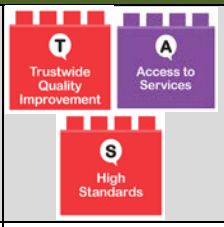
Leicestershire Partnership NHS Trust

Public Meeting of the Trust Board
9.30 am Tuesday 1 October 2019
Venue: Sparkenhoe Committee Room, County Hall

public meeting

Item No.	Timings	Item	Purpose	Paper Ref	Discussion to be led by
1	**9.30**	Apologies for absence: Faisal Hussain; Sue Elcock and welcome: Gordon King; Michele Morton; Suraiya Hassan			Cathy Ellis
2	10 mins	Patient voice film	Quality Improvement		Anne-Maria Newham
3	9.40	Declarations of interest in respect of items on the agenda			
4		Minutes of the previous meeting, 30 July 2019	Assurance	A	Cathy Ellis
5		Matters arising actions	Assurance	B	Cathy Ellis
6		Chairman's Report Board Meeting Dates 2020 Non Executive Directors' Portfolios	Information	Ci Cii Ciii	Cathy Ellis
7		Chief Executive's environmental scan	Information and Assurance	Di Dii	Angela Hillery
		Governance and Risk			
8	9.50 20 mins	Corporate Risk Register and Board Assurance Framework Risk Management Policy	Assurance	Ei Eii	Angela Hillery
9	10.10 10 mins	Brexit Briefing	Assurance	Fi Fii	Dani Cecchini
10	10.20 5 mins	External Governance Reviews	Assurance	G	Angela Hillery
11	10.25 5 mins	Corporate governance renewal	Assurance and Approval	H	Angela Hillery
Total for section = 60 minutes					

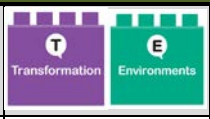
		Strategy and System Working			
12	10.30 5 mins	Better Care Together (BCT), Sustainability and Transformation Partnership (STP) status, and System Leadership Team (SLT) update	Information	I	Angela Hillery
Total for section = 5 minutes					
		Quality Improvement and Compliance			
13	10.35 10 mins	Quality Assurance Committee highlight reports August and September	Assurance	Ji Jii	Liz Rowbotham
14	10.45 10 mins	Waiting Lists	Performance	K	Anne-Maria Newham
15	10.55 10 mins	Director of Nursing's Report including AHP report	Assurance	L	Anne-Maria Newham
16	11.05 10 mins	Care Quality Commission (CQC) progress Action Plan	Assurance	M	Anne-Maria Newham
17	11.15 10 mins	Break			
18	11.25 10 mins	Mortality Surveillance Quarterly reports	Assurance	Ni Nii	Anne-Maria Newham
19	11.35 10 mins	Serious Incidents Quarterly report	Assurance	O	Anne-Maria Newham
20	11.45 10 mins	Annual Complaints Report	Assurance and Information	P	Anne-Maria Newham
21	11.55 10 mins	Infection Prevention Visit NHSi	Assurance and Compliance	Q	Anne-Maria Newham
22	12.05 5 mins	Guardian of Safe Working Hours (Junior Doctors contract) Quarterly	Assurance and Compliance	R	Anne-Maria Newham
Total for section = 85 minutes (excluding break)					
		Performance and Assurance			
Highlight reports (taken as read) from board committees: (those highlighted have been reviewed at one or more of the board committees)					
23	12.10 5 mins	Joint Quality Assurance Committee and Finance and Performance Committee September	Assurance	S	Liz Rowbotham Geoff Rowbotham

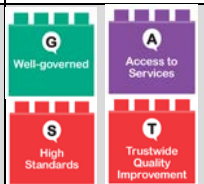
24	12.15 10 mins	Finance and Performance Committee highlight report August and September	Assurance	Ti Tii	Geoff Rowbotham
25	12.25 10 mins	Finance monthly report – month 5	Performance	U	Dani Cecchini
26	12.35 10 mins	Integrated Quality and Performance monthly report	Performance	Vi Vii Viii	Dani Cecchini
27	12.45 5 mins	Charitable Funds highlight report (September)	Assurance	W	Cathy Ellis
28	12.50 5 mins	Strategic Workforce Group highlight report (September)	Assurance	X	Sarah Willis
Total for section = 45 minutes					
29		Information Pack (circulated to Board members only) containing: • Corporate Risk Register • CQC Action Plan Excerpt • STP SLT meetings confirmed minutes • SLT Business Update August September 2019 • Annual Infection and Prevention Control report • Clinical Audit Annual Report • LLR System Plan • NHS Improvement Infection Prevention Visit Action Plan	Information		Cathy Ellis
30		Any other urgent business			Cathy Ellis
31		Public questions on agenda items			Cathy Ellis
32	12.55	**Date of next meeting:** The next public Trust Board meeting will be held on 1 November 2019			Cathy Ellis
It is recommended that, pursuant to Section 1 (2), Public Bodies (Admission to Meetings) Act l960, representatives of the press and other members of the public be excluded from the following meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.					

Leicestershire Partnership NHS Trust

Confidential Trust Board Meeting
1.30pm on Tuesday 1 October 2019
Venue: Sparkenhoe Committee Room, County Hall

AGENDA

Item No.	Timings	Item	Purpose	Paper Ref	Discussion to be led by
1	1.30	Apologies for absence: And welcome David Williams (NHFT)			Cathy Ellis
2		Declarations of interest in respect of items on the agenda			Cathy Ellis
3	1.30 60 mins	Our Future Our Way Big Reveal		Oral	Sarah Willis
4	2.30	Declarations of interest in respect of items on the agenda			Cathy Ellis
5	2.30 5 mins	Minutes of the previous confidential meeting, 30 July 2019	Assurance	AA	Cathy Ellis
6		Matters arising	Assurance	BB	Cathy Ellis
7	2.35 10 mins	Chief Executive's report	Assurance	Oral	Angela Hillery
Total for section = 75 minutes					
		Governance and Risk			
8	2.45 10 mins	Performance Management and Accountability Framework	Performance	Oral	Dani Cecchini
9	2.55 5 mins	Reportable issues log	Information	CC	Anne-Maria Newham
10	3.00 10 mins	Break			
Total for section = 15 minutes (excluding break)					
		Strategy and System Working			
11	3.10 10 mins	Sustainability Transformation Plan	Assurance/ Information	Oral	Angela Hillery
12	3.20 15 mins	Estates Strategy	Approval	DD	Dani Cecchini

13	3.35 15 mins	Mental Health Inpatients Strategic Outline Case	Approval	EE	Dani Cecchini
14	3.50 10 mins	Formation of an East Midlands Mental Health & Learning Disability Alliance	Approval	FF	Angela Hillery/ David Williams
Total for section = 50 minutes					
		Quality Improvement and Compliance			
15	4.00 5 mins	Interagency Safeguarding Review update and oversight report	Assurance and Information	GG	Anne-Maria Newham
16	4.05 5 mins	Safer Staffing August 2019	Assurance	HH	Anne-Maria Newham
Total for section = 10 minutes					
		Performance and Assurance			
17	4.10 5 mins	Financial Turnaround	Assurance	Slides	Dani Cecchini
Total for section = 10 minutes					
18	4.15	Confidential Board information pack: • Our Future Our Way Phase 1 Discover – Synthesis Report			
19	4.15	Confirmed minutes available to Board members on request (matters have previously been highlighted in the Chairs' reports): • Quality Assurance Committee • Finance and Performance Committee • Audit and Assurance Committee • Charitable Funds Committee • Strategic Workforce Group • Mental Health Act Assurance Committee	Assurance		Cathy Ellis
		Board development			
20	4.15 40 mins	FYPC Service presentation – CAMHS community waits and Intensive Support team	Assurance	Slides	Helen Thompson
21	4.55 5 mins	Board development action tracker on priorities	Assurance	II	Cathy Ellis
22	5.00 5 mins	Any Other Business	Assurance	Oral	Cathy Ellis

23	5.05	Close			

UNCONFIRMED

Leicestershire Partnership NHS Trust

Trust Board

Minutes of the Meeting held in public on Thursday 30 July 2019, 9.30 am

A

Leicestershire County Hall, Gartree Room

Present: Ms C Ellis, Chair
Mr G Rowbotham, Non-Executive Director/Deputy Chair
Mr F Hussain, Non-Executive Director
Professor K Harris, Non-Executive Director
Mrs E Rowbotham, Non-Executive Director
Ms Angela Hillery, Chief Executive
Ms D Cecchini, Director of Finance
Dr S Elcock, Medical Director
Ms Anne-Maria Newham, Director of Nursing

In Attendance:
Ms R Bilsborough, Director of Community Health Services
Ms H Thompson, Director, Families, Young People & Children Services and Adult Mental Health & Learning Disability Services
Mrs S Willis, Director of Human Resources & Organisational Development
Mr F Lusk, Trust Secretary
Ms Anna Pridmore, Interim Associate Director of Corporate Governance
Ms Cathy Geddes, NHSI Improvement Director

		ACTION
TB/19/118	Apologies and welcome Apologies for absence had been received from Ms Marchington Non-Executive Director and Mr Darren Hickman, Non-Executive Director. The Chair welcomed Angela Hillery to her first meeting as Chief Executive, Cathy Geddes, NHS Improvement Director; Anna Pridmore, Interim Associate Director of Corporate Governance; Mark Farmer, Healthwatch; John Edwards, Associate Director for Transformation (for TB/19/127); Haseeb Ahmad, Equalities Lead (for TB/19/128); Pauline Lewitt Freedom to Speak Up Guardian (for item TB/19/142); Deanne Rennie, Deputy Clinical Director FYPC and AHPs Lead; Kamy Basra, Head of Communications; Rosie Huckle, Communications; Kathryn Burt, Deputy Director of HR & OD; Head of Operational HR; Mariam Dindar (Reverse Mentor to Cathy Ellis); Dan Collard, Service Manager for Temporary staff & BAME Lead Advocate; Asha Day, Clinical Team Leader for City Health Visting services ; Sinead Ellis-Austin, Business Manager, NHFT, Mr Fisher (member of the public).	

		ACTION
TB/19/119	Patient Voice	
	A short video was shown to the Board with the theme of Inpatient to Rehabilitation illustrating three separate Stewart House Unit patient journeys.	
	The Chair commented on the perceived staff shortages at Stewart House and Mrs Hillery asked about the current position at the unit. Ms Thompson responded that staffing in the Rehabilitation service was not a "hot spot" at this time. A skill mix review had been undertaken and some 13 hours of rehabilitation activity per week for each patient was expected and monitored. The multi-disciplinary working in the service across all its units was seen as a strength when inspected by the Care Quality Commissioner (CQC) in 2018.	
TB/19/120	Declarations of interest Mrs Hillery's Declaration of Interest as a new Director was recorded and all other Board members confirmed that they had no conflicts of interest in relation to the agenda items. The Chair reminded all Board members to record any declarations, or a nil return, on the self-service LPT Declare.	
TB/19/121	Minutes of the previous public meeting, 23 May 2019 **Resolved: The minutes of the meeting held on Tuesday 23 May 2019 were confirmed.**	
TB/19/122	Matters arising actions	
	Trust Board members reviewed the list of matters arising actions at Paper B. 889 – Communication messages about the new Chief Executive had been published and would continue. **CLOSED** 892 - Ms Cecchini confirmed that we continue to forecast as not meeting the stretch financial position at this time. This consideration was not included in the Financial Recovery Plan work. **CLOSED** **Resolved: The Matters Arising had been reviewed by the Board and status of actions agreed and minuted.**	
TB/19/123	Chair's report	
	The Chair presented Paper C, which provided a report on her activities between 23 May 2019 to 30 July 2019 with patients, staff and stakeholders, and the events/committees she had attended. Also included were the activities of the Non-Executive Directors (NEDs).	
	Mr Farmer enquired about the outcome of the meeting held with the	

		ACTION
	Police Chief Constable and the Police and Crime Commissioner .that discussed partnership working. The Chair responded that the meeting had focused upon how much the police were involved in mental health incidents and the Chief Executive would be meeting the Chief Constable. This was a key relationships and mutual understanding of operational protocols was critical.	
	Resolved: The Trust Board received the Chair's report.	
TB/19/124	Chief Executive's Environmental Scan	
	Ms Hillery highlighted points from Paper D such as being very pleased with the Trust being one of the top ten Trusts for healthcare staff who have undertaken the joint Dementia Research Awareness tool training.	
	Resolved: The Trust Board received the Environmental Scan report for information only. The report provided an update on areas of focus locally, regionally and nationally.	
	Risk	
TB/19/125	Corporate Risk Register (CRR)	
	Ms Pridmore presented Paper E for further work planned to ensure the Board Assurance Framework (BAF) and CRR were simple and effective to use. She added that all identified risks from the Board meeting would be captured for the 30 August 2019 Trust Board development session on risk management. The Chair agreed that Board members should be highlighting key risks from papers presented during the Board meeting and these would be captured in the minutes to cross check with the BAF and CRR.	
	Resolved: The Trust Board received the information included in the report and took assurance that work to strengthen the risk system was progressing.	
	Strategy	
TB/19/126	Better Care Together (BCT) and Sustainability and Transformation Partnership (STP) status and System Leadership Team (SLT) updates	
	Ms Hillery presented paper E, the Better Care Together Partnership update. The update informed the Board on the key business and strategic work programme being discussed and taken forward by SLT.	
	Integrated Community Systems is a priority for STP and there would be an update to the Trust Board after August 2019.	
	Ms Bilsborough reported that all three local Clinical Commissioning	**RB paper**

		ACTION
	Groups (CCGs) had approved the service model and specifications scope for the Community Service Redesign. The 30 August 2019 Trust Board would receive a paper setting out the Trust's response. The Chair highlighted that there had been several public engagement events earlier in the year led by the CCGs with senior representatives from LPT. These were well attended by members of the public and staff and further communications in the local health community were expected. It was important to align the internal staff understanding of the Redesign to the external stakeholder messages circulated. Mr Hussain was keen to hear Ms Hillery's view at the 30 August 2019 Trust Board as a sense check.	**to 30 August board**
	Mr Farmer asked how had the CCGs involved patients and carers in the co-design work of the Review. Ms Bilsborough responded that Healthwatch had been engaged and would also have oversight of the Integrated Care Community Board.	
	Mr Rowbotham felt that a strategic debate would be helpful and where did LPT wish to be positioned in the future Primary Care and Integrated Care models.	
	Ms Bilsborough believed a key risk at this time was the lack of maturity of the recently formed Primary Care Networks as they were pivotal to the future model of care. The Chair highlighted that staff engagement, workforce retention, productivity and stakeholder communications were key risks to be considered prior to implementation.	
	Resolved: The Trust Board noted the Better Care Together Update Bulletin for June/July 2019 and oral update on the Community Services Redesign.	
TB/19/127	STP Workstream – Mental Health All Age Transformation Progress	
	Mr Edwards presented a review of the Mental Health All Age Transformation Programme Stage 4. He gave a brief re-cap of the Programme's work to date, the Model, and the moving to the Trialling and Implementation phase between November 2019 and March 2022.	
	Significant risks highlighted were: - Affordability of the Model - Organisational Development work for staff to "hold" the Model - Consultation timeline	
	Mr Farmer asked if there would be a target for how quickly non-urgent patients were reviewed, and would Healthwatch be involved in future Programme work. Mr Edwards replied that there were different waiting times for diagnoses but the national standards were the aim. He then confirmed that Healthwatch was due to meet soon as part of the engagement work of the Programme.	

		ACTION
	Dr Elcock was unclear as to medical sign-off of the model and so this was a possible risk to the development of the care pathways. Mr Edwards stressed that the model was not yet fixed and testing gave opportunities to alter it. Ms Hillery re-iterated that clinical buy-in was key as was clear communications. Professor Harris supported this with a view that there was a risk around moving mind sets from "old" to "new" ways of working. The organisational development was critical. He then enquired as to what was Plan B if the Model was unaffordable. Mr Edwards responded that the iteration approach gave scope for matching any model to affordability.	
	Ms Cecchini described the Programme as a very exciting prospect for positive change. The Inpatient unit re-design should complement the Programme and the business case for this work was coming to the Board for 1 October 2019. She highlighted a risk in the expectation for performance improvement and that development should be seen to be starting.	
	Mr Rowbotham asked when the Programme business case was coming back to the Board. Ms Hillery responded that the case would be back with clarity over priorities. Ms Cecchini expanded that the clarity was needed for the pre-consultation business case timeline and this would be considered by the Executive Team. Confirmation of Commissioners buy-in was also key.	**DC**
	Mr Edwards raised the risk around workforce supply of nursing staff. The Chair stated that there was a need to ensure the Programme Board's risk register was linked to the Corporate Risk Register. Additional risks highlighted by the discussion were performance and productivity during the change, workforce supply (particularly for mental health nurses) patient and staff engagement	**HT**
	The Chair thanked Mr Edwards for the presentation today.	
	Resolved: The Trust Board received the update of progress for the Mental Health All Age Transformation Programme.	
TB/19/128	Equality & Diversity annual report including WRES	
	Mr Ahmad presented the Annual Equality Report for the period April 2018 to March 2019 that also encompassed the Annual Workforce Equality Report, the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) Reports. The Gender Pay Gap (GPG) main findings were included in the Workforce Equalities Report however the detailed GPG Report would be presented at a future meeting. It was explained that the statutory deadline for GPG reporting was March 2020, which the Trust would meet.	

		ACTION
	The reports presented aimed to fulfil the Trust's duty to publish information regarding the protected characteristics of its employees, whilst ensuring that the Trust also had 'due regard' to the aims of the Equality Act with respect to its workforce by using this equality monitoring information in decision-making and planning. The WRES and WDES, in particular, were mandated in the NHS standard contract, as was the need to meet the Public Sector Equality Duty.	
	Mr Ahmad stressed that scaling-up of current programmes was key, and to give financial support to some programmes of work so they had "legs".	
	Mr Hussain has been attending the BME staff network meetings and has championed both race and disability equality around the Trust. He has met with over 30 staff as part of focus groups or 1:1 discussions. Staff have raised concerns about the discrimination they have experienced from colleagues in the Trust. Mr Hussain had passed on these concerns to Ms Willis and the Chair who have encouraged him to speak up on behalf of staff at the Board. They have emphasised their personal commitment to the zero tolerance campaign that is currently active.	
	The Chair thanked Mr Ahmad for his leadership of this work, and for the exemplary programmes being put in place with benefits being seen already.	
	Key points made were: - Lived experiences feedback was not that positive - Medical staff could influence behaviours as clinical leaders - The report was very helpful feedback to the "our future our way" cultural programme - Benchmarking was a blunt instrument we should work to improve our collection of the pertinent data - Many senior grade staff were not declaring their disabilities	
	It was agreed that Directors acting as sponsors for specific protected characteristics should be considered.	**SW**
	Ms Hillery concluded that the Equality and Diversity agenda was really valued and the "lived experience" feedback was challenging. Listening with understanding and acting was paramount. The Chair added that the risk identified is the impact of disengaged staff on the quality of patient care. She restated her vision for LPT to be a place where everyone feels welcome.	
	Resolved: The Trust Board **1. Received assurance that the Trust was meeting its statutory duties under the Equality Act 2010 and contractual requirements to publish certain information on the equality**	

		ACTION
	profile of its workforce. **2. Agreed to the actions highlighted in the WRES and WDES Action Plans included in the information pack.** **3. Approved the equality information including the Trust's WRES and WDES reports and action plans for publication, in line with our statutory duties.**	
	Performance and assurance reports	
TB/19/129	Joint Quality Assurance Committee (QAC) and Finance and Performance (FPC) highlight report 18 June 2019	
	This was the inaugural joint meeting of QAC and FPC and significant pieces of work benefitting oversight assurance from a joint committee were identified. Key risk areas were: • dormitory accommodation • quality impact assessment process • waiting times. The joint committee would meet on a quarterly basis with the next meeting being held in September. The efficacy of the Joint Committee would be reviewed in six months to see if it should be stood-down or not.	
	Resolved: The Trust Board received the Joint QAC and FPC highlight report for June 2019.	
TB/19/130	Quality Assurance Committee (QAC) highlight reports, 21 May 2019, 18 June 2019, 16 July 2019	
	Mrs Rowbotham presented the Highlight reports and pointed to the issue of maintaining momentum for the CQC Action Plan "should dos". Policies management and their monitoring had concerns and a review of the ways of working of the QAC sub-groups was underway. Finally a Red assurance for the BAF/CRR had been assessed based on the fact that due to the current development work in this area the risks had not been presented for review. Key risks highlighted were: • Progress on the CQC action plan • Sub-committee structure which was being addressed by implementing a new quality governance structure with a paper coming to 30 August 2019 Board • Health and Safety inspection in September 2019 • Infection control visit by NHS Improvement in August 2019	
	Resolved: The Trust Board received the QAC highlight reports for May, June and July 2019.	

