Leicestershire Partnership NHS
NHS Trust

quality account 2015-2016

living our values

Contents

Part 1 – Introduction

1.1 Statement on quality from the Chief Executive

This is my third year as Chief Executive of Leicestershire Partnership NHS Trust (LPT), and I continue to be proud of our staff and impressed with their continued commitment to our improvement journey. Not every organisation could say that over 95% of the people that received care from them would be likely or very likely to recommend our services to their family or friends.

Our 5,635 staff delivers a wide range of services across community health, mental health, learning disability and services for children and young people, through compassion, trust, respect and integrity. Over the last year, we have made over 1.7 million contacts with patients in the community through services, provided at 150 sites across Leicester, Leicestershire and Rutland, and made 289,144 bed days available.

Our focus remains on maintaining high quality, responsive services at times of increasing demands, increasing public expectations and financial constraint. The Quality Account reflects how well we are doing against these challenges.

We received a Trust-wide inspection by the Care Quality Commission (CQC) in March last year. We were pleased to see that the inspectors found that our staff involve and treat people with compassion, kindness, dignity and respect, and identified many 'good' areas within our practice and services. However, they highlighted some areas for improvement across the Trust, which resulted in a 'requires improvement' rating overall by the CQC.

We have already made a number of improvements since receiving the report in July 2015, and addressed most of the concerns raised. However, achieving sustainable improvements requires more than just action plans. We are committed to creating a culture of continuous improvement, working towards moving the 'requires improvement' to 'good' and the 'good' to 'outstanding'. Our focus remains on:

(a) Listening continuously to our users which include our patients, their families and carers;

(b) Working in an integrated manner to improve the coordination of care and delivery of services;

(c) Our staff working together in high performing multidisciplinary teams to deliver the right care for our users at the right time and place; and

(d) Enhancing the power of front line clinicians to innovate and continually improve care.

We are confident that we are heading in the right direction. In partnership with all our stakeholders, we will continue to build on our strengths and develop sustainable improvements.

We want to be a values-led organisation, and continue to engage with our staff on how they live our Trust values of compassion, trust, respect and integrity. These are now built into our training, induction, ongoing appraisals, and through the introduction of our monthly Valued Star Awards which recognise individuals and teams that have gone above and beyond in demonstrating our Trust values. Going out to present these awards has been something I've been very proud to do over the last year. This, coupled with our vision for effective leadership, and a motivated and engaged staff group, are critical to providing high quality care. We have continued to develop our leadership programmes, including our Leading Together Group, focusing on the skills we need to become effective leaders.

I was pleased to see that in this year's NHS staff survey, our overall staff engagement score has increased again, which means staff in general are feeling more motivated, able to contribute to improvements at work and would recommend LPT as a place to work or receive treatment. However, our overall result is still below average, with our worst performing areas being around team working, satisfaction in work undertaken, and support from immediate line managers.

We have continued to support staff in finding solutions to their barriers, with the 'Listening into Action' programme taking on another 17 teams who have been supported to make service improvements and then 'pass it on' to others. An online appraisal process 'uLearn' is working well to support staff, and various staff support groups and initiatives continue.

We continue to have good links with our partners. As CEO I have regular meetings with colleagues from Healthwatch and local voluntary sector organisations. During 2015, we invited Healthwatch to become part of our Board meetings, further developing our relationship and ensuring that we develop our services with the public. We now invite questions from the public at the end of Board meetings and also provide live highlights through Twitter.

We have also supported various innovative initiatives to improve our services including the dissemination of our Chat Health confidential messaging app for young people, an ECT app to dispel myths around electro-convulsive therapy, and a Young Onset Dementia app to name a few. I'm proud to say that we have also won various national awards that are highlighted in this report.

Looking ahead, in 2016/17 we will be working with everybody in Leicester, Leicestershire and Rutland (LLR) to consult on and then begin the implementation of Better Care Together (BCT) to deliver a sustainable health and social care system. This will be critical next year. As we move towards more out of hospital care, we will

be working harder with our local communities, staff and service users to focus on our strengths, to build a resilience and recovery plan in everything we do.

Although we continue to face challenges, we are continuing to improve services for our patients and their families. As I travel around the city and counties meeting staff and patients, I remain impressed by our staff's dedication, energy and professionalism. This Quality Account summarises the progress we continue to make.

Dr Peter Miller

Chief Executive

By Order of the Board

27/05/2016

1.2 Statement of Directors' responsibilities in respect of the Quality Account

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the Trust's performance over the period covered;

- The performance information reported in the Quality Account is reliable and accurate; with the exception of the matters raised in section 3.3.8 on the Gatekeeping indicator.

- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;

- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review;

- Reliable, accurate and relevant high quality data is a key organisational requirement. LPT is committed to improving data quality across all of its services and undertakes regular data quality audit reviews. The Trust continues to implement a Data Quality Improvement Programme (DQIP) which is supported by performance monitoring systems to ensure its continual improvement;

- The Quality Account has been prepared in accordance with Department of Health guidance.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

Dr Peter Miller

Chief Executive

By Order of the Board

27/05/2016

Cathy Ellis

Chair

27/05/2016

1.3 Statement of responsible person on behalf of Leicestershire Partnership NHS Trust

To the best of my knowledge the information included in this Quality Account is accurate.

Professor Adrian Childs

Chief Nurse/ Deputy Chief Executive

27/05/2016

Part 2 – Priorities for improvement and statements of assurance

2.1 Priorities for quality improvement in 2016/17

Improving quality is about making healthcare safer, more effective, patient centred, timely, efficient and equitable. Our central purpose is to provide the highest quality healthcare and promote recovery and hope to our patients. We are committed to improving the quality of our care and the services we provide. Our patients value clinical outcomes together with their overall experience of our services. We want to provide the very best experience for every person using our services.

The improvements we delivered in 2015/2016 will continue to be developed and embedded into our services to ensure deliver sustainable and continuous quality improvement.

In scoping our improvement areas, we took into account themes identified by: our CQC improvement actions; learning from serious incidents; complaints and patient feedback, and a staff 'Listening into Action' (LiA) event in November 2015. We reviewed the Trust-wide quality themes and have agreed three organisational priorities for 2016/17 as follows:-

1. We will improve clinical recording and care planning to support safe and effective patient centred care delivery.
2. We will improve discharge planning and follow up to support safe transfer of care.
3. We will evidence improved engagement in clinical supervision for all staff delivering care.

Against our three priority areas, our services have identified a number of quality improvement areas for 2016/17. These have been agreed by local services and are included in our 2016/2017 quality improvement plan.

Clinical Priorities 2016/2017

We will improve clinical recording and care planning to support safe and effective patient centred care delivery.

Adult Mental Health and Learning Disabilities

Improving the physical health care planning and recording of progress in support of the parity of esteem agenda

Improving patient and carer involvement in care planning (Inpatients and community).

Community Health Services

Review record keeping documentation for Community Hospitals in line with the introduction of nerve centre and trust objectives around improved record keeping and personalised care planning.

To enable the safety of patients on Mental Health Service for Older People Wards (including those who suffer from falls) via good assessment of patient strengths and needs and good-standard care-planning.

Families, Young People and Children's Services

First Episode Psychosis – Nationally there is a need for people to have access to National Institute for health and Care Excellence compliant treatment within two weeks of their first episode of psychosis.

Evidence improved engagement in clinical supervision for all staff delivering care.

Adult Mental Health and Learning Disabilities

To improve the actual and recorded clinical supervision rates for all staff in the Trust.

Community Health Services

To improve the actual and recorded clinical supervision rates for all staff in the Trust.

Families, Young People and Children's Services

To improve the actual and recorded clinical supervision rates for all staff in the Trust.

We will improve discharge planning and follow up to support safe transfer of care.

Adult Mental Health and Learning Disabilities

To understand the reasons for delays in high complex transfers of care including those who may require a hospital to hospital transfer.

Community Health Services

Transition of patients through our hospitals is a key priority to improve the flow of patients and ensure that patients are cared for in the most appropriate setting.

Families, Young People and Children's Services

To launch and establish a neonatal pathway for all preterm babies who remain in neonatal unit at the new birth review (10-14) to ensure they have a health visitor contact at the Unit.

The priorities are important to our service users, carers, patients and staff. The performance of these priorities will be managed and monitored through our performance and quality governance arrangements. See further details on each priority in **Appendix 1**.

We have an implementation action plan to address existing quality concerns identified by the CQC who rated LPT in July 2015 as requires improvement. See section 3.3.5.
We have in place a plan to deliver improvements and aim to get our rating to 'Good' by 2017 and this is underpinned by our approach to self-regulation.

2.2 Self-Regulation

We have continued to strengthen our approach to regulation in 2015/16 – building upon the achievements we introduced in 2014/15.

Our strengthened approach to regulation has been encapsulated in our new model the 'Step-up' approach. This approach enables teams to identify areas for improvement and demonstrate compliance with the expected regulatory requirements. It is based around the CQC's five key questions;

Our model empowers teams to self-assess to identify areas for improvement using a variety of different approaches. Led by their Team Leader, teams can use peer review to bench-mark quality standards across similar service types or request an objective partial review of the quality of their services from staff working outside of their team and service. Our approach to regulation involves a four-step process which encompasses team and peer review.

Self-Regulation support is divided into four key components:

- Confirming expected standards
- Improving standards
- Monitoring and keeping track of performance
- Accountability and ownership for delivery and assurance.

Our self-regulation approach will be the bedrock of our Quality Improvement Programme (QUIP) in the future as it presents a risk-based step-down or step-up

process and facilitates the utilisation of improvement plans and methodologies to improve standards. Services currently utilise Process Mapping and Plan, Do, Study, Act (PDSA), cycles to support changes. The Trust is also introducing a common change model to be used across the Trust from 2016/17 onwards. During 2016/17 all services will be required to re-assess their position against expected standards, drawing upon both internal quality assurance reviews and the feedback from the CQC comprehensive inspection of March 2015.

2.3 Delivering our quality improvement priorities

The Trust Board is committed to achieving excellence and members discuss quality performance at every Trust Board meeting. We will report and monitor our progress against delivery of the clinical priorities at the Quality Assurance Committee (QAC), which is a Trust Board Committee. The QAC provides advice and assurance to the Board in relation to quality performance. The QAC shapes, influences and provides overall assurance about the quality of our services and reports any concerns to the Board.

2.4 Statements relating to the quality of NHS services provided

This section includes information which we are required to report to enable comparison between different health organisations. The content of this section contributes towards the mandatory reporting requirements, as outlined in the Quality Account toolkit (www.gov.uk).

2.5 Review of services

During 2015/16 LPT provided and/or subcontracted 85 NHS services. Mental Health and Learning Disabilities account for 44 services and Community Health Services make up the remaining 41. See full list in **Appendix 2**.

LPT has reviewed all the data available on the quality of care in 85 of these NHS services, both for services directly provided and for those services subcontracted. Robust monitoring both externally with commissioners (via contractual requirements to monitor over 70 clinical quality performance indicators) and internally (via performance reviews and quality reports) ensures the highest standards are adhered to in the areas of infection control, patient safety, service user and carer experience, safeguarding, clinical effectiveness and compliance with regulatory requirements.

The income generated by the NHS services in 2015/16 represents 100 per cent of the total income generated from the provision of NHS services by the LPT for 2015/16.

2.5.1 Examples of how we reviewed our services in 2015/16

Board members remain visible in our services

During 2015/16 we made some changes to our Trust Board and welcomed a new Chair and a new Non-Executive Director. Our Healthwatch representatives from the City and County continue to contribute at Trust Board meetings as participating observers.

A new system of Board Walks was implemented during 2015 to further develop the relationships between Board members and patients, carers and frontline staff. Board Walks provide board members with opportunities to highlight areas of good practice and understand where changes may be needed. During 2015-16, Board members completed 62 visits to our services.

Assuring quality improvement of our services is reviewed each year

Governance arrangements are reviewed each year in order to ensure that our assurance arrangements are effective and patient-centred. Each operational service has in place arrangements for assurance and review on clinical, financial, and workforce issues. The corporate governance assurance arrangements are focused upon the Board committees and their duties delegated from the Trust Board to test and ensure that the Trust is in control of the quality of clinical and financial performance, and any risks. Periodically the Trust will test, by use of external agencies, the efficacy of the arrangements of the Board committees. There are also annual self-assessments by each committee, to ensure the adequacy of the terms of reference and work plans. These are reviewed by the Audit and Assurance Committee, with an overall review by the Trust Board.

Internal audit

We have in place through external auditors a programme of internal audits for the year that is developed and reviewed and agreed by our Audit and Assurance Committee.

Topics cover key areas where the Trust is either required to provide assurance such as the Information Governance Toolkit compliance, or where we want to have assurance around risks areas in our Board Assurance Framework, or for assisting in the development of our processes and systems.

Whilst the Trust had nine significant assurance reports issued by Internal Audit there were three limited assurance reports for:

- Infection Control
- Clinical Coding
- Duty of Candour

There were four split opinion limited /significant assurance opinion reports covering:

• Management of Change

• Medical Appraisal and Revalidation Systems Processes

• Staff Appraisals

• Payroll Expenditure

Actions are in place to address the areas of improvement identified in the limited assurance reports.

Commissioners are visible in our services as they undertake quality visits

During 2015/16 there were 12 Commissioner-led 'quality visits' to some of the places where we provide services. The commissioning teams included senior managers and doctors from the commissioning groups. The visits were undertaken to gain assurance of 'quality', for example good leadership, staff supervision and patient records. The methods used included observing the care environment, talking to nursing staff/patients and reviewing care records. The visits took place at a variety of services including; the District Nursing Service, local prisons, community hospitals and inpatient centres.

2.6 Participation in clinical audits

During 2015/16, five National Clinical Audits and one National Confidential Enquiry covered NHS services that LPT provides.

During that period LPT participated in 80% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The National Clinical Audits and National Confidential Enquiry that LPT participated in and for which data collection was completed during 2014/15 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Title	Number of cases submitted as a percentage of the number of registered cases required
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	100%
Prescribing Observatory for Mental Health (POMH-UK) / Prescribing for substance	100%

misuse - alcohol detoxification (POMH Topic 14b)	
Prescribing Observatory for Mental Health (POMH-UK) / Prescribing for ADHD in children, adults and adolescents (POMH Topic 13b)	100%
Prescribing Observatory for Mental Health (POMH-UK) / Prescribing for bipolar disorder (use of sodium valproate)	0%
Sentinel Stroke National Audit Programme (SSNAP)	100%
National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	100%

*(POMH-UK) = 0%, - The deadline was missed for submissions for this audit; however the Prescribing Group consider this to be an important topic and has commissioned a local audit.

The reports of three National Clinical Audits were reviewed by LPT in 2015/16 and the following actions are planned to improve the quality of healthcare provided.

National Audit Title	Actions to be taken
Prescribing anti-dementia drugs: POMH Topic 4b	100% of patients had a formal cognitive assessment conducted prior to initiating anti-dementia medication. The results of the audit and actions were shared with all doctors and nurses. Staff were reminded of the need to document the patient's capacity to consent, the carer's and patient's views, pulse rate, BP and any side effects at the start of the treatment and at every follow up.
Prescribing for People with Personality Disorder Re-audit POMH Topic 12b	Documentation of reasons for prescribing anti-psychotics was slightly lower than the national average at 67%. However 91% of patients had a documented crisis plan (compared with 80% nationally). The results of the audit were disseminated to all consultants and registrars and additional presentations were made on the completion of off-licence forms.
National Audit of Intermediate Care (NAIC) 2014	100% compliance with all criteria. No actions to be taken.

The reports of 94 local clinical audits were reviewed by LPT in 2015/16 and LPT intends to take the following actions to improve the quality of healthcare provided.

Audit Title	Actions to be taken
Record Keeping Children's Occupational Therapy (#1217) A record keeping audit is undertaken every two years as part of LPT's audit programme to ensure that members of staff are maintaining clinical records in accordance with policy and guidance.	• All OTs to have mandatory training on risk assessment including manual handling risk. • All OTs shown where to locate medication information and to record this if it is missing from the record. • Obtain list of approved abbreviations and email out to staff to aid consistency.
Record Keeping Audit - Primary Health – FYPC (#1212)	• Detailed discussion at the team meeting and agree standard operating procedures. • Induction programme for new staff to focus on health record expectations.
CAMHS Psychotherapy vs State of Mind Assessment (#1222) The aim of the audit was to analyse the clarity of referrals to the CAMHS Child and Adolescent Psychotherapy Service. The particular focus was on whether the referral clearly stated whether the request was for a psychotherapy assessment or a state of mind assessment.	Following the audit the actions below are to be implemented. • Create a flow chart outlining the referral process. • Copies of new referrals to be held centrally. • Disseminate this information to the CAMHS clinics, highlighting the new referral form.
Pressure Ulcer (SSKIN) MHSOP re-audit (#1186) The previous audit highlighted that the standard of care for pressure ulcers was mixed, and therefore the aim of this re-audit was to assess if the quality of care had improved.	The actions included: • Replacing outdated SSKIN leaflet in ward information pack. • Developing a SSKIN audit poster for distribution and display on wards.

VTE Risk Assessment and Appropriate Prophylaxis in Community Hospital and MHSOP Inpatient Wards Re-audit (#1129) This audit was undertaken to ensure that VTE risk assessment and appropriate prophylaxis is given in the Community Hospital and Mental Health Services for Older People (MHSOP) inpatient wards. The audit showed that MHSOP did not routinely document VTE risk assessments within 24 hours of admission to hospital.	The e-prescribing system to be amended so that it cannot be used unless the VTE assessment has first been completed.
Blood tests and other medical investigations of patients discharged from inpatient settings (MHSOP) (#1053) This audit aimed to provide quantitative data as to whether blood test results are reported in the discharge letter and to provide qualitative data as to whether blood test results should be reported. The audit showed that 88% of patients had either a medical condition or medication which required them to have at least one blood test monitored and that 33% of patients had comments included about the clinical relevance of the investigations.	The discharge summary system has been changed from the JAC system to Sunquest ICE. Sunquest ICE is considered to be a more user-friendly system with a heading in the discharge summary that relates to investigations done and results can be imported into the letter from other programmes. This may act as a reminder and potentially improves the process of completing discharge letters.
Section 132: Informing Patients of their Rights Re-audit (#721) Section 132 of the Mental Health Act places a responsibility upon hospital managers to ensure all practicable steps are taken to ensure that detained patients are given information about their rights under the Act. It remains an important aspect of the Code of Practice and is important for delivery of quality care. Previous audits have identified failings within inpatient settings.	The Trust was non-compliant with all criteria. The following actions have been taken. • A new form has been developed specific to MHSOP and AMH to identify shortcomings in MHA documentation. This does not replace the “Section 132 Form”. • A reminder has been set up on RiO to inform patients of their rights. • A section added to weekly MDT form to ensure that patient has been provided with information about their rights. • Each inpatient ward to nominate a named nurse to be responsible for

	ensuring that Sec 132 is adhered to for each detained patient.
Safe and Therapeutic Observation of Inpatients (Handover from one shift to another) (#901) The aim of this audit is to provide assurance of compliance with the Safe and Therapeutic Observation of Inpatients Policy: - to ensure that if patients are placed on observation levels 1 and 2 their monitoring requirements are passed on to relevant staff during handovers. Of the five criteria the Trust was fully compliant on three and partially compliant on two: the duration of observation and the continued maintenance of observation.	AMH and LD services to undertake monthly spot checks to measure "continued maintenance of observation", "duration of observation" and "staffing level requirements".
Quality of Medic Review of Patients Accepted for Home Treatment re-audit (#838) The current practice standard for quality of medical reviews within the LPT Crisis Resolution Home Treatment (CRHT) team states that all service users with a diagnosis of a serious mental illness should be reviewed by a doctor from the team. In addition this assessment should take place within the first week of introduction to CRHT services.	• An email will be sent to all CRT doctors to include a proforma with a structure for the initial medical review. There will also be printed sheets available in the crisis office to act as reminders to this. • Morning multi-disciplinary team meetings to be reintroduced. New cases discussed with team, including medics. • Medic appointments to be booked as required from this meeting.

