health, mental health, housing and financial issues which can have a significant impact on the individual and on wider society.

The NHS Long Term Plan makes reference to establishing Alcohol Care Teams in hospitals that have the highest rate of alcohol dependence-related hospital admissions. If made available locally, these teams have the potential to enhance local provision by working in partnership with local authority commissioned drug and alcohol services.

What do we want to achieve?

- A reduction in the impact of parental alcohol and/or drug misuse on children.
- An increase in the number of individuals referred into substance misuse treatment services.
- A reduction in the number of hospital admissions for alcohol related ill health.

How will we get there?

- LCC Public Health and Children and Family Services to continue to work in partnership to strengthen the 'whole family' approach to those exposed to the harmful impact of drug and/or alcohol misuse.
- Optimise the link between the commissioned drug and alcohol treatment service and local alcohol care teams once they are established..

Priority 3:

Develop an approach to the provision of treatment and recovery services that is responsive to the changing trends in drug and alcohol addiction among residents of Leicestershire.

Where we are now?

The evidence shows that there is an increasing problem of misuse and dependence associated with some prescription and over-the-counter medicines. Nationally, the number of individuals in drug treatment for problems with prescribed, or over-the-counter medicines has increased year on year since 2009 with opioids cited as the most common cause. Locally, it is estimated there are in the region of 10,000 long-term prescribed opioid users across Leicester, Leicestershire and Rutland. This cohort represents a large number of individuals who are at-risk of developing dependency on prescribed drugs. Also, in 2017/18, there were 112 individuals in treatment services who cited addiction to a prescription only medicine or an over-the-counter medicine in Leicestershire, which accounts for 8% of those in treatment.

Other new patterns of drug use and health risk behaviour are also becoming established, including drug use alongside high-risk sexual behaviour (often referred to as Chemsex). This practice is more common in men who have sex with men and can have an adverse impact on their health and wellbeing. Currently, very little information is known on the prevalence of Chemsex amongst the population of Leicestershire. Another emerging pattern of drug misuse is the misuse of anabolic steroids which has increased year on year since 2007/08.

There are also specific cohorts of the population who are disproportionately affected by substance misuse. Locally, 1 in 5 individuals accessing treatment services are referred from criminal justice services. Meeting the health needs of people in contact with the criminal justice system can help to achieve reductions in crime, reduce offending and improve the individual's health. Locally, NHS England commissions a substance misuse treatment service within HMP Leicester which is provided by the same treatment provider as that of the community treatment service.

This setup has strengthened continuity of care for those released from prison with engagement exceeding national figures (64% vs 32%).

An additional at-risk cohort is those who are homeless. Evidence suggests an increase in the use of new psychoactive substances among those who are homeless and that a third of all deaths of homeless people in 2017 were due to drug poisoning.

The HM Government Drug Strategy (2017) places emphasis on facilitating a joined-up approach to commissioning a wide range of drug and alcohol services. The strategy also places emphasis on helping people attain wider social and personal resources which promote recovery. These include employment, housing, financial security, social networks and good health and wellbeing. Data from the local treatment service indicates that:

- 64% of individuals in treatment report being unemployed or on long-term sick
- 16% of individuals in treatment report a housing problem
- 50% of adults in treatment report a mental health treatment need and out of these, 13% are not receiving treatment for their mental health need.
- 32% of young people in treatment report a mental health treatment need and out of these, 24% are not receiving treatment for their mental health need.
- 49% of adults and young people in treatment report smoking tobacco and only 0.3% received a smoking cessation intervention. Smoking prevalence among Leicestershire residents accessing substance misuse treatment services is significantly higher than that of the general population of Leicestershire (12%).

It is likely that the above data is an underestimate as it does not capture information on those who are not in treatment. For example, there are large numbers of individuals accessing Adult Social Care Services who have a dual diagnosis of substance misuse and mental health issues who find it difficult to maintain engagement with treatment services and therefore place a heavy burden on public sector services.