		ACTION
TB/19/131	Finance and Performance Committee (FPC) highlight reports, 21 May 2019, 18 June 2019, 16 July 2019	
	Mr Rowbotham presented the papers and drew the Board's attention to matters of importance. There were concerns over not meeting some national targets and in-depth reviews were now scheduled.	
	Mrs Rowbotham asked how the reoccurring data quality themes were being addressed. Ms Cecchini felt that closer alignment of data quality to the Performance Management Framework and Integrated Quality and Performance Report (IQPR) would help. A more strategic approach to data quality was underway in FPC. Mr Rowbotham was unclear as to whether the data quality issue was a singular issue or systemic. The kite marking of data quality information is being implemented and would assist with the analysis. The Chair noted that the risk was the pace around data quality improvement and being clear as to what we wanted to see as being different in six and twelve months time. Other key risks highlighted were: • The financial position which was being addressed by the early development of a recovery plan • Waiting times for 2 out of 6 national standards not being met • Estates and facilities management responsiveness • New work being undertaken as Eating Disorders regional lead • The electronic patient record switchover from Rio to SystmOne for mental health services in 2020	
	Mr Farmer asked for more detail about the Eating Disorder Service developments. Ms Hillery explained that there was potential for Provider Trusts to collaborate in the East Midlands region for Eating Disorders and LPT was bidding to be the regional lead for this service.	
	Resolved: The Trust Board received the FPC highlight reports for May, June and July 2019.	
TB/19/132	Finance Report – Month 3	
	Ms Cecchini presented paper K that outlined the financial position for the period ended 30 June 2019 (month 3). The progress was significantly off-plan with a £3m operational overspend. A draft Financial Recovery Plan had been presented to the Executive Team on 29 July 2019 and agreement for more internal focus for savings such as with Agency staff. Ms Newham had suggested and would now be reviewing all Agency Healthcare Support Worker requests for the short-term as this had been identified as a "hot spot". Ms Cecchini was looking to all for inventive ways of delivering Step Up to Great whilst achieving our cost improvement targets. However whatever scheme was suggested would be considered in the context of being counter-intuitive to quality of care or not. Mr Rowbotham felt the	

		ACTION
	scale and size of the financial recovery were needed given the current position. The outcomes of the Step Up To Great priorities would be underpinned by financial sustainability. Ms Cecchini responded that careful considerations were needed but to give perspective the 1% gap for savings target was not the largest in the NHS.	
	Mr Hussain fed back that from his boardwalks he had detected a sense of nervousness about the cost savings challenge from staff. Ms Cecchini felt that some "change" savings were still possible in the Trust so avoiding the "more with less" approach. Mrs Rowbotham whilst assured about the process for quality impact assessment of proposed savings needed to know this approach was applicable to the financial recovery proposals and this was confirmed by the Executive Directors.	
	Ms Hillery commented that having a Turnaround approach and use of benchmarking information would help along with a consideration to the complexity of layers of management in some service areas.	
	Ms Cecchini confirmed that we would be managing capital expenditure within the local NHS system Capital Control Levels.	
	It was agreed that a risk should be articulated for the Recovery Plan and the Plan should be brought to the Board accompanied with the quality impact assessments.	**DC**
	Resolved: The Trust Board received the Finance Report for the period ended 30 June 2019.	
TB/19/133	Integrated Quality and Performance (IQPR) Report	
	Ms Cecchini presented the IQPR and reminded the Board that the Trust was in the NHS Providers Segment 3 category of "challenged Trust" for oversight scrutiny.	
	There was discussion around the possible format of a revised IQPR document. It was important that there should be only a single version of the performance position despite reporting against many requirements and to multiple organisations. Ms Geddes added that it will need to cover both national targets and Trust Step Up To Great priorities. Ms Newham emphasised the benefit of triangulation by having current multiple reporting by staff held in just one place. Narrative could then focus upon exceptions. The risks at this time were a lack of data triangulation and potential data inaccuracies through data quality.	
	Resolved: The Trust Board received the Integrated Quality and Performance Report.	
TB/19/134	Audit and Assurance Report highlight report 5 July 2019	

		ACTION
	The key lack of assurance from the report concerned a lack of traction for the completion of internal audit follow-up report actions. The Executive Team had considered the matter on 29 July 2019 and agreed measures to further strengthen the process.	
	Resolved: The Trust Board; received the Audit and Assurance Committee highlight report for 5 July 2019.	
TB/19/135	Strategic Workforce Group highlight Report 10 July 2019	
	Mrs Willis introduced the highlight report and commented that the core mandatory training requirements for the Trust were set very high with 29 mandatory training topics and this was under review and will be benchmarked with mother trusts. Bank staff training compliance was also a focus but the risks was being managed carefully so as to avoid disruption with workforce supply. Ms Bilsborough enquired if we were tracking the non-compliance of Bank staff mandatory training as this has impact on the levels of Agency staff usage. Mrs Willis undertook to ensure that analysis was happening so that the level of risk could be monitored by services.	**SW**
	Resolved: The Trust Board received the SWG highlight report for 10 July 2019.	
TB/19/136	Mental Health Act Assurance Committee highlight report 11 June 2019	
	Mr Hussain reported that the focus of meeting had been around future quality governance arrangements and that a paper was due to the 30 August 2019 Trust Board.	
	Resolved: The Trust Board received the Mental Health Act Assurance Committee highlight report for 11 June 2019.	
TB/19/137	Charitable Funds Committee highlight report 9 July 2019	
	The Chair presented the report and explained that the committee was paying careful attention to the forecasting of cash flow around both regular income and expenditure.The committee was keen to support projects which improved patient or staff experience and commit funds for appropriate spend. For the year ahead the cahirty was focusing on improving patient gyms and gardens. Raising of the Charity's profile at the Trust's premises, particularly community hospitals, was needed and the new website would facilitate improvement of awareness.	
	Resolved: The Trust Board received the Charitable Funds Committee highlight report for 9 July 219.	

		ACTION
	Quality improvement and compliance reports	
TB/19/138	Quality Improvement Plan	
	Ms Newham presented the Quality Improvement Plan the purpose of which was to provide an overarching framework that identifies the key Trust priorities for driving improvement within the organisation. Underpinning the plan was a framework of Quality Improvement methodology and the proposal for a Quality Improvement resource to support staff in the delivery of this plan.	
	Following discussion the following key risks were identified: - the resources for the Programme Management Office were not yet secured - Healthwatch had not been engaged in creating the plan and were keen on co-production. Ms Newham responded that the Step Up To Great bricks were the "what" at this point and had a strong correlation to the CQC report. Healthwatch's input was very much wanted for the next stage of development. - Lack of staff awareness in some areas of the Trust of Step Up To Great and understanding what the bricks meant. Ms Hillery stressed that more communication was needed so that staff can connect the trust priorities with their own work. - Funding of the programme of work	**AH**
	Ms Hillery concluded that that what we were trying to achieve by when for the Quality Improvement Plan was not developed fully but the Board was receiving the report today for progress.	
	Resolved: The Trust Board received the progress in the development of the Trust Quality Improvement Plan and supported the next steps in finalising and delivering the plan.	
TB/19/139	Care Quality Commission Progress Update	
	The CQC report published in February 2019 relates to the inspection dated 19th November 2018 to 13th December 2018. The report describes the CQC's judgement of the quality of care provided with respect to the Trust's well led framework and an inspection of five of our core services. The CQC issued a Warning Notice to the Trust on the 30th January 2019.	
	Ms Newham presented the report and confirmed that the Trust continued to make progress against the CQC inspection action plan however the pace had slowed. The Trust was taking a number of steps	

		ACTION
	to ensure that traction was maintained with the delivery of the CQC action plan, and in particular, provide support for action owners where any difficulties may exist.	
	Mr Rowbotham asked about the understanding of why the pace had slowed. The Executive responded that some actions needed financial backing, others were complex for delivery, and the workload in Adult Mental Health inpatient wards had been very busy clinically over the last ten weeks. The key risk highlighted here was the pace of delivery. The oversight group, led by Ms Newham agreed to chase evidence so that actions could be signed off as completed on a timely basis.	
	Resolved: The Trust Board received the Care Quality Commission Progress report and took assurance that work to implement actions was progressing.	
TB/19/140	Safe Staffing June 2019 Review	
	The report provided an overview of the nursing safe staffing during the month of June 2019, triangulating productivity, workforce metrics, quality and outcomes linked to Nurse Sensitive Indicators (NSIs) and patient experience feedback. Part one referred to inpatient areas and part two related to community teams.	
	Ms Newham informed the Board that she was now signing-off Health Care Agency worker emergency staffing requests.	
	Mr Farmer fed back that Healthwatch had received reports of a "hotspot" for staffing in Charnwood Community Mental Health teams (CMHT). Risks were being only just managed and the time to appointments was lengthening. Ms Thompson responded that whilst specialist mental health teams had received funding boosts from central government the CMHTs had not even though they were the "bread and butter" of our community service provision. At this time to assist the Charnwood CMHTs temporary internal funding had been released to provide two Health Care Support workers to each of the teams and some additional Peer support worker resource.	
	Ms Rowbotham enquired about the impact on patient groups for the potential decommissioning of elements of the Healthy Together service. Ms Thompson responded that no decommissioning route could be followed without the impact on patient groups being considered. If the quality impact assessment had uncomfortable findings then risks would be raised. The Chair was particularly concerned about the Early Start service and the impact on vulnerable young mums. The proposal to allocate cases to other Public Health nurses (Health Visitors) needs to take account of the complexity and high risk nature of the intensive work undertaken by the Early Start service.	

		ACTION
	The Chair expressed concern over public statements being made by the Clinical Commissioning Group in announcing the "repurpose" of a ward in the Hinckley and Bosworth Community Hospital. This was very unsettling for staff. Senior staff support for such situations was key. She then summarised key risks alerted to in the report following the Board discussion as pertaining to the staffing gaps, hotspots and ensuring key mitigations were in place.	
	Resolved: The Trust Board received assurance that processes were in place to monitor and ensure the inpatient and community staffing levels were safe and that patient safety and care quality were maintained.	
TB/19/141	6 Monthly Safe and Effective Staffing review	
	The paper provided a progress update following the January 2019 staffing review and outlines the national overview including the NHSi workforce safeguards recommendations and NQB guidance. The report also highlighted any emerging risks and their impact on the Trust.	
	All NHS Trusts are required to deploy sufficient, suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively, National Quality Board (NQB) 1 , Safe sustainable and productive staffing.	
	Resolved: The Trust Board received assurance that processes were in place to ensure compliance with the NQB and Developing Workforce Safeguards policy.	
TB/19/142	Biannual Freedom to Speak Up Guardian (FTSUG) Report	
	Ms Lewitt presented her report update as the Trust's FTSUG on progress and the ongoing plans for strengthening arrangements for staff to speak up creating effective speaking up systems, and processes that help to protect patients and improve the experience of NHS workers.	
	A breakdown was provided on the speaking up figures raised with the FTSU Guardian during the period January 2019 – June 2019. The report also highlighted updates from the National Guardians Office.	
	Ms Lewitt commented that robust and immediate communications around a recent "difficult matter" had been much appreciated by staff. The message had been clear that such issues would be dealt with by the Trust.	
	Ms Hillery concluded that the Trust very much wanted staff to speak up if needed and also to see the numbers of anonymous reporting-in to fall. The priority was to ensure the FTSUG's work was embedded in the	

		ACTION
	Trust and this will be enabled by mainstreaming the work of the FTSUG.	
	Resolved: The Trust Board received the Biannual Freedom Speak Up Guardian Report and : 1. Noted the progress made in respect of strengthening the FTSU arrangements and plans for on-going development of this work. 2. Supported the current mechanisms and activities in place for raising awareness of the FTSU agenda. 3. Approved the proposed next steps to maintain momentum and embed FTSU in a culture of openness and transparency within the Trust.	
TB/19/143	Annual Report on Medical Appraisal and Revalidation	
	Dr Elcock introduced the paper that was an annual report to the Trust on progress in implementing and managing appraisal and revalidation for doctors that had a prescribed connection to the Trust. The report provided an overview of the elements defined in the Responsible Officer regulations.	
	Dr Elcock confirmed that the medical appraisal and revalidation systems and processes were well established in LPT, and that the Trust was compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).	
	Resolved: The Trust Board approved the report and authorized the signing of the "statement of compliance" confirming that the organization, as a designated body, is in compliance with the regulations.	
	Governance and Risk	
		ACTION
TB/19/144	Performance Management and Accountability Framework progress update	
	Ms Cecchini updated the Board on the development of the Performance Management and Accountability Framework. Ms Geddes had provided very helpful links to the work in this area being undertaken at another NHS Trust. The aim of the review was very much to have an outcome of a fit for purpose Framework. Initial performance review meetings had been set up for Services and Enabling functions as part of the development. Oversight would be from the Executive team and assurance to the FPC.	
	Resolved: The Trust Board received the progress being made towards the development of the Performance Management and	

		ACTION
	Accountability Framework.	
TB/19/145	Board Committees' annual reports 2018-19	
	Following the Well-Led review outcome from the CQC inspection in 2018 there had been a series of reviews of the LPT governance arrangements. The reports by committees in the Paper presented by Mr Lusk reflected the 2018-19 look back "as was" and forward plans as known at the time of authorship of the papers.	
	A Board development session on 30 August 2019 will have presented to it the outcome of a current review of the approach to Quality Governance by the Director of Nursing and Chief Executive. This will strengthen the committee structure reporting into the Quality Assurance Committee.	
	Resolved: The Trust Board reviewed and approved the Board Committees' annual reports 2018-19 and approved the amendments to the Terms of Reference.	
TB/19/146	Review of Risk Board members felt the following should be re-considered in light of the current Board discussions: • Finance Risk • STP Governance • CQC compliance • Equality and Diversity	
TB/19/147	Receipt of documents for information	
	Resolved: The Trust Board confirmed receipt of; • **Documents Signed Under Seal Q4 2018-19 and Q1 2019-2020** • **Mental Health Act Annual report** • **WRES Action Plan** • **Disability Confident Employment – Self-assessment Level 2** • **CQC Action Plan**	
TB/19/148	Any other Business	
	There was no other business.	
TB/19/149	Public questions on agenda items	
	Mr Fisher requested to feedback to the Board his views on some aspects of the Trust's healthcare provision. The Chair agreed and Mr Fisher gave his views on the topics below:	

		ACTION
	- Variable quality of food in inpatient wards - Disquiet at use of shared accommodation in patient wards and the priority for privacy and dignity of patients - Poor discharge care planning - The need for more effort in explaining MHA Section paperwork to patients - For the Trust to push on at pace for resolving the CQC actions	
	Mr Fisher was thanked for his time in attending the Board meeting and consideration to the matters raised.	
TB/19/150	Date of next meeting	
	The next public meeting would be held at 9.30 am on Tuesday 1 October 2019 at County Hall.	

B

Leicestershire Partnership NHS Trust

TRUST BOARD 1 October 2019

MATTERS ARISING FROM THE PUBLIC TRUST BOARD MEETINGS

All actions raised at the Trust Board will be included on this 'Matters Arising action list' master. This will be kept by the Assistant Trust Secretary. Items will remain on the list until the action is complete and there is evidence to demonstrate it.

Each month a list of 'matters arising' will be provided with the Board papers, for report under this item. The list will not include where evidence has been provided (and therefore can be closed). Red = incomplete, amber = in progress, green = complete

Action No	Meeting month and minute ref	Action/issue	Lead Officer	Due date	Outcome/evidence (actions are not considered complete without evidence)
893	July TB/19/127	All-age mental health transformation: Clarity was needed for the pre-consultation business case timeline and this would be considered by the Executive Team. Confirmation of Commissioners buy-in was also key.	Dani Cecchini	1 October 2019	
894	July TB/19/127	All-age mental health transformation: There was a need to ensure the Programme Board's risk register was linked to the Corporate Risk Register.	Helen Thompson	1 October 2019	The All Age Transformation Programme risks have been reflected in the overarching BAF risk as part of the BAF and CRR review.

Action No	Meeting month and minute ref	Action/issue	Lead Officer	Due date	Outcome/evidence (actions are not considered complete without evidence)
895	July TB/19/128	It was agreed that Directors acting as sponsors for specific protected characteristics should be considered.	Sarah Willis	1 October 2019	Discussed at Equalities, Diversity and Inclusion group in September and now action with Equalities Lead.
896	July TB/19/132	Risk to be logged for the Financial Recovery Plan and the Plan to be presented to the Board accompanied with the quality impact assessments.	Dani Cecchini	1 October 2019	
897	July TB/19/135	Tracking the non-compliance of Bank staff to mandatory training was needed.	Sarah Willis	1 October 2019	This goes to Strategic Workforce Group bank staff compliance report.
898	July TB/19/138	Step Up To Great: further communication was needed to help staff connect the Trust priorities with their own work.	Angela Hillery (Head of Communications action)	1 October 2019	SUTG Comms plan presented to the Executive Ops team 16.9.19 having had CEO input.

Ci

LPT Chair's report summarising activities and key events which are part of our STEP up to GREAT journey:

Trust Board 1st October 2019

The period covered by this report is from 30th July 2019 to 30th September 2019

Hearing the patient and staff voice	• Chair 4 boardwalks to District Nursing (Hinckley), Wards 1 and 2 at Coalville Hospital, CAMHS ward 3 and Paediatric Occupational Therapy at Hinckley • Non-Executive Directors 10 boardwalks to: o FYPC - CAMHS Ward 3, Health Visiting/School Nursing Blaby o CHS- District Nursing in 4 bases : City, Rutland, East-South and Charnwood/Loughborough o AMH/LD - Arts in Mental Health, Community Mental Health Team West Leicestershire, Outreach team, LD Occupational Therapy
Connecting for Quality improvement	• "Tightening the Bolt" event for the CAMHS new building on the Glenfield site with stakeholders, patients and staff, the new unit opens in August 2020 • "Lets Get Gardening" visited all ward gardens that had entered the competition. Great to see fantastic patient and staff engagement to create better environments - winners were Phoenix ward. • Launch of the newly refurbished Involvement Centre & Cafe at the Bradgate Unit • LPT / NHFT Buddy meeting with good progress being made on focus areas : quality governance, mental health clinical review, CQC support, communications.
Promoting Equality Leadership & Culture	• Ashiedu Joel joined LPT as part of the NHSI Next Director development programme for aspiring Non-Executive Directors – Ashiedu observed Quality Assurance Committee, Finance & Performance Committee • Two Reverse Mentoring meetings with my Mentor, Mariam Dindar. Great to discuss ideas to improve patient experience and staff experiences of working in LPT • Mentoring meeting with an Aspirant Chair
Building strong Stakeholder relationships	• Briefing with Health & Safety inspectors prior to inspection on 18/19 September • CQC engagement meeting to review LPT progress • NHSI System Improvement & Assurance Meeting to review LPT progress • Productive meeting with City Mayor Sir Peter Soulsby, Chair of Health & Wellbeing Board Cllr Vi Dempster, Strategic Director Social Care & Education Steven Forbes and Director of Public Health Ivan Browne . We discussed better stakeholder engagement from LPT and areas of work where we had common objectives • LLR STP multi-agency Partnership Board meeting to review the draft STP long term plan • Meeting with new Accountable Officer for the CCGs and STP lead, Andy Williams • University of Leicester : Finance Committee meeting and meeting with the new Chair of Council Gary Dixon
Good Governance	• Board development session on 30th August focused on risk, statistical process control charts, quality improvement and patient involvement • Observed NHFT Public Board in September • Attended Quality Assurance Committee, Finance & Performance Committee • Mental Health Act Managers annual appraisals

Abbreviations:

LLR = Leicester, Leicestershire & Rutland; **STP** = Sustainability and Transformation Partnership; **NHSI** = NHS Improvement who give regulatory oversight & support improvement of NHS provider trusts; **CQC** = Care Quality Commission; **UHL** – University Hospitals of Leicester; **NHFT** – Northamptonshire Helathcare Foundation Trust; **CCG** – Clinical Commissioning Group; **FYPC –** Families Young Persons and Children's services**; CHS –** Community Health Services**, AMH –** Adult Mental Health Services; **CAMHS** – Children's and Adolescents Mental Health Services; **LD** - Learning Disability

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NHS
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NHS Trust

2020 TRUST BOARD MEETINGS

Date	Meeting type	Meeting format	Venue
Tuesday 14 January - 9.30am	Core business	Public Board Confidential Board meeting/board development	TBC
Tuesday 4 February - 9.30am	Board development/ Strategic thinking time	(plus any urgent confidential business including finance report, reportable issue log, IQPR)	TBC
Tuesday 3 March - 9.30am	Core business	Public Board Confidential Board meeting/board development	TBC
Tuesday 7 April - 9.30am	Board development/ Strategic thinking time	(plus any urgent confidential business including finance report, reportable issue log, IQPR)	TBC
May TBC – subject to year end financial timetable	Core business and Extraordinary confidential meeting (to receive annual accounts)	Public Board Extraordinary Confidential meeting (part 1) Extraordinary Confidential meeting (part 2)	TBC
Tuesday 2 June - 9.30am	Board development/ Strategic thinking time	(plus any urgent confidential business including finance report, reportable issue log, IQPR)	TBC
Tuesday 7 July - 9.30am	Core business	Public Board Confidential Board meeting/board development	TBC
Tuesday 4 August - 9.30am	Board development/ Strategic thinking time	(plus any urgent confidential business including finance report, reportable issue log, IQPR)	TBC
Tuesday 1 September - 9.30am	Core business	Public Board Confidential Board meeting/board development	TBC
Tuesday 6 October - 9.30am	Board development/ Strategic thinking time	Public Board Confidential Board meeting/board development	TBC
Tuesday 3 November - 9.30am	Core business	Public Board Confidential Board meeting/board development	TBC
Tuesday 1 December - 9.30am	Board development/ Strategic thinking time	(plus any urgent confidential business including finance report, reportable issue log, IQPR)	TBC

Notes –

- In each 6 month period, this gives 3 public meetings, and added development time for wider ranging strategic discussion in which to focus on key challenges.