2.7 Participation in clinical research

LPT continues to provide our service users and carers the opportunity to participate in research in the knowledge that this enhances care, enables services to deliver innovative interventions and contributes to the development of staff.

We are committed to developing, hosting and collaborating with local, national and international research through our partnerships with academic and other NHS organisations as part of the National Institute of Health Research (NIHR), in particular with the Clinical Research Network: East Midlands (CRN: EM), Collaboration for Leadership in Applied Health Research and Care: East Midlands (CLAHRC: EM) and East Midlands: Academic Health Science Network (EM: AHSN). Our research profile includes projects adopted across a number of areas including

Children, Dementia and Neurodegenerative Diseases, Diabetes, Learning Disabilities and Mental Health.

The number of patients receiving NHS services provided or sub-contracted by LPT in 2015/16 that were recruited to participate in portfolio studies approved by a research ethics committee was 560.

The portfolio studies hosted by the Trust in 2015/16 are listed in the table below:

Sample Portfolio Studies Title/Acronym	Key aim/principle of study
ACTIFCare	ACTIFCare: Access to timely formal care
AD Genetics	Detecting Susceptibility Genes for early onset Alzheimer's disease
AFFECT	A randomised controlled trial of calcium channel blockade with **A**mlodipine **F**or the treatment o**F** subcortical ischa**E**mic vas**C**ular dementia
AQUA	A randomised controlled trial comparing the effects of providing clinicians and patients with the results of an objective measure of activity and attention (QbTest) versus usual care on diagnostic and treatment decision making in children and young people with ADHD
BDR	Brains for Dementia – Longitudinal assessment of potential brain donors
CADL	Changes in the motivation and performance of activities of daily living in dementia and their relationship to well-being
Cardiac rehab and Stroke	A feasibility study to identify attitudes, determine outcome measures and develop an intervention to inform a definitive trial that will determine the effectiveness of adapted cardia rehabilitation for subacute stroke patients
CIRCLE	Randomised controlled trial of the clinical and cost effectiveness of a contingency management intervention for reduction of cannabis use and of relapse in early psychosis
DAPA	Physical activity programmes for community dwelling people with mild to moderate dementia
DEME 3728 LEGATO-HD	A multicentre, multinational, randomised, double blind, placebo controlled, parallel group study to evaluate the efficacy and safety of Laquinimod (0.5, 1.0 and 1.5 mg/day) as treatment in patients with Huntington's Disease
ENROLL-HD	Enroll-HD: A Prospective Registry Study in a Global Huntington's Disease Cohort
EpAID	Improving outcomes in adults with epilepsy and intellectual disability: A cluster randomised controlled trial of nurse-led epilepsy management (EpAID)
ESMI	The effectiveness and cost effectiveness of mother and baby units versus general psychiatric inpatient wards and crisis resolution team.

EXCEED	Extended cohort for e-health, environment and DNA (EXCEED) Study
EQUIP	EQUIP: Enhancing the quality of user involved care planning in mental health services Evaluation of the efficacy and cost effectiveness of user/carer involved care planning
HIND	Hypertension in Dementia
LISTEN UP	Understanding and helping looked after young people who self-harm
LYNC	Improving health outcomes for young people with long term conditions: the role of digital communication in current and future patient-clinician communication for NHS providers of specialist clinical services (long term, young people, networked digital communication technology, clinical communication)
MADE	Minocycline in Alzheimer's disease efficacy trial: The MADE Trial. (Professor Robert Howard: Kings College & SLAM)
MATCH	People with autism detained within hospitals: defining the population, understand aetiology and improving care pathways.
MARQUE	The quality of life of people with memory problems who live in care homes
MOLECULAR	A national study investigating the genetic basis of Bipolar Disorder.
MOLGEN	Molecular Genetics of Adverse Drug Reactions
Passive Fluenz Tetra Safety Surveillance	Passive enhanced safety surveillance (ESS) of the Quadrivalent live attenuated influenza vaccine (QLAIV) fluenz tetra in children and adolescents during the early 2015/16 influenza season in England.
PBS	Clinical and cost effectiveness of staff training in Positive Behaviour Support (PBS) for treating challenging behaviour in people with intellectual disability (Angela Hassiotis – UCL).
PPIP2	Prevalence of neuronal cell surface antibodies in patients with psychotic illness
RADAR	Reducing pathology in Alzheimer's Disease through Angiotensin taRgeting. The RADAR Trial. A phase II, two arm, double-blind, placebo-controlled, randomised trial to evaluate the effect of losartan on brain tissue changes in patients diagnosed with Alzheimer's disease
REGISTRY 3 (ENROLL-HD)	A Prospective Registry Study in a Global Huntington's Disease Cohort
Servicer S38093	Efficacy and safety of 3 doses of S38093 (2, 5 and 20mg/day) versus placebo in co-administration with donepezil (10mg/day) in patients with moderate Alzheimer's Disease. A 24 week international, multi-centre, randomised, double-blind, placebo-controlled phase IIb study
The use of guided self-help in Anorexia Nervosa	A study of feasibility and effectiveness of the addition of self-help aid and recovery guide for eating disorders (SHARED) to treatment as usual for anorexia nervosa.
SPRING	The Study of psychosis and the role of inflammation and GABA/Glutamate
STOP	Diabetes screening and prevention for people with Learning

	Disabilities
SUICIDE	Study of Suicide in the Criminal Justice System: Nested Case-Control (Prof Jenny Shaw (Manchester))
	In-patient suicide whilst under non-routine observation (Prof Jenny Shaw, Manchester)
Surviving Crying	Development and Preliminary Evaluation of an Intervention Package to Support Parents of Excessively Crying Infants

Fourteen clinical staff members participated as Principal Investigators in portfolio research approved by a research ethics committee at LPT during 2015/16. These staff participated in research covering a range of specialities including old age psychiatry, adult mental health, children, learning disability, child and adolescent mental health and public health.

In the last three years we have not had any National Institute of Health Research (NIHR) funded Chief Investigators within the Trust. However our staff have been disseminating their research through various publications, showing commitment to transparency and desire to improve patient outcomes and experience. Fifty six articles have been published in 2015 in a wide range of journals.

A full list of all research activity is available upon request via email to: research@leicspart.nhs.uk

2.8 Goals agreed with Commissioners

2.8.1 Use of contractual arrangements

Local authorities, West Leicestershire Clinical Commissioning Group, East Leicestershire and Rutland Clinical Commissioning Group and Leicester City Clinical Commissioning Group (CCGs) commission services on behalf of people living in Leicester, Leicestershire and Rutland. As part of our relationship with the three Clinical Commissioning Groups we have agreed quality targets and goals and these are translated into a Quality Schedule and a Commissioning for Quality and Innovation (CQUIN) payment framework. Progress against delivery has been monitored by our Commissioners on a monthly basis through formal meetings and visits to review our services in 2015/16.

The Trust's Quality schedule for 2016/17 has been agreed with our commissioners. Further details of the Quality Schedule for 2015/16 can be requested via email to: feedback@leicspart.nhs.uk

2.8.2 Use of the CQUIN payment framework

A proportion of LPT's income in 2015/16 was conditional on achieving quality improvement and innovation (CQUIN) goals between West Leicestershire Clinical Commissioning Group, East Leicestershire and Rutland Clinical Commissioning Group and Leicester City Clinical Commissioning Group for the provision of NHS services, through the CQUIN framework. In 2015/16 we agreed 11 CQUIN goals with our Commissioners and we partially achieved 3 and fully achieved 8 CQUIN goals. The table below outlines our CQUIN goals for 2015/16.

CQUIN	Description of goal
Cardio Metabolic Assessment for patients with psychosis	National CQUIN to improve the assessment, documentation and action on cardio metabolic risk factors in patients with psychosis.
Patients on CPA: Communication with general practitioners	National CQUIN to improve communication with patients' GPs, focussing on patients on CPA.
LD – Reducing the risk of patients choking	Local CQUIN to develop risk management plans aimed at supporting patients with LD and risk of choking to remain at home safely
LD – Preventing admissions	Local CQUIN to implement a gatekeeping function for admissions to the Agnes Unit - to challenge admission at the point of referral and consider alternatives to admission.
Physical activity (Assertive Outreach)	Local CQUIN to encourage opportunities for patients with severe and enduring mental illness to develop a healthy lifestyle.
Carer Support	Local CQUIN to implement the " Triangle of Care" carer support programme in MHSOP ,Complex Care and LD inpatient services
Leg Ulcer pathway	Local CQUIN to improve the standards of care and healing for patients with venous leg ulcers
Dementia care and discharge planning *	Local CQUIN to ensure that all patients referred to the memory service have a memory assessment and a multidisciplinary care plan on discharge from the clinic
Patient Experience	Local CQUIN to improve organisational responsiveness to complaints through external scrutiny and support from service users.
CAMHS- Quality Standards	Local CQUIN to implement a selection of quality standards produced by the Royal College of Psychiatrists and the Quality Network for Community

	CAMHS. The indicators support improvements in referrals, care planning and partnership working.
Continuing Health Care *	Local CQUIN to improve the timeliness and accuracy of Continuing Healthcare Assessments.

*LPT did not demonstrate full compliance with this CQUIN. Further discussed in Section 2.8.3

2.8.3 Improved patient outcomes as a result of CQUINs

As a result of the 2015/16 CQUIN programme the following are some examples of improved patient outcomes:

- A process for assessing, documenting and acting on cardio metabolic risk factors within two user groups - inpatients and Community Early Intervention in Psychosis (EIP) team has been fully implemented.

- 100% of patients at risk of choking had a personalised care plan in place (69% in Quarter 2).

- 100% of consenting patients under the care of the Assertive Outreach Team had a physical health assessment and individualised care plan.

- 92% of patients with leg ulcers had compression bandaging in accordance with the Lower Limb Pathway (69% in Quarter 2) and 100% of patients were reviewed in the hub clinic as planned.

We could not demonstrate full compliance with three CQUINs in 2015/16 and therefore received partial payment. The CQUINs that we partially met were:

- Dementia Care and Discharge Planning - 55.2% of patients referred to the memory assessment clinic received a memory assessment within 6 weeks of referral (Target 60%) – in order to improve access to memory clinics LPT has highlighted issues relating to the Shared Care Agreement with GPs to the commissioners.

- CAMHS- Quality Standards –The CAMHS service have an action plan to address the Quality Standards that have not been met and will re-audit in 2016/17.

- Continuing Heath Care – LPT marginally missed the target of 95% of fully /accurately completed Continuing Health Care Assessments to be sent to Arden and Greater East Midlands Commissioning Support Unit (GEM) each month. The learning from the incomplete documents has been shared with staff and is being taken forward through the CHC training programme.

Further details of the CQUIN programme for 2015/16 and 2016/17 can be requested via email to: feedback@leicspart.nhs.uk

2.9 What others say

2.9.1 Care Quality Commissioners

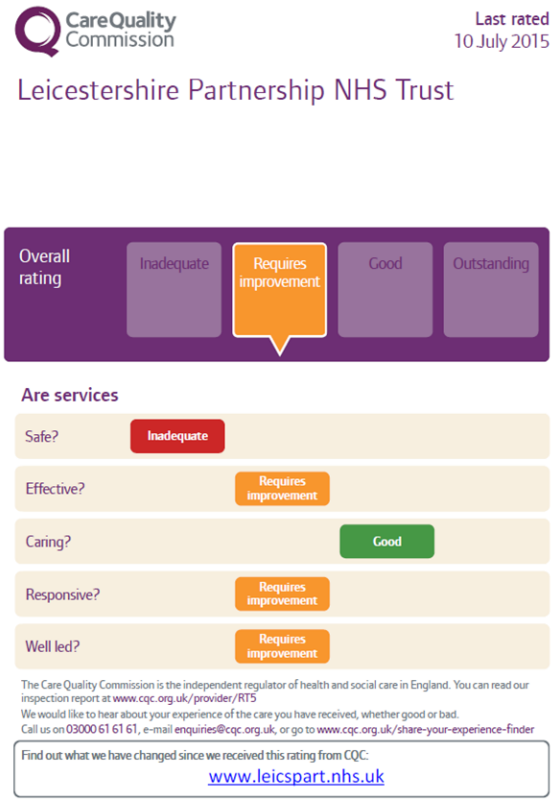
The Care Quality Commission (CQC) was established by the Health and Social Care Act 2008 to regulate the quality of Health and Adult Social Care. From 1 April 2010 all NHS providers were required to register their services with the CQC. The Trust received notification of full registration without any conditions on 1 April 2010. During 2015/16 LPT maintained an accurate Statement of Purpose as set out in the Health and Social Care Act 2008 regulatory requirements, LPT has a total of 20 registered locations.

Chief Inspector of Hospitals Comprehensive Inspection of Services

Following their Comprehensive Inspection in 2015 the CQC issued their final inspection reports during July 2015. The Trust received seventeen reports, covering sixteen 'Core Services' plus an overarching 'Provider Level' Report. The Trust was rated as 'Requires Improvement' overall. Within these reports the CQC issued Requirement Notices across a range of eighty areas where the Trust is required to make improvements. In response each 'Core service' has identified improvement plans to address the findings including: strengthening scrutiny arrangements for patients subject to the MHA; introduction of a mandatory training requirement for clinicians working with the MHA 1983; revising policy and procedures; improvements to inpatient bed management. The overall 'Provider Level' rating is detailed in the grid below.

CQC inspection reports can be accessed at http://www.cqc.org.uk/provider/RT5

CQC Ratings Grid



A summary of all the ratings (as determined by the CQC) is shown as **Appendix 3**.

We are implementing a comprehensive action plan and anticipate that by the end of quarter 3, 2016/2017 our agreed improvement actions will have been fully implemented. Our progress is monitored monthly through our Quality Assurance Committee.

Our Trust Board has undertaken a self-assessment against the Well-led Framework and agreed a development programme for 2016/17. We have also recognised that developing a coaching and supportive approach, leads to a more engaged workforce. In order to create this change in culture we are reviewing and revising our people strategy and the way in which we develop leaders.

Prison Visits:

On 5 October 2015 the CQC, in conjunction with Her Majesty's Inspectorate of Prisons (HMIP) inspected HMP Leicester. As a result of this joint inspection the Trust was issued with two Requirement Notices and asked to make improvements to staffing and care planning. As a result improvement plans focused on investment and recruitment to staff roles, review of various staff duties and strengthening the care planning processes.

During 9-13 November, in conjunction with Her Majesty's Inspectorate of Prisons (HMIP) the CQC inspected HMYOI Glen Parva. Following this visit the CQC found there were no breaches of the regulations.

HMP Locations	CQC Inspection Dates
HMP Leicester	28th September 2015
HMP Glen Parva	9th November 2015

Further information is available from the CQC web site at www.cqc.org.uk

CQC Mental Health Act Commissioner visits in 2015/16

In 2015/16 the **CQC Mental Health Act Commissioner** visited the following locations:

LOCATION:	DATE OF VISIT:
Kirby Ward	11 & 19/06/15
The Agnes Unit	22/10/15
Stewart House	29/10/15

Welford Ward	19/11/15
Thornton Ward	28/01/16
Coleman Ward	10/02/16
Wakerley Ward	17/02/16

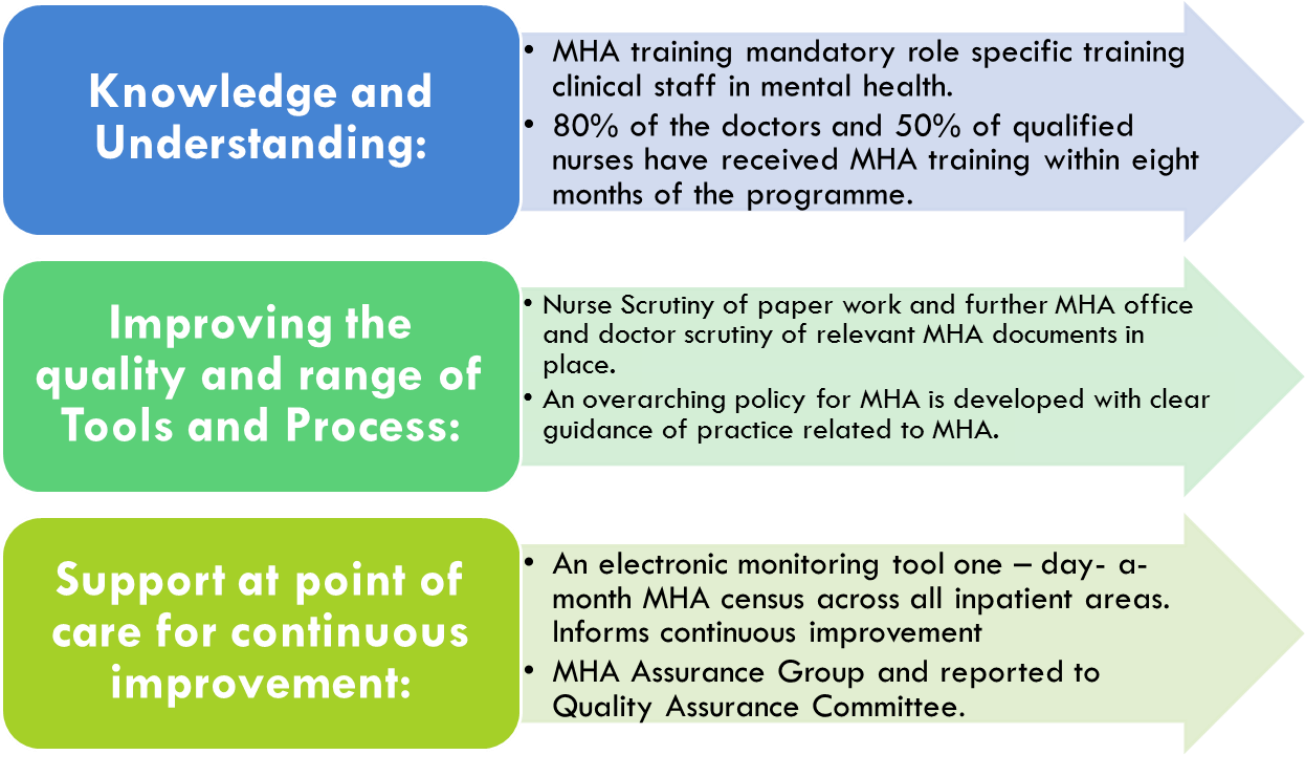
The CQC continue to monitor application of the Mental Health Act (MHA) 1983 for patients whose rights are restricted under the Act. These types of visits are normally unannounced and there were seven visits undertaken in 2015/2016.

