19 JUL 2017

Lincolnshire Community Health Services
NHS Trust

Our Ref: REG28/KT
Your Ref: PSC/AR 592-2016
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18th July 2017

HM Acting Senior Coroner
Unit 1
Gilbert Drive
Endeavour Park
Boston PE21 7TQ

Reference : Regulation 28 report in respect of the late Ruth MILNE

Dear Mr Cooper

This is the response on behalf of Lincolnshire Community Health Services in respect of the Regulation 28 report received dated 16th May 2017, with reference to Matters of Concern Point 3. You make reference to the Action Plan, Monitoring and Recommendations' of the safeguarding report (pages 11 and 12) and the requirement to provide you with information as to whether these have been implemented or not.

I can report as follows:

Ongoing actions Page.11 (all now complete)

1. **Ambulatory patients to be managed through case management identifying appropriate management through clinics and evaluated through care plan**

There are now two leg ulcer clinics held 5 days a week within Skegness and one clinic held 5 days a week in Mablethorpe. There is also a plan to hold a Saturday clinic from late July to September to provide extra service provision for holiday makers. Provision of care to these patients is evaluated as part of care planning.

2. **Integrated support/review with specialist nurses i.e. heart failure, lymphoedema and continence**

Where an integrated/joint visit is required these take place. Specialist nurses share office accommodation with the community nursing team so there are well established channels of communication between specialist and community staff to ensure patient needs are reviewed ensuring the correct specialists are involved.

3. **Review of caseloads and utilisation of ambulatory clinics**

Clinics are held as identified in point 1. There is also a caseload review tool that has been implemented since this case which has been implemented across LCHS (please see Appendix A)

Chair: Elaine Baylis, QPM
Chief Executive: Andrew Morgan

4. Allocation of case managers within the team

Each GP practice has an allocated case manager and each case manager is now allocated a day a week to go through their caseloads using the tool (Appendix A). This is undertaken patient by patient. Care delivery is checked against the pathways in the community catalogue to ensure that the patient is receiving the appropriate care and visits and also identifying if over visiting is an issue.
This weekly undertaking ensures cleansing and discharging of patients and also checks that patients are not discharged too early.

There have been a lot of recent journal articles on the development of caseload dependency / complexity tools for the community, as until recently many of those developed were for secondary care use. A good document from this year is by NHS Improvement 'An improvment resource for the district nursing service' and gives examples of case studies where patient complexity tools have been implemented - this followed on the back of the work from NICE and other sources.
As a result LCHS undertook a project looking at the use of a dependency tool. Two senior community nurses were asked to implement this within the teams and its use in plotting visits (Appendix B). The action plan is relation this project , as you will see is very current and as yet hasn't been signed off as the project is not yet at it's final stage (Appendix C)

17. Recommendations, Page 11 (all now complete)

17. 1 Review of development of true case management within the Skegness community team including the integration of specialist nurses

As identified above in points 2&4

17.2 Team dynamic, to review the current culture of the team including the integration of specialist nurses

Review of clinical leadership to the community team and to develop appropriate support mechanisms

The Clinical Team Leader (CTL) in post at the time of Mrs Milne's death has now left the Trust. With the appointment of a new CTL into that post the team have evolved, progressed and become more cohesive. Communication has enhanced. Clinical and safeguarding supervision takes place on a regular basis and the team recognise when support is required and access that support readily. The team also receive annual level 3 safeguarding training and there is a deputy named nurse for safeguarding allocated to each team to provide the supervision. Adult safeguarding competencies have also been introduced for the band 7 nurses. Monthly operation meetings now take place which include the Heads of Clinical Services, Matrons and Clinical Team Leads.
As stated previously there is much more integration of specialist nurses as they now share office accommodation with the team which facilitates a higher engagement in regular discussion.

17.3 Carry out an in depth review of the teams' activity in relation to the transient population and their long term conditions both internal and external to Lincolnshire

A piece of work internally has been completed to align population to both a case manager and the rest of the team. In addition, LCHS employed an external consultancy company to look at productivity in the trust as a whole and this also included work specific to community team's activity in relation to population and condition taking into account the transient population footfall. This then resulted in workforce modelling to ensure this reflected patient need. In terms of the Skegness team the staffing model that was proposed by the review has been fully implemented.

17.4 **Staff needing competencies around lower limb care signing off to be supported by the tissue viability associate nurse**

Staff can access a "lower limb course" and whilst this is highly recommended it is not mandated. All training needs are fed into a centralised training needs analysis, this then informs a competency matrix which identifies which staff require training in a specific area. If staff do not attend the "lower limb course" then training is provided within the workplace and sign off is supported by the tissue viability associate nurse. Staff within the Skegness team have received bespoke training of this nature.

There are also two documents that support lower limb care these being :

- The Clinical Guidelines for The Assessment and Management of Lower Limb Ulceration within Adult Community Services (Appendix D)

- Standard Operating Procedure for Use of Handheld Dopplex Vascular Doppler Ultrasound Within Adult Community Services, including competencies (Appendix E)

Action plan (all complete)

The action plan covered 5 specific issues

- Case management of patients on caseload- covered above at 2&4
- Team dynamics covered above at 17.2
- Clinical leadership – covered above at 17.2
- Capacity within the team to respond to transient population with long term conditions- covered above at 17.3
- Individual Competency in relation to lower limb care- covered above in 17.5

Monitoring arrangements (Page 12)

The action plan and outcomes are monitored as identified in the report. In addition LCHS have recently introduced an action plan tracker. All actions from an action plan are added to the tracker for monitoring through to completion. Any stated evidence on the action plan is required in order to be marked as complete. The tracker headings are as below:

Date reported	STEIS Ref	Recommendation	Action	Responsible officer	Responsible for sign off	Target date	Completed	Evidence	Link to evidence	Comments

The tracker is presented at the monthly LCHS Patient Safety and Safeguarding Committee to ensure that target dates are on track and that required evidence is available.

I hope that the above response and attached appendices provide the assurance that the recommendations and action plan have been fully implemented and monitored.

If you require any further information in regards to this Regulation 28 report, please do not hesitate to contact me

Yours Sincerely

Kim Todd,
Practitioner Performance Manager, LCHS