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NHS
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NHS Trust

NON EXECUTIVE DIRECTOR APPOINTMENTS AND DUTIES
as at October 2019

Role	Non-Executive
Deputy Chair	Geoff Rowbotham
Senior Independent Director	Darren Hickman
Audit and Assurance Committee (A&AC) *Membership = 3 NEDs* *Quoracy = 2 members*	Darren Hickman (Chair) Liz Rowbotham Geoff Rowbotham
Remuneration Committee *Membership = all NEDs except A&AC Chair* *Quoracy = 2 members*	Ruth Marchington (Chair) Liz Rowbotham Geoff Rowbotham Kevin Harris Cathy Ellis Faisal Hussain
Charitable Funds Committee (CFC) *Membership = 2 NEDs* *Quoracy = 1 NED, 1 senior manager*	Cathy Ellis (Chair) Ruth Marchington
Quality Assurance Committee (QAC) *Membership = 3 NEDs* *Quoracy = 3 members, including 1 NED*	Liz Rowbotham (Chair) Ruth Marchington Kevin Harris
Finance and Performance Committee (FPC) *Membership = 2 NEDs* *Quoracy = 4 members, including 1 NED*	Geoff Rowbotham (Chair) Faisal Hussain
Mental Health Act Managers team meeting	Cathy Ellis
NED Champions	
Equality & Diversity / Staff Health & Wellbeing	All to champion
Better Care Together / Sustainability & Transformation Partnership Group	Cathy Ellis
UNICEF Baby Friendly Guardian	Cathy Ellis
Information governance	Cathy Ellis
Leicester University nominated NED	Kevin Harris
Resilience reporting	Darren Hickman
Freedom to Speak Up	Darren Hickman
Workforce Race Equality Standard (including BAME network) and Workforce Disability Equality Standard	Faisal Hussain
Carter programme / Procurement	Geoff Rowbotham
Mortality Governance	Liz Rowbotham
End of Life Care	Liz Rowbotham
Other activities	
Board walks to visit services	All (minimum 8 per year)
Serious Incident investigations	All NEDs by rotation for Level 2 SIs
HR related employee appeals	By exception
Consultant interviews	Cathy Ellis or NEDs

Wording in italics is specified in current terms of reference

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board 01.10.2019
Paper number	Di

Name of Report: CEO Environmental Scan

For approval		For assurance		For information	Yes

Presented by	Angela Hillery, CEO	Author (s)	Angela Hillery, CEO

Alignment to CQC domains:		Alignment to the LPT strategic objectives:		Alignment to LPT priorities for 2019/20 (STEP up to GREAT):	
Safe		Safe	Y	S – High Standards	
Effective		Staff	Y	T - Transformation	Y
Caring		Partnerships	Y	E – Environments	
Responsive		Sustainability	Y	P – Patient Involvement	
Well-Led	Y			G – Well-Governed	Y
				R – Single Patient Record	
				E – Equality, Leadership, Culture	Y
				A – Access to Services	Y
				T – Trustwide Quality improvement	Y
Any equality impact (Y/N)		N			

Report previously reviewed by	
Committee / Group	Date
N/A	

Assurance : What assurance does this report provide in respect of the Board Assurance Framework Risks?	Links to BAF risk numbers

Recommendations of the report
The Board is asked to receive the report for information only. The report provides an update on areas of focus locally, regionally and nationally.

September 2019: ENVIRONMENTAL SCAN

National

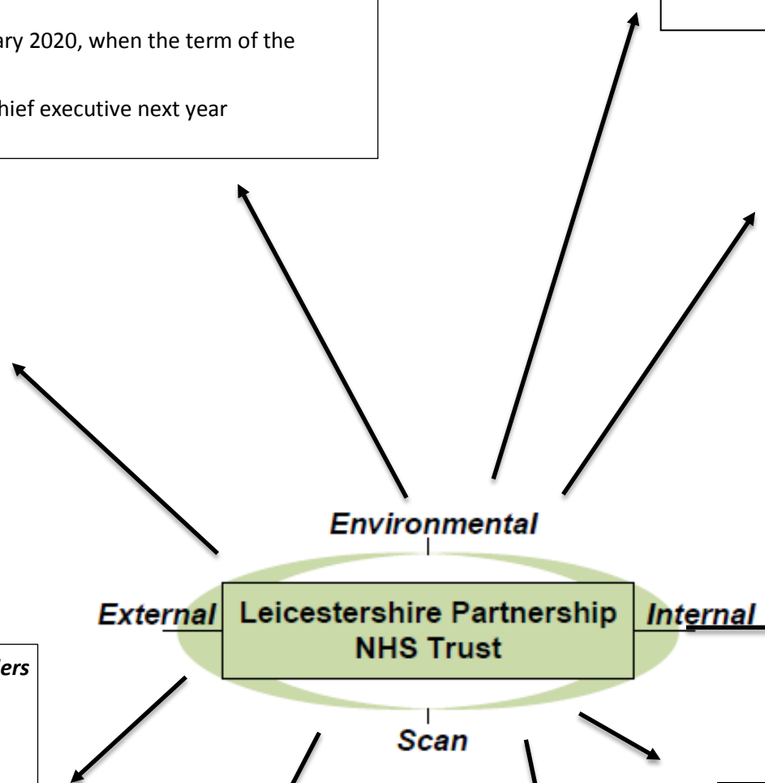
- The Single Oversight Framework (introduced in 2016) is being replaced by the NHS Oversight Framework covering both providers and clinical commissioning groups.
- Reducing the NHS's carbon footprint: Simon Stevens, Chief Executive of NHSE/I, and Andy Burnham, Mayor of Greater Manchester, have announced plans for NHSE/I and Greater Manchester to work together to reduce the NHS's Carbon Footprint
- NHS England and NHS Improvement have appointed Professor Em Wilkinson-Brice to the role of Deputy Chief People Officer.
- Sir Ron Kerr will take over as the next chair of NHS Providers on 1 January 2020, when the term of the current chair, Dame Gill Morgan, ends
- Sir Andrew Dillon has announced his intention to stand down as NICE chief executive next year

Regional

- Draft submission of the Better Care Together Five Year Plan is being produced for the end of September 2019, prior to a final submission by 15 November 2019
- East Midlands strategic event: Understanding Mental Health in the Long Term Plan – 6th Sept
- Development of New Care Models, LPT are lead for Eating Disorders in the East Midlands and supporting Forensics and CAMHs
- Derbyshire Community Health Services NHS Trust received outstanding CQC rating
- Transforming care; Learning Disabilities is subject to regional escalation within LLR

Local Stakeholders

- Strategic Partnership Board & Violence Reduction Unit Senior Leaders Workshop: 6th August 2019
- Meeting with Chief Constable, Simon Cole
- Visit to Bradgate Unit from Police & Crime Commissioner
- Attendance at Health & Wellbeing Scrutiny Committees – Update on regulatory assurance
- Attendance at Primary Care Network events/meetings
- Engagement with Council/MPs regarding PCN/CRSs and All Age Transformation



Board of Directors

- Risk Assessment Board Development Session took place on 30th August, next session will be focusing on CQC preperation
- Appointment of interim Adult Mental Health Director, Gordon King and general continued support via buddy relationship
- Introduction of revised Executive Meetings and introduction of Quality Improvement Board
- Health & Safety Executive Visit – 18th/19th Sept

Organistational Development

- Cultural change: Our future our way' – Synthesis complete 9 key themes identified
- Development of revised Trust vision underway change champion involvement
- Re-launch of the senior leadership briefings commenced in September
- Equalities - WRES – Sessions on race and cultural awareness training have been undertaken with divisional senior management teams and positively received, unconscious bias training and interview skills training commenced.
- Rainbow badge campaign extended and sponsorship secured for further badges which has been very well supported
- LPT staff celebrated the Leicestershire Pride event

Directorate Focus: FYPC

- Healthy Weight Service transferring to the County LA 1st October.
- CAMHS In-patient new building event – Friday 20th Sept
- Electronic Consent for this year's Immunisation Programmes now live
- Leicester City 0-19 Healthy Child Programme Soft Market Testing work underway

Directorate Focus: CHS

- CSR management of change process commenced wc 23 Sept (as plan)
- Initial meetings held with City and County PCN Accountable Clinical Directors to commence relationship building as co-providers of the CSR model
- Singapore delegation visited Neville Centre to observe health and care integrated model and ways of working

Directorate Focus: AMH/LD

- Out of Area Recovery Plan developed and programme management in place and seeing significant reduction in OOAPs
- Mobilisation of Crisis Recovery and Home Treatment Team expansion underway
- Secured £532k Core 24 liaison transformation funding from April 2020
- LD and Autism Transforming Care Partnership have developed a recovery plan

EM Research/Innovation

- LLR Academic Research and Innovation Liaison Group has been established to promote research and innovation across LLR which is aligned to the priorities of a local integrated care system and designed to improve the health and care of LLR. Prof Susan Corr represents LPT on this group.
- **Pre–doctoral Clinical Academic Fellowship**: There were 10 applicants from East Midlands, including 4 from LPT, into the NIHR (National Institute for Health Research) for the pre–doctoral Clinical Academic Fellowship for Nurses and AHPs. Only 1 of the 10 was successful and that was FYPC's dietician Gemma Phillips (a resubmission). A great achievement for this very competitive opportunity.

Angela Hillery
Chief Executive

Service visits by Executive Directors since the last Trust Board

Board Walk Hinckley and Bosworth planned nursing team
Board Walk Coalville Ward 1 (Stroke Unit)
Board Walk District Nursing: East/South Lutterworth and Blaby
Boardwalk CAMHs Community Therapy
Boardwalk Hospice at Home Team
CAMHS at Valentine Centre
Herschel Prins Centre
Recovery College
Mill Lodge – Fruit Fly Festival
Involvement Centre at Bradgate Unit
Bed Management Team at Bradgate Unit
Early Intervention Services
PICU
Griffin Ward
ICS/District Nursing/ Therapy Team - Melton
ICS Team at Neville Centre
ICS Team at Hinckley
Feilding Palmer Hospital
Agnes Unit
CAHMS Eating Disorder at Mawton House
Beaumont Leys Health Centre - Healthy Together City - FYPC
FYPC at Bridge Park Plaza
Melton Mowbray Hospital
Loughborough Hospital
Wakerley Ward - Evington Centre

Relevant External Meetings attended since last Trust Board meeting:

AUGUST 2019	SEPTEMBER 2019
LPT/NHFT Buddy Forum	East Midlands Mental Health/Learning Disabilities CEOs
Police Strategic Partnership Board	Meeting with Mayor
LPT/PCN Provider Partnership Meeting	Chief Officers Forum
LLR Financial Escalation Meeting	
LLR UEC Escalation Meeting	
Senior Leadership Team Meeting	
Health & Wellbeing Scrutiny Committee	
Chief Officers Forum	

Trust Board Update
Quality Improvement Strategy
Step up to Great

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Our Quality Improvement Plan 2019-2021

- agreed strategic framework
- measures of improvement
- governance arrangements

Strategic Framework

Priorities	
High Standards - Improve standards of safety and quality	
Trust-wide QI - Implement a Trust wide approach to quality Improvement	
Equality, Leadership, Culture - Improve Culture equality and Inclusion	
Patient Involvement - Involve our patients, carers and families	
Well Governed - Be well governed and sustainable	
Single Patient record - Implement single electronic patient record	
Environments - Environments will be welcoming, clean and safe	
Access to Services - Make it easy for people to access our services	
Transformation - Transform our mental health and community services	

9 Strategic Priorities – make up the strategic framework and form the basis of the QIP.
4 Values - Compassion, Respect, Integrity, Trust

Trust Vision is being revised and will be co-produced with staff and patients.

Draft KPI's – due to be completed by end of September

Quality Improvement Plan - Performance on a Page 2019/2020

Reporting Period: Oct-19

Key: ↑ → ↓ Denotes movement in performance - not value

S High Standards			T Transformation			E Environments			P Patient Involvement			G Well-governed			R Single Patient Record			E Equality, Leadership, Culture			A Access to Services			T Trustwide Quality Improvement		
Measure			**Measure**			**Measure**			**Measure**			**Measure**			**Measure**			**Measure**			**Measure**			**Measure**		
Reduce the number of repeat falls by 10% Target <=83 By March 2020	2	↓	Increase rate of patients dying in preferred place of death Target: TBC% By TBC	50%	↓	Improve performance against urgent response times Target: >=75% by end 2020 Q1	56%	↓	Improve Mental Health FFT response rate in line with England average Target >= 3% By 31 Mar 2020	2%	→	Audit assurance measure against Performance Framework Target =Significant Assurance By TBC	6	→	Reduce data errors Target TBC By Mar 20	45%	↑	No deterioration in staff survey results 2019 Target >=7.0 By 2019/20 Q4	Due 2019/20 Q4	↑	Increase % of services with a demand and capacity plan Target >=75% By 30 April 2020	45%	↑	Train improvement advisors Target >=15 By TBC	6	→
Increase % of community hospitals been through one accreditation process with a second cycle planned Target = 100% By 31 Dec 2019	55%	↑	% new services meet complete wait times Target: 100% From Dec 19	Due Jan 2020	→				Acknowledge complaints within 3 days Target 100% By TBC	78%	↑	Audit assurance measure against Governance plan Target =Significant Assurance By 2019/20 Q4	6	↓				Improve staff survey results in 2020 Target >=7.1 By 2020/21 Q4	Due 2020/21 Q4	↓	Increase % of services with a service improvement plan Target >=75% By 30 April 2020	56%	↑	Proposed ambition in QI project growth Target >= 30 By end 2019/20	6	↓
Reduce clinical complaints by 10% Target TBC By end March 2020	3	↓	% attendance at MDTs Target: 100% From when CPNs are established	75%	↓				Respond to complaints within 25 days Target >= 70 % by 2018/19 Q3	0.87	↑	Improve CQC Well Led rating Target: Requires Improvement By TBC	5	↓				Improve uptake of race and cultural understanding training Target >=360 By 2020/21 Q4	5	↑	Improve specialist continence performance Target >=70% By 30 April 2020	89%	↑	Proposed ambition in QI project growth Target >=70 By end 2020/21	5	↓
10% Increase in compliance with Hand Hygiene across the Trust Target TBC By Aug 2020	2	→	Awaiting AMH KPIs	4	↑				Respond to complaints within 25 days Target >= 90 % by 2018/19 Q4	87%	↑	Increase % staff trained on new Risk strategy Target TBC By TBC	100%	↑				Increase uptake of reverse mentoring Target >=50 By 2020/21 Q4	6	→	Improve specialist continence performance Target >=95% By end 2020/21 Q1	98%	↓	Proposed ambition in QI project growth Target >=80 By 2021/22	1	↑
Increase % AMH/LD and FYPC inpatient wards been through one accreditation process Target = 100% By Dec 2020	0%	→							Increase instances of collaborative care planning Target >=40% By end 2019/20	98%	↓							Increase rate of diverse interview panels Target 100% By By 2019/20 Q3	0.36	↑	Improve CINNS performance Target >=70% By 30 April 2020	87%	↓	Proposed ambition in QI project growth Target >=80 By 2022/23	6	↓
Increase in patient and carer satisfaction (NHSI Self-Assessment Improvement Tool) Target 3 out of 5 By December 2020	2	→							Increase instances of collaborative care planning Target >=70% By end 2020/21	88%	↓							Increase rate of BAME staff receiving interview skills training Target >=30 By 2019/20 Q4	6	↓	Improve CINNS performance Target >=95% By end 2020/21 Q1	89%	↑	Proposed ambition in QI project growth Target >=80 By 2023/24	5	↓
Reduce the number of cat 2 PU's developed and deteriorated to a 3 or 4 in our care Target TBC By Dec 2019	0	→							Increase instances of collaborative care planning Target >=100% By end 2021/22	78%	↑							Decrease sickness rate Target <=4.5% By 2019/20 Q4	7%	↑	Awaiting FYPC and AMH KPIs	6	↓			
									Recruit experts by experience Target >=30 By end 2020/21	6	↑							Decrease vacancy rate Target <=10% By 2019/20 Q4	9%	↑						
									Recruit experts by experience Target >=70 By end 2021/22	7	↑							Decrease turnover rate Target 8-10% By 2019/20 Q4	11%	↑						

Quality Improvement Plan - Milestones on a Page 2019/2020

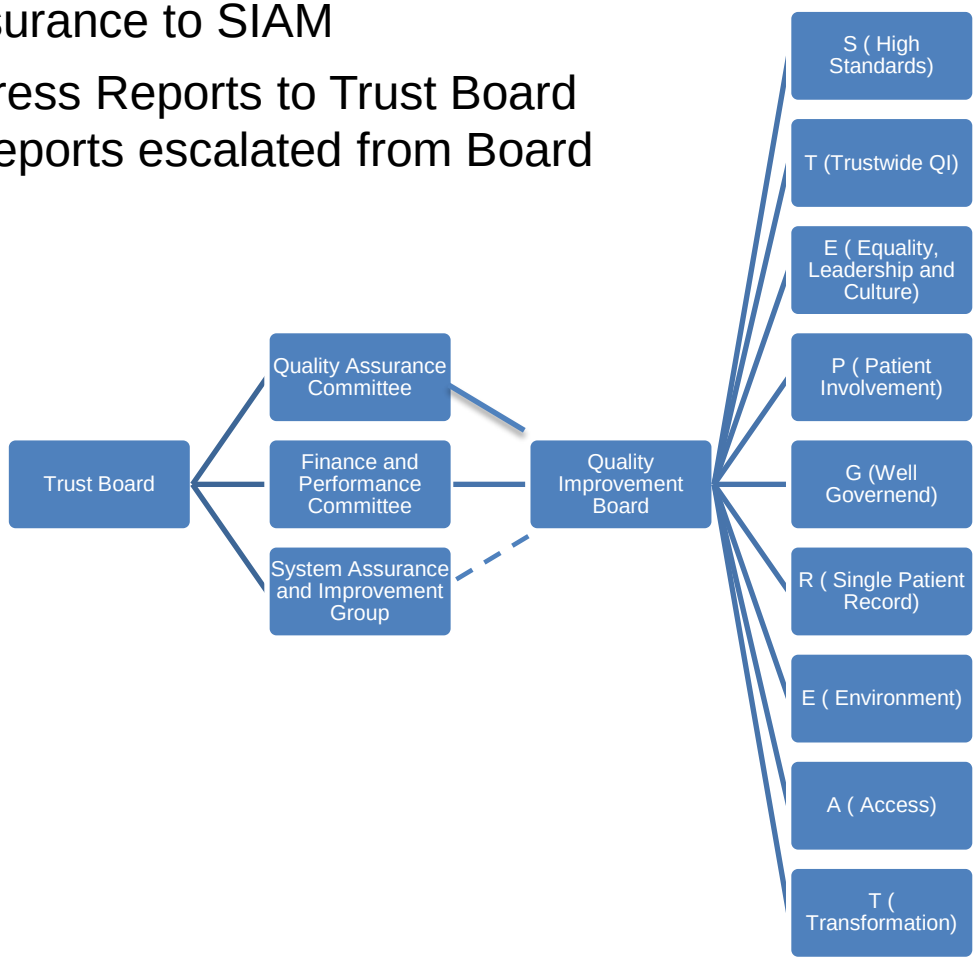
Reporting Period: Oct-19

Key:
- On target and under control
- Off target and under control
- Off target and not under control
- Not due

		S High Standards	T Transformation	E Environments	P Patient Involvement	G Well-governed	R Single Patient Record	E Equality, Leadership, Culture	A Access to Services	T Trustwide Quality Improvement
		Milestones								
2019/20	Q1							APR 19 - Launch of the discovery phase of the culture leadership programme		
	Q2				NOW - quarterly and annual reports to evidence patient feedback and thematic reviews	31 AUG 19 - Receive finance recovery plan		SEP 19 – Receive Culture Leadership Programme Board report		30 SEP 19 - QI electronic introductory resources pack published
						31 AUG 19 - Buddy arrangements in place				
						30 SEP 19 - Exec performance reviews established and embedded				
						30 SEP 19 - Receive revised BAF and CRR				
	Q3	31 DEC 19 - Increase learning from patient and carer experience and impact on the reduction of clinical complaints – benchmark baseline to be identified	DEC 19 - Implement new community services redesign model	1 OCT 19 - Provide estates strategy to Board - Year 1 detail	31 DEC 19 - Implement a patient satisfaction survey for complaints	TBC - Approve and implement Performance Framework	30 OCT 19 - confirm configuratin requirements for MHSDS	NOV 19 - Co-design solutions and formation of a new People Strategy		
		30 OCT 19 - Launch Trust-Wide real time IPC and Hand Hygiene data capture system via APP		1 OCT 19 - Bradgate Strategic Outline Case - sign off at board and kick off outline business case	31 DEC 19 - Co-produce 'Experts by experience' programme	1 OCT 19 - Risk management strategy and policy presented to Board	31 DEC 19 - Complete design phase (as-is and to-be process mapping	NOV 19 - Launch the People Strategy		31 OCT 19 - QI governance structure in place
		31 DEC 19 - Identify key pressure ulcer themes in Community Hubs based on Q1 baseline data and agree clear measurements and trajectories		NOV 19 - FM options paper and recommendations to Board		31 OCT 19 - Receive 'information flow report' recommendations				22 NOV 19 - Improvement conference
				31 DEC 19 - Estate backlog maintenance plan - 3 year plan		31 OCT 19 - Receive Trust Governance pack inc ToR				
				31 DEC 19 - Formalise disposal plan		31 DEC 19 - Service governance arrangements in place				
				31 DEC 19 - Scope costs for interim dormitory solution		31 DEC 19 - Establish reporting group and revise IQPR				
				TBC 19 - Agree escalation process with UHL						
	Q4	31 MAR 20 - Develop and implement new complaints process with a focus on learning and quality improvement	APR 20 - Develop patient outcome measures (CHS)	MAR 20 - Provide estates strategy to Board - Year 2 and 3 detail	MAR 20 - Implement real time patient experience questions pilot	31 JAN 20 - Directorate level IQPR	31 JAN 20 - Completed and sign-off system designs			TBC - Recruit Project manager and admin
		MHSOP functional wards to maintain standards of AIMS accreditation and achieve re-accreditation				TBC - Deliver CIP in line with plan				TBC - Establish QI training programme questionnaire
2020/21	Q1				APR 20 - Implement real time patient experience questions Trust wide		31 MAR 20 - Complete system configuration and sign-off			
	Q2				SEP 20 - Identify areas for concern from 2019 community mental health survey report and deliver actions to achieve national average		TBC - Single EPR Go-live			
	Q3									
	Q4									

Governance

- 9 Executive Workstream Leads – Responsible for delivery of overall workstreams,
- Report monthly on performance to Quality Improvement Board (QIB)
- Assurance reports to QAC and FPC depending on workstream with system level assurance to SIAM
- Quarterly progress Reports to Trust Board plus exception reports escalated from Board Committees.



Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board 1st October 2019
Paper number	Ei

Name of Report: Corporate Risk Register

For approval	✓	For assurance	✓	For information	

Presented by	Angela Hillery, Chief Executive	Author (s)	Kate Dyer, Head of Assurance

Alignment to CQC domains:		Alignment to the LPT strategic objectives:		Alignment to LPT priorities for 2019/20 (STEP up to GREAT):	
Safe	✓	Safe	✓	S – High Standards	✓
Effective	✓	Staff	✓	T - Transformation	✓
Caring	✓	Partnerships	✓	E – Environments	✓
Responsive	✓	Sustainability	✓	P – Patient Involvement	✓
Well-Led	✓			G – Well-Governed	✓
				R – Single Patient Record	✓
				E – Equality, Leadership, Culture	✓
				A – Access to Services	✓
				T – Trust-wide Quality improvement	✓
Any equality impact		No impact on equal opportunities			No

Report previously reviewed by	
Committee / Group	Date
Audit and Assurance Committee Workshop At this workshop, further clarification was requested regarding; - Timescales of when to expect a higher quality content and level of maturity on the BAF/CRR - The process for determining whether a risk should be included on a risk register or tolerated, particularly in the interim period before the Trust's risk appetite is confirmed.	23rd September 2019

Assurance: What assurance does this report provide in respect of the Board Assurance Framework Risks?	Links to BAF risk numbers
This report provides a summary of the Board Assurance Framework and the Corporate Risk Register, including current and residual risk scores.	Whole BAF

Recommendations of the report
The Trust Board is recommended to: • Agree the proposed current CRR • Approve the addition of a cyber security related risk (risk 22) • Agree to a future board development session on risk appetite

Trust Board of Directors – 1 October 2019

Leicestershire Partnership NHS Trust

Corporate Risk Register

Introduction

The board assurance framework and corporate risk register (CRR) is presented as part of an ongoing review process. At each meeting the Board will receive the summary CRR highlighting any risk changes and updates since the last Board. The Executive Team first regularly considers and updates the full CRR, with the Quality Assurance Committee and the Finance & Performance Committee exercising their delegated responsibility from the Board to review, update and gain assurance on their allocated risks. The CRR is then updated to reflect committee recommendations and the revised summary CRR presented to the Board of Directors for agreement.

This report is the first of this new template and cycle of risk review, and proposes the new CRR mapped against the 'step up to great' strategic framework.

Discussion

Board development session on Risk Management held 30 August 2019
A board development session on risk management was held on 30 August 2019. This included a presentation on the principles of risk management and assurance. The Board considered the revised Corporate Risk Register and Board Assurance Framework in groups to consider the risk score of those risks identified, and to ensure that there were no missing risks at this time.

Ongoing management of the Corporate Risk Register and Board Assurance Framework
A new regime is being set up to ensure that the Directors have an opportunity to review their risks on the Corporate Risk Register on a monthly basis. Following the review by the Directors, the Corporate Risk Register and Board Assurance Framework will be reviewed by the Executive Team. Once satisfied, the register will be split and presented to the Finance and Performance Committee and the Quality Assurance Committee. The Board will be provided with an update at each Board. As this is a new process, the sub-committees have not yet reviewed their assigned risks prior to presentation to the Board on 1st October 2019 and therefore, risks may be reviewed and amended following these debates. Appropriate risk owners have been identified and assigned to each risk.

Closing down the existing Corporate Risk Register held on the Ulysses system
For each of the existing risks in the Ulysses system on the previous board assurance framework and corporate risk register, these will be closed and linked to a new risk included in the revised board assurance framework and corporate risk register, or

- Closed as addressed, or
- Relegated to a Directorate Risk Register.

Strategy and Policy

A revised risk management strategy and policy has been drafted and is being presented to Trust Board on 01.10.19
This has made a number of key changes as follows:

- Create a gatekeeping process with the governance leads and risk team
- Change from a three tiered approach, to local and directorate risk registers
- Only includes risks with mitigation plans on the risk registers
- Controlled risks are stored as risk assessments (within the risk management system)
- Limited trained staff with access to the risk system

Stage 1 – Head of Internal Audit Opinion

The recent stage 1 Head of Internal Audit report did not identify any recommendations for the Trust in readiness for subsequent stages and the final reporting of the Head of Internal Audit Opinion. This is in recognition of the work taking place to refresh the CRR, the reporting and review cycle, and the revised risk management strategy and policy presented to the 1st October 2019 Trust Board for approval.

Points to note

An additional risk regarding cyber security has been identified (risk number 22). This has been included within the Well-Governed element of the CRR. This needs approval by the Executive Directors before final detail can be completed; “Financial, reputational and service delivery harm or loss resulting from information breaches and attacks on information systems”.

A further development session is planned with the Trust Board to develop the Trust’s risk appetite statement during Q4 2019/20

Proposal

Board assurance framework and corporate risk register (CRR) as at 16.09.19 (full CRR in Board information pack)

Monthly trend data will be available from 1st November 2019.

The corporate risk register was last reviewed by risk owners on 02.09.19

Risk ID	Risk Title	Risk Owner	Responsible Committee	Risk Level @ Aug	Risk Level @ Sept	Current Risk Level		Residual Risk Level
Strategic theme: S - High Standards								
1	The Trust's systems and processes for the management of patients may not be sufficiently effective and robust to provide harm free care on every occasion that the Trust provides care to a patient	DoN	QAC		16	16		12
2	The Trust's safeguarding systems do not fully safeguard patients	DoN	QAC		12	12		9
3	The Trust does not demonstrate learning from incidents and events and does not effectively share that learning across the whole organisation	DoN	QAC		15	15		10
4	Services do not have the right number of staff with the right skills at the right time	DoN	QAC		12	12		9
5	Capacity and capability to deliver KLOEs	DoN	QAC		12	12		9
Strategic theme: T - Transformation								
6	The co-produced future model for all age mental health services does not deliver the required transformation to meet population needs	DoMH	QAC		16	16		9
7	Failure to implement the Community Service Redesign may result in loss of business opportunities	DoCHS	QAC		9	9		6
8	Failure to deliver LPT's contribution to the LLR Transforming Care Plan will adversely impact on the quality of life and outcomes for people with a Learning Disability or Autism	DoMH	QAC		16	16		9

Strategic theme: E – Environments								
9	Failure to maintain the level of cleanliness required within the Hygiene Standards	DoF	QAC		12	12		8
10	Failure to implement planned and reactive maintenance of the estate leading to an unacceptable environment for patients to be treated in	DoF	FPC		16	16		12
11	The current states configuration is not fit for the delivery of modern mental health, community and LD services	DoF	FPC		20	20		20
Strategic theme: P – Patient Involvement								
12	The Trust does not positively impact on the experience of service users, carers and families that use our services	DoN	QAC		12	12		6
13	The Trust does not increase the number of service users that are positively participating in their care, treatment and service improvement	DoN	QAC		12	12		9
14	Patients do not always find it easy to share their experiences and the Trust does not as a result receive feedback	DoN	QAC		12	12		9
Strategic theme: G – Well Governed								
15	Risk of disruption to service and detrimental impact on patient safety as a result of EU exit	DoN	FPC		15	15		12
16	The Leicester/Leicestershire/Rutland system is unable to work together to deliver an ICS by April 2020	CEO	FPC		16	16		12

17	Failure to meet financial plan and statutory breakeven duty	DoF	FPC		16	16		12
18	The Trust does not routinely achieve regulator standards which impacts on the achievement of the step up to great framework set by the Trust	CEO	QAC		12	12		8
19	There is a risk that inaction or failure to deliver on agreed plans results in a persistent and detrimental impact on LPT's reputation	CEO	QAC		12	12		12
20	Performance management framework is not fit for purpose	DoF	FPC		20	20		12
21	Operations are disrupted due to supplier failing to deliver their payroll contract	DoHR	FPC		15	15		10
22	Financial, reputational or service delivery harm or loss resulting from information breaches and attacks on information systems	MD	FPC					
Strategic theme: R – Single Patient Record								
23	Failure to deliver the EPR system and realise the benefits of the system	MD	FPC		16	16		8
Strategic theme: E^2 – Equality, Leadership and Culture								
24	Failure to deliver workforce equality, diversity and inclusion	DoHR	QAC		12	12		9
25	Failure to create a culture of collective leadership that empowers staff to improve the services we provide	DoHR	QAC		16	16		9

26	Insufficient staffing levels to meet capacity and demand, and provide quality services	DoHR	QAC		16	16		12
27	Failure to improve the health and well-being of our staff	DoHR	QAC		9	9		6
Strategic theme: A – Access to Services								
28	Failure to deliver timely access to assessment and treatment which could impact on patient safety and outcomes	Divisional Directors	QAC		16	16		12
29	Failure to achieve the out of area placement trajectory by the end of 20/21 will result in local people not having timely access to a local acute mental health bed	DoMH	FPC		20	20		15
30	Unmitigated demand may result in patients being unable to access services in clinically appropriate timescales	DoF / DDs	FPC		16	16		12
Strategic theme: T^2 – Trust-wide Quality Improvement								
31	Projects will not deliver sufficiently to embed a consistent QI framework	MD	QAC		9	9		9
32	Failure to secure the resources and develop a PMO to support the delivery of the Trust QI plan	DoN	QAC		12	12		8

Heat Map

The heat maps below illustrate the current and residual risk levels of the corporate risk register. The strategic theme is indicated alongside each risk ID.

Current risk levels given the existing set of controls.

This shows that currently, the majority of risks are likely to occur and will have a major impact. The elements of the strategic framework with the greatest scoring risk profile is Access to Services (A) and Well-Governed (G) each with a risk scoring 20.

Consequence	5			3S, 21G	28A	
	4			4S, 9E, 18G, 19G, 32T^2	1S, 6T, 8T, 10E, 16G, 17G, 20G, 22R, 24E^2, 25E^2, 27A, 29A	11E
	3			7T, 26E^2, 30T^2	2S, 5S, 12P, 13P, 14P, 23E^2	15G
	2					
	1					
		1	2	3	4	5
		Likelihood				

Residual risk levels remaining once additional controls are implemented.

This shows that there are two high residual risk scores; the estates configuration risk (11E) scoring 20 and the out of area risk (28A) scoring 15. The current control framework indicates that the majority of corporate risks will be still be possible, and will have a major or moderate impact.

Consequence	5		3S, 21G	28A		
	4		9E, 18G, 22R, 32T^2	1S, 10E, 16G, 19G, 25E^2, 27A, 29A		11E
	3		7T, 12P, 26E^2	2S, 4S, 5S, 6T, 8T, 13P, 14P, 23E^2, 24E^2, 30T^2	15G, 17G, 20G	
	2					
	1					
		1	2	3	4	5
		Likelihood				

Directorate Level Current Significant Risks (excerpt as at 16.10.19)

Strategic Framework	Number	Department Division	Description	Action Description	Handler	Current Risk Rating	Residual Risk Rate
Well Governed	1111	AMH/LD	Failure to deliver AMH/LD planned financial target.		Divisional Director AMH.LD	20	12
Well Governed	1199	FYPC	Insufficient data and quality of service data within FYPC and 729.	Directorate is working with the Trust Information Team, HIS and governance structure to mitigate.	Divisional Director FYPC	20	16
High Standards	1360	FYPC	Nurse staffing levels across FYPC Services are at risk of being below funded or required establishment of WTE posts.	The Inpatients staffing establishment will be discussed at the Inpatient assurance meetings, including the use of agency and bank staff.	Divisional Director FYPC	16	12
High Standards	1473	Enabling	LPT has a high proportion of aged medical devices across its services that need to be decommissioned and replaced utilising capital budgets.		Director Of Finance	16	6
Quality Improvement	1856	Enabling - Learning & Development	The impact of funding restrictions as a result of the reduction / removal of Health Education England education funding support will have an impact on staff being able to undertake the courses which support their skills and knowledge development this will have an impact on the quality of patient care.	Develop recruitment process for those courses which are high priority but more applicants than funding available for places e.g. Mentorship; Consultation Skills and NMP	Director Of HR And OD	15	9
Well Governed	2255	FYPC	If the staffing arrangements do not support safe, effective and consistent delivery of care, and enable timely delivery of the expectations detailed in the new Inpatient unit business case there is a risk to the sustainability of	To develop a 5 year plan with benchmarking against QNIC standards. To develop a weekly service development meeting to address the risks and drive the plans for	Divisional Director FYPC	15	10

			the service.	establishing the new inpatient unit. workforce development environment local systems and processes.			
Well Governed	2509	Enabling - Safeguarding	There is a risk that staff do not consistently apply the Deprivation of Liberty Safeguards (DoLS) when required.		Director Of Nursing, AHP's & Quality	16	8
Well Governed	3001	FYPC	If appropriate and timely action is not taken the FYPC directorate will not achieve the agreed financial outturn position for 2019/20.	To establish, through the finance report, a summary which informs the senior leadership team of the progress against CAMHS improvement targets in relation to the spend. Head of Finance for FYPC developing summary of financial recovery plans. Meeting with senior management team scheduled. Head of Service to establish sign-off process for service changes with commissioners to provide increased certainty in timely delivery of cost reductions. Finance team to support costings of service changes and clear reporting processes to sustainability meeting. Arrangements to be presented at the 15th August Business Day within the Healthy Together update report.	Divisional Director FYPC	25	15
High Standards	3691	FYPC	There is a risk to the safety of children and young people because the current waiting times for assessment and	Analysis tools to manage productivity to be fully deployed into neurodevelopmental and	Divisional Director FYPC	25	20

			treatment within CAMHS Outpatient services are too long.	treatment work. Version 2 of the ND Recovery plan to be presented to the FYPC Sustainability meeting in July 2019 detailing all interventions including outsourcing, referral management, steps to improve productivity and discharge, and workforce developments. To follow up longer term procurement process for outsourcing of ND assessments through digital providers with procurement team. When final report is received, feedback from the NHSi IST inspection to be formed into a joint action plan with the CCG and progressed through CAMHS Q&P commissioning meeting and FYPC Business Day.			
High Standards	3756	Enabling - Safeguarding	The trust is at risk of the safeguarding agenda not being delivered in line with statutory requirements and commissioner expectations due to an increased workload, with a significantly reduced capacity.	Recruitment of the vacant wte Band 7 Senior Safeguarding Practitioner External Safeguarding consultant commissioned to review capacity in the team	Director Of Nursing, AHP's & Quality	20	15
High Standards	3757	Enabling - Safeguarding	Safeguarding Training 1. There is insufficient safeguarding training places for the demands of LPT	Update all training packages in line adult and children intercollegic guidance	Director Of Nursing, AHP's &	15	15

			staff. 2. There has been new statutory guidance for the training frameworks introduced (Intercollegiate Document_ Adults (September 2018) & Children (January 2019). Following the changes and introductions of these new guidance documents, it will be difficult for the trust to deliver the core outcomes of knowledge as a part of the expectations. Additionally, there will be difficulties in the design and delivery of the new courses as a result of a lack of capacity within the safeguarding team (see risk 3756).		Quality		
Well Governed	3777	Enabling - Safeguarding	The commencement of the new statutory arrangements 01/09/2019 - resource has not been allocated to enable the delivery of the commissioned service which is in line with the statutory requirements as described in Working Together to Safeguard Children (2018) and the new Child Death Review arrangements also published in 2018.	Awaiting confirmation of funding from CCG / LPT Finance and Contracts team. Business case to be developed to increase capacity to provide two band 7 CDOP nurses	Director Of Nursing, AHP's & Quality	20	16
Well Governed	3784	Enabling - Safeguarding	There has been a change in multi-agency working practices regarding High Risk Domestic Violence and the MARAC which has moved from a Weekly MARAC process to a Daily MARAC process. There is a risk that the trust (and its staff) will not be updated to information and cases in a timely manner if the Specialist Nurse is on		Director Of Nursing, AHP's & Quality	20	10

			annual leave / sick. This poses a risk to the staff working with vulnerable patients / perpetrators and the victims themselves.				
High Standards	4067	FYPC	If the workforce model on Langley Ward is not sustainable and if the environmental issues surrounding mixed sex accommodation and ligature are not adequate then there is a risk to the patient safety and sustainability of the service provision.	Fortnightly assurance meetings to be planned with Ward Matron, Service group manager and members of FYPC SMT External review to be conducted by an experienced CQC inspector, Anne-Maria Newham has offered to support with planning this. Internal quality review to be completed. Finance recovery plan to be scrutinised in FYPC business day.	Divisional Director FYPC	20	9
High Standards	818	CHS	There is a risk that the inability of CHS to recruit sufficient substantive and qualified workforce could impact on the quality of services delivered at the point of care. Linked to CR 1932.	Review of LPT NHS job adverts MHSOP functional mapping for Inpatients supported by HEEM completed and action in place to implement	Divisional Director CHS	16	12
High Standards	906	Enabling - HR	There are a number of bank only postholders who are not compliant with all mandatory training required for their role. This could have an adverse impact on the safety of the worker, their colleagues and patients.	Produce a template to enable managers to risk assess staff who are not fully compliant with mandatory training before deciding whether to accept them on shift. Bank workers who joined the Trust in 2019 are being followed up as part of the bank 90 day onboarding process to ensure that training	Director Of HR And OD	16	8

				booked at induction has been completed.			
High Standards	953	FYPC	If the Healthy Together Service does not agree and implement changes to the service offers in a safe and timely manner in response to the reduction in the public health grants, the service will over spend significantly from 1st April 2020. Whilst agreement to the iterative approach has been reached with Leicestershire County Council, timely and formal sign off of service changes is still outstanding. Agreement to a programme of changes is as yet undecided for Leicester City Council. Therefore if this does not occur by September 2019, delivery of Year 4 (July 2020 - July 2021) may not be possible if there is an expectation of significant reduction in cost. This also applies to Rutland who have not to date agreed any changes for April 2020.	Head of Service to provide FYPC Business Day with proposal for joint sign off of changes to County contract and to ensure that this also enables oversight of the financial impact and progress of the programme of changes. Head of Service and Contracts Team to meet with Rutland Commissioners to clarify their intentions for the 2020/21 contract year To Review monthly finances and staffing vacancies in adherence to future funding. Engage fully with risk assessments and appropriate clinical governance arrangements. Assistant Director to escalate the risk to the Executive Team, regarding sustained delivery of this contract under increased financial pressure and staffing risk and maintaining patient safety.	Divisional Director FYPC	25	20