Each visit generates an action plan from the CQC which requires a response within a defined time frame. The CQC use the MHA Code of Practice as their monitoring tool and identify concerns on the action plan using quotes from the Code.

Services are responsible for the continued management of the action plans. A significant review of the Code of Practice in March 2015 provided the opportunity for services to review previous action plans to ensure continued compliance.

The improvement programme on MHA initiated in 2015/16 is progressing with further work to build on the achievements in the last year.

Key areas of development have been:



This programme has provided a platform for change in developing knowledge and understanding, and the tools necessary to ensure compliance not only with the

regulatory aspects of the Act but also the five guiding principles that underpin the Act and are reflected in the work of the organisation in its commitment to meeting those standards in its service provision.

2.9.2 HM Coroner

The Trust has received seven Prevention of Future Death (PFD) Reports under Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. The new Regulations provide the Coroner with a duty not just to decide how somebody came about their death but also where appropriate to report the death with a view to preventing future deaths.

The concerns raised by the Coroner for each inquest are considered and responded to by the Chief Executive within the timeline set-out by the Regulation Report. Any emerging themes are also considered for actions to be considered wider than the specific team or service provision. Learning from themes has informed our Trust quality priorities for 2016/2017.

2.9.3 Quality Network for Inpatient CAMHS

A Quality Network for Inpatient (QNIC) visit took place to the CAMHS In-patient unit at Coalville Hospital on 30/10/15. QNIC is the 'Quality Network for Inpatient Child and Adolescent Mental Health Services' and is part of the Royal College of Psychiatrists. Achievements included the ward environment was described as welcoming and friendly, parents and carers reported good communication and staff include them in care planning.

2.9.4 Health Education East Midlands

Health Education East Midlands (HEEM) visited LPT on 4 November 2015. This was a level 2 visit (medium risk). The Trust was able to show a high level of engagement and commitment to multi-professional education and training and inter-professional working through a very well-organised visit. The education team was able to demonstrate improvement and innovation across the Trust. In general, most learners were happy with their education and training experience, felt well supported and regarded the Trust as a good place in which to work. The majority of trainers, mentors and supervisors were satisfied with the support provided by the Trust to undertake their roles. The visiting team did not identify any significant patient safety issues. However there were two issues that the visiting team raised with the Trust's senior team in immediate feedback which appear as requirements in the final report. A third requirement related to academic research capacity and research opportunities for trainees in the Trust. Immediate actions have been taken to address these issues.

2.10 What do our staff say?

The 2015 NHS Staff Survey was conducted between October and December 2015. In addition to enabling LPT to understand the views of staff, the national survey enables LPT to benchmark performance against other similar Trusts. 2158 LPT staff completed the survey - a response rate of 43% which is average for comparator Trusts.

The areas where staff experience improved the most were:

- Staff motivation at work
- % of staff able to contribute towards improvements at work
- % of staff suffering work related stress in last 12 months
- Effective use of patient / service user feedback
- Staff recommendation of the organisation as a place to work or receive treatment.

In response to our national staff survey results, LPT has had in place during 2015/16 a focused improvement programme across four areas as follows;
Areas where LPT staff responses compared least favourably with other Trusts were identified as:

Health and Wellbeing	Effective Leadership/Management Support	Effective Teams	Communication and Engagement
• Emotional resilience workshops • Staff Physiotherapy scheme • Wellbeing zone • Staff mental health & wellbeing conference • Anti-bullying and harassment advice service	• Leadership Framework • Line manager development pathway • Mentoring & Coaching/Action learning • New electronic appraisal process • Essential HR for managers training	• Line managers team development skills toolkit • Team development framework • Trained facilitators for bespoke interventions	• Listening into Action (LiA) approach • Use of Vodcasts and social media • Values Toolkit • Induction handbook revised • Celebrating Excellence awards, Valued Star awards/Long service awards

- Staff satisfaction with the quality of work and patient care they are able to deliver
- Effective team working
- Support from immediate managers
- % of staff feeling pressure in the last 3 months to attend work when feeling unwell
- Quality of non-mandatory training, learning or development.

Through the 2015 NHS Staff Survey, 21% of staff told us that they had experienced harassment, bullying or abuse from staff in the last 12 months. This result was the same as in 2014 and reflected the average for similar Trusts. We have introduced a number of initiatives to manage and reduce workplace bullying and harassment. We have an Anti-Bullying, Harassment and Victimisation policy which was re-launched during the year, an Anti-Bullying and Harassment Advice Service run by trained advisors. We also have a group of trained mediators and access to mediation through the staff counselling and psychological support service. Our aim is to reduce bullying and harassment through increased awareness raising and development opportunities for line managers in supportive management behaviour and holding healthy conversations.

The percentage of staff highlighting that that they believe LPT provides equal opportunities for career progression and promotion was 89%. This is the same position as in 2014 and reflects the national average for similar Trusts. In analysing the response rate we noted variation across our services in relation to this indicator and have undertaken some targeted work, including an additional survey, during 2015/16 to understand the issues faced by staff.

Compared with 2014 LPT's overall staff engagement score improved significantly with an increase from 3.63% in 2014 to 3.72% in 2015. This response does remain below the comparator Trust average of 3.81 and national average across all sectors of 3.78 and we will continue our staff experience improvement and engagement programmes during 2016/17.

2.11 Data quality

The Trust is taking action to improve data quality through a significant programme of work which commenced in 2015/16 and will continue through 2016/17 to review and improve all aspects of the information lifecycle. This solution includes the development of a new fit for purpose data model and a rolling programme of Key Performance Indicator (KPI) reviews incorporating clinical systems training, system configurations and a review of how our services enter information onto clinical systems and use their performance data to improve patient care.

The Trust continues to build self-service on-line web-based reporting of core indicators to support staff to deliver high quality care and is reviewing its Information Management and Technology Strategy to ensure it underpins the Trust's objectives and service development plans.

2.12 Use of NHS number

LPT submitted records from April 2015 to March 2016* to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's **valid NHS number** for LPT was:

100% for outpatient care
99.7% for inpatient care

The percentage of records in the published data which included the patient's **valid General Medical Practice Code** was:

99.6% for admitted patient care
100% for outpatient care

*This data is accurate up to end of February 2016

2.13 Information Governance Toolkit attainment levels

Information plays a key part in the clinical and corporate governance of Leicestershire Partnership NHS Trust and the quality in the provision of patient services. Planning, performance management, assurance and financial management rely upon accurate and available information.

The Information Governance Assurance Framework (IGAF) is the national framework of standards that brings together all statutory, mandatory, and best practice requirements concerning information management. The standards are set out in the Information Governance Toolkit (IGT) as a roadmap enabling organisations to plan and implement standards of best practice and to measure and report compliance on an annual basis.

LPT's Information Governance Assessment Report score overall for 2015/16 was 94% and was graded green against the information governance toolkit grading scheme. 360 Assurance completed an audit to assess the robustness of LPT's approach to establishing an information governance control framework and reviewed evidence to demonstrate compliance with the recommendations set out in the Caldicott 2 Review: 'To Share or Not to Share', which had been mapped to Information Governance Requirement Standards for Version 13 of the Toolkit.

The review was completed in accordance with the internal audit standards for the NHS and was performed to provide an objective and unbiased opinion.

The outcome of this review was that we received 'significant assurance' in relation to the Information Governance Toolkit Assessment for 2015/16.

2.14 Clinical coding error rates

Clinical Coding is the medical terminology used by clinicians to record a patient's diagnosis and treatment in a standard, recognised code. The accuracy of this coding is a key quality standard, to help us ensure that patient's records are accurate.

The Mental Health Minimum Dataset (MHMDS) is a mandatory requirement for all providers of specialist adult mental health services in a secondary care setting. The requirement is to collect person focused clinical data which includes all relevant treatment and care for service users in a mental healthcare setting using ICD-10 for diagnoses and OPCS-4 for procedures. The coded clinical data inputted helps provide local clinicians and managers with better quality information for clinical audit, and service planning and management.

The principal aim of this requirement is to ensure all mental health trusts are providing accurate and concise quality data and continue to do so into the future. By providing a standard development framework it is possible to outline what is considered to be best practice and drive the production of good quality data inputted by staff using the application of national standards. This will ensure consistent, meaningful and comparable data.

If the quality of the coding is of an unsatisfactory standard this could have far-reaching consequences for both this trust and also the NHS as a whole, so it is important to audit not only the work of the Clinical Coding Department but also the quality, accuracy and completeness of the documentation the clinical coding staff are required to work with.

An Annual Audit is undertaken in order to conform to Information Governance Toolkit requirement 13-514, which states that all Mental Health Trusts should have an audit of a minimum of 50 Finished Consultant Episodes (FCEs) undertaken during each year. The audit is to compare the completed coded data with the information held in a full set of case notes, this data can then be assessed against the national standards, rules and conventions for coding as produced by the NHS Classifications Service.

In 2015/16 the quality of the clinical coding undertaken by the Clinical Coding Team was audited across a number of mental health services within the Trust and a total of 50 Finished Consultant Episodes were selected.

The NHS Classifications Service recommends the following percentage accuracy scores measured by procedure and diagnosis error rates as targets.

HSCIS Attainment Level for Information Governance Purposes		
	Level 2	Level 3
Primary diagnosis	>= 85%	**>= 90%**
Secondary diagnosis	>= 75%	**>= 80%**
Primary procedure	>= 85%	**>= 90%**
Secondary procedure	**>=75%**	**>= 80%**

Audit results

Primary diagnosis correct	Secondary diagnosis correct	Primary procedures correct	Secondary procedures correct
100%	**96.77%**	**N/A**	**N/A**

The figures for primary and secondary diagnosis coding far exceed the recommended 90% accuracy for primary diagnoses and 80% accuracy for secondary diagnoses recommended for Information Governance purposes for attainment of level 3.

All of the recommendations from last year's audit have been followed up although the recommendation regarding the level of detail on the discharge summaries could not be checked at audit as the clinical coding department does not have access to the complete case notes. However the coding deadline date has been amended and it is evident that more validation of the coded data is taking place.

LPT was not subject to the Payment by Results clinical coding audit during 2015-16 by the Audit Commission.

2.15 Duty of Candour

The Trust has a Being Open/Duty of Candour Policy in place. This policy ensures that we are always open and honest with patients and/or their families following an incident where a patient has been harmed. We have a duty to contact the patient and/or their family within 10 days of the incident. Where an investigation has taken place we arrange to meet with the patient and/or their family to share the findings with them. The policy contains a flow chart guide, crib sheet and assurance template document which captures information related to the discussions that we have with

patients and/or families. The Trust reports to commissioners each month on our compliance with Duty of Candour.

Duty of Candour training has been delivered to all senior managers. Staff training is delivered and a new e-learning package will be available in spring 2016.

2.16 Sign up to Safety Plan

LPT has pledged to strengthen patient safety within its services with an aim to deliver harm-free care for every patient, every time and everywhere. The campaign champions openness, honesty and supports everyone to improve the safety of patients.

There are 5 Sign up pledges;

To deliver our safety programme, we have agreed an improvement plan to deliver improvements across the three areas as follows;

- Reduce harm from medication errors
- Reducing the risk of harm from medical devices
- Reduce harm from falls

Part 3 – Review of quality performance in 2015/16

Our Quality Strategy (2013/2016) articulates our three-year vision for continuous quality improvement and this will be reviewed during 2016, it is currently based on three key pillars of quality and underpinned by self-regulation:

We aim to provide care which provides excellent clinical outcomes for our patients and to do so with compassion that is evident to those patients, their families and carers.

We want to be transparent about the continued challenging economic climate that we are facing where we are expected to make cost improvement savings year on year, which could impact not only on our organisation, but in the local healthcare economy in Leicester, Leicestershire and Rutland. We need to be assured that any efficiency gains that the Board and senior clinical leaders agree are underpinned by robust monitoring, to identify the smallest risk of impact on local services. The risk of impact on our services continues to be rigorously assessed and monitored by senior leaders to ensure that we continue to deliver quality-led services, whilst maximising the best use of the available resource.

Whilst we know we provide good quality care - through levels of patient satisfaction and feedback, we work towards ongoing, continuous quality improvement.

This section of the report demonstrates our progress against the priorities that we set out to achieve in 2015/16 and includes progress against the mandatory national measures that all NHS Trusts have been asked to report on, and the breadth and quality of the vast range of services that we provide.

During 2015/16 we have had a focused approach to embedding the learning from the Francis report by utilising five priority themes. Each of these themes has an executive lead responsible for mapping the improvements to demonstrate how they are embedded into the core business of the organisation. The five themes are;

(i) Openness and transparency
(ii) Listening
(iii) Working together
(iv) Capacity within teams
(v) Leadership

1. **Openness and transparency**
   Our Chief Executive has led the work to improve openness and transparency. We have developed and adopted the revised Trust values through staff and service user engagement. We work closely with service users and their families to investigate service incidents. All serious incidents are discussed at the public Trust Board and where Healthwatch are a participating observer.

2. **Listening to our service users and staff**
   Our service users and their carers are actively involved in staff selection and service development initiatives across the Trust. We have revised our Complaints Policy to enhance the involvement of service users and implemented a revised framework for our 'Boardwalks'. We continue to utilise Listening in to Action (LiA) for staff engagement in service improvement and change.

3. **Learning and working together as teams**
   We support team development across the Trust, and our LiA approach supports working as teams. We have also implemented a values-based recruitment approach. Our Leading Together Programme continues to get stronger with 150 staff successfully completing the first cohort; the 6 days had the following themes;

   - Personal effectiveness
   - Partnership
   - Team effectiveness
   - Vision
   - Innovation
   - Change management

4. **Capacity within teams**
   We have in place an established approach to reporting and reviewing safer staffing and will continue to build on this in-line with national direction. We work closely with the East Midlands Leadership Academy to support our staff to access training to develop capacity and capability. Our Appraisal Training Programme and approach has been revised and we continue to empower leaders to follow the new process, set meaningful objectives and have support conversations.

5. **Leadership development**
   We have initiated and sustained a number of methods of leadership development which included the training programs such as Covey – 7 Habits of Healthcare; Supportive Management Behaviour Training Programme, Leading for Change – bespoke programme with health skills, Leadership and Management Skills, Workplace Mentoring Programme, Workplace Coaching and Supervision Programme and ILM Level 3 Leadership and Management Programme.

Sir Robert Francis published his report on the 'Freedom to Speak Up' which recommended wide-ranging reform of healthcare culture, to ensure that healthcare staff feel safe to raise concerns over patient care and treatment without fear of reprisal. The Report emphasised the requirement for NHS bodies to encourage openness and transparency in handling concerns. There was a real emphasis on the continued need for cultural change, with a focus on leadership, training and the proper management of complaints. All NHS bodies were encouraged to embrace this new culture. LPT are committed to creating this cultural change, and have implemented a range of actions during the last year including: clinical supervision focus, a revised policy and e-learning on raising concerns and commencing recruitment to a 'Freedom to speak up guardian' role.

3.1 Progress on quality priorities for 2015/16

3.1.1 Our local priorities – our achievements in 2015/16

Our progress to date as measured against the local priorities that we set out to achieve in 2015/16. We will continue to monitor progress with these priorities, where some have been achieved but need to be sustained and in others where we have achieved some improvement, but they still require further work and this will be monitored by the groups responsible for monitoring the quality of our services. See **Appendix 4**.

3.1.2 Mandatory reporting criteria 2015/16

The Trust considers that the data presented in the table below is as described for the following reasons:

These figures have been reported in both the Integrated Quality and Performance Report (IQPR) which is presented to the Trust Board on a monthly basis or through the sub committees of the Trust Board.

The Trust submits some mandatory national measures on a quarterly basis either through the Omnibus Survey data collection system on behalf of the Health and Social Care Information Centre (HSCIC) for the Crisis Resolution Home Treatment measure and via the Unify2 web portal on behalf on the DH Information Centre for Care Programme Approach seven day follow-up. The Trust submits data to the

National Reporting and Learning System (NRLS) which is published bi-annually by the NHS Commissioning Board.

The Trust monitors and discusses the performance of all performance measures on a routine basis to ensure continuity and enable services to provide high quality care.

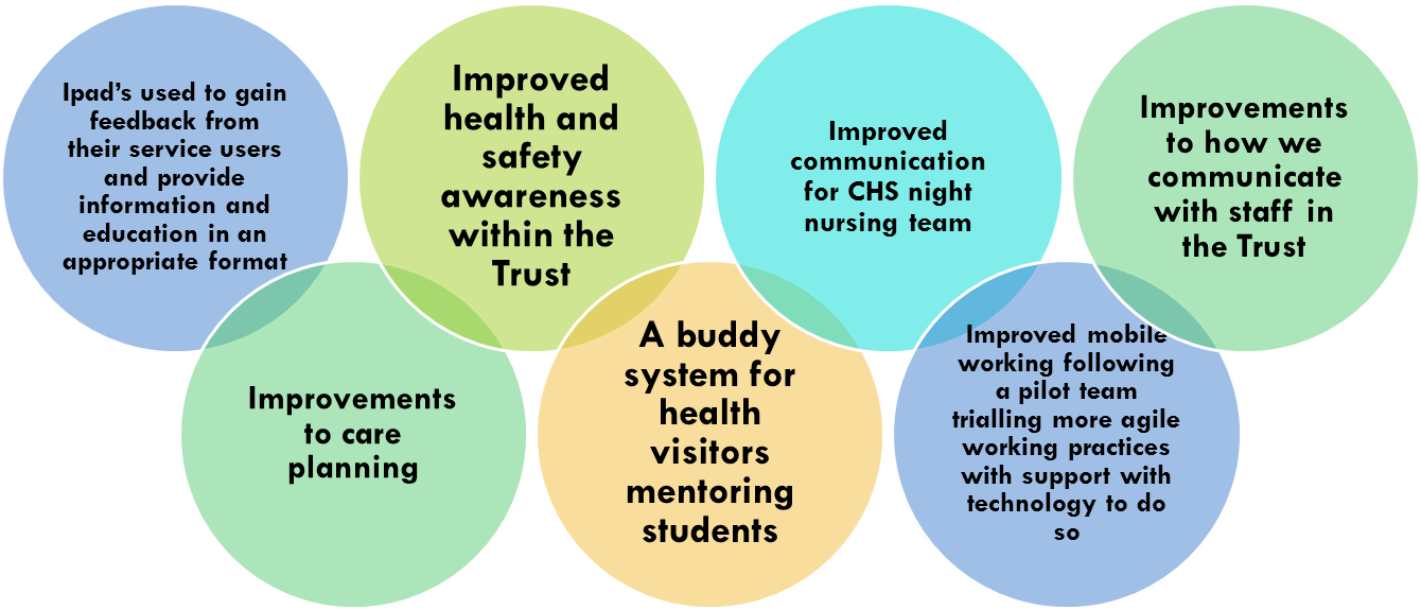
Mandatory National Measure	Quarter Period Totals/ Percentage				Year End	National Average
	Q1	Q2	Q3	Q4		
The percentage of patients on Care Programme Approach who were follow-up within 7 days after discharge from psychiatric in-patient care during the reporting period. Source: *HSCIC – mental health community teams activity*	95.8%	96.9%	97.6%	96.9%	96.9%	97.2% Average 100% Highest 53.5% Lowest *As at Q3*
The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends. Source: *NHSstaffsurveys.com*	2014 Staff Survey 55% - LPT 66% - all organisations 93% Highest 36% Lowest				2015 Staff Survey 59%	68% - all organisations 93% Highest 18% Lowest
The "Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period. Source: *nhssurveys.org*	2014 National NHS Community Mental Health Service User Survey 7.8 Score				2015 National NHS Community Mental Health Service User Survey 7.6 Score	8.2 score Highest 6.8 score Lowest

3.2 Listening into Action (LiA)

Listening into Action began in May 2013, and is now one of the key ways that the Trust empowers staff to make changes that improve working life and patient care. The programme enables staff to take bold steps to deliver better outcomes for our patients, staff and the Trust as a whole.