Historically, the responsibility for local drug and alcohol services fell to Drug and Alcohol Action Teams which were funded predominantly by a Pooled Treatment Budget via the National Treatment Agency for Substance Misuse (A special health authority within the NHS). Following the Health and Social Care Act 2012, the functions of the National Treatment Agency transferred to Public Health England and in 2015/16, a condition was added to the public health grant which required local authorities to provide an accessible drug and alcohol treatment and recovery service as part of their duty to reduce health inequalities and improve the health of the local population.

Alongside this change, NHS England has the responsibility for commissioning healthcare across all secure and detained settings which includes the provision of substance misuse treatment services in prisons, and Clinical Commissioning Groups have the responsibility for commissioning healthcare services.

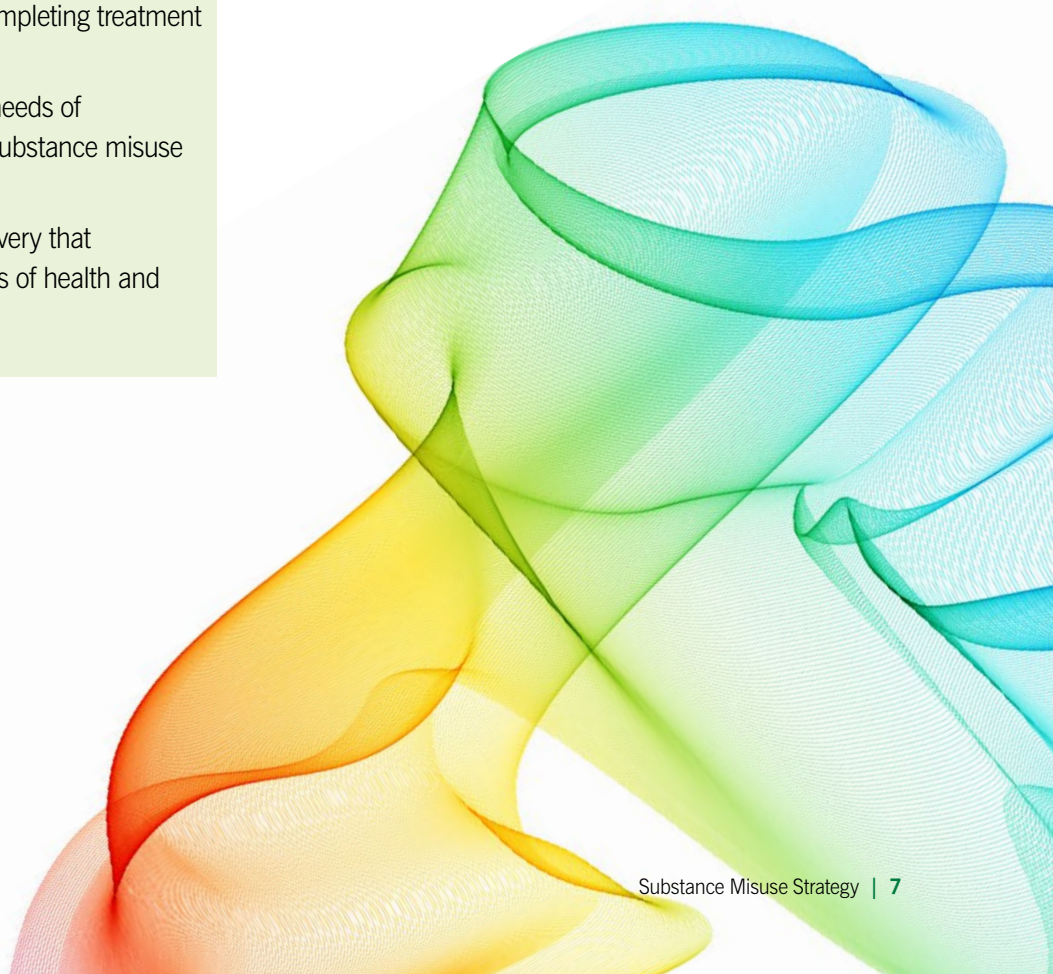
Considering the ongoing financial pressures placed on individual organisations and a risk of fragmentation of services, further work is needed to explore opportunities to integrate substance misuse service provision across all commissioners to ensure that the system is responsive to the needs of the local population and meets the physical and mental health needs of individuals while also placing a strong emphasis on recovery. This also has the potential to reduce the burden on public sector services from people who are frequent users of these services.