Decision required

- Agree the current CRR proposed above
- Approve the addition of a cyber security related risk (risk 22)
- Agree to a future board development session on risk appetite

Governance Table

For Board and Board Committees:	**Trust Board 01.10.19**	
Paper sponsored by:	Anne-Maria Newham – Director of Nursing, AHP's and Quality	
Paper authored by:	Kate Dyer – Head of Assurance	
Date submitted:	17.09.19	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):		
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:		
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Monthly review and update of corporate risk register	
STEP up to GREAT strategic alignment:		
S: High Standards	S	✓
T: Transformation	T	✓
E: Environments	E	✓
P: Patient Involvement	P	✓
G: Well-Governed	G	✓
R: Single Patient Record	R	✓
E^2: Equality, Leadership and Culture	E^2	✓
A: Access to Services	A	✓
T^2: Trust wide Quality Improvement	T^2	✓
Corporate Risk Register considerations: List risk number and title of risk	All	
Is the decision required consistent with LPT's risk appetite:	N/A this month	
False and misleading information (FOMI) considerations:	None believed to apply	
Equality considerations:	None believed to apply	

LPT RISK APPETITE (to follow)

MATURITY MATRIX

Descriptor	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Patient harm / outcome / experience	▪ No obvious harm. ▪ Patient dissatisfaction.	▪ Minimal harm. ▪ Experience readily resolvable. ▪ 1-2 people affected	▪ Some harm. ▪ Mismanagement of patient care. ▪ Short-term effects <week. ▪ 3-15 people affected.	▪ Permanent harm. ▪ Serious mismanagement of care. ▪ Misdiagnosis/poor prognosis. ▪ 16-50 people affected. ▪ Increased level of care (> 15 days)	▪ Death/life threatening. ▪ Totally unsatisfactory outcome/experience. ▪ > 50 people affected (e.g. screening concerns, vaccination errors).
Staff / Visitor etc. Injury / Psychological /	▪ No injury/illness not requiring first aid.	▪ Minor Injury/Illness requiring first aid/minimal treatment or care. ▪ Short-term staff sickness (< 3 days)	▪ Moderate injury/illness requiring medical intervention. ▪ Staff sickness (> 3 days) - RIDDOR ▪ 3-15 people affected	▪ Major injury/illness requiring long-term treatment/incapacity/disability. ▪ Long-term sickness	▪ Death. ▪ Life threatening injury/illness. ▪ Permanent injury/damage/harm.
Health Inequalities (Equity of access to care and/or inequity in wider public health)	▪ Possible/minor loss of potential for reducing health inequalities,	▪ Unable to investigate, develop/pilot future improvements in services/activities that are likely to	▪ Unable to implement intended developments in services/activities that have significant potential to reduce health inequalities.	▪ Reduced effectiveness of existing service/activity that is targeted at reducing health	▪ Probability of increase in health inequalities OR permanent loss of existing service/activity targeted to reduce health inequalities.
Complaint/Litigation	▪ Locally resolved complaint.	▪ Justified complaint peripheral to patient care. ▪ Litigation unlikely.	▪ Justified complaint involving lack of appropriate care. ▪ Litigation/enforcement action possible. ▪ Below excess.	▪ Multiple justified complaints. ▪ Claim above excess level. ▪ Litigation/enforcement action expected	▪ Multiple claims or single major claim. ▪ Unlimited damaged. ▪ Litigation/prosecution certain.
Business/Service Loss	▪ Minimal impact. ▪ No service disruption.	▪ Minor loss/interruption (> 8 hours)	▪ Moderate loss/interruption (> 1 day)	▪ Significant loss/interruption (> 1 week)	▪ Permanent loss of service/facility. ▪ Impact in further areas.
Staffing & Skill Level	▪ Short-term low staffing level that temporarily reduces service quality.	▪ On-going low staffing level reduces service quality.	▪ Late delivery of key objectives/service due to staffing levels. ▪ On-going unsafe staffing level, skill	▪ Uncertain delivery of key objective/service due to staffing levels. ▪ Unsafe staffing levels,	▪ Non-delivery of key objective/service due to lack of staff. ▪ Serious incident due to insufficient training.
Financial	▪ Small loss	▪ Loss > 0.1% of budget.	▪ Loss > 0.25 of budget. ▪ £500,000 loss of contractual income.	▪ Loss > 0.5% of budget. ▪ £1M loss of contractual income.	▪ Loss > 1% of budget. ▪ £2M loss of contractual income.
Reputation/Publicity	▪ No adverse publicity or loss of confidence in the Trust.	▪ Local Media – short term low impact on confidence and effect on staff morale.	▪ Local media – long term relations with public affected. ▪ Moderate loss of confidence in the Trust and significant effect on staff morale.	▪ Widespread adverse publicity. ▪ National Media (< 3 days) ▪ Major loss of confidence in the Trust	▪ National Media (> 3 days) ▪ MP concern – questions in the House. ▪ Major loss of confidence in the Trust. ▪ Viability of the Trust threatened.
Governance (Inspection/Audit & Policy Compliance)	▪ Minor non-compliance with standards. ▪ Minor recommendations.	▪ Non-compliance with standards. ▪ Recommendations given.	▪ Reduced rating. ▪ Challenging recommendations. ▪ Non-compliance with core standards, legislation.	▪ Low rating. ▪ Enforcement action. ▪ HSE intervention. ▪ Critical report. ▪ Major non-compliance with core standards, legislation.	▪ Zero rating. ▪ Prosecution. ▪ Severely critical report. ▪ Loss of contracts. ▪ Public enquiry.
Objectives & Projects	▪ Insignificant cost increase/schedule slippage. ▪ Barely noticeable reduction in scope or quality.	▪ < 5% over budget/schedule. ▪ Minor reduction in quality/scope.	▪ 5-10% over budget/schedule slippage. ▪ Reduction in scope or quality.	▪ 10-25% over budget/schedule slippage. ▪ Failure to meet secondary	▪ 25% over budget/schedule slippage. ▪ Doesn't meet primary objectives.
Estates & Environmental	▪ Inconsequential damage to buildings/environment/historic resources that requires little or no remedial action.	▪ Recoverable damage to 'non-priority' buildings/environment/historic resources.	▪ Recoverable damage to 'priority' buildings, or loss of 'non-priority' buildings/environment/historic resources.	▪ Loss of or permanent damage to 'priority' buildings/environment/historic resources. ▪ Affecting part of the site.	▪ Loss of or permanent damage to 'priority' buildings/environment/historic resources. ▪ Affecting the whole site.

Risk Severity Matrix Identify the highest consequence of this risk, taking account of the controls in place and their adequacy, how severe would the consequence by of such an incident? Apply a score according to the scale above.

How likely is it that such an incident could occur? From the descriptors below determine the likelihood of the incident recurring or the risk identified actually occurring. *N.B When deciding on the likelihood always remember to consider the risk controls you already have in place.*

Likelihood descriptors

	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
or					
Probability	<1% Will only occur in exceptional circumstances	1 – 5% The event is not expected to happen	6- 20% The event may occur occasionally	21 – 50% The event is likely to occur	>50% A persistent issue

Use the Matrix below to Grade the Risk. (i.e. 2 x 4 = 8 = Orange or 5 x 5 = 25 = Red) Risk scoring = consequence x likelihood (C x L)

Likelihood					
Consequence	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows - 1-3 Low, 4-6 Moderate, 8-12 High, 15-25 Significant

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board 1st October 2019
Paper number	Eii

Name of Report: Corporate Risk Register

For approval	✓	For assurance	✓	For information	

Presented by	Angela Hillery, Chief Executive	Author (s)	Kate Dyer, Head of Assurance

Alignment to CQC domains:		Alignment to the LPT strategic objectives:		Alignment to LPT priorities for 2019/20 (STEP up to GREAT):	
Safe	✓	Safe	✓	S – High Standards	✓
Effective	✓	Staff	✓	T - Transformation	✓
Caring	✓	Partnerships	✓	E – Environments	✓
Responsive	✓	Sustainability	✓	P – Patient Involvement	✓
Well-Led	✓			G – Well-Governed	✓
				R – Single Patient Record	✓
				E – Equality, Leadership, Culture	✓
				A – Access to Services	✓
				T – Trust-wide Quality improvement	✓
Any equality impact (Y/N)		No impact on equal opportunities			No

Report previously reviewed by	
Committee / Group	Date

Assurance : What assurance does this report provide in respect of the Board Assurance Framework Risks?	Links to BAF risk numbers
This report includes the revised risk management strategy and policy and summarises the proposed changes to the risk system. This will support the effectiveness of the board assurance framework.	Whole BAF

Recommendations of the report
The Trust Board is recommended to: • Note the content of the covering paper • Approve the Risk Management Strategy and Policy • Agree to a future board development session on risk appetite

Leicestershire Partnership NHS Trust

Risk Management Strategy and Policy Covering Report

Introduction

The Risk Management Strategy and Policy 2019 (enclosed) replaces the Trust's former Risk Management Strategy and Framework version 11, 2018 and the Board Assurance and Escalation Framework 2017.

The new Strategy and Policy addresses the recommendations made by the internal audit review of risk management issued in June 2019 (Ref 1819/LPT/35). It also addresses the weaknesses identified by the Care Quality Commission report issued in February 2019 relating to the inspection visit in November to Dec 2018 which concluded that 'due to the lack of a trust overarching strategy, the BAF did not provide an effective oversight against strategic objectives, gaps in control and assurance' (p4, *RT5 Leicestershire Partnership NHS Trust Inspection report*, CQC).

The Strategy and Policy aligns to the successful model used by Northamptonshire Healthcare NHS Foundation Trust (NHFT). This Strategy and Policy has been reviewed by mentors in NHFT in line with the Trust's buddy relationship.

Discussion

In producing the revised Risk Management Strategy and Policy, the Trust has reviewed the current risk system and has proposed a number of key changes as summarised in the table below:

Current approach	**Revised approach**
Tiers are known as: T1 – Directorate T2 – Service Line T3 – Team	Replace tiers for: Directorate Local (team and directorate level) and Team) Risk Registers
Risks can be live or tolerated	Risks on the register can only be live.
Risks are entered into the risk register whether they are controlled or not.	Risks are entered as assessments and if they are appropriately controlled are marked as so and called risk assessments. They are excluded from the risk register. Only risks which need additional mitigation feature in the risk register.
Health and Safety compliance risks are entered into a separate LPT Compliance organisation	Health and Safety compliance risks will feature in main system as a controlled risk assessment.

Anyone can add a risk onto the risk register	Limited number of staff within each directorate can add/amend risk; this role will be allocated to governance teams. Staff are only given add/amend access rights if they have been trained.
Two matrices feature in the risk assessment form – one for current score and the other for residual score.	The scoring base remains for current and residual but matrices do not feature in the form. Just measures of likelihood and consequence to encourage assessors to think about the score more.
CQUIN and CIP risks are included in risk register.	CQUIN and CIP risks relate to projects and therefore sit outside of the risk register.

Work is underway to enact these changes; these include

- Changes to the Ulysses risk system
- The development of risk training modules
- Liaison and consultation with relevant staff groups
- Validation of existing risk
- Implementing a risk review cycle
- Improving reporting templates

A risk management development session will be held with the Audit and Assurance Committee on the 23rd September 2019. This will include a presentation on the revised Risk Management Strategy and Policy and an evaluation of the impact on existing systems and processes for managing risk in the Trust.

Conclusion

The proposed changes to the systems and processes for managing risk address known weaknesses, and align to a best practice model. These simplify and streamline the approach to risk management in the Trust, and allow for a greater degree of quality control, governance and oversight.

The required changes to the risk system have been identified and plans are in place to enact these in a timely way.

Leicestershire Partnership NHS Trust

Risk Management Strategy and Policy

This Strategy and Policy sets out the Trust's approach to managing risk.

Key Words:	Risk Management Board Assurance Corporate Risk Register Ulysses	
Version:	V1 September 2019	
Adopted by:	Audit and Assurance Committee Trust Board	
Date Adopted:	[1st October 2019 presentation to Board]	
Name of Author:	Head of Assurance	
Name of responsible Committee:	Audit and Assurance Committee	
Date issued for publication:	TBC	
Review date:	March 2021	
Expiry date:	September 2021	
Target audience:	All staff	
Type of Policy	Clinical ✓ For those affecting patient care	Non Clinical ✓ e.g. HR or Education related
Which Relevant CQC Fundamental Standards?	Regulation 12 Safe Care and Treatment Regulation 17 Good Governance	

Contents

Version Control and Summary of Changes

Version number	Date	Comments (description change and amendments)
V1	August 2019	This Strategy and Policy is new. It replaces the former Risk Management Strategy and Framework version 11, 2018 and the Board Assurance and Escalation Framework 2017.

For further information contact:

Head of Assurance

Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

Due Regard

An analysis on the impact on equality' (Due Regard) has been included in the development of the policy, please refer to Appendix 7.

Definitions that apply to this Strategy and Policy

Board assurance framework	The Board Assurance Framework (BAF) is a tool used by the Board to collate relevant information on the risks to the board's strategic objectives
Corporate risk register	Is the document used to detail Trust-wide corporate risks.
Directorate risk register	Is the document used to detail risks that cannot be controlled at a team/service level or other risks to the overall directorate identified from other sources, for example a business or staffing risk.
Local risk register	Is the document used by team / service level managers to register risks at that level that need addressing, and detail actions arising from the risk assessment process in their areas. The document is also recognised as an action plan.
Risk	A risk is something uncertain which, if it happens, will have an effect on the achievement of objectives. The more likelihood of harm occurring or the higher the severity of consequences the higher the risk is.
Risk management	Is the process of identifying, quantifying, and managing the risks that an organisation faces.
Risk Assessment	Is consideration of what may cause harm to people or the function of the Trust and whether or not precautions to prevent harm or loss are possible.
Current	Is the level of risk based on existing controls and sources of assurance
Action	Is putting controls in place to manage risks that have been

	identified and assessed. These measures are; avoidance and prevention, reduction, transfer and sharing.
Residual	Is the level of risk remaining once additional controls are applied.
Monitoring	Is putting checks in place to evaluate whether the controls are effective and still applicable and to evaluate possible changes in the risk level.
Terminate	Avoid the risk by making the likelihood of its occurrence totally impossible.
Operational risk	Operational risks emanate from day-to-day operations of the business.
Corporate risk	Refers to the risk that the Trust may fail to deliver its strategic objectives.

1.0 Purpose of the Strategy and Policy

This Strategy and Policy sets out the approach for the Trust's vision in relation to the management of risk, detailing the systems and processes in place, and highlighting roles and responsibilities.

Summary and Key Points

Local Risk Registers – locally identified operational risk held at local level.

Operational risks emanate from day-to-day operations of the business. Those risks requiring further controls are managed in a local risk register by the relevant teams and services and are discussed at service line governance groups. Where any significant risks and/or where risks require action outside of the remit of the local team or service, these are highlighted at the directorate governance groups to consider the appropriateness of escalation onto the relevant directorate level risk register.

The addition of risks onto local risk registers is gate-kept by the risk team and the directorate governance leads.

Directorate Risk Registers - locally identified operational risk held at directorate level.

Operational risks emanating from day-to-day operations of the business managed at directorate level. For the clinical directorates, these are discussed at directorate governance meetings. For enabling services, these will be discussed at relevant, service line team meetings.

The relevant governance / team meetings will approve the inclusion of all new risks on the directorate risk register.

Corporate Risk Register (CRR) - operational risks which cannot be resolved at directorate level, and/or are significant to the Trust's objectives.

Executive Directors are responsible for ensuring that any local risks that cannot be resolved at directorate level, and/or have a significant impact on the Trust's objectives, are included in a risk register report submitted to the Executive Management Team for recommended addition to the Corporate Risk Register.

The Executive Management Team will approve the inclusion of all new risks on the Corporate Risk Register.

Board Assurance Framework (BAF) – corporate risk determined by board decisions concerning the objectives and direction of the Trust.

Corporate risks are determined by the Trust Board and concern the achievement of its strategic objectives and the Trust's direction of travel. These are included within the corporate risk register for ongoing oversight and scrutiny at the Executive Management Team and Trust Board.

The Trust has a combined BAF/CRR.

2.0. Strategy

Introduction

The achievement of strategic, directorate and clinical objectives is subject to uncertainty, which gives rise to threats and opportunities. Uncertainty of outcome is how risk is defined.

Through the management of risk, the Trust seeks to minimise, though not necessarily eliminate, threats, and maximise opportunities.

The Strategy and Policy seeks to ensure that:

- The Trust's risks in relation to the delivery of services and care to patients are minimised, that the wellbeing of patients, staff and visitors is optimised and that the assets, business systems and income of the Trust are protected
- The implementation and ongoing management of a comprehensive, integrated Trust-wide approach to the management of risk is based upon the support and leadership offered by the Trust Board.

Standards

The over-riding principle is that the Trust will have in place an effective risk management system. This can be defined as the effective and systematic application of management policies, procedures and practices to the tasks of establishing the context of, identifying, analysing, evaluating, treating, monitoring and communicating risk.
The Trust has embraced the Australian/New Zealand Risk Management Standard (AS/NZS ISO 31000:2009 – see Appendix 1). The standard defines risk as "the effect of uncertainty on objectives ". It is measured in terms of consequences and likelihood (see Appendix 2).
The Trust is using the principles of the National Patient Safety Agency (NPSA) model risk matrix to inform the grading of severity (see Appendix 2).

Duties

Chief Executive

Accountable for ensuring that the Trust discharges its legal duty for all aspects of risk and has delegated effectively the responsibility for implementation of risk management.

Director of Nursing, Quality and AHP's

Delegated responsibility for the assurance of systems to ensure effective risk management within the Trust.

Other Executive Directors

Delegated responsibility as per director portfolios.

Service/Clinical Directors

Responsible for ensuring that appropriate and effective risk management processes are in place within their Directorate, and that all staff are aware of the risks within their work environment, together with their personal responsibilities. They ensure that risks are captured on local and directorate risk registers, risks are reviewed at least quarterly, and will ensure appropriate escalation of risks from local to directorate level.

Service Directors are responsible for ensuring that all staff receive the relevant elements of risk management training.

The Trust Secretary has a specific responsibility to advise the Board in order to ensure that its corporate risks are managed effectively.

Senior and Line Managers

Must ensure that appropriate and effective risk management processes are in place within their designated area(s) and scope of responsibility, including:

- Identifying a co-ordinator for risk management within their designated area to facilitate the risk management process.
- Ensuring compliance with Trust Policies.
- Ensuring that all staff, subcontractors, volunteers, visitors and members of the public are made aware of the risks within their work environment and of their personal responsibilities, and that they receive appropriate information, instruction and training to enable them to work safely.
- Preparing specific directorate/departmental policies and guidelines to ensure that risk assessments are carried out as necessary.

Head of Assurance and Risk Management Leads

Responsibility for the operational management of risk. Oversight of the delivery of risk management processes across the Trust including risk assessment and management of risk registers across the Trust.

All Employees, Agency and Contractors

Recognise, act on and report risks in the Trust. In addition, all staff are expected to know and understand the risk management systems within the Trust, to follow the Trust's policies, guidelines and procedures, use correct documentation and ensure that their training in risk management is up to date. Staff are expected to recognise and act within their own skills and competencies in the management of risks. Staff should be encouraged to develop skills in risk management as part of their personal development plan. Such skills and competencies should be monitored through the appraisal process.

- Be familiar with the Trust's Risk Management Strategy and Policy together with all directorate/department and Trust policies, relevant to their role and comply with these.
- Comply with all Trust rules, regulations and instructions to protect health, safety and welfare of anyone affected by the Trust's business.
- Comply with Trust and professional codes of conduct.

- Comply with statutory and mandatory risk management training.
- Contribute to and assist in the risk assessment/risk register process in the Trust.
- Embrace and embed learning from outcomes such as incidents, complaints, claims, aggregated data and risk assessments to improve safety and quality.
- In situations where significant risks have been identified and where local control measures are considered to be potentially inadequate, managers are responsible for bringing these risk to the attention of their director if local resolution has not been satisfactorily achieved. If the director assesses the risk as significant, the lead director for risk will be notified for update to the Corporate Risk Register and Trust Board of Directors.

Trust Board of Directors (The Board)

The accountable body for risk and is responsible for ensuring the Trust has effective systems for identifying and managing risks.
The responsibility for managing risk across the Trust has been delegated by the Board to the following committees:

- Audit and Assurance Committee
- Quality Assurance Committee
- Finance and Performance Committee

Audit Committee

Responsible for reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities (both clinical and non-clinical); to support the achievement of the Trust's strategic framework. The committee will monitor and gain assurance on the timely implementation of internal audit report actions. The Executive Team also reviews outstanding internal report actions and ensures appropriate follow up takes place.