LiA is now an essential part of our programme to improve the quality of care across all of our services. More and more teams are recognising the programme as a way to make improvements to their areas and are requesting to use the methodology. Fifty two teams have now taken part to date.

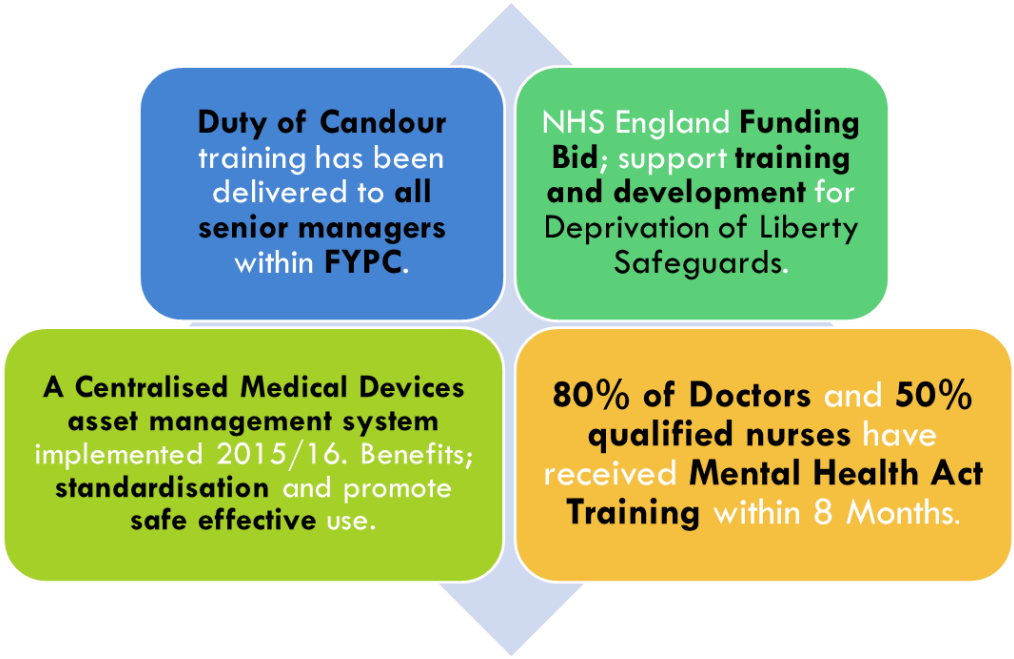
Highlights from LiA's 2015/16:



There have been five pass-it-on events held, where teams present and celebrate the changes they have achieved. In the past year there have been 22 big conversation held, around a variety of topics, giving staff the chance to contribute their opinions and ideas, engaging them in potential change and improvement. This year's annual NHS Staff Survey results show more of our staff feels able to make contributions to improvements at work than in 2014.

3.3 Quality of services 'Safe Care'

Key Achievements in 2015/2016, Safe Care



3.3.1 Safer staffing

Our workforce plays a critical role in ensuring delivery of high quality care and excellent outcomes for our patients. Evidence tells us that staffing levels are linked to the safety of care and that staff shortfalls increase the risk of patient harm, poor quality care and leads to increased stress and low levels of job satisfaction amongst staff.

We have focused our attention on the need for greater transparency within the Trust with regards to staffing levels. Having the right people, with the right skills, in the right place at the right time to meet the changing needs of our patients is a priority for us.

We have in place the following:

1. Monthly safer staffing reporting to the Trust Board,
2. Six monthly establishment reviews presented to the Trust Board,
3. Each ward display planned versus actual staffing numbers.

Our directorates regularly review our staffing levels so that we can ensure that staffing levels continually meet the changing patient needs and dependency on our wards. The range and nature of services provided across LPT means that there is no single ratio or formula that can be used to determine the optimum staffing levels for LPT inpatient areas. Each service area utilises a range of approaches to review our staffing establishment. In addition to using nurse sensitive indicators, these reviews take account of patient, ward and nursing staff factors. The acuity/dependency of

patients (how sick or dependent they are) is also monitored closely as this ultimately affects the type and amount of care they need.

Safer staffing compliance is scrutinised monthly by lead nurses in each division and the Chief Nurse to ensure that safe staffing standards are adhered to. There is a process for escalating any concerns and ensuring action is taken.

Our lead nurses' work with human resources to develop recruitment strategies and ensure bank staff availability is optimised to meet service needs. We continue to proactively recruit to our vacancies using a combination of recruitment activities (rolling recruitment including open days, monthly interviews and recruitment fairs) to attract and retain the best staff we possibly can in line with our workforce needs.

3.3.2 Learning from incidents

During 2014/15 our staff reported a total of 8,649 incidents, of these 103 incidents were considered serious. The definition of a serious incident is: 'any reportable event which could have, or did lead to unintended harm, loss or damage (including reputation)'.

Trained staff investigate every serious incident to identify the root causes and share lessons learnt with all staff to prevent recurrence. Our commissioners also review our investigations to ensure that they have been rigorous.

The most frequent type of serious incident reported this year has been suspected suicide, but there are other incidents such as sudden unexpected deaths; pressure ulcers; attempted suicides; slips, trips and falls resulting in serious injury; safeguarding vulnerable adults and children and confidential information breaches which require a full root cause analysis investigation. When something has gone seriously wrong or where someone has been seriously harmed in our care, we have a duty of candour to be open and honest with those people who have been affected.

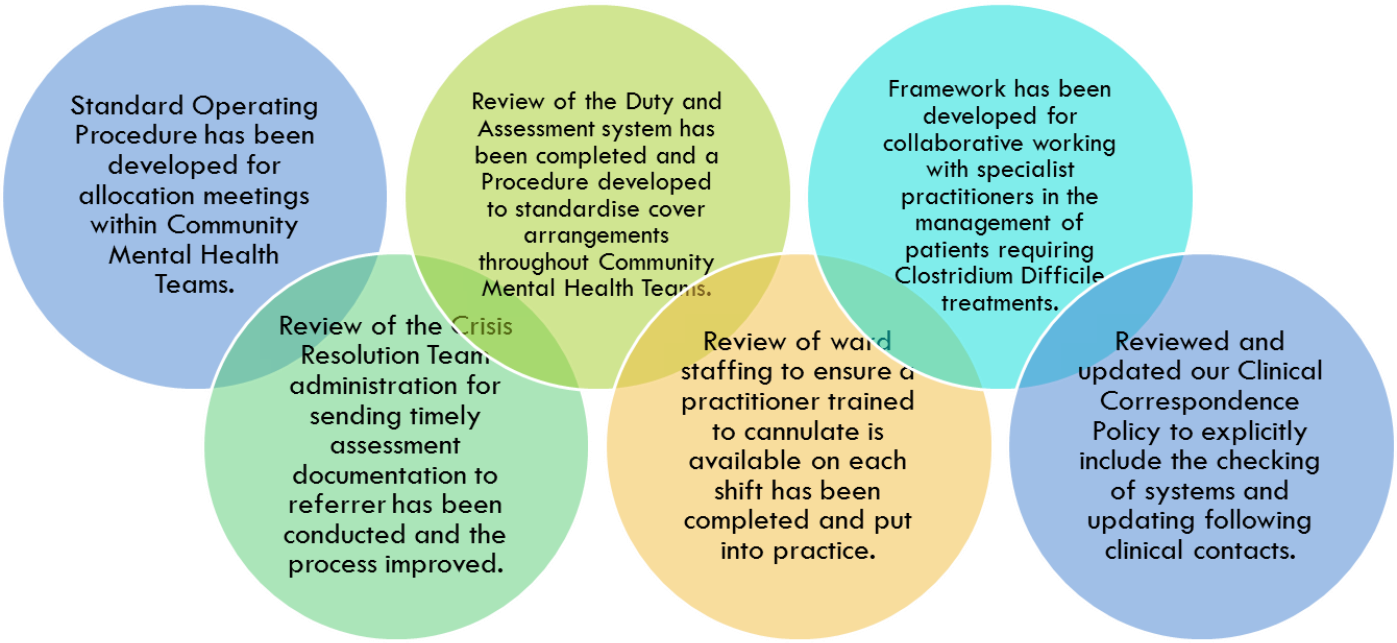
From the 103 serious incident investigations completed in 2015/16, we have identified lessons to be learnt and shared them with staff to ensure that the risks associated with similar occurrences are reduced.

The Trust has developed a framework for mortality governance which includes identification of learning lessons from deaths which take place within the care of Trust. This framework supports the review of avoidable mortality utilising the agreed NHS methodology once this is published, and the Trust will participate in the annual publication of avoidable deaths in line with the agreed guidance.

Each directorate has a spot-check audit programme to revisit closed serious incident action plans and ensure that learning and change has been embedded and

maintained. There is evidence that change has been sustained (e.g. better staff handovers of care, standardisation of administrative processes).

Some of the lessons learnt include:



3.3.3 Never Events

Never Events are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers'.

For an incident to be classed as a 'Never Event' it must fulfil the following criteria:

- The incident has clear potential for or has caused severe harm/death
- There is evidence of occurrence in the past (i.e. it is a known source of risk)
- There is existing national guidance and/or national safety recommendations on how the event can be prevented and support for implementation
- The event is largely preventable if the guidance is implemented
- Occurrence can be easily defined, identified and continually measured.

The Department of Health has outlined 25 Never Events which aim to ensure the safety of patients and further information about these is available at www.dh.gov.uk

During 2015/16 zero Never Event occurred.

3.3.4 Patient Safety Collaborative

The East Midlands Academic Health Sciences Network has established a local Patient Safety Collaborative. Their role is to offer staff, service users, carers and patients the opportunity to work together to tackle specific patient safety problems, improve the safety of systems of care, build patient safety improvement capability and focus on actions that make the biggest difference using evidence based improvement methodologies.

LPT is committed to working with the East Midlands Patient Safety Collaborative and has pledged to contribute to the safety priorities below:

- Falls
- Medication errors
- Medical devices

In addition, we pledge to support the core priorities identified below:

- Developing a safety culture/leadership
- Measurement for improvement
- Capability building

3.3.5 Medication Safety Project

During February and March of 2016, a Medication Safety project was undertaken at a Short Breaks Home for adults with learning disabilities - The Gillivers, in collaboration with colleagues from the Design School at Loughborough University. The project sought to understand errors within the medication processes and make recommendations for improving patient safety. Results of the project will be available in June 2016.

We piloted the use of a safer device used for drawing up and administering injectable medicines and as a result we expect to be using these new devices throughout the adult mental health inpatient facilities from March 2016.

We have commenced a schedule of remedial works at the Herschel Prins Centre in order to create a safer environment for patients by removing ligature points and improving the seclusion facilities. We have also undertaken some additional action at the Bradgate Unit to address ligature risks.

3.3.6 Infection Prevention and Control/ Healthcare Associated Infections (HCAIs)

Infection prevention and control and the reduction of healthcare associated infections are patient safety priorities. Our annual programme for infection prevention and

control is reviewed by our commissioners on a quarterly basis, and six-monthly by the Trust Board.

We have a statutory responsibility to ensure that our infection control systems and processes are robust to prevent and control Health Care Associated Infections (HCAIs). During 2015/16 we had 0 cases of MRSA bacteraemia attributed to our care delivery. We had 12 confirmed cases of clostridium difficile which we investigated, against a local target of seven. Further work has been undertaken to review the environment in which our patients are cared for to ensure this supports preventable infections.

During 2015/16:

A week long roadshow took the infection prevention and control team to various geographical locations to raise awareness of the IPC agenda.

We have continued to develop a programme of audits across all of our services, including urinary catheter, the management of sharps, uniforms, Clostridium Difficile care pathways and hand hygiene and build these into the working environment.

We supported delivery of the Trust flu vaccination programme for 2015/16 with the introduction of peer vaccinators within clinical environments. This enabled staff to access their free vaccine without having to travel or leave their work environment and supported an uptake of 46% by staff.

3.3.7 Safeguarding Children and Vulnerable Adults

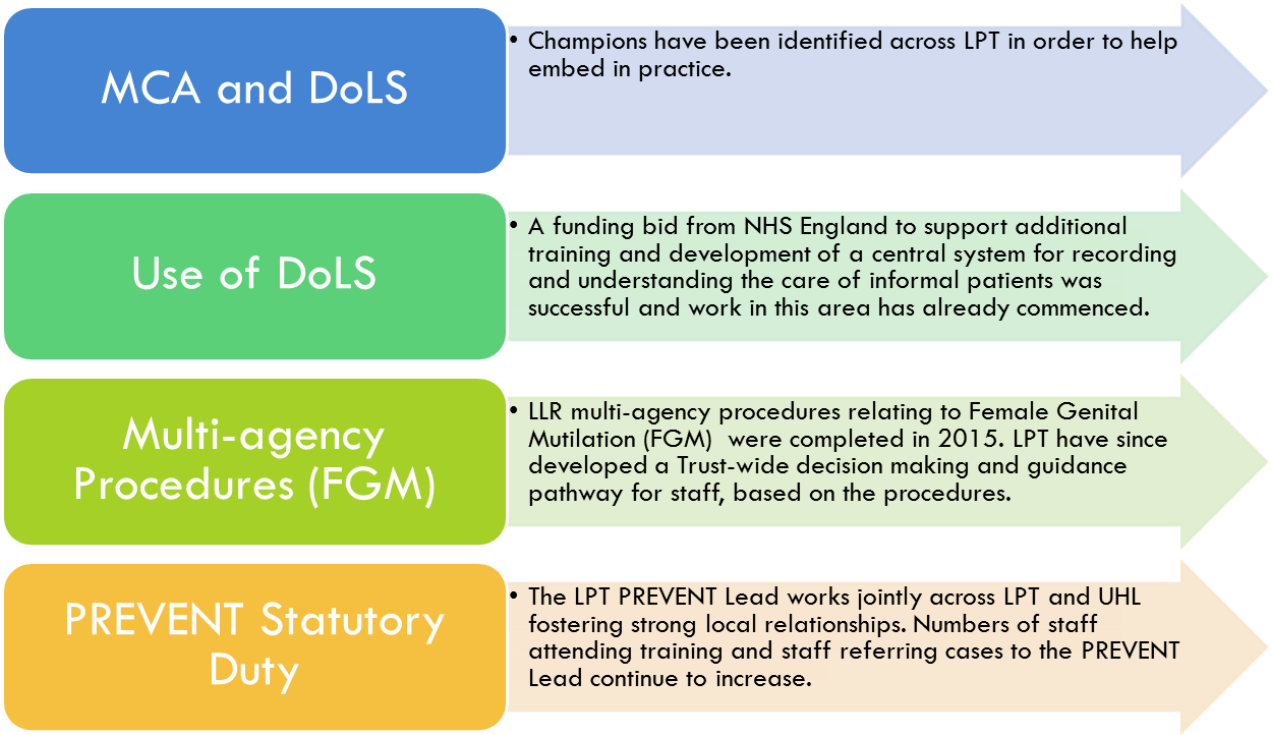
The Trust continues in its commitment to safeguarding children and vulnerable adults and ensuring that its services meet with statutory requirements. The Care Act 2014 was fully implemented in April 2015, with the local authority now holding a statutory responsibility to oversee safeguarding enquiries carried out by health providers. LPT will work with the Safeguarding Adults Board over the coming year to ensure LPT is ‘Care Act Compliant’.

2015 also saw updates to “Working Together to Safeguard Children”. One area felt to be having specific impact is related to the criteria for commissioning Serious Case Reviews (SCR). The criteria is now less open to interpretation which may have had an impact on the number of SCR’s commissioned, this has increased from approximately two in 2013/14, to a current figure of 6 SCR's plus 4 alternative reviews.

LPT continues to work in partnership with multiple local agencies via the Local Safeguarding Children Boards (LSCB) and Local Safeguarding Adults Boards

(LSAB) - and works to implement their policies and procedures, to ensure that we maintain best practice and compliance with essential standards to deliver safe, high quality care.

Safeguarding Achievements in 2015/16:



3.3.8 External assurance on quality indicator testing

Two mandated indicators were subject to external audit as follows:

- The percentage of reported Patient Safety Incidents (PSI) resulting in severe harm or death.
- The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team (CRHT) acted as a gatekeeper during the reporting period (gatekeeping).

Mandatory National Measure	Quarter Period Totals/ Percentage				Year End	National Average
	Q1	Q2	Q3	Q4		
The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period;	2125 psi out of 3730 incidents reported	2354 psi out of 3819 incidents reported	2549 psi out of 4171 incidents reported	2419 psi out of 4048 incidents reported	9447 psi out of 15768 incidents reported *Rate = 63.46per 1000 bed	*Median = 38.62 per 1000 bed days *(Data only available for April – September 2015)*

Mandatory National Measure	Quarter Period Totals/ Percentage				Year End	National Average
	Q1	Q2	Q3	Q4		
Source *National Reporting and Learning System Organisational Patient Safety Incident Report, Reported incidents between 01 April 2015 to 30 September 2015, published April 2016.					days *(Data only available for April – September 2015)*	
The number and percentage of such patient safety incidents that resulted in severe harm or death. Source: Trust - published data for 2015 is not yet available *These incidents are subject to further validation through the serious incident investigation process which may result in a variation in the number of incidents as investigations conclude.	n=5 0.24%	n=2 0.08%	n=12 0.47%	n=10 *0.41%	N=29 0.31%	Less than 1%

A limited assurance opinion was provided in respect of the PSI indicator.