What do we want to achieve?

- Joined up commissioning of substance misuse services, including across organisational boundaries, that is patient-centred, equitable, takes a life-course approach and is evidence-based.
- Seamless pathway for individuals accessing support for substance misuse issues leading to an increase in those successfully completing treatment and maintaining recovery.
- A strengthened response to the needs of individuals with dual diagnosis (substance misuse and mental health issues).
- A strengthened approach to recovery that addresses the social determinants of health and wellbeing

How will we get there?

- An agreed approach to commissioning substance misuse services over the next 3 years with endorsement from all commissioning organisations.



Priority 4:

Reduce ill health and deaths as a result of alcohol and drug misuse.

Where we are now?

The local treatment service provides an array of harm reduction interventions. For example, individuals receiving treatment support for opioid addiction (e.g. heroin addiction) are encouraged by the treatment service to keep an accessible supply of naloxone which is crucial in reversing the effects of opioid overdose. Family members are also encouraged to do the same should the need arise for this treatment to be administered. Other harm reduction interventions available locally include:

- Blood borne virus screening (e.g. Hepatitis C testing), immunisation and support
- Needle and syringe exchange programmes
- Safer injecting information and support
- Sharps bins for the safe disposal of used injecting equipment

Harm reduction also encompasses mental health support. Leicestershire County Council has recently launched a campaign (Start a Conversation) to help break the stigma around suicide, encouraging people to be more open about their worries and showing them where to seek help. The campaign includes the provision of a website that gives people information on where to get help in a crisis, as well as providing information on how to maintain good mental health and how to support others in need.

In addition to harm reduction interventions, the local substance misuse treatment service conducts a thorough review of all drug-related deaths of its service users to identify lessons learned and implement any changes required to service provision. However, there isn't currently a coordinated approach to reviewing drug related deaths for those not accessing treatment services. Drug misuse is a significant cause of premature death and is entirely preventable. Locally, during the period 2015-17 there were almost 4 times more deaths from drug misuse in males compared to females which highlights a need for a coordinated approach to the review of drug-related deaths in Leicestershire.

What do we want to achieve?

- Reduce the risk of drug-related harm among Leicestershire residents
- Reduce the number of drug-related deaths occurring among Leicestershire residents.

How will we get there?

- Ensure that harm reduction interventions form an ongoing component of substance misuse treatment provision.
- Develop a partnership approach to the review of drug related deaths among Leicestershire residents to identify lessons learned and respond to these in a systematic way.

Priority 5:

Ensure a joined up and timely response to changing patterns of substance misuse and emerging issues relating to substance misuse.

Where are we now?