Quality Assurance Committee

Oversee all aspects of the Trust's quality management and to provide assurance to the Board and to have oversight of and assurance on those corporate level risks assigned to it.

Finance and Performance Committee

Oversee all aspects of the Trust's financial and performance management and to provide assurance to the Board and to have oversight of and assurance on those corporate level risks assigned to it.

Other Trust operational committees

There are a number of sub-groups reporting into committees in relation to risk management; these responsibilities are detailed with group terms of reference and the Trusts governance structure.

The committees/groups have the responsibility, through the Directors, for the risk of their services and for the putting in place of appropriate arrangements for the identification and management of risks.

Governance

The merged BAF/CRR maps risks, controls and assurances to the Trust's strategic framework. This provides the Board with information on a timely basis to support the Annual Governance Statement. Disclosures within the Annual Governance Statement are consistent with the self-declaration on compliance with regulatory requirements.

There is a monthly business cycle for reviewing, managing and monitoring risk on the BAF/CRR:

- Week 1. The Trust Board will receive the latest version of the BAF/CRR.
- Week 2. The Head of Assurance will meet with Executive Directors; this will provide an opportunity for reflection on existing risks, with any changes to risk scoring, controls and assurances being updated. New risks and any potential escalations can be discussed.
- Week 3. An updated BAF/CRR report will be presented to the Executive Team.
- Week 4. The BAF/CRR will be presented to the Board Sub-Committees.
- The Audit and Assurance Committee will receive the BAF/CRR each quarter; the covering report will include narrative pertaining to any changes to the systems and process underpinning the management of risk within the Trust.

The Board of Directors receives minutes and reports from its sub-committees. These will be discussed and progress with management actions will be noted as necessary. The Board, in exercising its responsibility, will also consider key indicators capable of showing improvements in risk management and/or providing early warning of risk (e.g. incident and complaints statistics, Care Quality Commission inspection report findings).

Trust Board of Directors will review and approve annually the Trust's Risk Management Strategy and Policy.

A Board committee structure is in place which supports the risk management accountability arrangements within the Trust and ensures that all significant risks are properly considered and communicated to the Board. The structure is devised to ensure a co-ordinated and holistic approach to risk management with committee cross- membership arrangements in place to ensure risk management activities are integrated.

Each service line and directorate governance meetings consider risk, quality and performance information alongside the risk registers for their relevant areas.

Risks that can be managed at department level will be under local management control. Where risks are estimated as significant or high within local risk registers, or where resources are inadequate to address risks at directorate level they will be brought to the relevant Director's attention. This includes enabling and hosted services risk.

Risk Appetite Statement

The risk appetite statement will be updated every six months and will be made available on the Trust's website.

The Trust is not risk averse and recognises that decisions with the potential to improve services can also carry risks. This should not deter from making the

decision, but is considered before making an informed decision based on risk assessment and a decision on the level of tolerance of any risks. Decisions or actions that may have consequential high risks will be discussed by the Board and if relevant the Board will agree how the risk(s) will be proactively managed and contained.

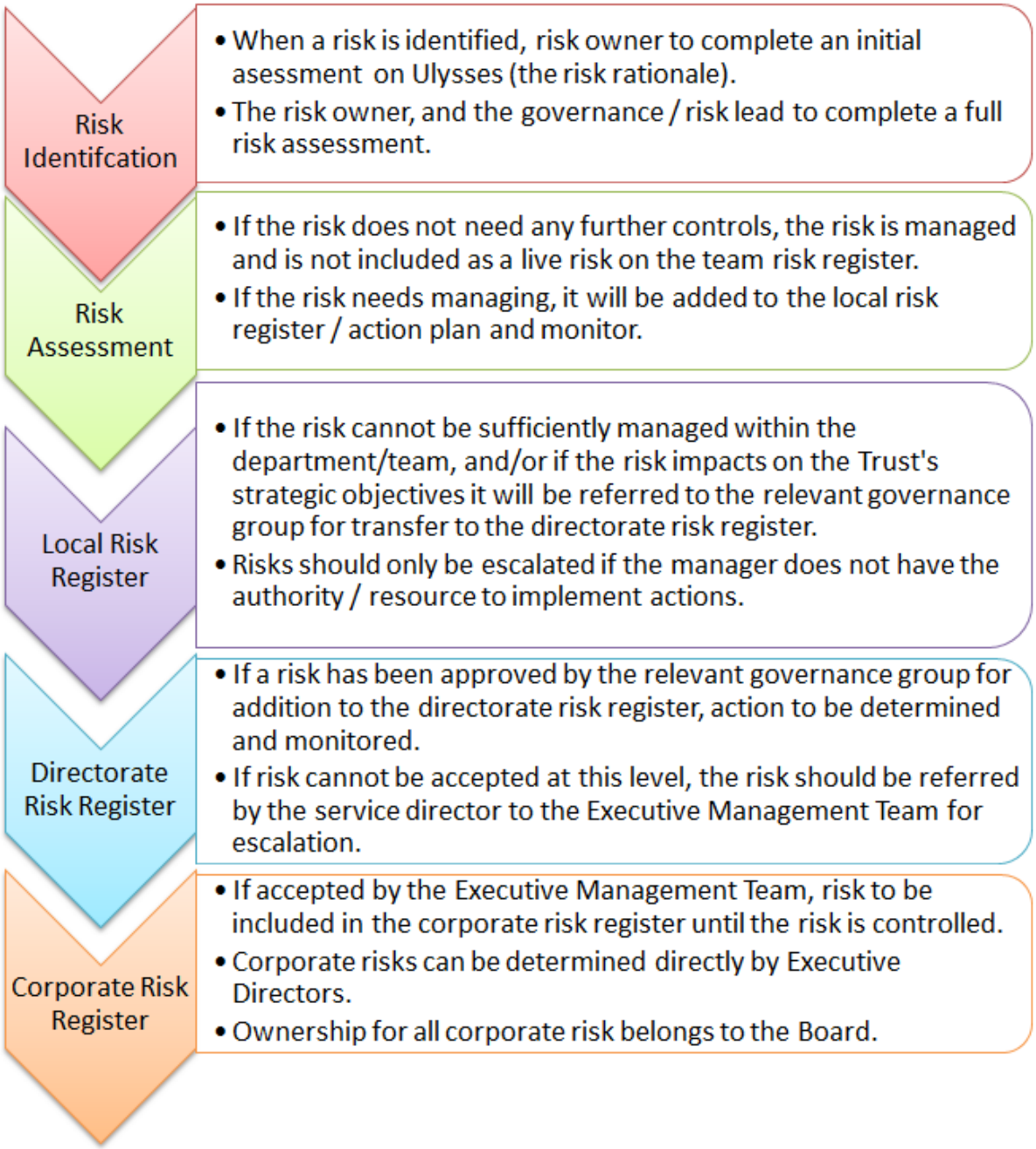
The Trust accepts that no system can be totally risk-free and that there are occasions when the Trust will have to accept a degree of risk in the course of its undertakings. For each assessed risk, the managed risk level must be considered for acceptability and risk registers should be populated and reviewed regularly in accordance with the Strategy and Policy.

New developments and business proposals that the Trust is planning will be risk assessed and included in all relevant levels of risk registers and the Trust's agreed risk appetite for the management of risks will be applied.

3.0 Policy

Risk Registers

This section details the hierarchy of the process of risk registers in the Trust. The flowchart below illustrates the process.



Local risk register

- Members of staff identify a risk and enter a risk rationale onto the Ulysses System.
- The governance / risk teams work with the risk owner to complete a full risk assessment. Risks that need further controls are entered onto the local risk register.
- The local risk register is review and maintained through service line governance meetings / enabling service team meetings.
- Significant risks and risks requiring action outside the remit of the local team/service are flagged at directorate governance meetings for consideration and inclusion onto the directorate risk register.

Directorate risk register

- As part of the review of the directorate risk register, the reviewer considers the content of all local risk register to identify potential overall risks to the service. This could be an amalgamation of a cluster of the same low level risk in local areas, but on a grouped basis poses a risk to the service.
- The directorate risk register is reviewed and monitored by the departmental/service management groups. Each service will be supported by the governance and risk teams to manage the process.
- Updated directorate risk registers are regularly submitted to the risk review group and to the relevant Executive Directors.
- Significant risks and risks requiring action outside the remit of the service are referred to the Executive Team for potential inclusion onto the corporate risk register.

Immediate escalation of significant risks

Uncontrollable risks which are significant to the Trust should be referred directly to the Trust's Executive Team for consideration to resolve immediately or to enter onto the corporate risk register.

Risk Assessment (Describing a risk and assigning controls)

The risk assessment process for risk registers considers all identified risks within the Trust inclusive of internal and external risk factors and from all sources including clinical and non-clinical risks, and those risks that could impact on the delivery of safe, high quality services.

For a consistent approach to risk assessment the following sections below must be addressed. The Ulysses System must be used to record risks identified and how they are being controlled.

Initial risk rational

In the first instance, the risk rational will be submitted prior to a full risk assessment being undertaken with relevant governance / risk leads.

Controls

Only controls that are in place and working must be considered when first evaluating the risk. Where controls exist they must always meet the minimum legal standards and there must be procedures in place to ensure they remain effective.
If the controls in place are not controlling and lowering the risk as far as is reasonably practicable and acceptable then recommendations must be put forward to do this.
This is the point at which the risk and required control measures should be entered onto the risk register. Note, if the risk is sufficiently controlled it will not be entered onto the risk register.
The register should provide the source of the identified risk, description of the risk, action required including interim control measures, risk score, deadline and review date, cost, identify the person responsible for implementing the control and show a residual risk rating after implementation of controls.
When implementing controls, the Trust can consider 3 options;

- Treat - Work is carried out to reduce the likelihood of the risk (this is the most common action).
- Transfer - Shift the responsibility or burden for loss to another party e.g. the risk is insure against or subcontracted to another party.
- Terminate - Avoid the risk by making the likelihood of its occurrence totally impossible.

Assurance

Assurance may be provided by inspection of areas, clinical processes, work, financial controls, planned preventative maintenance, regular testing of equipment, relevant board reports, performance indicators, 3rd party assurance e.g. internal/external audit. This should be recorded on the risk assessment form.

Evaluate and Record the Findings

The risk assessment form provides a mechanism and evidence that a risk assessment has taken place and whether this risk is immediately controlled or requires further action(s).

The overall risk depends on the likelihood of the unsafe event occurring, the number of people who might be exposed and the severity of the consequences. The overall risk is the most likely outcome not worst case scenario.

Risk = Likelihood of Occurrence X Severity of Consequences

The overall risk should be considered in term of low, moderate, high or significant and justification for the rating must be given. The risk level is calculated using the risk scoring matrix see Appendix 3.

Risk Review

All risk registers must be reviewed formally on a quarterly basis as a minimum, to ensure risks are being identified and controls/action plans are in place. The governance and risk teams will co-ordinate and undertake the review. Hosted services are required to undertake their own review.
The risk register is a 'live' working document to be considered as part of the management of each area. It is recommended that risk forms part of the standard governance / service line team meeting agenda with regular discussion on progress with actions required to mitigate the risks.
Review of the risk register also includes a review of the risk assessment forms and consideration of any new potential risks. Risk assessments should be reviewed periodically either 6 monthly, on implementation of new controls or when there are changes to the working environment. This is to ensure that the focus does not remain on the risk register alone and therefore have the potential for other risks to be missed.

4.0. Training needs

Knowledge of risk management is essential to the successful embedding and maintenance of effective risk management. Training required to fulfil this Strategy and Policy will be provided in accordance with the Trust's Training Needs Analysis.

- E-learning modules and local, tailored training courses are available for all staff.

- Specific training will be provided in respect of high level awareness of risk management for the Board and senior staff.
- Risk Awareness Sessions are included as part of the ongoing development programme for the Board and the Audit and Assurance Committee.

A record of any training and any names of attendees / non attendees will be recorded and passed to the training department for recording on the training database. The training department will alert managers of any non –attendees and managers will be responsible for following this up.
Only competent persons can carry out risk assessments. Therefore anyone who is to carry out risk assessment must have successfully completed the risk register training A manager may delegate this duty to a member of the team. However, it is required that managers also complete the training.

5.0. Monitoring Compliance and Effectiveness

This Strategy and Policy is subject to annual review. The table below outlines the basis in which compliance with the Strategy and Policy will be reviewed.

Ref	Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
1.	Local and directorate risk registers are fully compliant with the Strategy and Policy	Review of local and directorate risk registers		Governance / risk leads	6 monthly
3.	Board assurance framework and corporate risk register is fully compliant with the Strategy and Policy	Review of board assurance framework and corporate risk register		Risk leads / Trust Board	6 monthly

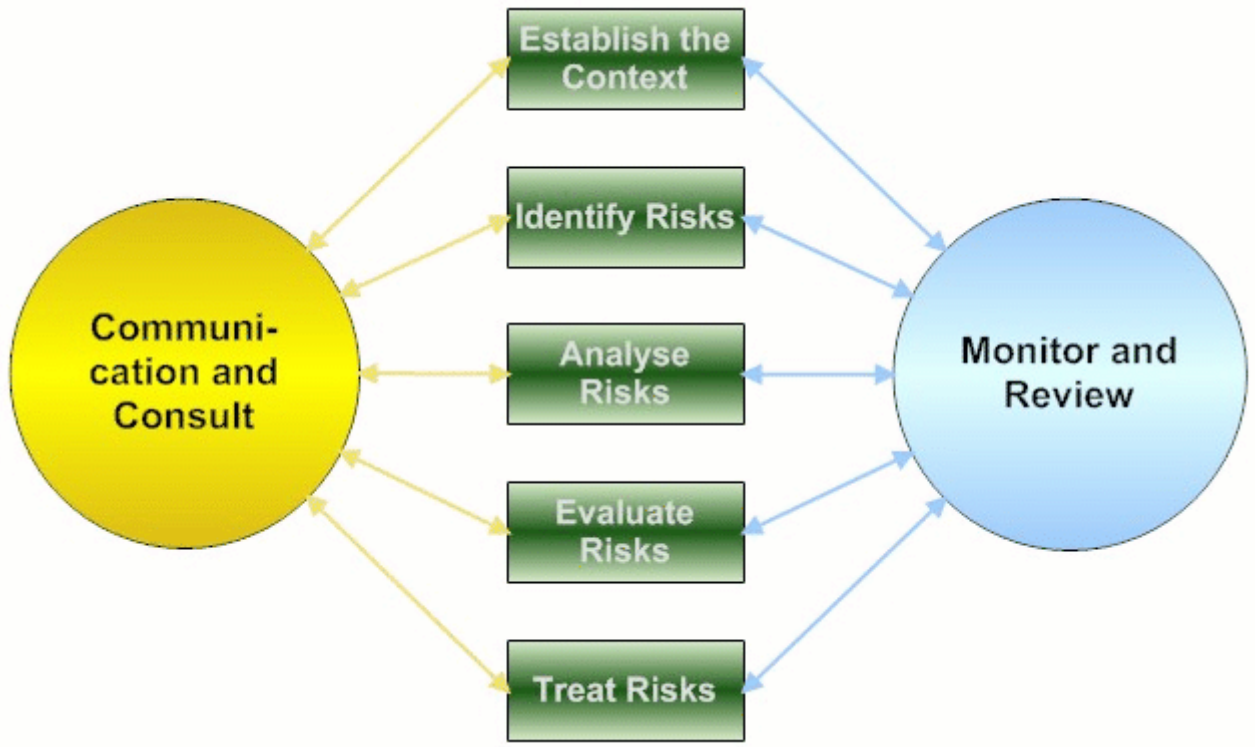
6.0. References and Bibliography

The Strategy and Policy was drafted with reference to the following:

Northamptonshire Healthcare NHS Foundation Trust:

- Policy and guidance for the use of risk registers – HSC002
- Risk Management Strategy – CRM001v1.5 July 2019

Appendix 1 Risk Management Process (AS/NZS ISO 31000:2009)



The elements of the AS/NZS ISO 31000:2009 risk management process in more detail:

- **Establish the Context**: It is necessary to fully understand the external and internal aspects of the organisation or organisational part which is subject to risk management.
- **Identify Risks**: This step shall uncover risks, their location, timeframe, root causes, and scenarios.
- **Analyse Risks**: The output of risk analysis is the likelihood of a risk and the consequence in case of risk occurrence.
- **Evaluate Risks**: Risk analysis provides an outcome which is basis for decision making which risks need treatments and in which priority.
- **Treat Risks**: Treatments are responses to risks. Alternative treatments need to be identified, assessed, selected, planned, and implemented.
- **Monitor and Review**: This step shall ensure that the risk management plan remains relevant and all input data, including likelihood and consequence, are up-to-date. Monitor and review relates to all of the above five elements of the risk management workflow.
- **Communication and Consult**: Successful risk management relies on communication with all stakeholders. Communication will improve the level of understanding and treating risks. Communication is important throughout the entire risk management cycle.

Appendix 2 Risk severity matric

Identify the highest consequence of this risk, taking account of the controls in place and their adequacy, how severe would the consequence by of such an incident? Apply a score according to the following scale:

Descriptor	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
Patient harm / outcome / experience	▪ No obvious harm. ▪ Patient dissatisfaction.	▪ Minimal harm. ▪ Experience readily resolvable. ▪ 1-2 people affected	▪ Some harm. ▪ Mismanagement of patient care. ▪ Short-term effects <week. ▪ 3-15 people affected.	▪ Permanent harm. ▪ Serious mismanagement of care. ▪ Misdiagnosis/poor prognosis. ▪ 16-50 people affected. ▪ Increased level of care *(> 15 days)*	▪ Death/life threatening. ▪ Totally unsatisfactory outcome/experience. ▪ > 50 people affected *(e.g. screening concerns, vaccination errors).*
Staff / Visitor etc. Injury / Psychological / Social	▪ No injury/illness not requiring first aid.	▪ Minor Injury/Illness requiring first aid/minimal treatment or care. ▪ Short-term staff sickness *(< 3 days)* ▪ 1-2 people affected.	▪ Moderate injury/illness requiring medical intervention. ▪ Staff sickness *(> 3 days)* - RIDDOR ▪ 3-15 people affected	▪ Major injury/illness requiring long-term treatment/incapacity/disability. ▪ Long-term sickness ▪ > 15 people affected.	▪ Death. ▪ Life threatening injury/illness. ▪ Permanent injury/damage/harm.
Health Inequalities *(Equity of access to care and/or inequity in wider public health)*	▪ Possible/minor loss of potential for reducing health inequalities,	▪ Unable to investigate, develop/pilot future improvements in services/activities that are likely to reduce health inequalities.	▪ Unable to implement intended developments in services/activities that have significant potential to reduce health inequalities.	▪ Reduced effectiveness of existing service/activity that is targeted at reducing health inequalities.	▪ Probability of increase in health inequalities OR permanent loss of existing service/activity targeted to reduce health inequalities.
Complaint/Litigation	▪ Locally resolved complaint.	▪ Justified complaint peripheral to patient care. ▪ Litigation unlikely.	▪ Justified complaint involving lack of appropriate care. ▪ Litigation/enforcement action possible. ▪ Below excess.	▪ Multiple justified complaints. ▪ Claim above excess level. ▪ Litigation/enforcement action expected.	▪ Multiple claims or single major claim. ▪ Unlimited damaged. ▪ Litigation/prosecution certain.
Business/Service Loss	▪ Minimal impact. ▪ No service disruption.	▪ Minor loss/interruption *(> 8 hours)*	▪ Moderate loss/interruption *(> 1 day)*	▪ Significant loss/interruption *(> 1 week)* ▪ Temporary service closure.	▪ Permanent loss of service/facility. ▪ Impact in further areas.
Staffing & Skill Level	▪ Short-term low staffing level that temporarily reduces service quality.	▪ On-going low staffing level reduces service quality.	▪ Late delivery of key objectives/service due to staffing levels. ▪ On-going unsafe staffing level, skill level ineffective.	▪ Uncertain delivery of key objective/service due to staffing levels. ▪ Unsafe staffing levels, skill levels inadequate.	▪ Non-delivery of key objective/service due to lack of staff. ▪ Serious incident due to insufficient training.
Financial	▪ Small loss	▪ Loss > 0.1% of budget.	▪ Loss > 0.25 of budget. ▪ £500,000 loss of contractual income.	▪ Loss > 0.5% of budget. ▪ £1M loss of contractual income.	▪ Loss > 1% of budget. ▪ £2M loss of contractual income.
Reputation/Publicity	▪ No adverse publicity or loss of confidence in the Trust.	▪ Local Media – short term low impact on confidence and effect on staff morale.	▪ Local media – long term relations with public affected. ▪ Moderate loss of confidence in the Trust and significant effect on staff morale.	▪ Widespread adverse publicity. ▪ National Media *(< 3 days)* ▪ Major loss of confidence in the Trust.	▪ National Media (> 3 days) ▪ MP concern – questions in the House. ▪ Major loss of confidence in the Trust. ▪ Viability of the Trust threatened.
Governance *(Inspection/Audit & Policy Compliance)*	▪ Minor non-compliance with standards. ▪ Minor recommendations.	▪ Non-compliance with standards. ▪ Recommendations given.	▪ Reduced rating. ▪ Challenging recommendations. ▪ Non-compliance with core standards, legislation.	▪ Low rating. ▪ Enforcement action. ▪ HSE intervention. ▪ Critical report. ▪ Major non-compliance with core standards, legislation.	▪ Zero rating. ▪ Prosecution. ▪ Severely critical report. ▪ Loss of contracts. ▪ Public enquiry.
Objectives & Projects	▪ Insignificant cost increase/schedule slippage. ▪ Barely noticeable reduction in scope or quality.	▪ < 5% over budget/schedule. ▪ Minor reduction in quality/scope.	▪ 5-10% over budget/schedule slippage. ▪ Reduction in scope or quality.	▪ 10-25% over budget/schedule slippage. ▪ Failure to meet secondary objectives.	▪ > 25% over budget/schedule slippage. ▪ Doesn't meet primary objectives.
Estates & Environmental	▪ Inconsequential damage to buildings/environment/historic resources that requires little or no remedial action.	▪ Recoverable damage to 'non-priority' buildings/environment/historic resources.	▪ Recoverable damage to 'priority' buildings, or loss of 'non-priority' buildings/environment/historic resources.	▪ Loss of or permanent damage to 'priority' buildings/environment/historic resources. ▪ Affecting part of the site.	▪ Loss of or permanent damage to 'priority' buildings/environment/historic resources. ▪ Affecting the whole site.