Gatekeeping indicator (see table below)

Mandatory National Measure	Quarter Period Totals/ Percentage				Year End	National Average
	Q1	Q2	Q3	Q4		
The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period. Source: **HSCIC – mental health community teams activity* Source: Trust - published data for 2015 is not yet available	98.3%	99.7%	100%	100%	99.5%	*98.2% average *100% Highest *84.3% Lowest *As at Q3*

A limited assurance opinion was not provided in respect of the gatekeeping indicator. The testing identified that there was insufficient evidence over the accuracy, completeness, validity and reliability of the reported data. The electronic record was not consistent with the patient record in 5 of the 25 cases tested. Actions have been implemented to ensure clinical staff accurately input data into the electronic record and regular checks have been introduced to check that this is consistent.

The external audit opinion on the two indicators selected can be found on page 67.

3.3.9 Delayed Transfer of Care DToC

LPT has made improvements to the data collection and reporting of DToC monthly situation reports (sitreps) following internal audit recommendations. These include a review of the monthly sitrep to ensure it complies with the standard 2015/16 methodology and a review of the Trust Discharge Policy in line with national version 1.08. Clinical system reviews also took place to help resolve the issue of duplicate DToC records and staff members have been reminded of best practice data entry.

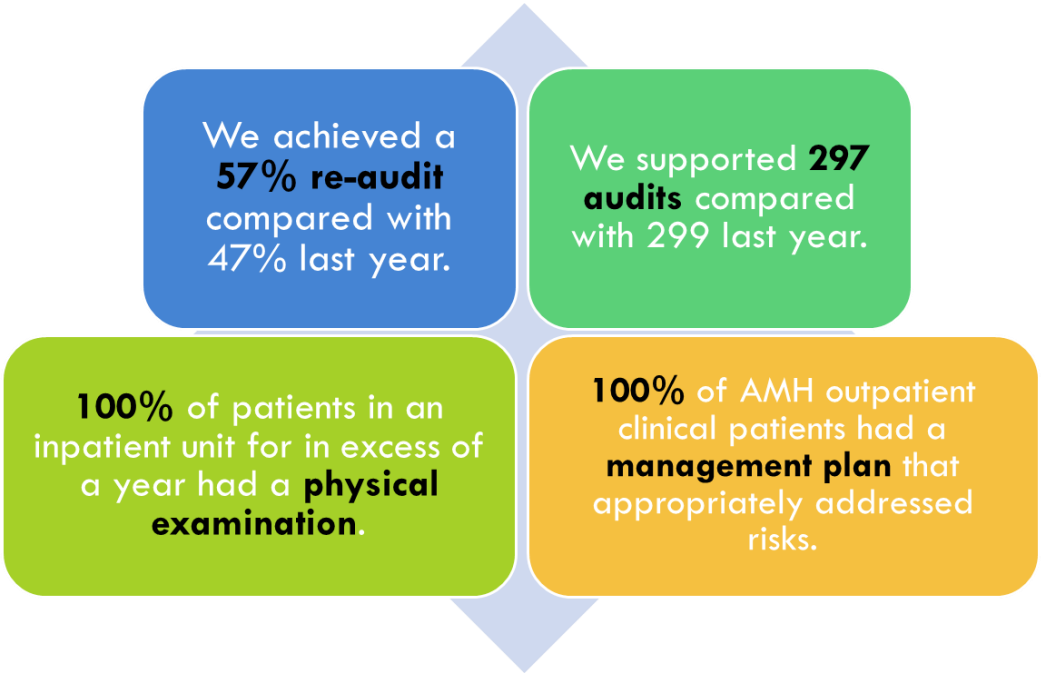
Further improvements such as sampling of case notes for accuracy will continue as best practice. The Trust will re-submit DToC sitreps for 2015/16 following a year-end review by services.

3.3.10 Waiting times

During 2015/16, the Trust embarked on a data quality improvement plan which included a deep dive on waiting time management and reporting. The Trust introduced a 'Patient Access Policy' and patient tracking list (PTL) meetings to further support and manage patient waiting times as well as capacity and demand modelling to forecast future demand and help to better shape our services for patients. The Trust will continue to embed this best practice throughout 2016/17.

3.4 Quality of services 'Effective care'

Key Achievements in 2015/2016, Effective Care



3.4.1 Clinical audit key achievements

Providing high quality care means taking the best clinical decision to achieve the best patient outcomes. Undertaking clinical audit provides us with an opportunity to assess the effectiveness of clinical care and also enables continuous quality improvement.

During 2015/16 the Trust's Clinical Audit Support Team supported 297 audits and achieved a 57% re-audit rate which is a 10% improvement on last year's re-audit rate (47%). Over 600 audit criteria have been used to re-audit whether standards have been applied to practice, for the benefit of patients in our care.

Re-auditing after changes have been made enables clinical staff to demonstrate change and identify those areas where further improvement is required.

3.4.2 Quality improvement as a result of clinical audit

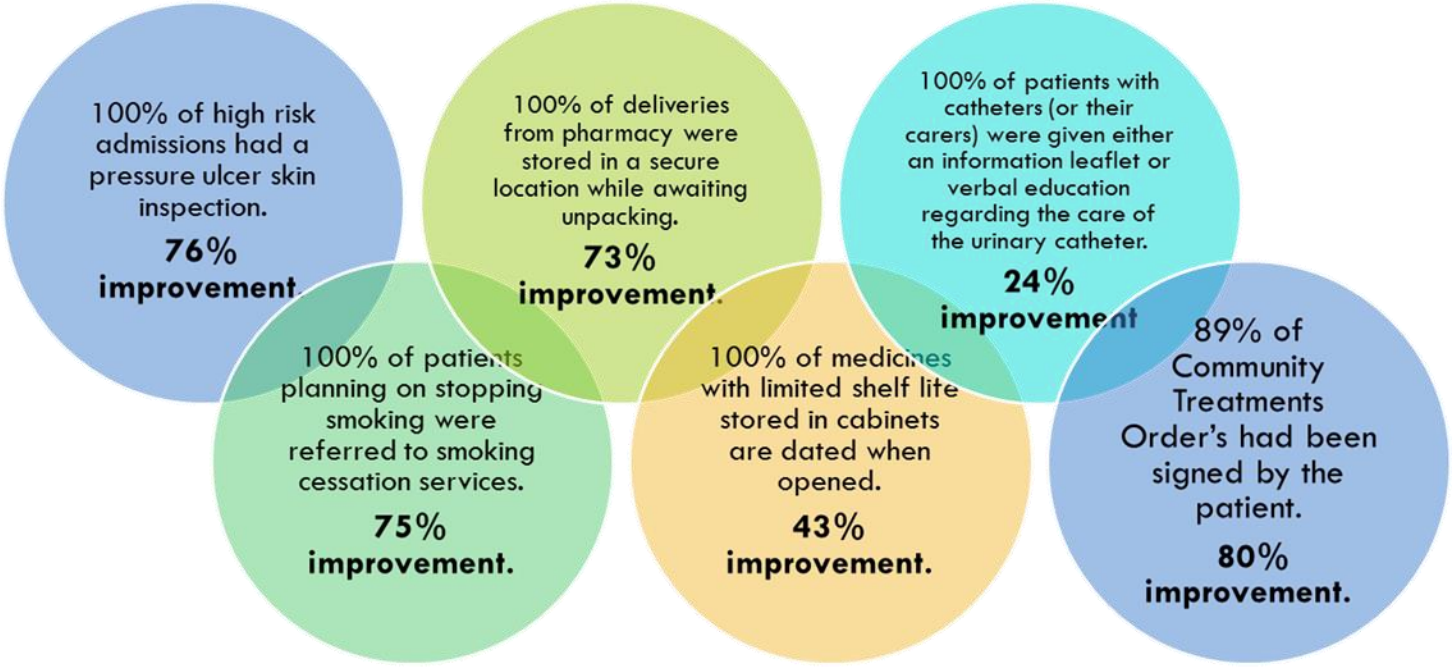
Audit results are communicated to staff in a variety of ways including team meetings, staff briefings and communication posters which provide staff with a snapshot of the key results.

We held our annual clinical audit conference on the 9th February 2016 and 103 staff and visitors attended the conference. The focus of the conference was the requirement of 'Revalidation' for Healthcare Professionals. Audit presentations from

a wide range of services provided by LPT demonstrated the benefit of clinical audit in the Revalidation process.

Service users were invited to attend and participate in the conference. One service user delivered a presentation of his experiences of the services provided by LPT and, along with a representative from Healthwatch, judged the poster competition providing useful feedback from a service user perspective.

Figures below show the improvements since the last audit.



3.4.3 Quality improvement as a result of research and development

We utilise research to improve the quality of care for our service users in LPT. Three examples below;

Community Health Services

There has been the adoption of innovative telehealth monitoring in patients with chronic obstructive pulmonary disease (COPD) as part of the service specification for our Respiratory services. Following a three- year research based pilot study of the introduction of a Clinitouch tele-monitoring device into homes of patients with severe COPD who have high risk of hospital admissions; this was found to have great clinical impact and a cost reduction of over £600k for care services. The project won Silver award from the East Midlands Academic Health Science Network and learning has been shared across our cardio respiratory service.

Family, Young People and Children's Services
The Adult Eating Disorders Service recently evaluated a motivational and psychoeducational package for people with eating disorders (MOPED), developed to help motivate individuals who are often undecided about recovery and change. This showed that patients who received MOPED pre-treatment had a higher overall engagement rate than those who did not. Specifically those in the anorexic spectrum group had higher rates of engagement and completion of therapy compared to treatment not including MOPED.

Adult Mental Health/Learning Disability Services
A study on the mortality of adults with intellectual disability who died of Sudden Unexpected Death in Epilepsy (SUDEP) in LPT found that this topic had been rarely discussed with the patients and their carers/families. This led to collaborative work to develop accessible pictorial leaflets on how to improve epilepsy management and reduce the risk of SUDEP. Following sharing with a national UK Learning Disability research network and charities (SUDEP.org (based in the UK) and SUDEP aware (based in North America) further development has resulted in leaflets used internationally to help reduce mortality for patients with LD and epilepsy.

3.4.4 Working with our local healthcare partners

The Trust continues to play a proactive and pivotal role in the local sustainability and transformation partnership (Better Care Together).

Better Care Together is the five-year programme of work to transform the health and social care system in Leicester, Leicestershire and Rutland by 2019 by empowering people to have control over their own health and wellbeing, and provide timely care closer to home.

Work streams are addressing inequalities in care (both physical and mental) across and within communities in the Leicester, Leicestershire and Rutland (LLR) local health and social care economy. Plans are in place to increase the number of citizens with mental, physical health and social care needs reporting a positive experience of care across all health and social care settings. Partners are also optimising the opportunities for integration and the use of physical assets across the health and social care economy, ensuring care is provided in appropriate cost effective settings. This will go a long to reduce duplication and eliminate waste in the system. This transformation will enable all the health and social care organisations in Leicester, Leicestershire and Rutland to achieve financial sustainability by 2020/21.

For more information about the programme visit: www.bettercareleicester.nhs.uk

3.4.5 Nerve Centre

Following last year's successful bid from NHS England's Nursing Technology Fund, Community Health Services has now rolled out the 'Nervecentre' System to all 12 community hospital wards. The system replaces paper charts, and allows staff to record electronically patient observations such as blood pressure and pulse and provides automatic prompts when these observations are due. It is also used to exchange information about patients at shift changes ensuring that vital information is not lost and thus improving safety and quality of care. Early feedback indicates that 76% of staff recognises an improvement in record keeping with the use of Nerve Centre, 71% recognise an improvement in information sharing and communication and 79% of staff find the system easy to use.

3.5 Quality of services 'Patient experience'

Key Achievements in 2015/2016, Patient Experience

3.5.1 My Care, My Voice – Collaborating on Service Improvements

A 'sharing' event for service users, carers and staff from our learning disability services has provided a milestone for an innovative service improvement programme.

The event was the culmination, to date, of six months of experience-based co-design work on a project called *My Care, My Voice* which is using people's personal experiences of our services to lead the drive for quality improvements. The project is part of our Trust's contribution to the Better Care Together programme.

Work to date has seen staff, service users and carers working together with interviews, workshops and films to gather personal experiences of our services. The 'sharing' event at The Brite Centre in Braunstone brought together some of the key themes that have emerged from the work. By the end of the morning, participants had identified key areas for action and work will soon get underway on two projects – one to increase awareness and improve access to information about learning disability services and another to improve communication with people who use the service and their families.

3.5.2 Baby Friendly Award

Our Health Visiting Service achieved the Unicef Baby Friendly Award. This award is hard to gain and, as such, is recognition of the hard work of the infant feeding and

health visiting teams and leadership. This award recognises that best practice standards around breastfeeding are in place in all LPT venues.

This is a great achievement, and means that all mums using LPT services can be assured that they are receiving support, care and guidance at the highest possible standard. Promoting sustained breastfeeding has important, well-evidenced effects on infant/maternal bonding. The incidence of common childhood infections and obesity, and our local drive to increase breastfeeding rates, will therefore have important health impacts in the short, medium and long term.

3.5.3 Chat Health

Chat Health is a web based messaging tool for health and care professionals. The system allows students to conveniently access timely and confidential health advice whilst school nurses continue to provide the opportunity to meet during face to face clinics. Robust accompanying guidelines for staff, with a specific focus on safeguarding young people who are at risk of harm have been developed in collaboration with the Police and Royal College of Nursing and the system also has a number of built in safety features.

An example of a benefit for service users: improved choice around when and how to access confidential help and advice. An example of a benefit for staff: earlier intervention due to lowered barriers to access.

Between June 2014 and June 2015, 747 messaging conversations took place in our area, with over 3400 messages received.

3.5.4 Patient Feedback – Complaints, PALS and Compliments

The patient experience team work with service staff to ensure that all patient concerns and complaints are dealt with quickly and effectively. Complaints provide valuable opportunities to identify ways of improving patient care and we are committed to capturing all patient and carer feedback to ensure that lessons are learnt.

To inform the changes we have made during 2015/16 we have undertaken three Complaint Panel Reviews using the Patients Association Toolkit. We have been pleased to receive support from a wide range of people, both internal and external to the Trust in this improvement work which has allowed us to further strengthen our complaint handling processes in line with the NHS Complaint Regulations.

During 2015/16 we received a total of 346 complaints (*a decrease of two from the previous year*). ‘One case was upheld by the HSO, two cases were partially upheld and two cases were not upheld (This related to complaints received in 2011, 2013 and 2014).

We monitor our complaints and look for themes and trends, so that we can ensure that appropriate changes are made to improve services and improve the experience of our patients.

Trust Wide Themes

- Staff Attitude
- Waiting Times
- Access to Services
- Continuity of Care
- Effective Communications

For example, we know that cancellation of outpatient appointments is a problem for our mental health patients. The service has taken action to strengthen the process for booking planned annual/study leave which has previously resulted in cancellations; developed a system of calling patients a week before their appointment to confirm their attendance; have implemented a patient questionnaire to obtain patient's views about how they would like to receive appointment reminders.

We receive complaints relating to staff attitude and have continued to focus on developing our Trust values and on leadership skills and team working. Towards the end of 2014/15 we introduced our new staff appraisal process, which asks staff to evidence values- based behaviours, this work continues to be embedded.

During 2015/16 we received 1048 compliments from service users and carers. Compliments are very important to us as it confirms that we have got it right from the patients', service users' and carers' perspective.

During 2015/2016 we received 1053 concerns and 443 enquiries.

Top 5 Concern Themes

- Medication error/issues
- Appointment - delay (OP)
- Patient expectations and service delivered
- Nursing care
- Attitude of staff - nursing

Patient Advice and Liaison Service (PALS) concerns about staff attitude and behaviour are reviewed at local level within teams and with individual staff members. They continue to be addressed at local level with discussion and reflection in supervision.

3.5.5 Mental Health Surveys

Inpatient Survey

The Mental Health Inpatient Survey was undertaken for LPT between August and December 2015 and the results were published on 16 January 2016. The Trust response rate was 22%; that is 111 completed surveys were received from the cohort of 510 services users. The response rate of all Trusts was 21%.

The Trust saw notable variances across the survey results when compared to the 2014 results, with improvements including 90% of patients indicating they were made to feel welcome on arrival at the ward.

The Trust scored only 37% for patients being given an adequate explanation of the purpose of their medication, a significant reduction to the 2014 survey where the score was 54%.

Areas for improvement have been identified as:-

- Purpose of medication completely explained
- Access to out of hours phone numbers
- Contact by the Mental Health Team
- Food and cleanliness

Our AMH.LD directorate will lead the implementation of the improvement plan.

CQC Community Survey

The Care Quality Commission (CQC) published the results of the 2015 national community mental health survey 28 October 2015. The 2015 survey of people who use Community Mental Health services involved 55 NHS Trusts in England. The result of the 2015 survey was compared with the Trust's 2014 results, as well as against the overall performance from all 55 Trusts that participated in the 2015 survey.

The Trust response rate was 32% that is 258 completed surveys were received from the cohort of 850 services users. The response rate of all Trusts was 29%.

The survey consists of ten sections, with a total of 33 questions.

In total the Trust scored 'worse than' other trusts in eight of the 33 questions, and did not score 'better than' other Trusts in any question. When compared to 2014 the Trust scores for 30 of the 33 questions remained unchanged, however there was deterioration in 3 questions, these related to:-

• How well care and services are organised

• Involvement in agreeing what care will be received

• Involvement of family or someone else close as much as desired

Actions are in place to address the areas of improvement.

3.5.6 Involving patients and carers in the infrastructure of the organisation

Involving our patients, their relatives, carers and the local community to improve patient experience is vital to our success as an NHS Trust. In 2015 the Trust revised the Patient and Carer Experience and Involvement Strategy, which includes three promises:

- We will listen and learn from our patients, their carers and families about their experiences and ask for their suggestions about how services will be improved.
- We will do this by systematically gathering and analysing qualitative and quantitative evidence in a range of different ways and use this evidence to continuously measure and improve our services in order to provide our patients, carers and families with the best possible experience.
- We will involve stakeholders, especially those from vulnerable or seldom heard groups, in the planning, development and delivery of our services.

The strategy work plan gives us a clear focus and will help us to build on the work we already have in place. This includes working with our Patient and Carer Reference Group, which provides the Trust with a patient and carer perspective on planned changes and improvements to the way that we deliver our services. This group meets quarterly and have considered areas such as:

- LPT financial accounts
- The redesign of Adult Mental Health services in the community
- The Community Health Services Out of Hospital Care Shift programme

The Trust has continued to ensure that patients and carers are involved in the recruitment of staff across all levels of the organisation including consultant psychiatrists, nurses and health care assistants.

Our Chief Executive, Dr Peter Miller meets quarterly with representatives from the Leicester, Leicestershire and Rutland local Healthwatch teams. The Healthwatch teams contact their members, inviting any questions for Dr Miller. These questions are wide ranging and very varied. Topics of questions include:

- Services provided by school nursing teams
- Support available for NHS staff when raising concerns or complaints
- Alzheimer's services for people under 65
- Information about care pathways for children experiencing a mental health crisis.

Patient Stories

The Patient Experience Team is building a library of patient stories held securely on video. The stories can be used for a variety of purposes, e.g. staff training and induction, team meetings and service development sessions.