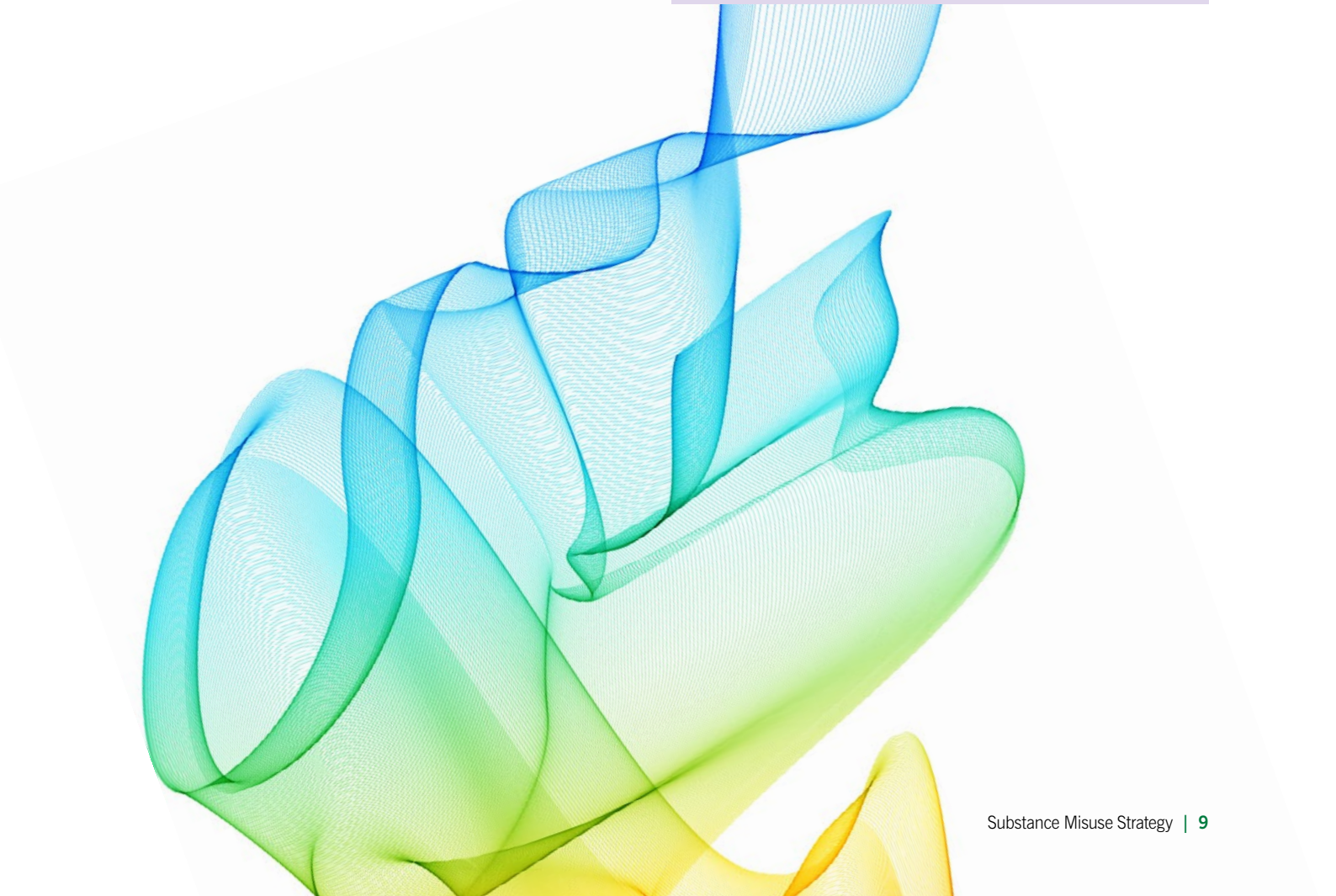
Currently, there is not a forum for local service providers, commissioning organisations and partners to jointly discuss and manage changing patterns of substance misuse (e.g. New Psychoactive Substances) and emerging issues specifically relating to substance misuse such as County Lines (gangs and organised criminal networks involved in exporting illegal drugs into small towns, usually exploiting children or vulnerable adults to conduct their activity). This has the risk of impeding the development of a timely response to issues and could also lead to fragmentation and duplication of work delivered across all partners.

What do we want to achieve?

- Close monitoring of and timely response to the changing patterns of substance misuse and substance misuse related issues using a multi-agency approach.

How will we get there?

- Develop a substance misuse partnership group involving local service providers, voluntary sector organisations, commissioning organisations and partners, that meets quarterly and can feed effectively into strategic groups such as the Health and Wellbeing Board, Leicestershire Safer Communities Strategy Board and the Strategic Partnership Board.



Key activities to deliver this approach

To ensure the strategic approach is delivered we will;

- **Develop new ways of partnership working**. An approach to this has been described under priority 5.
- **Keep partners informed of progress.** We will develop a detailed implementation plan which will be regularly reviewed and updated to track progress. The strategy's implementation and progress will be monitored by the Director of Public Health within LCC and regularly communicated to key stakeholders via substance misuse networks and relevant meetings/Boards.
- **Monitor performance through delivery of the implementation plan and development of a substance misuse dashboard.** The key public health indicators to assess whether this strategy has made a difference are presented as part of the Public Health Outcomes Framework. These include: proportion of individuals with substance misuse issues who are not in treatment, parents in drug treatment, successful completion of treatment, hospital admissions due to substance misuse, deaths from drug misuse and waiting times for accessing treatment services. Information will be collated to produce an annual progress update against the implementation plan and to review how this has translated to improved outcomes across Leicestershire.

Notes

Leicestershire
County Council