Appendix 3 Likelihood and consequence

How likely it is that such an incident could occur.
From the descriptors below determine the likelihood of the incident recurring or the risk identified actually occurring.
N.B when deciding on the likelihood always remember to consider the risk controls you already have in place.

Likelihood descriptors

	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
or					
Probability	<1% Will only occur in exceptional circumstances	1 – 5% The event is not expected to happen	6- 20% The event may occur occasionally	21 – 50% The event is likely to occur	>50% A persistent issue

Use the Matrix below to Grade the Risk. (i.e. 2 x 4 = 8 = Orange or 5 x 5 = 25 = Red)
Risk scoring = consequence x likelihood (C x L)

	Likelihood				
Consequence	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Significant risk

Instructions for use

Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.
Use question 1 to determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.
Use question 2 to determine the likelihood score(s) (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.

Calculate the risk score, as per question 3, by multiplying the consequence by the likelihood: C (consequence) x L (likelihood) = R (risk score)
Identify the level at which the risk will be managed in the Trust, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings, and the Trust's risk management system. Include the risk in the risk register at the appropriate level.

Appendix 4 Training Needs Analysis

Training topic:	Risk
Type of training: (see study leave policy)	☐ Mandatory (must be on mandatory training register) ☐ Role specific ✓ Personal development
Division(s) to which the training is applicable:	✓ Adult Mental Health & Learning Disability Services ✓ Community Health Services ✓ Enabling Services ✓ Families Young People Children ✓ Hosted Services
Staff groups who require the training:	All clinical and non-clinical staff. Emphasis on training provision for Governance and Risk Staff.
Regularity of Update requirement:	Annual
Who is responsible for delivery of this training?	Risk Team
Have resources been identified?	Risk Team
Has a training plan been agreed?	Training plan subject to on-going refinement
Where will completion of this training be recorded?	✓ ULearn ✓ Other (please specify) tailored training to be recorded by the Risk Team.
How is this training going to be monitored?	In regular reports to the Audit and Assurance Committee

Appendix 5 The NHS Constitution

The NHS will provide a universal service for all based on clinical need, not ability to pay. The NHS will provide a comprehensive range of services

Shape its services around the needs and preferences of individual patients, their families and their carers	✓
Respond to different needs of different sectors of the population	✓
Work continuously to improve quality services and to minimise errors	✓
Support and value its staff	✓
Work together with others to ensure a seamless service for patients	✓
Help keep people healthy and work to reduce health inequalities	✓
Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	✓

Appendix 6 Stakeholders and Consultation

Key individuals involved in developing the document

Name	Designation
Kate Dyer	Head of Assurance

Circulated to the following individuals for comment

Name	Designation
Anne-Maria Newham	Director of Nursing, Quality and AHP's
Frank Lusk	Trust Secretary
Anna Pridmore	Interim Associate Director of Governance
Fern Barrell	Risk Manager
Heather Darlow	Governance Lead
Jennie Palmer-Vines	Governance Lead
Chris Brookes	Governance Lead

Appendix 7 Due Regard Screening Template

Section 1	
Name of activity/proposal	Development of a Risk Management Policy
Date Screening commenced	August 2019
Directorate / Service carrying out the assessment	All
Name and role of person undertaking this Due Regard (Equality Analysis)	Kate Dyer, Head of Assurance
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: This Policy sets out the Trust's approach to managing risk.	
OBJECTIVES: This Policy sets out a clear approach for the Trust's vision in relation to the management of risk, detailing the systems and processes in place, and highlighting roles and responsibilities. The objective of this Policy is to promote an integrated and consistent approach across all parts of the Trust to managing risk.	

Section 2	
Protected Characteristic	**If the proposal/s have a positive or negative impact please give brief details**
Age	No
Disability	No
Gender reassignment	No
Marriage & Civil Partnership	No
Pregnancy & Maternity	No
Race	No
Religion and Belief	No
Sex	No
Sexual Orientation	No
Other equality groups?	No

Section 3			
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.			
Yes		No	
High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4.	✓

Section 4			
If this proposal is low risk please give evidence or justification for how you reached this decision:			
Full statement of commitment to policy of equal opportunities is included in the policy.			
Signed by reviewer/assessor	Kate Dyer	**Date**	19 August 2019
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed		**Date**	

Appendix 8 Data Privacy Impact Assessment Screening

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy. **The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.**			
Name of Document:	Risk Management Policy		
Completed by:	Kate Dyer		
Job title	Head of Assurance		**Date** August 2019
Screening Questions		**Yes / No**	**Explanatory Note**
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.		No	The only data collection relates to the list of staff attending training. This will be held securely and staff will not be named in committee reports.
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.		No	
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?		No	
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?		No	
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.		No	
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?		No	
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.		No	
8. Will the process require you to contact individuals in ways which they may find intrusive?		No	
If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk **In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.**			
Data Privacy approval name:	**n/a**		

Date of approval	**n/a**

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board, 1st October 2019
Paper number	Fi

Name of Report: EU exit briefing

For approval		For assurance	X	For information	X

Presented by	Danielle Cecchini, Director of Finance	Author (s)	Sharon Murphy, Deputy Director of Finance

Alignment to CQC domains:		Alignment to the LPT strategic objectives:		Alignment to LPT priorities for 2019/20 (STEP up to GREAT):	
Safe		Safe		S – High Standards	
Effective		Staff		T - Transformation	
Caring		Partnerships		E – Environments	
Responsive		Sustainability	X	P – Patient Involvement	
Well-Led	X			G – Well-Governed	X
				R – Single Patient Record	
				E – Equality, Leadership, Culture	
				A – Access to Services	
				T – Trustwide Quality improvement	
Any equality impact (Y/N)		N			

Report previously reviewed by	
Committee / Group	Date
N/A	N/A

Assurance: What assurance does this report provide in respect of the Board Assurance Framework Risks?	Links to BAF risk numbers
Provides assurance that the Trust is preparing for a no deal EU exit, within the guidance set out by DHSC.	Brexit risk

Recommendations of the report
The Trust Board is asked to note the EU exit update briefing.

Update on LPT's operational readiness for EU Exit

LPT had an EU exit group which met regularly in the run up to the EU exit date of 31st March 2019. The meetings were paused when Brexit itself was paused.

The LPT EU Exit group restarted its regular meetings on 9th September in preparation for a 31st October leave date, and in anticipation of NHSE/I sit rep reporting being reinstated.

There has been no new DH guidance issued since the pause, but there have been preparedness reviews undertaken by the LLR Resilience Forum and LLR CCGs. Both of these documents were circulated to the group and discussed at the meeting.

At the 9th September meeting, the group reviewed the risk & action log as it was in early April when Brexit was paused. The attached updated risk & action logs show the responsible officer for each area & the risk rating as we currently rate it.

There has been no change in the risk rating of any of the risks, but there are some new actions that have arisen as more information has come to light through the last few months, or due to the fact that the proposed new exit date means that impacts could be realised at the start of and on into the winter.

A regional workshop was held on the 17th September, which the Head of Procurement attended on behalf of the Trust. Key updates from the workshop:

- There was focus on ensuring we are very clear about the difference between winter pressure issues (which we have every year) and Brexit issues. There will be no tolerance for Trusts who report Winter Pressures through the Brexit Sit Rep process.

- There was also a focus on communications and the fact that these will need to be more detailed this time round and we need to be really focused on communications to the patient directly:

    a. Frontline staff must be fully briefed this time because they will need to convey confidence to the patient. It won't be acceptable to say "everything will be okay" this time. They will need to be informed with the facts.
    b. There are comms packages being developed and comms workshops taking place. There is far more comms work to do this time.
    c. The government will start communicating to the public from 23rd September and the NHS will align with this. There will be comms for staff and comms for patients.
    d. Senior Responsible Officers must be identified for each area and communicated.

- There was more scrutiny on the risks to social care which has a knock on effect to the NHS. We are being asked to work closely with our social care stakeholders (e.g. care homes) because they will suffer significantly due to zero hours contracts and minimum wage staff that they heavily depend upon.

- For medicines and clinical goods, there continues to be the six pillars of contingencies that are being centrally managed:

    - 6 weeks buffer stock
    - Re-routing of stock regionally
    - Government run warehouse capacity
    - Regulatory changes
    - Increased procurement capacity at the centre
    - Trader readiness

- The Commercial and Procurement Cell at NHSI will continue as before and react to supply changes on a national level and help Trusts with any logistics changes should they be required. This time the cell has been strengthened by bringing on board subject experts in areas like Estates and Facilities. And there is also a tier of clinical advisors that can help with any clinical product switches that may be required. There is an escalation model for SME advice and shortage response.

- The daily sit reps will start again on 21st October.

The LPT EU exit business continuity plans will be reviewed in light of the new exit date, and the new information above, to ensure that the plans are still robust, take account of any new guidance and appropriately factor in any winter impacts.

The group will continue to meet fortnightly, and have meetings planned until the end of November.

Sharon Murphy

Deputy Director of Finance & procurement

18th September 2019

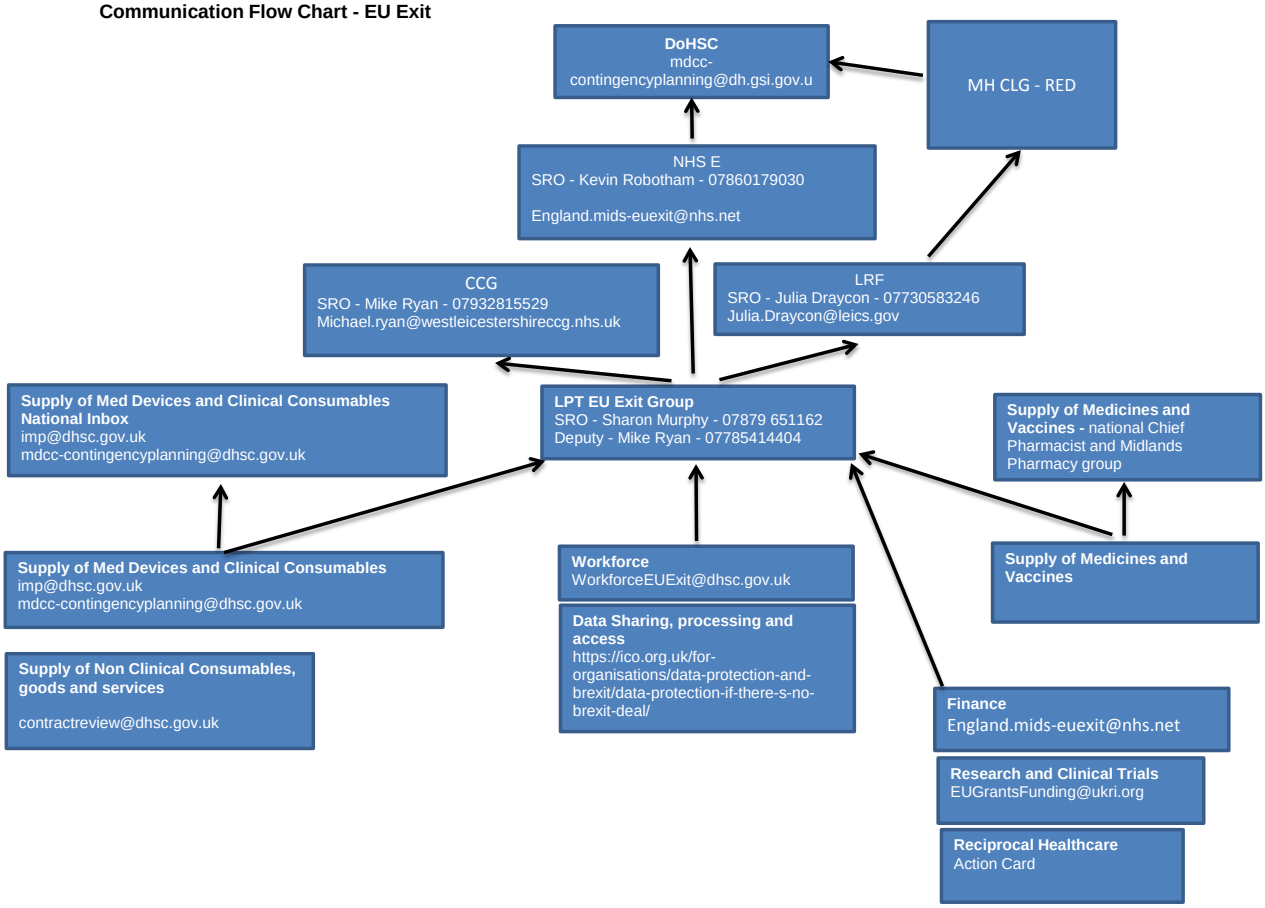
The group membership is:

Dani Cecchini (Executive SRO) Sharon Murphy (LPT Brexit SRO), Michael Ryan (LPT Brexit operational lead), Kamy Basra, Sophie Ion, Sarah Holliehead, Sarah Willis, Antony Oxley, Bernie Keavney, Helen Walton & Sam Kirkland. A HIS representative is informing discussions as & when required.

	National Key Area Identified	Action required per Provider action card	Lead & Timeline	Potential impact/risk	Implications of realisation & to whom	Mitigation/Controls	Action status	Current RAG Rating	Trigger points to evoke BC plans	Recovery/BC Plan Evoked/ DRA	Residual Risk RAG & Date	LPT Escalation route
1	**Communications and Escalation**											
1.1		Escalation flowchart to be developed and shared; to include external regional lead and CCGs	LPT - Mike Ryan 14/1/19									
1.2		Identify nominated regional lead and their contact details	LPT - MR /SM(SRO)				Complete	Green			Green	
1.3		Identify LPT SRO and other persons with responsibility to support & lead in their areas including contact details	LPT- Sharon Murphy is SRO				Complete	Green			Green	
2	**Reporting , Assurance & Information**											
2.1		NHS England & Improvement will provide guidance as and when	NHSE/I			LPT to provide access to relevant staff to enable access into reporting systems	Open	Green				
2.2		Reporting strands are CCG, NHS E & LRF										
3	**Supply of Medicines and Vaccines**											
3.1		LPT not to stock pile beyond business as usual	LPT - Anthony Oxley	Inability to provide required medicines to patients	Patient care compromised	4 weeks agreed stock levels within pharmacy	Open	Green	When stock level reduces to under 4 weeks			Medical Director; SRO
3.2			Dh			6 weeks agreed stock levels held nationally	Open					
3.3						Ability to attain medicines from alternative suppliers	Open					
3.3						Escalation process through regional communication channels	Open					
3.4						Airfreight will make medicines a high priority nationally	Open					
3.4						AO Chief pharmacist is engaged with the midlands pharmacists group	Complete	Green			Green	
3.4						Define stock system being implemented nationally, will support sharing of drugs across NHS providers	open					
4	**Supply of Medical Devices and Clinical Consumables**											
4.1		LPT not to stock pile beyond business as usual	SH	Inability to replace medical devices; shortage of continence & pulp products, Enteral feeds, BOC gasses	Patient care compromised	Medical devices assets could be sweated during this period if unavailable	Open	Amber	When notification is received that there is a potential delay in receipt of goods			SRO
4.2		Keep in contact with any direct suppliers and send queries provided by Supply Chain through normal contact	SH			Clinical consumables - assurance received via SH that the majority of items are manufactured in the UK	Open	Amber				
5	**Supply of non-clinical consumables, goods and services**											
5.1		Undertake internal reviews of purchase goods and services if there is a disruption in supply	SH	Inability of contractors e.g. UHL FM services to provide patient facing services e.g, catering & cleaning due to supply issues	Patient care compromised	Remain in contact with key suppliers to ensure they have robust business continuity plans	Open	Amber	When notification is received that there is a potential delay in receipt of goods or services			SRO
5.2		Submit results of the LPT assessment against non-clinical goods and services to DhSC	SH				Complete	Green			Green	
6	**Workforce**											
6.1		Assess number of nationals in workforce	SW				Complete 11/12/2018	Green			Green	
6.2		Publicise the EU settlement scheme to all relevant staff	SW				Complete 11/12/2019	Green			Green	
6.3		Monitor impact on EU exit on LPT workforce	SW & via Eteam	Staff shortages	Patient care compromised	150 staff identified as EU nationals (mostly bank); 324 not clear	Open	Amber	When staffing shortages impact on ability to safely deliver services			SRO
6.4		Notify local commissioner and regional NHS EU exit team if there is a risk to the delivery of your contracted services	SW/AS				Open	Amber				SRO
6.4		Professional regulation - Refer to action card to progress	SW				Open	Amber				SRO
7	**Research & Clinical trials**											
		Ensure funding for EU funded projects identified	DC	Loss of funding		Assessment undertaken & return submitted to DH	Open	Green				SRO
		Assess impact on clinical trials of supply issues re medical devices etc	DC				Open	Green				
8	**Reciprocal healthcare**											
8.1		Reciprocal healthcare will remain the same until 29/03/2019; updates will be received via any changes from the Dh - refer to action card for web details	SM (SRO)				Open	Amber				Executive Team
9	**Data sharing, processing and access**											
9.1		Normal IG/GDPR arrangements will cover this element - information in action card that links to the ICO	SK				Complete TBC	Green			Green	SRO
		Annual data security assessment to be in date	SK				Complete TBC	Green			Green	
		Self audit against the 10 Data security standards is mandatory to be completed by 31/03/2019	SK				Complete TBC	Green			Green	
10	**Finance**											
10.1		To record all costs incurred by complying with this EU guidance	SM(SRO)				Open	Green				Executive Team
10.2		Direct costs to be recorded separately to opportunity costs	SM(SRO)				Open	Green				

Date action raised	Risk log reference	National Key Area Identified	Action required	Lead	Timeline	Action status	Current RAG Rating	Pause	09/09/2019
07/01/2019	3	Supply of Medicines and Vaccines	Maintain links into regional meetings/discussions	Antony Oxley	Ongoing				AO - No further update; check if flu vaccine supply impacted & any impact re measles?
07/01/2019	4.1	Supply of Medical Devices and Clinical Consumables	Follow up Enteral feeds & BOC gasses supply queries	Sarah Holliehead	Ongoing				SH - no further update; will check if anything changed
07/01/2019	5.1	Supply of non-clinical consumables, goods and services	Request assurances from UHL re business continuity plans for FM services	Sarah Holliehead	Ongoing				HW - queried with UHL, NHSPS, PFI etc;
07/01/2019	6	Workforce	Ensure on call rota robust for dates around 29th March, Brexit leads to support on call director	Sarah Willis	Ongoing				will do if needed for 31st October
28/01/2019	6.3	Workforce	Ensure status of 150 EU nationals (& 324 requiring clarity) clear; we identify where they work and impact on any high risk areas	Sarah Willis	ongoing				no update
28/01/2019	9.1	Data sharing, processing and access	SH review contract database (including HIS) & let SK know if any contracts at risk of LPT data being held in EU	Sarah Holliehead	ongoing				SK - no further update - National providers providing assurance; Kaushik & HIS relooking at contracts to check no gaps
28/01/2019	9.1	Data sharing, processing and access	PECA bill going through parliament; SK to review provisions within it for Brexit impacts & any actions needed for LPT	Sam Kirkland	ongoing				SK - no further update
12/02/2019	4.1	Supply of Medical Devices and Clinical Consumables	Need to prepare for extended lead times & prepare for 24 hour receipt of goods? SH to share comms	SH	ongoing				Bradgate, Loughborough & Coalville can accept deliveries 24 hours; SH check how can be distributed - use volunteer drivers? Maintenance staff & porters could assist. Fuel availability would be managed via LRF lists, SH check original fuel guidance.
12/02/2019	4.1	Supply of Medical Devices and Clinical Consumables	need to have assurance from UHL FM re replacement parts in emergency situations?	SH	ongoing				will respond when DH allow them to; checking with Arden Partnership. HW to ensure generator replacements in capital plan are prioritised.
20/03/2019		ALL	Daily sit rep reporting	SM/MR/BK/SH	ongoing				not currently active
02/04/2019	4.1	Supply of Medical Devices and Clinical Consumables	National supply disruption response	SH	ongoing				No national update
02/04/2019	5.1	Supply of non-clinical consumables, goods and services	National supply disruption response	SH	ongoing				No national update
09/09/2019	Winter		Could bad winter exacerbate Brexit impacts?						MR - review BCP to see if need to amend to include winter impact
09/09/2019	Servers			SK					Check with HIS re servers/parts availability

Communication Flow Chart - EU Exit



Leicestershire Partnership NHS Trust

Meeting Name and date	**Trust Board – 1 October 2019**
Paper number	G

Name of Report: **Update on External Governance Reviews**

For approval		For assurance	x	For information	

Presented by	Angela Hillery Chief Executive	Author (s)	Anne-Maria Newham Director of Nursing, AHP and Quality Anna Pridmore Interim Associate Director of Corporate Governance Hilary McCallion Independent Healthcare Consultant

Alignment to CQC domains:		Alignment to the LPT strategic objectives:		Alignment to LPT priorities for 2019/20 (STEP up to GREAT):	
Safe	X	Safe	X	S – High Standards	X
Effective	X	Staff	X	T – Transformation	X
Caring	X	Partnerships	X	E – Environments	X
Responsive	X	Sustainability	X	P – Patient Involvement	X
Well-Led	X			G – Well-Governed	X
				R – Single Patient Record	X
				E – Equality, Leadership, Culture	X
				A – Access to Services	X
				T – Trust-wide Quality improvement	X
Any equality impact (Y/N)					N

Report previously reviewed by	
Committee / Group	Date
Executive Team meeting	16 September 2019

Assurance : What assurance does this report provide in respect of the Board Assurance Framework Risks?	Links to BAF risk numbers
The paper provides assurance on the progress against completion of the recommendations identified in the two external reports commissioned by the Trust	Well Governed

Recommendations of the report
The Board is asked to note the progress against completion of the recommendations included in the two external governance reports commissioned by the Trust.