Patient video stories are shown routinely to the Trust Board as part of the Patient Voice agenda. These have included a patient's story of her experiences on the ward at St Luke's Community Hospital, a carer's experience of Families, Young People's and Children's Services and a patient and carer talking about their experiences of the Tissue Viability and Podiatry Services.

Exit questionnaires

An exit questionnaire is in place for patients discharged from our inpatient mental health areas. Embedded within the questionnaire is the Friends and Family Test (FFT) question. The FFT results show that 79% of patients who completed the questionnaire stated they were likely, or extremely likely to recommend the ward to friends and family if they needed similar care or treatment

There were 42% of mental health inpatients who completely understood why they were on medication, 60% of patients felt highly- involved with decisions regarding their care and 72% rated ward staff as very caring and kind.

3.5.7 The NHS Friends and Family Test

During 2015-16 the Friends and Family Test (FFT) was implemented across the whole of LPT. Patients are asked '*How likely are you to recommend our ward / service to friends and family if they needed similar care or treatment*?' and then asked to score the service using a 5 point range from; 'Extremely likely' to 'extremely unlikely'.

The Patient experience questionnaire is in place across nearly all our commissioned services. Over 11,000 responses have been received in 2015/16 so far and consistently over 97% of responders would recommend the service we provide to their friends and family if they needed similar care or treatment.

Patients are also given the opportunity to make a comment and offer suggestions to help improve the service. On average, 96% of the comments made are positive and are shared with staff to show appreciation from our patients. On average 1.5% of comments have contain a suggestion for ways things could be improved about how things could be improved, with the outstanding submitted without comment.

FFT Feedback improvements:

Comment: Patient feedback from the older persons unit was that on occasion it felt chilly or cold.

IMPROVEMENT: The team there have now got blankets available to people if required whilst they are waiting.

Comment: Welford ward had feedback about more toilets on the ward.

IMPROVEMENT: They gained capital funding to convert a store room into a toilet and shower. Work is underway and the work is with interserve to commence the conversion.

Comment: Inpatient areas get a few comments about staffing.

IMPROVEMENT: Staffing levels are constantly monitored. Levels are reviewed and adjusted as required and dependent on patient acuity.

Comment: Memory service has comments relating to the handover to GP and waiting times.

IMPROVEMENT: The memory service is now under redesign and therefore we are looking at waiting times as a priority.

Comment: Springfield road DN nursing clinics had comments relating to nurse continuity.

IMPROVEMENT: Clinics have been allocated to staff on a weekly basis to give some continuity to patients.

3.5.8 Volunteers

We have around 400 members of the local community, including service users, volunteering in our services for the benefit of patients. In 2015 we recruited an additional 160 volunteers. Our volunteer drivers completed 626 journeys per month on average during the year, enabling service users and patients to access services across the Trust.

Using the formula recommended by NCVO (National Council of Voluntary Organisations) the financial value of this volunteering to the Trust in 2015 was over £500,000.

A five- year work plan for Voluntary Services was initiated in September 2015 to ensure that volunteering reaches its full potential to enhance the quality of Trust services, improving the experience of patients and service users and also providing opportunities for improved outcomes for service users.

A quarterly e- newsletter for volunteers was launched during Volunteers' Week in June. Examples of new volunteer roles which have been established this year include volunteering in PALS, CAMHS, Community Development, and membership of the Complaints Peer Revew Panel. Volunteer experience surveys have been introduced one month following commencement of volunteering and a final evaluation on leaving the Trust. In partnership with Arts in Health all volunteers now receive a birthday card with thanks from the team for their contribution to the Trust.

3.5.9 Medication

The pharmacy service has been reconciling all patients' medication on admission to in-patient care for several years. This ensures that what is prescribed at the point of admission matches what was being prescribed prior to admission. This has conventionally relied on ringing GP surgeries and asking for the information; sometimes this is faxed but sometimes it is read out by a member of the surgery administration team. This year, to reduce the risk of errors in this process, the pharmacy team has secured access to patients summary care records. This allows us, with the patient's consent, to access a computer record of what is being prescribed in primary care and reduces the likelihood of transcription errors. It also enables us to access the information when the patient's GP information at ward level is incorrect or when they have just moved surgeries. Hence the likelihood of medication prescribing errors at the point of admission is reduced.

3.5.10 Premise Assurance Model

The inaugural self-assessment for the premise assurance model (PAM) was undertaken in 2015. The PAM demonstrates that there are robust governance arrangements in place via management systems and processes to support the assurance and performance for our estates and facilities.

The outcome resulted in the Trust achieving an overall rating of "Good". Good equates to no action required.

3.5.11 Quality Improvement

Clinical Supervision

Clinical Supervision is a mandatory requirement for clinical staff, as per our policy. It is a requirement of the Quality Schedule that all clinical staff undertake a minimum of one clinical supervision session per quarter.

From April 2015 the process of recording clinical supervision was changed so that it is recorded electronically directly on uLearn (the Trust's learning and appraisal system) by the individual. We now capture the mode of delivery for clinical

supervision and also feedback on how staff rated their supervision sessions, which shows 91.7% rate their supervision as good, very good or excellent.

During February we commenced an intensive communication campaign on clinical supervision and, in particular, the ease of recording on uLearn and the importance of doing so. Whilst the most important thing is clinical staff participating in a quality supervision experience, we felt that until we had a clear picture of the true extent of this we needed to focus on encouraging staff to see the recording of their supervision as important and their responsibility. This campaign was headed by our Medical Director, Satheesh Kumar who filmed a short video for our February launch on recording of clinical supervision.

Suicide Prevention

The Trust has renewed the focus on suicide prevention working with agencies across Leicester, Leicestershire and Rutland, involving community and all health, social care and voluntary organisations. Early plans are:

- The development of a personal safety plan for patients. This plan will focus on the strengths of the individual, what support they have and how this support can be increased and accessed.
- Developing appropriate suicide awareness training programs for all staff.
- Review and audit of investigations into previous suicide cases to ensure that lessons are identified and learnt in order to reduce the likelihood of future incidences.
- Enhanced focus on safety in Crisis Resolution and Home Treatment Services (CRT): National Confidential Inquiry Annual report (2015) identified the need for a rigorous focus on safety in the Crisis and Home Treatment teams. The LPT CRT team has undergone a number of service changes following an external review of suicides within the CRT. Currently there is ongoing multi-agency work in relation to the crisis concordat. The suicide prevention plan in CRT is less focused on service change and more focused on bringing a culture of safety awareness and ensuring rigorous approaches to safety improvement by the practitioners at all stages of the patient pathway.
- Learn from other organisations such as Mersey Care NHS Trust which is piloting an approach to depression which has been very successful in America.

PREVENT

Leicestershire Partnership NHS Trust is committed to ensuring vulnerable individuals are safeguarded from being radicalised into violent extremism and supporting or

becoming terrorists themselves, in line with the Prevent Statutory Duty which comes under the UK Counter Terrorism and Security Act 2015.

In the period for 2015/16 Leicestershire Partnership NHS Trust has delivered basic awareness and WRAP (Workshop to Raise Awareness about Prevent) training to over 1400 staff and assisted in over 100 cases in that period. The Trust has also seen a significant increase in concerns raised by its staff contributing to the overall figure of **17%** of NHS Prevent referrals nationally ensuring embedding of the Notice, Check, Share, principle.

Children's Physiotherapy Helpline for Health Visitors

FYPC launched a helpline in January 2016 to help health visiting staff identify developmental delay earlier. The helpline was set up in response to two incidents where concerns were raised about a child's development, however therapy input and first timely referral to the Physiotherapy Service was not timely. It was identified that health visitors would benefit from access to timely advice and information around gross motor development. Through discussion of cases with a Physiotherapist, unnecessary referrals are avoided as well as ensuring appropriate assessment is undertaken at the earliest point. Any health visitor who has a concern about a child can speak to a Physiotherapist during an allocated session on Wednesday lunchtimes. The helpline is being evaluated and outcomes will be reviewed in six months' time.

3.6 Commentary received from stakeholders

Comment on LPT Quality account 2015/16

Statement prepared by Leicester City, West Leicestershire and East Leicestershire and Rutland Clinical Commissioning Groups (CCG)

We would like to thank Leicestershire Partnership Trust for the opportunity to review and comment on the 2015/16 Quality Account. This is a wide ranging document and covers the key element required within a quality account. It acknowledges a number of areas of achievement and good practise and in particular CCG commissioners would like to note:

- The aspiration and acknowledgement noted within the Chief Executive's statement in regards to the importance of continued improvement in Quality.
- The national awards received in relation to telehealth monitoring in patients with COPD and the Unicef Baby Friendly Award.
- The achievements made in line with the 15/16 clinical properties.
- The trust's Compliance with DToC, which the CCG has gained additional assurance through quality site visits.

The commissioners fully support the focus in 2016/17 on improving clinical recording and care planning across The Trust and to address performance in order to improve patient experience, patient safety outcomes and waiting times. We support the acknowledgement and aspiration to work towards moving the CQC rating of 'requires improvement' to 'good' and ultimately 'outstanding'.

There are a number of areas that CCG commissioners believe could further enhance this Quality Account to provide a more balance picture of the trust performance:

Further detailed assessment of areas of concern/difficulty.

The Account provides details of areas of improvement and good practise, however it would be improved with increased emphasis on areas which are not performing well and what actions have been put in place to mitigate risk and work towards improvement.

Staffing Concerns

Workforce recruitment and retention continue to pose a risk to the quality of services being provided across the trust. It is acknowledged that more focus will be placed on the need for greater transparency with regards to staffing levels and emphasis is placed on a range of Trust wide initiatives to address this. Whilst this is acknowledged in the quality account, It would be useful to lay more emphasis on the associated risks and promote the strategic plan of action to mitigate staffing concerns.

Acknowledgement of Patient Feedback

The account provides a variety patient experience feedback activity and methods. For example, patient voice video and patient stories being stored securely and utilised for staff

training and education purposes. Commissioners are aware of the organisation's commitment to improving the quality and safety of services provided to patients. LPT has demonstrated their commitment to involving patients and the public in their plans for improvements and have also listened to feedback from patients who use their services.

Further clarity on the services provided by LPT

It is acknowledged the Quality Account provides an overarching summary of the services provided by LPT. It would be beneficial to detail the variety of service provision to include key areas of good practise as well as areas requiring improvement. This would allow the account to provide the public with a balanced picture of service provision, current performance and future aspirations.

We look forward to continued positive working relationship with the trust and providing ongoing support for the improvement ambitions identified within this Quality Account.

19 May 2016

HW LLR Joint Response
LPT Quality Account 2015 - 2016

Healthwatch Leicester, Healthwatch Leicestershire and Healthwatch Rutland (HW LLR) acknowledge the receipt of the Leicestershire Partnership draft Quality Account (QA) and for the opportunity to comment.

General Overview

We would like to provide some general observations and comments to the QA. In terms of the presentation of the Quality Account it would have been helpful if the Care Quality Commission findings from July 2015 had been shown in the body of the report.

We are mindful that there is a prescriptive framework for Quality Accounts that does not allow providers the freedom to produce reports that are as publicly accessible as they might be. There is an over reliance on acronyms which is not helpful to the uninitiated. We have therefore welcomed the simpler summary presentations of the QA at different forums and meetings to enable greater accessibility for the public. This is particularly important as our dealings with the general public indicate that a significant number are not aware of the full range of services provided by LPT.

As with most providers prevention seems to have a relatively low priority, although it is acknowledged that suicide prevention is starting to receive more attention.

The ability to recruit and retain the correct number of suitably qualified will remain a significant challenge.

Specific Questions

We have used the structure provided by Healthwatch England to frame our response with reference to the questions set out below.

Questions	Responses
Does the draft QA reflect people's real experience told to local Healthwatch by	• When comparing the Draft Quality Account with feedback

service users and their families and carers over the past year?	we have received, it seems to accurately reflect the reality of patients' experiences.
From what people have told local Healthwatch, is there evidence that any of the basic things are not being done well by the provider?	• Although there are always individual instances where things have gone wrong, we have identified no underlying trends that point to areas where things are consistently not being done well.
Is it clear from the draft Quality Account that there is a learning culture within the provider organisation that captured and used to enable the provider to get better at what it does year on year?	• From an examination of the Quality Account and from our dealings with LPT it is clear that a learning culture has been successfully introduced. • The Board is cohesive and well led. They seem intent on learning from patient experience and embedding that learning throughout the organisation. • There are clear indications that the Trust is getting better at providing better care as a direct result of its listening and learning initiatives.
Are the priorities for improvement as set out in the draft Quality Account challenging enough to drive improvement and it is clear how improvement has been measured in the past and how it will be measured in the future?	• The Quality Account clearly sets out the Trusts priorities for improvement. • The priorities are aligned to the CQC's findings and are challenging but realistic. We have noted that there is a improvement plan in place with the aim of securing a CQC rating of Good by 2017-18. • The Trust recognises its shortcomings and is committed to resolving them. • Good progress has already been made in many areas with lots of examples of measured improvement having, been given. • The Trust is clearly heading in the

	right direction.

Rick Moore

Chair of Healthwatch Leicestershire

Karen Chouhan

Chair of Healthwatch Leicester

Jennifer Fenelon

Chair of Healthwatch Rutland

LEICESTERSHIRE HEALTH OVERVIEW AND SCRUTINY COMMITTEE

COMMENTS ON THE LEICESTERSHIRE PARTNERSHIP NHS TRUST QUALITY ACCOUNT FOR 2015-16

MAY 2016

The Health Overview and Scrutiny Committee welcome the opportunity to comment on the Leicestershire Partnership NHS Trust (LPT) Quality Account for 2015-16. The Committee accepts LPT's Quality Account as a balanced representation of the Trust's work over the past year and is not aware of any major issues omitted from the report. Areas of concern or of particular interest to the Committee are set out below.

The Committee welcomes the focus of the priorities for improvement during 2016/17 on clinical recording, care planning and discharge planning and evidence of engagement in clinical supervision. The evidence provided in the Quality Account supports the choice of these priorities. In particular, the focus on clinical supervision will help staff to feel supported in their role and may improve retention rates. It will also help to ensure that quality standards are met when temporary or agency staff are used. The Committee also welcomes the commitment to monitoring the progress of quality improvements in 2016-17.

The Committee is pleased to note the improvements made at the Trust since the Care Quality Commission (CQC) inspection during March 2015 which resulted in a 'requires improvement' rating by the CQC. At a meeting of the Committee in September 2015, members recognised efforts being made and the drive for continuous improvement within the Trust.

The Committee is pleased to note the progress on delivery of LPT's priorities based around safe and effective care, patient experience and regulation for 2015-16. It is noted that the learning from the Francis report is being imbedded, focused around the themes of openness & transparency, listening, working together, capacity within teams, and leadership. It is noted that the need for a culture change has been recognised with particular regard to dealing with complaints and healthcare staff feeling able to raise concerns. However, the Committee wishes to remind LPT that the Francis Inquiry emphasised the importance of putting patients first and would like to see this explicitly, rather than implicitly, referred to in this section of the Quality Account. The Committee looks forward to seeing whether the actions taken by the Trust in response to the Francis report have had the desired impact.

The Committee is pleased to note that LPT fully achieved 9 of the 11 Commissioning for Quality and Innovation (CQUIN) goals set out between West Leicestershire Clinical Commissioning Group, East Leicestershire and Rutland Clinical Commissioning Group and Leicester City Clinical Commissioning Group with regards to the provision of NHS services. It is understood that LPT did not fully meet the following goals, which remain a subject of concern for the Committee:

- Local CQUIN to ensure that all patients referred to the memory service have a memory assessment and a multidisciplinary care plan on discharge from the clinic;
- Local CQUIN to improve the timeliness and accuracy of Continuing Healthcare Assessments.

It is pleasing to note that the Quality Network for Inpatient Child and Adolescent Mental Health Service (CAMHS) visit to the CAMHS In-patient unit at Coalville Hospital found the ward environment to be welcoming and friendly and good communication was taking place with patients. However, the Committee did previously express concern regarding the move to Coalville hospital as Coalville has poor transport links to the rest of the County which could make visitation by relatives difficult. The Committee was assured that, where appropriate, transport for families would be subsidised. It would be helpful for the Quality Account to include information regarding the accessibility of the CAMHS In-patient unit including whether there have been any complaints and whether the unit is assured that access is equitable across Leicestershire. In addition, it would have been useful for the Quality Account to make specific reference to how patient experience is being measured in this unit.

This Committee supported proposals to relocate the Charnwood Community Mental Health Teams to Loughborough Hospital, although some concern was expressed regarding the availability of appropriate public transport to the new location. It would be of benefit if the Quality Account included reference to how successful that transition has been, particularly with regard to accessibility.

The Committee notes from page 45 of the Quality Account that the Trust continues to play a proactive and pivotal role in the Better Care Together scheme. However, the Quality Account would benefit from further detail on how Better Care Together is developing and being imbedded. The Committee has previously sought assurance that action was being taken to improve end of life care and was advised that although improvements had been made, the work to develop a system wide protocol, which was being done through the Better Care Together workstream, although progressing, was not yet completed. Treating Patients in their own home rather than a hospital means that staff will need different skills. In particular, they would need to be comfortable with working alone in a one-to-one setting with the patient. Evaluation of progress needs to be robust and the metrics need to be clearly set out. The Committee looks forward to progress updates on this topic in the future.

The Committee notes that 3 Complaint Panel Reviews have been undertaken using the patients Association Toolkit and is pleased that action has been taken to avoid cancelled/missed appointments. However, members of the Committee remain concerned that staff attitude is a theme in complaints as stated on page 49 of the Quality Account despite this being highlighted as an issue in the previous year's Quality Account. The Committee endorses the use of Exit Questionnaires and hopes that actions are taken with regard to any negative feedback.

The Committee notes that 103 serious incident investigations were completed in 2015/16 and lessons to be learnt were identified and shared with staff. It would be

useful if the Quality Account stated how this compared to previous years and whether similar incidents were recurring year after year.

In conclusion, the Committee would like to thank LPT for producing such a clear Quality Account and, based on the Committee's knowledge of the provider, is of the view that the Quality Account is accurate and provides a just reflection of the healthcare services provided. The Committee is looking forward to the improvements to be made in the year 2016-17 to the LPT's healthcare provision in line with the priorities set out in the Quality Account for 2015-16.

INDEPENDENT AUDITORS' LIMITED ASSURANCE REPORT TO THE DIRECTORS OF LEICESTERSHIRE PARTNERSHIP NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We are required to perform an independent assurance engagement in respect of Leicestershire Partnership NHS Trust's Quality Account for the year ended 31 March 2016 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2016 subject to limited assurance consist of the following indicators:

- The percentage of admissions to acute ward for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period (Gatekeeping); and
- Percentage of patient safety incidents resulting in severe harm or death indicator (PSI)

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of the Directors and the auditor

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;

- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2015 to May 2016;
- papers relating to quality reported to the Board over the priod April2015 to May 2016;
- feedback from the Commissioners dated May 2015/16;
- feedback from Local Healthwatch dated 19th May 2016;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, for each quarter;
- feedback from other named stakeholder (s) involved in the sign off of the Trust's Quality Report;
- the latest national patient survey dated August and December 2015;
- the latest national staff survey dated October and December 2015;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated May 2016;
- the annual governance statement dated May 2016;
- the Care Quality Commission's Intelligent Monitoring Report dated 10th July 2015; and
- any other relevant information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information.

This report, including the conclusion, is made solely to the Board of Directors of Leicestershire Partnership NHS Trust.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Leicestershire Partnership NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of man gement;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope tha n a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations t han fina ncial information, given the characteristics of the subj ect matter and the methods used for determining such information.

The absence of a significa nt body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different meas urements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Acco unt in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omiss ion of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Leicestershire Partnership NHS Trust.

Basis for qualified conclusion

As set out in the Statement of Director's Responsibility from the Chief Executive of the Trust on page six of the Trust's Quality Accou nt the Trust currently has concerns with the accuracy of data for the "Percentage of admissions to acute ward for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period" (the Gatekeeping indicator).

We found from our testing uncertainty over the reliability of information, due to cases being wrongly recorded as "gatekept" or "not gatekept". As a consequence we are unable to conclude on the completeness, reliability, validity and accuracy of the Gatekeeping indicator included in the published Quality Account

As a result of the issues described above we are unable to give limited assurance on the Gatekeeping indicator included in the Quality Account for the year ended 31 March 2016.

Qualified conclusion

Based on the results of our procedures, with the exception of the matter(s) reported in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; ?nd
- the remaining indicator in the Quality Account subject to limited assurance (the Percentage of patient safety incidents resulting in severe harm or death has not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

KPMG LLP.

KPMG **LLP**
Chartered Accountants
One Snowhill
Snowhill Oueensway
Birmingham
84 6GH

1 June 2016

Appendix 1: Clinical Priorities for 2016/17

	What is the priority?	Division	Why we have chosen this priority	How we will measure this
1	**Improve clinical recording and care planning to support safe and effective patient centred care delivery.-** First Episode Psychosis – Nationally there is a need for people to have access to NICE compliant treatment within two weeks of their first episode of psychosis.	Families, Young People and Children's	FYPC have identified a need to improve timely access to intervention packages for service users.	Waiting times from referral to first episode of treatment.
2	**Improve discharge planning and follow up to support safe transfer of care-** To launch and establish a neonatal pathway for all preterm babies who remain in neonatal unit at the new birth review (10-14 days) to ensure they have a health visitor contact at the Unit.	Families, Young People and Children's	Benefits for the parent and perinatal mental health. To ensure transition from hospital to home remains seamless. Increased communication between the neonatal team and health visitors across LLR.	We will develop an audit of neonates who receive a birth visit whilst on the unit. We will monitor feedback from the staff delivering the pathway and the people using our services. Progress will be monitored via the FYPC Patient Safety & Experience Group.
3	**Improve clinical recording and care planning to support safe and effective patient centred care delivery-** To enable the safety of patients on MHSOP Wards (including those who suffer from falls) via good assessment of patient strengths and needs and good standard care-planning.	Community Health Services	Significant progress has been made during 2015/16 with the introduction of weekly care planning monitoring for all MHSOP inpatient areas which is quality assured and reviewed with named nurses. This remains as a priority for 2016/17 to ensure that standards are maintained. To further support good care planning and the effective translation of the 'who am I' document into person centred care and to embed the principles of SMART care-planning, assessment and care planning training will continue in 2016/17. The need to improve this area has been discussed through the clinical network and is a key priority in terms of improving safety of patient on the wards.	The number of staff who have attended the training. Continual monitoring of the assessment and care-planning. Maintenance of 85% to be achieved across all domains. 75% of qualified staff to have attended sessions during 2016/17. Progress will be monitored by the MHSOP Governance Group.

4	**Improve clinical recording and care planning to support safe and effective patient centred care delivery-** Review record keeping documentation for community hospitals in line with the introduction of nerve centre and Trust objectives around improved record keeping and personalised care planning.	Community Health Services	Good record keeping continues to be a theme for ongoing improvement and is fundamental to ensuring personalised care planning. Identification through the service development work within service	Establish a task and finish group to review and consider duplication. An improvement in record keeping audit results undertaken in Quarter 4 of 2016/17. An improvement in record keeping as theme demonstrated through complaints and incidents in Quarter 4 of 2016/17. Progress will be monitored by Divisional PSEG quarterly.
5	**Improve discharge planning and follow up to support safe transfer of care-** Transition of patients through our hospitals is a key priority to improve the flow of patients and ensure that patients are cared for in the most appropriate setting.	Community Health Services	A discharge information folder has been developed and shared with the ward managers. A bed co-ordinator and an occupational therapist are visiting the 12 wards to discuss discharges and ensure the wards have all the information required. The need to improve this area has been discussed through the clinical network and is a key priority in terms of ensuring the patients are cared for in most appropriate setting.	Undertake an LIA event to discuss discharges and the documentation that goes with it. Implement agreed actions. Development and implement of an e-learning package around discharge which will be for all the multi-disciplinary (MDT). We will report progress through The transfer of care group
6	**Improve clinical recording and care planning to support safe and effective patient centred care delivery.** Improving the physical health care planning and recording of progress in support of the Parity of Esteem Agenda.	Adult Mental Health and Learning Disabilities	This priority has been highlighted by the national research showing the comorbidity of serious physical health issues for people with MH and LD, trend in incidents and feedback from commissioner and CQC visits.	We will increase the number of registered general nurses to support physical health assessment and care. We will ensure the physical check on admission for all MH and LD patients takes place within 48 hours, with exceptions managed via the ward MDT. Spot checks will be carried out, to ensure actions are completed on a regular basis. A change in our staffing and skill mix an increase in RGN appointments, the development of a tracking system via RiO to monitor completion of the physical health assessment on admission. We will report progress to ICL's Clinical Governance Group and Clinical Forums. Progress will be highlighted to DAG.

7	**Improve clinical recording and care planning to support safe and effective patient centred care delivery -** Improving patient and carer involvement in care planning (inpatients and community)	Adult Mental Health and Learning Disabilities	This priority has been highlighted by patient feedback via the patient survey, by trend in incidents and feedback from commissioner and CQC visits.	A new care plan being available to patients. Patient feedback on the new care plan. Audit of Care Plans – patient agreement. For community LiA event to be carried out and progress the outcomes to improve the level of involvement/engagement in care planning. Outcome measures from the LiA and the directorate Community Mental Health Survey. We will report progress to ICL's Clinical Governance Group and Clinical Forums. Progress will be highlighted to DAG
8	**Improve discharge planning and follow up to support safe transfer of care -** To understand the reasons for and delays in high complex transfers of care including those who may require a hospital to hospital transfer	Adult Mental Health and Learning Disabilities	Multi-agency approach to Length of Stay management on a weekly basis. Reduction in DToC's due to social and housing issues. This priority has been highlighted by feedback from commissioners and a limited change in mean LoS across the units during 15/16.	Appoint the final member of the complex discharge planning team (May 16). We will conduct a deep dive analysis into long LoS patients and complex DToC's to improve our understanding of the outstanding issues and to improve effective escalation of issues. An improvement in the number of DToCs on our wards, a reduction in the LoS of DToC patients and a reduction in mean LoS across our wards. We will report progress to ICL's Operational Group. Progress will be managed by AMHLD FPC.
9	**Evidence improved engagement in clinical supervision for all staff delivering care -** To improve the actual and recorded clinical supervision rates for all staff in the Trust.	ALL	This priority has been highlighted by feedback from the CQC and Commissioner visits and Trust Audits. Our priority is to ensure clinical supervision is effective and meaningful. Also essential for maintaining registration with regulatory bodies such as the HCPC, NMC, GMC. (FYPC)	An improvement in the rate of recorded clinical supervisions. We will develop a bite size training programme to improve knowledge and understanding of those receiving supervision. (CHS) Numbers of staff undertaking training. Clinical supervision will be rated as good or excellent on U-learn or through clinical audit. (FYPC) Frontline visits will show evidence of clinical supervision being embedded in practice. (FYPC) We will report progress to CEG.

Appendix 2 List of LPT Services 2015/16

During 2015/16 Leicestershire Partnership NHS Trust provided and/or subcontracted 81 NHS services. Mental Health and Learning Disabilities account for 44 services and Community Health Services make up the remaining 41. (See details below).

Mental Health and Learning Disabilities

Services - Inpatients

Assertive Outreach
District Forensic - Non Secure
General Psychiatry
Huntington's Disease Service
MHSOP - Functional Assessment
MHSOP - Organic Assessment
Psychiatric Intensive Care
Rehabilitation
Learning Disabilities - Short Breaks
Learning Disabilities - Agnes Unit - Short stay
Learning Disabilities - Agnes Unit - Longer stay
Adult Low Secure
CAMHS Tier 4
Eating Disorder Tier 4

Non Inpatient Services

Acquired Brain Injury
Adult ADHD Service
Aiming High
Aspergers
Assertive Outreach
CAMHS
Cognitive Behaviour Therapy
Community Forensic Team
Court Diversion
Crisis Resolution
Dynamic Psychotherapy
Early Intervention
Eating Disorders
Employment Services
General Psychiatry
Huntingtons (Neuro Psychiatry)
IAPT (Open Mind Service)
Liaison Psychiatry
Memory clinic
MH Homelessness
MH Integrated Nurses
Older Persons
Personality Disorder Service
PIER (Early Intervention)
Place of Safety
SEND
SPA Assessment
Triage Car
Triage Nurse
Learning Disabilities

Community Health Services

Inpatients

Intermediate Care and Community Hospital Beds
ICS Beds

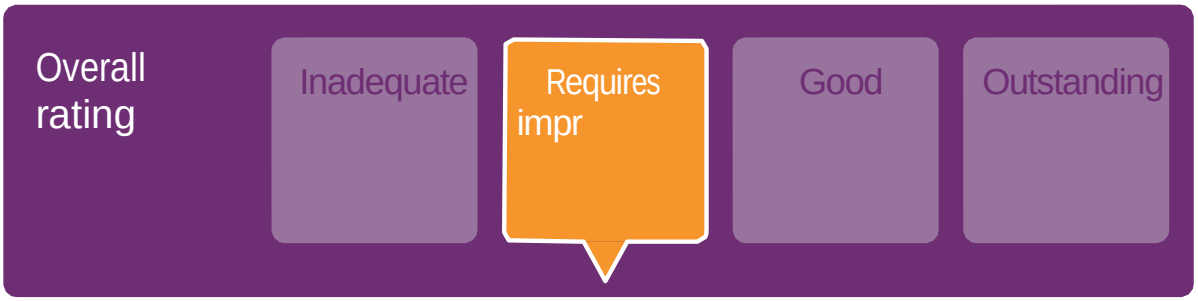
Non Inpatient Services

Children's Audiology
Children's Occupational Therapy
Children's Physiotherapy
Children's Rapid Assessment Follow-up Team
Children's SALT
Community Health Volunteer Scheme
Continence Nursing Service
Diana Children's Services
Nutrition and Dietetics services (provided in community)
District Nursing
End of Life Nursing care
Generalist Community Matrons
Paediatric Medical Services
Outpatient Physiotherapy
Podiatry
Rapid Response Teams
Safeguarding Children
School Nursing
Single Point of Access (SPA)
Speech and Language for Adults
Travelling Families Services
Ujala Resource Centre
Reablement
Adult MSK Physiotherapy
Heart Failure Service
Chronic Obstructive Pulmonary Disease Service
Health Development Co-ordinators
Food & Activity Buddies
Healthy Living Centres
Care Homes
Primary Care Coordinators
Integrated Community Health
Assertive Inreach
Phlebotomy services
ANP's Physical Health Assessment MHSOP patients
Drug & Alcohol Community services
Health Visiting
School-Aged Immunisations Services
Prison Healthcare Services

Appendix 3 CQC Grid

Last rated
10 July 2015

Leicestershire Partnership NHS Trust



	Safe	Effective	Caring	Responsive	Well led	Overall
Community health inpatient services	Requires improvement	Good	Requires improvement	Good	Requires improvement	Requires improvement
Child and adolescent mental health wards	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Community mental health services for people with learning disabilities or autism	Good	Good	Good	Good	Good	Good
Acute wards for adults of working age and psychiatric intensive care units	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Forensic inpatient/secure wards	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Community-based mental health services for adults of working age	Good	Requires improvement	Good	Good	Good	Good
Community-based mental health services for older people	Good	Requires improvement	Good	Good	Good	Good
Long stay/rehabilitation mental health wards for working age adults	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Community health services for children, young people and families	Good	Good	Good	Good	Requires improvement	Good
Community health services for adults	Good	Good	Good	Good	Good	Good

	Safe	Effective	Caring	Responsive	Well led	Overall
Wards for people with learning disabilities or autism	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Mental health crisis services and health-based places of safety	Requires improvement	Good	Good	Requires improvement	Not rated	Requires improvement
Specialist community mental health services for children and young people	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Wards for older people with mental health problems	Good	Requires improvement	Good	Good	Good	Good
End of life care	Good	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Summary ratings Poster

CareQuality Commission

Last rated
10 July 2015

Leicestershire Partnership NHS Trust

Overall rating	Inadequate	Requires improvement	Good	Outstanding

Are services

Safe?	Inadequate
Effective?	Requires improvement
Caring?	Good
Responsive?	Requires improvement
Well led?	Requires improvement

The Care Quality Commission is the independent regulator of health and social care in England. You can read our inspection report at www.cqc.org.uk/provider/RT5

We would like to hear about your experience of the care you have received, whether good or bad.
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Find out what we have changed since we received this rating from CQC:
www.leicspart.nhs.uk

Appendix 4: Clinical Priorities for 2015/16

Quality Priority	Why this is important to us	How this will be achieved	How this will be monitored and measured	Supporting Comments against current/expected delivery	Division
Improve the administration of insulin and reduce administration errors	Medication errors are a cause of concern. Insulin administration errors have been identified to be higher than expected. A Standard Operating Procedure for administrating medicines has been launched and a campaign to raise awareness of insulin administration has been completed. We want to achieve a sustained reduction in insulin administration errors.	Insulin safety awareness week/campaign will be repeated and alternative methods of staff engagement will be explored. 'Know how you're doing' boards to be incorporated into insulin safety (insulin errors to be separated from medication errors).	We will monitor the number of reported incidents each month. We will gather feedback from staff following the insulin safety campaign We will request staff feedback regarding the usefulness of safety campaign.	Achieve a sustained reduction in insulin administration errors This has been achieved through: • Insulin incidents are reviewed, analysed and reported to PSEG on a monthly basis. • Have achieved zero drug administration errors for 2 months out of the year. • Averaging 3 or less administration errors a month. • November had a higher incidence but on further analysis - there were no specific trends identified. 3 teams were reviewed who had errors over a number of months and appropriate actions are in place. • End of year position likely to demonstrate a sustained improvement in the reduction of drug administration errors. (Currently 19 administration errors Apr15-Jan16, 2014/15 = 35). Insulin safety awareness campaign 'Know how you're doing' boards to be incorporated into insulin safety (insulin errors to be separated from medication errors).	CHS Heather Darlow
Develop and implement a Trust-wide anticoagulation policy and reduce	The development of this policy as a priority has been prompted by incident concerns regarding Dalteparin,	We will develop and implement a Trust-wide policy and develop an action plan with a particular focus	We will measure this by reducing the number of Dalteparin administration errors.	This has been achieved through: • Policy remains under development in collaboration with UHL • Communication to all staff regarding	CHS

administration errors	There is also no current initiation, management policy for Warfarin, which a significant number of our patients require during a hospital stay.	on low molecular weight heparins and their delivery in the community.		relevant policies and SOP regarding administering medicines in the community circulated and discussed in June 2015 • Dalteparin knowledge analysis audit undertaken and results shared. • Low molecular weight heparin incidents are reviewed, analysed and reported to PSEG on a monthly basis. • Have achieved zero drug administration errors for 6 months out of the year. • Averaging 2 or less administration errors a month. • Sustained improvement in the reduction of drug administration errors • End of year position likely to demonstrate a sustained improvement in the reduction of drug administration errors. (Currently 6 administration errors Apr15-Jan16, Qtr 4 2014/15 = 3).	Heather Darlow
Increase awareness and management of sepsis in our community hospitals	Sepsis is one of the top 3 causes of in-hospital deaths. The national work on sepsis recognition and management has identified that early intervention in sepsis management can reduce hospital mortality. In line with the Better Care Together Strategy and left- shift work with UHL resulting in a move towards higher acuity patients within our hospital the occurrence and severity of sepsis is likely to increase.	Increasing staff awareness can influence the management and outcome of sepsis cases and during 2015/16 we plan to engage our MDT and define a sepsis tool. We will educate ward staff in recognition and management of sepsis. We will introduce sepsis boxes onto all community ward areas following discussion with microbiology.	We will evaluate implementation and the education package. We will undergo an audit of staff knowledge regarding recognition and management of sepsis.	This has been achieved through: • Community hospitals sepsis awareness event 7-11 September • Sepsis pathway agreed and being printed, to be launched March 2016 • CHS representative at Sepsis nurse forum Engage our MDT and define a sepsis tool. Educate ward staff in recognition and management of sepsis. Introduce sepsis boxes onto all community ward areas following discussion with microbiology.	CHS Heather Darlow

Improve our approach to family- focused care and strengthen relationships between staff groups working with different members of the same family	Staff Link (an internal electronic service directory) is being used across our Families Young People and Children's Services to provide contact information for staff working with children and families in each locality. In 2015/16 we want to strengthen relationships between front line staff across LPT who are working with different members of the same family.	The Trust is rolling out the development of the Staff Link service (which is currently only available in FYPC) and therefore all staff across LPT will be on the Staff Link system and will be able to identify who works within their locality area.	We will measure this by the number of staff using Staff Link. Leaders across LPT will meet regularly to review progress through family stories and staff feedback.	Staff Link has been superseded by We Connect. LPT are currently working on the development of a virtual workspace where users can access web based applications and tools that will inspire staff to connect, collaborate and develop new ideas and innovations across the trust. WeConnect encourages people to communicate around areas of common interest and WeCreate is an ideas sharing platform for moving an idea from conception through to implementation. Neighbourhood team meetings bring together a range of LPT leaders to discuss local arrangements to join up care for children and families.	FYPC Vicki Spencer
Improve and increase engagement with people who use our services by developing service co-design and quality improvement opportunities	We want to find better ways to engage with people living in Leicester, Leicestershire and Rutland, particularly in our Families, Young People and Children's service (FYPC) and our Learning Disability services. We want to provide a person centred Learning Disability (LD) Service based on the views of people who use our services and their family/carers. The LD Service has carried out listening events and collected information from people who use our services in a variety of creative ways in order to ensure that people with a learning disability can have a voice. During 2014/15 the Health for Kids	Learning Disability Services would like to develop their work further and set up an Experience Based Co-Design project to truly involve people in planning how our services are delivered in the future. They also want to continue to develop ways of providing patients with choice and control in our services and gaining feedback at the point of contact. FYPC will identify and deliver during 2015/16 three key service quality improvements developed in partnership with service users.	FYPC will measure this by having service users involved in co design. Progress within learning disability services will be measured against the project plan which sets out the time scales for preparation, piloting, delivering and evaluating the project. We have a range of measures we will be working on with people who use our LD Services to evaluate	Evolving Minds is a service user group of 22 young people that have formed to provide feedback on the current CAMHS transformational plans. Of these 22 young people 6 have formed into a Board and will meet with CAMHS SMT on a quarterly basis to discuss changes as well as the roles and functions of the Young Person's Board. There are 2 Band 5 co-Design practitioners in post.	FYPC Vicki Spencer

	and Health for Teens websites were successfully designed and delivered in FYPC using a co-design approach by using School Nurses and local children and young people to develop the new websites. We want to build on this, the neighbourhood programme, and the Asset Based Community Design approach further.	They will recruit two Band 4 co-design practitioners to support this work.	any improvements in their experience of our services.		
Improve the understanding and application of the Mental Health Act (MHA) and Mental Capacity Act (MCA)	This is a continuation of a programme of improvements developed in light of learning and is also in response to the CQC inspection in March 2015 where deficiencies relating to the application of the MHA and MCA were identified. We will actively be seeking to improve and ensure the robust application and subsequent scrutiny for adherence to the Mental Health Act Code of Practice and the application of the Mental Capacity Act across the Trust	We will undertake training needs analysis for all staff involved in the application of the MHA and the new Code of Practice 2015 and for all staff involved in the application of the MCA to: 1. Improve and evidence robust scrutiny procedures for application of the MHA code of practice. 2. Ensure the correct application and management of Section 17 authorisation and leave management. 3. Ensure the correct application in regards to consent to treatment arrangements and recording. 4. Improve the current process and arrangements for patients	Using a mixed methodology of quantitative and qualitative approaches to develop an audit process that embeds best practice. Continue to develop and apply audit and scrutiny processes with the Mental Health Act Office for application of MHA, the application and management of: A) section 17 authorisation and leave management, B) the application and consent to treatment C) arrangements and recording	CHS MHA/DOLS Champions forum established and in place. Monthly MHA Audits ensure regular spot checking of all areas of concern. MHA Audit Data to be included in ward meetings as routine Development and implementation of a Mental Health Act checklist to be progressed. Training Needs Analysis/Evidence robust scrutiny procedures. Training programme/Community of practice to share learning. MCA awareness through supervision, clinical supervision, peer support. Proactive application of the MCA which is consistently sought and recorded.	CHS Heather Darlow Richard Apps Allison Wheelton Laura Belshaw

		to understand their rights under section 132. 5. Improve staff's understanding of the MHA by providing a training programme and developing a community of practice to share learning across the service line. 6. Develop and improve staff knowledge in the awareness of the MCA requirements through; supervision, clinical supervision, peer support, further training. 7. Through improving knowledge ensure that there is a proactive application of the MCA which is consistently sought and recorded.	through case file reviews We will also review service user and carer feedback.		
Ensure physical and mental health needs are met and given equal priority	The physical healthcare of patients with mental health problems and learning disability has been highlighted in several national documents and has been highlighted as an area of improvement following a review of incident reports. .	We plan to develop a Physical Health Strategy for Inpatient Services to support the reduction in mortality in people with mental health problems and people with a learning disability We will implement improved prevention and management strategies including physical health monitoring, advice and guidance and treatment for patients. The Physical Health Strategy	Process outcomes will be developed in parallel to the physical health pathway.	The strategy group has identified the Rethink Physical Health CQUIN toolkit as a suitable pathway to monitor physical health; this has outcomes built into the pathway. The implementation of the pathway has been delayed due to additional RGN recruitment to support physical health assessment, monitoring and training. The pathway will be launched in 2016/17.	Sateesh Kumar Jacqueline Burden

		Group will be engaging with service user representatives to develop the Physical Health Strategy.			
Improve access to Child and Adolescent Mental Health services and provide consistent packages of care	During 2014/15 we undertook a review of the Tier 3 CAMHS service along with commissioners, services users and local voluntary groups. We identified actions and four key work-streams, and want to take this work forward during 20151/6	We will ensure everyone on the CAMHS waiting list is appropriate, and that people on the waiting list know what to expect, and support and advice is made available. Children and young people will be offered consistent packages of care prior to handover to more local services.	We will be looking for demonstrable service improvements from the Friends and Family Test results Reduction in complaints	Friends & Family Test replies are consistently returned as 'Likely' or 'Extremely Likely' to recommend the services. Responses include: - Good communication between staff and family. Friendly and kind staff, supportive of patient. - Because they are really supportive and help you get better. All the staff is lovely too. CAMHS Complaints have continued to decrease from 14 in Q4 2014/15 to 4 in Q3 2015/16	FYPC Vicki Spencer
Develop and improve care pathways for people with a learning disability	We have already begun development of LD pathways in response to various national drivers. The model of care pathways has been discussed in DT meetings and with stakeholders (Commissioners, Local authorities) in the AMH-LD Clinical Forum where the model was introduced Our service users have outlined what is important to them and we will continue to work with them as part of an Experience based Co-Design Project.	A list of conditions, assessment and interventions offered by LD services has been developed, and the first draft of care pathways is currently being updated. As a priority we now want to take these forward. We will launch pathway based practices within Teams.	We will develop information reporting, based on clinical pathways. There will be clear time-lines within the pathway implementation plan. Pathway based activity will inform data quality. We will monitor feedback from the staff delivering the pathways and people who use our services	• Care pathway development and formatting now complete and this is awaiting sign-off from the Service Development Initiative. • All care pathways have supporting documents on clinical roles/responsibilities. • The implementation of the pathways is likely to happen through 2016/17, as we are waiting for the Community Teams to get established and have the right management in place, which is expected to happen over the next 2 months. Care pathway development and	AMH Jacqueline Burden

	We want to improve Learning Disability (LD) Care Pathways by: • developing care pathways based on conditions • developing care pathways that are based on evidence based standards of assessment and treatment • reducing variation in professional input and service delivery • enhancing the practice of patient centred service by incorporating patient reported outcome measures, alongside clinical outcome measures • developing an equitable, productive and effective locality based service		We will ensure final versions are formatted, developed and placed on the Staff Intranet	formatting now complete. Awaiting sign-off from the SDI. All care pathways have supporting documents on clinical roles/responsibilities. The implementation of the pathways is likely to happen through 2016/17, as we are awaiting for the Community teams to get established and have the right Management in place, which is expected to happen over the next 2 months	
Reduce the number of mental health patients delayed in hospital	We want to reduce the number of patients that become delayed transfers of care by virtue of controllable variables such as housing, social care and after care. We have established monitoring of patient flow within a Multi-Agency Length of Stay (LOS) panel, supported with the development of a real-time patient census. The panel centres on multi-agency discussion and agreement, working collaboratively to look at the nature of delays and help ensure that any potential barriers to patients returning home are identified early.	We plan to; - Further develop the panel to include regular input and attendance by Consultants. - Complete the pilot process successfully. - Develop and share the operating procedure. - Develop improved working arrangements with GEM regarding funding decisions and communication. - Continue to work closely with Housing Support Officers to ensure housing related delays are minimised.	We will be monitoring the number of patients delayed in returning home.	Team continue to work together to ensure the most appropriate representation at the panel. The panel go through all patients to identify DToC patients early rather than just people who have been in for over 25 days. This also helps predict potential movement for bed management purposes. The panel has representation from housing and the in-reach team as well as each ward (nursing staff) and is chaired by the bed management manager.	AMH Jacqueline Burden

	The panel looks at patients who have been on the wards over 25 days. Membership has been widened to include, Rehabilitation Services, Occupational Therapy, Step Down Services, Local Authority Housing, and GEM, all of whom contribute to the patient pathway.			SOP for bed management covers the LOS meeting. This is being reviewed after the MoC process that is currently happening in the team.	

Table of Data Sources

SOURCES OF DATA	
Royal College of Psychiatrists	Care Quality Commission website materials for published inspections
Contractual performance monitoring by Commissioners	NHS England (Unify submissions for 2014/15)
CQUIN achievements from Quality Schedule	Staff survey results 2014
Trust's Clinical Audit Database	2014 National NHS Community Mental Health Service User Survey
EMIAS (audit services)	Care Quality Commission Community Mental Health Survey
360 Assurance (audit services)	Trust wide risk management reporting systems
Trust Board visits	Trust Board Integrated Quality and Performance Report
Coroner's inquest reports	Secondary Uses Service for hospital episode statistics
Mental Health Minimum Dataset	Information Governance Toolkit audit requirements NHS Connecting for Health
Friends and Family Test results	NHS England Organisational Patient Safety Incident Report
Omnibus Survey data collection System on behalf of the Health & Social Care Information Centre (HSCIC)	National Reporting and Learning Service (NRLS)
Care Quality Commission Inspection visits, and MHA inspections	National Clinical Audits
Health Education East Midlands	Summary Hospital Level Mortality Indicator (SHMI)

Glossary

Adult Mental Health Services (AMH)
This is the division which provides adult mental health services.

Adult Mental Health - Learning Disabilities (AMH-LD)
A sub-division of AMH responsible for the provision of Learning Disability Services.

Better Care Together (BCT)
A programme of work which will transform the health and social care system in LLR by 2019, by ensuring that health and social care services in LLR are capable of meeting the future needs of the local population. BCT brings together partners, including local NHS organisations and councils, to ensure that services change to meet the needs of local people, and future challenges.

Care Pathways
These determine the locally-agreed, multi-disciplinary practice based on guidelines and evidence, where available, for each specific service user group.

Care Programme Approach (CPA)
A system of delivering community services to those with a serious mental illness, based upon the four principles of assessment, care plan, care co–ordination and review.
Implicit in all of them is involvement of the person using the service, and where appropriate, their carer.

Care Quality Commission (CQC)
The Care Quality Commission (CQC) replaced the Healthcare Commission, Mental Health Act Commission and the Commission for Social Care Inspection in April 2009. The CQC is the independent regulator of health and social care in England. It regulates health and adult social care services, whether provided by the NHS, local authorities, private companies or voluntary organisations. Local application of the Mental Health Act is now included as part of the CQC's Comprehensive Inspection Programme. For further information, visit www.cqc.org.uk

Child and Adolescent Mental Health Services (CAMHS)
CAMHS is a range of services for children and young people aged up to 18. Young people between 16 and 18 years can access CAMHS or other adult services, depending on which is felt to be more useful for their needs.

Clinical audit
Clinical audit measures the quality of care and services against agreed standards and suggests or makes improvements where necessary.

Clostridium difficile (CDiff)
CDiff is a species of bacterium that causes diarrhoea and other intestinal disease when competing bacteria are wiped out by antibiotics.

Commissioning for quality and innovation (CQUIN)
The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of healthcare providers' income to the achievement of local quality improvement goals.

Commissioners
Commissioners are responsible for ensuring adequate services are available for their local population by assessing needs and purchasing services. Clinical Commissioning Groups are the key organisations responsible for commissioning healthcare services for their area. They commission services for the whole of their population, with a view to improving their population's health.

Community Health Services and Mental Health Services for Older Persons (CHS/MHSOP)
This is the division which provides inpatient community services, community services, and mental health services for older people.

Deprivation of Liberty Safeguards (DoLS)
These are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

Families, Young People and Children's Services (FYPC)
This is the division which provides services to families, young people and children.

Friends and Family Test (FFT)
FFT is a patient metric to test likelihood of recommending our ward / service to friends and family if they were to need similar care or treatment. Scores are now shown as the percentage of people who express 'extremely likely' and 'likely' to recommend the service to their friends and family (from a 5 point range from; 'Extremely likely' to 'Extremely unlikely').

GEM - Arden and Greater East Midlands Commissioning Support Unit.
One of the largest Commissioning Support Units in the country, serving 37 Clinical Commissioning Groups, with a population of around 6.3 million; they deliver commissioning support.

Health & Social Care Information Centre (HSCIC)
A national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care; HSCIC is an executive non-departmental public body, sponsored by DoH.

Healthcare Associated infections (HCAI)
HCAI are infections acquired as a consequence of a person's treatment by a healthcare provider, or by a healthcare worker in the course of their duties. They are often in a hospital setting, but can also be associated with clinical care delivered in the community.

Healthwatch
Healthwatch England is the national consumer champion in health and care. We have significant statutory powers to ensure the voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and care services.

Integrated quality and performance reports (IQPR)
A monthly report which gives levels of compliance with our improvement priorities, the Monitor Compliance Framework and CQC registration requirements. The report also provides the current monthly data and trend analysis across each of the Trust strategic objectives including all local commissioning targets and internal Trust targets.

ICD-10
the 10th revision of the International Statistical Classification of Diseases and Related Health Problems, a medical classification list by the World Health Organisation.

Information Governance Toolkit
The framework by which the NHS assesses how well we meet best practice for collecting, storing and sharing information about people. These standards cover information governance management, confidentiality and data protection, information security, information quality and the keeping of all records.

Leicester, Leicestershire and Rutland (LLR)
Our local healthcare area.

Learning Disabilities Services
This is the division which provides services for adults with learning disabilities.

Listening into Action (LiA)
LiA is one of the key ways that the Trust empowers staff to make changes that improve working life and patient care. The scheme works to bring people together to share their thoughts and ideas, and to make improvements together. It is now an essential part of our programme to improve the quality of care across all of our services.

Mental Capacity Act 1983 (MCA)
This is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over.

Mental Health Act (MHA)
Amended in 2007, the MHA sets out treatments, rights, etc., for those with mental disorders, and also the legal powers of detention of doctors and Approved Mental Health Professionals. It outlines a legal framework which must be followed to ensure rights are protected.

Mental Health Minimum Dataset (MHMDS)
A mandatory requirement for all providers of specialist adult mental health services in a secondary care setting, to collect person focused clinical data which includes all relevant treatment and care for service users. The coded clinical data inputted helps provide local

clinicians and managers with better quality information for clinical audit, service planning and management, with the aim of ensuring provision of accurate and concise quality data.

Methicillin-Resistant Staphylococcus Aureus (MRSA)
A common skin bacterium that is resistant to a range of antibiotics. 'Methicillin-resistant' means the bacteria are unaffected by Methicillin, a type of antibiotic that used to be able to kill them.

Multi-Disciplinary Team (MDT)
MDTs are composed of members from different healthcare professions with specialised skills and expertise, who collaborate together to make treatment recommendations that facilitate quality patient care.

NHS number
The NHS number is the mandated national unique identifier for patients. It must be used alongside other demographic information to identify and link the correct records to a particular patient.

National Institute for Health and Clinical Excellence (NICE)
The National Institute for Health and Clinical Excellence provides guidance, sets quality standards and manages a national database to improve people's health and prevent and treat ill health.

National Institute of Health Research (NIHR)
A national body established to commission and fund NHS and social care research in public health and personal social services. Its role is to develop the research evidence to support decision making by professionals, policy makers and patients, make this evidence available, and encourage its uptake and use.

National Patient Safety Agency (NPSA)
A national agency which leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector.

National Reporting and Learning System (NRLS)
A central database of patient safety incident reports. Since the NRLS was set up in 2003, over four million incident reports have been submitted. All information submitted is analysed to identify hazards, risks and opportunities to continuously improve the safety of patient care.

Non-portfolio Research
The majority of these studies are relatively small-scale, local studies (formerly known as "own account" research).

Patient Safety Thermometer
A point of care survey instrument, the Patient Safety Thermometer measures local and system progress in providing a care environment free of harm for patients. It allows clinical teams to measure the proportion of patients that are 'harm free' during their working day.

Portfolio Research
These are studies that are of "high quality", as determined by being awarded funding on a competitive basis from an eligible funding body (such as MRC, NIHR, HTA, SDO, RfPB etc.). In most cases these are multi-centre studies aiming to recruit large numbers of participants, so as to produce the best possible evidence. The majority of these studies are "adopted" by Topic Specific Networks such as MHRN (Mental Health Research Network), CRN (Cancer Research Network), DRN (Diabetes Research Network) or directly on to the UKCRN Portfolio through the NIHR-CSP (Central Sign-off for NHS Permission) system managed by the Comprehensive Local Research Networks (CLRN).

Quality Schedule
LPT's Quality targets and goals as agreed with the three local Clinical Commissioning Groups. Progress against delivery is monitored by Commissioners on a monthly basis through formal meetings, and by visits.

Secondary Users Service (SUS)
A single source of comprehensive data, available to the NHS, to enable a range of reporting and analysis.

Summary Hospital Level Mortality Indicator (SHMI)
An indicator which reports on mortality at trust level across the NHS in England using a standard and transparent methodology. It is produced and published quarterly as an official statistic by the Health and Social Care Information Centre (HSCIC) with the first publication having been in October 2011. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

Trend
A trend refers to the concept of collecting information and attempting to spot a pattern, or trend, in the information. A trend line presents the 'trend'.

360 Assurance
Established in July 2013, 360 Assurance brings together two long standing internal audit services. They assist LPT in the identification of key business risks and in the gaining of assurances that these are being managed effectively.

Feedback your views

This is the Quality Account and we want this report to be used to inform discussions about how we could improve our services. The Trust welcomes your questions or comments on the issues raised in this document or any of its services.

Comments should be sent to:

Chief Executive
Leicestershire Partnership NHS Trust
Riverside House/Bridge Park Plaza
Bridge Park Road
Thurmaston
Leicester
LE4 8PQ

Telephone: 0116 295 0994 and ask for the communications team
Email: feedback@leicspart.nhs.uk

This document is also available on our website at www.leicspart.nhs.uk
(after 30th June 2016)

If you need this information in another language or format please telephone 0116 295 0903 or email: Patient.Information@leicspart.nhs.uk

Arabic

إذا كنت في حاجة إلى قراءة هذه المعلومات بلغة أخرى أو بتنسيق مختلف، يرجى الاتصال بهاتف رقم0116 295 0903أو إرسال بريد إلكتروني إلى: Patient.Information@leicspart.nhs.uk

Bengali

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Polish

Jeżeli są Państwo zainteresowani otrzymaniem niniejszych informacji w innym języku lub formacie, prosimy skontaktować się z nami telefonicznie pod numerem 0116 295 0903 lub za pośrednictwem poczty elektronicznej na adres: Patient.Information@leicspart.nhs.uk

Punjabi

ਜੇ ਤੁਹਾਨੂੰ ਇਹ ਜਾਣਕਾਰੀ ਕਿਸੇ ਹੋਰ ਭਾਸ਼ਾ ਜਾਂ ਫਾਰਮੈਟ ਵਿਚ ਚਾਹੀਦੀ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ 0116 295 0903 ਤੇ ਟੈਲੀਫ਼ੋਨ ਕਰੋ ਜਾਂ ਇੱਥੇ ਈਮੇਲ ਕਰੋ: Patient.Information@leicspart.nhs.uk

Somali

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Urdu

اگرآپ کو یہ معلومات کسی اور زبان یا صورت میں درکار ہوں تو براہ کرم اس ٹیلی فون نمبر 0116 295 0903 یا ای میل پر رابطہ کریںPatient.Information@leicspart.nhs.uk