Leicestershire Partnership NHS Trust

1. Introduction/Background

In the last couple of years the Trust has received a number of key reports:

- NHSI Well led Review September 2018
- CQC report following unannounced inspection January 2019
- CQC Enforcement letter January 2019
- Corporate Governance report May 2019
- NHS England and NHS I Letter of undertaking May 2019
- Serious Incident review June 2019

In September 2018 the Trust received a report on the well led review undertaken by NHSI, following which the Trust had a visit from the CQC and the 2018 report and enforcement letter were published by the CQC in January 2019. The report covering the CQC visit in 2018 concluded the Trust's ratings as follows:

Trust overall	Requires Improvement
Are services safe?	Requires Improvement
Are Services effective?	Requires Improvement
Are services caring?	Good
Are services responsive?	Requires Improvement
Are services well led?	Inadequate

Following receipt of the CQC report and the enforcement notice in 2019, the Trust commissioned two separate reviews that concentrated on different aspects of governance. The two reviews concentrated on:

1 The governance and assurance processes for the delivery of the CQC action plans. This report was submitted as a first draft April 2019, and final draft May 2019

2 The examination of processes and procedures within the Trust for reporting, investigation and learning from serious incidents requiring investigation. The draft report was first submitted in April 2019 and final draft June 2019.

Both reports were considered by the Directors and recommendations from the reports were agreed. Several actions were agreed and implemented initially. The report covering the CQC action plan was considered by the Audit Committee and the Trust Board, and the report covering serious incidents was considered by the Quality Assurance Committee. The outcome was reported to the Board through the standard reporting systems.

Since production of the reports, both authors have been engaged by the Trust to support completion of the recommendations.

2. Aim

The paper is designed to provide the Board with an update on progress against the recommendations included in the two governance reviews commissioned by the Trust earlier this year.

3. Recommendations

The Board is asked to note the progress made to completing the recommendations included in the two external governance reports commissioned by the Trust.

4. Work being undertaken

4.1 NHSI well led report published September 2018

In 2018 the Trust commissioned NHS Improvement to undertake a well led development session. The outcome of the session included some detailed feedback which was provided to the Trust is September 2018. The key points from the review correlate with the findings of both external review reports.

The review made five recommendations as follows:

1 The Trust was asked to review and build on its approach to QI. The Trust has reviewed and started to build its QI approach. The Trust is developing a central QI knowledge hub and has started to introduce QI champions. This programme is a long term programme and is now starting to be embedded into the Trust. The governance arrangements for the QI programme have been developed as part of the review of the Quality Governance Framework and there is now a direct line of reporting from the Executive Team through to the Board Committee and the Trust Board.

2 The review asked the Trust to change its approach to staff engagement. The Trust has introduced a programme called ‘Our Future Our Way’ which is a full leadership programme that addresses culture, inclusion and leadership across the organisation.

The Trust has completed the first phase of discovery and design work and the Board has reviewed and approved the strategy and programme of work that is now being implemented. To support this work the Trust has recruited 80 volunteer change champions who have been provided with training. Leadership and team development programmes have been introduced and a communications engagement strategy is in place. The Board received a paper providing details of progress to date at its meeting on 1 October 2019.

3 The Trust was tasked with strengthening clinical leadership with particular attention to how it informs decision making in the organisation. This is linked to the first point around QI and the QI work that has been undertaken. The Executive lead for the QI

work is the Medical Director and she is putting in place systems as described above with the support of her other executive colleagues. The programme uses the Plan, Do, Study, Act (PDSA) approach and a number of improvement fundamental days have been arranged. The Trust has introduced the Improvement Fundamentals in a Day toolkit to support the improvement fundamental days. An improvement Knowledge Advisory Team and Ambassadors have been introduced to support the whole Trust in developing its QI work. There are currently 131 active projects of which 62 have been completed, 65 are being progressed and 31 are due to start. The clinical leadership has been strengthened with the appointments into a number of key posts across the organisation.

4 The Trust was asked to strengthen the leadership programme specifically targeting groups of staff. This is being addressed through the 'Our Future Our Way' programme which includes leadership and development programmes across the Trust at different levels.

5 The Trust was tasked with ensuring the framework to develop a culture of co-ordination and improvement for delivery was across quality, performance and finance and included a clear understanding of responsibilities and accountabilities. The Trust has been developing a new performance framework and has introduced the use of SPC charts for some key indicators. Work is progressing on the revision of the accountability and responsibility framework and is being informed by the work coming out of 'Our Future Our Way'.

The two external reports covered aspects of governance included a large number of recommendations to address. A full list of the recommendations from both reports is attached at appendix 1

4.2 Governance systems and processes following the CQC report.

Over recent months the Trust has worked to introduce a new Quality Governance Framework. The Board reviewed the revised framework at the August Board meeting and the final preparations for its launch are taking place during September with a final launch date of 1 October 2019. The Trust has also worked carefully to revise and strengthen the corporate governance framework with revision of terms of reference and template documents being put in place. Additional work is being undertaken with the Directorates to review and revise their operational governance to ensure it reflects the corporate governance arrangements and there is a clear line from Ward to Board.

Part of this work has included reviewing the work of the Board Committees and ensuring the responsibilities for the Board Committees is clear and they are receiving appropriate assurance. This has been underpinned by the work that has been undertaken around the Board Assurance Framework and Corporate Risk Register. The Trust Board agreed to maintain a single document and a revised structure for the document has been introduced, reviewed and discussed at Board in August and has been approved by the Trust Board on 1 October 2019. A revised process for the management of risk and the updating of the Corporate Risk Register and Board

Assurance Framework has been put in place to ensure ongoing maintenance of the document.

The Trust is continuing to develop and improve its governance arrangements including introducing further additional resources under the budding arrangements with NHFT around strategy and mental health services.

Significant work is being undertaken around the general preparation for any regulator visit. The Trust is developing a culture of ensuring the Trust is always in a ready state for a visit.

There are pieces of work that need further discussion within the Trust including:

- The management of policies
- The increased use of internal audit where they can provide assurance about evidence to support regulator inspections
- The development of a central corporate office

4.3 Process and procedures around Serious Incidents

The review identified significant work that needed to be undertaken to improve the management of serious incidents across the Trust. Work has been on the revision of the SI Policy although at this stage the policy remains in draft. Work is underway to progress this policy as an interim policy until the publication from NHSI of the SI framework in autumn 2019. The introduction of the policy addresses a number of the recommendations on an interim basis. The expectation being that the final policy should be in place within a short space of time after the publication of the SI framework and by the end of quarter 4.

The recommendations include the suggestion that an organisational wide Learning lessons forum and LPT conference is developed. Both of these aspects of the recommendation have been progressed. The Trust are introducing post incident learning/ briefing process for staff affected by an incident and broader learning for the whole organisation.

It is recommended to introduce a centralised safety team using existing resources. This work is being linked to the development and revision of the operational governance arrangements. Directorates are currently reviewing resources to enable this.

The Trust is also introducing further support for staff with Human Factors training. This training will start with the core investigation team and then be rolled out to other staff. The Medical Director and Director of Nursing, AHP and Quality feel strongly that the support given to staff around Coroners courts should be improved. The intention is to include pre-inquest meetings with legal support and improve the attendance at Coroners court for more complex cases with Director attendance when appropriate.

The expectation is that the majority of the work included in the recommendations in both external reports will be completed by the end of the calendar year.

5. Conclusions

The report demonstrates good progress has been made on completing the recommendations. The report demonstrates that there is further work to be completed, but it is anticipated that the majority of the recommendations will be completed by the end of the calendar year.

Appendix 1

External Governance Review – corporate governance and Serious Incident reviews

The Trust commissioned two governance reviews early in 2019 following receipt of the report and warning notice from the CQC in January 2019. Both reports made a number of recommendations. This report provides an update on progress against those recommendations as follow:

Recommendations from the corporate governance review	
Recommendation	**Action**
1 Review all Board Committee terms of reference (including work programmes) to ensure they describe the role of each committee and are complimentary to the other Board Committees.	The terms of reference for the Audit Committee, Quality Assurance Committee and Finance and Performance Committee were considered and amended so that they are consistent. The Strategic Workforce Group and the Mental Health Act Assurance Committee were not reviewed at the same time as amendments were being made to the Quality Governance Framework that impacted on both Committees. The amendments of the terms of reference for these committees are being done by the Trust Secretary as part of a review of all the terms of reference for the groups and committees included in the Quality Governance structure. It is expected this work will be completed by the beginning of November 2019
2 Specifically review the Audit Committee terms of reference to ensure they are in line with the HMFA audit handbook which is accepted as best practice.	Completed.

3 Ensure the Audit Committee has oversight and understanding of the internal control mechanism of the CQC action plans.	Completed. This has been included as part of the terms of reference,
4 Consider the amount of information that is provided to the Board and Board Committees for a meeting and if better assurance could be provided with simpler reports. Review the highlight report format and the information that is provided in the reports.	As part of the introduction of the revised Quality Governance structure, the Trust Secretary is reviewing the template documents including the highlight report system. It is expected this work will be completed by the beginning of November 2019. Work does still need to be undertaken to consider if the papers for committees and the Board could be simplified.
5 Address the outstanding actions including 2016 action.	Completed – the Head of Assurance has reviewed and closed off the actions from 2016.
6 Consider requesting Internal Audit to undertake spot checks on the assurance being provided by the services to address actions in the CQC action plans.	Included as part of an internal audit to take place in quarter 4
7 Ensure evidence being used to support the assurance that an action has been addressed is known and travels through the governance structure and is evident to the CQC.	Ongoing development of the governance frameworks. Discussions are being held with the Directorates to develop their governance structures to ensure information flows. It is expected this work will be completed by the beginning of November 2019.
8 Actively consider how the Board learns from different parts of the Trust and externally and evidence that learning.	Board learning encompassed as part of the extensive work being undertaken around creating a learning environment across the organisation. A new Learning lessons exchange group has been introduced which will report to the Quality Improvement Board, Quality Forum and Quality Assurance Committee and on to the Board. This will provide a structure for learning to be understood across the

	organisation.
9 Consider how decisions are made in the Trust and if the right level of information is available when the decision is made.	Ongoing as part of the revision of the governance structures at all levels. It is expected this work will be completed by the beginning of November 2019.
Recommendation	**Action**
10 Consider a development session to understand the Board members individual risk appetite and develop a bespoke risk appetite statement for the Trust.	Risk management development held with the Board on 30 August 2019. Further development of the BAF/CRR undertaken as part of that exercise. It is expected this stage of the work will be completed and approved by the Trust Board 1 October 2019. The Trust has put in place a process for the continuing updating of the BAF/CRR.
11 Consider reviewing the approach to risk management including the scoring system.	New policy written and out to consultation. Policy and strategy to be approved by the Trust Board on 1 October 2019
12 Consider reviewing the Board agenda to ensure time is allocated to the discussion of risk and assurance and that the Corporate Risk Register and Board Assurance Framework are discussed early in the meeting and the meeting continues to consider risk as it goes along.	Ongoing process – part of the review of the governance structures and introduction of revised templates. . It is expected this work will be completed by the beginning of November 2019.
13 Consider the communication that should go from the Board to the rest of the organisation about the discussions and decision the Board has had and made at the last meeting.	Work has not progressed on this item, but it is anticipated it will be part of the governance review work being undertaken by the Trust Secretary. It is expected this work will be completed by the beginning of November 2019.
14 Consider the level of scrutiny information should go through before it is released to external agencies.	Ongoing –Picked up as part of the review of the governance structures and the flow of information from operational directorate level through to Board. . It is expected this work will be completed by the beginning of November 2019.

15 Develop the governance framework so information is shared amongst the Directors before it is shared with the Board and Board Committees for assurance.	Ongoing - Part of the development of the governance structures. . It is expected this work will be completed by the beginning of November 2019.
Recommendation	**Action**
16 Consider the level of information provided to the Directors and assurance to the Board Committees.	Ongoing – part of the review of the governance structures. It is expected this work will be completed by the beginning of November 2019.
17 Consider the relationship of policies in the Trust and ensure there is signposting between policies. Consider the effectiveness of the implementation of policies.	A Trust Policy Committee has been introduced that will have oversight of the revision, introduction and removal of policies and other procedural documents
18 The Trust should consider the purpose and expectations of the Trust Secretary role and ensure the post is central to the corporate governance arrangements.	The CEO assumes responsibility for corporate governance systems and processes and is reviewing the roles and responsibilities to inform the buddying arrangements
19 Consider if the Trust should introduce a Corporate Governance Office.	Ideas being put forward and early discussions taking place as to how this might work, what it might include and the benefits it provides to the Trust.
20 Agree the metrics that will be measured in the Trust and used as part of the performance management framework.	Revised performance management system being developed and introduced by the Director of Finance. The intention is to introduce the framework by quarter 3.
21 Chief Pharmacist to consider the possibility of arranging to attend the Divisional monthly	Medical Director and Chief Pharmacist have worked together to revise the governance arrangements, this work has been completed

governance meeting.	
22 MRRG must review its reporting into the Patient Safety Group to ensure it is reporting to the Group on a regular basis.	Medical Director and Chief Pharmacist have worked together to revise the governance arrangements, this work has been completed
Recommendation	**Action**
23 Consider increasing the frequency of the medicine code audit to quarterly if it is felt that it would provide the additional assurance needed.	An online tool has been developed that give pharmacy feedback. There is current deployment to 75% of inpatient services with a plan to roll to the remainder and community by November 19. The current monitoring arrangements and actions are two weekly (via matrons) – When sustained improvement has been seen this is likely to drop to monthly monitoring. External scrutiny will continue via the annual quality schedule.
24 Consider arranging for ward pharmacists to visit the wards more frequently. Consider introducing a regular information fact sheet that updates staff on the key pieces of information they need to know this month.	Considered as part of the revision of the governance arrangements for pharmacy.
25 Consider if the estates team have the right skills to manage the collaborative arrangements and what support they can provide to the renegotiation of the agreement.	Additional resource has been introduced to the estate team to manage the contract. Contract review to be completed during quarter 4. Expected date of first report 31 November 2019.
26 Consider if the allocation of finance to support backlog maintenance is sufficient.	Review underway, the Trust has put itself into turnaround and as a result all allocation of funding is being reviewed. End of financial year.

27 It is worth the Trust investing in time to review the PIR before submission to the CQC, to ensure time is given to support the organisation before the CQC enters the organisation and to spend time reviewing the draft report and challenge anything that does not reflect the Trust or is factually incorrect along with the usual typographical mistakes.	PIR review and completion approach has been considered and changed so the Director of Nursing, AHP and Quality will review the PIR prior to submission. Work is being undertaken to prepare the Trust for the next CQC inspection including regular meetings with senior managers to support them in developing their understanding of the requirements of CQC KLOEs and inspections.
Recommendation	**Action**
28 Consider providing some training for those administration staff taking minutes for key meetings.	Discussions have taken place with the Trust Secretary around asking NHS Providers to hold a minute taking course in the Trust that will ensure a significant number of staff will be trained. NHS Providers are holding the next course of minute taking in London in December 2019.
29 Consider any training the Board members may need around assurance and risk management.	Risk management and assurance training session provided to the Board on 30 August 2019. Further ongoing training will be provided as requirements become apparent.
30 Consider undertaking a self-assessment of the Trust against the Code of Governance.	Not progressed at this stage.

Recommendations from the SI review		
No	**Recommendation**	**Progress**
1	It is recommended that amendments of the LPT Incident and Serious Incident Reporting Policy are made with immediate effect to bring the policy up to date and reflect the organisational and external changes that have taken place, this policy will have a temporary role until the policy can be rewritten and ratified for implementation.	Revised policy has been drafted and final review being undertaken before it is submitted for approval. Policy includes good practice from NHFT policies. The policy will be introduced to the Trust at the conference 25 October 19. For ratification and launch in November 2019.New policy to be consulted and written following publication of NHSI SI framework (Quarter 4)
2	It is recommended that the LPT Incident and Serious Incident Reporting Policy is reviewed and developed to reflect the publication of the Serious Incident Framework in July 2019, and that this policy should provide comprehensive, practical and accessible information for all LPT staff. This policy rewrite will include:	Revised policy has been drafted and final review being undertaken before it is submitted for approval. Policy includes good practice from NHFT policies. The policy will be introduced to the Trust at the conference October 19 .New policy to be consulted and written following publication of NHSI SI framework (Quarter 4)
2A	A definition and description of the reporting of incidents, the investigation process and guidance and tools to support the investigation.	Revised policy has been drafted and final review being undertaken before it is submitted for approval. Policy includes good practice from NHFT policies. The policy will be introduced to the Trust at the conference October 19. New policy to be consulted and written following publication of NHSI SI framework (Quarter 4)
2B	A recommendation and findings workshops with all those involved in the incident and Senior Management to enable ownership at the clinical level and commence the embedding of learning from the incident.	Change from present policy, awaiting NHSE SI Framework publication (Quarter 4) for consultation and rewrite
2C	An alignment of incident processes with Safeguarding, Health and Safety, Mortality reviews, complaints, claims and Inquests so that the inter-relationship provides a collaborative and cohesive approach to incident management.	Some inclusion as a variation to the draft policy submitted. Awaiting NHSE SI Framework publication (Autumn 2019) for consultation and rewrite and to be able to fully align with organisational sign up

No	Recommendation	Progress
2D	A description of roles and responsibilities in the investigation process plus the involvement of staff, families and carers and other agencies in the process.	Draft policy completed and submitted, variation of present policy and includes good practice from NHFT policies. New policy to be consulted and written following publication of NHSI SI framework (quarter 4)
2E	An organisational approach to decision making regarding the level of incident; the terms of reference and the investigator/investigation panel.	Draft policy completed and submitted, variation of present policy and includes good practice from NHFT policies. New policy to be consulted and written following publication of NHSI SI framework (quarter 4)
3	It is recommended that a recommendation and findings workshops should be implemented in all Serious Incidents as routine practice and should include those involved in the incident and Senior Management to enable ownership at the clinical level and commence the embedding of learning from the incident.	For discussion at Learning Organisation day (25/10/19) Change from present policy, awaiting NHSE SI Framework publication (Autumn 2019) for consultation and rewrite. Discussions re: pilot to be tested in clinical services, and dashboard to be developed.
4	It is recommended that the overview, and management of the incident and serious incident process for the trust be centralised for at least eighteen months to have consistent standards in incident and serious incident management and processes across the Trust and that these processes should include:	Business plan provided for phase one implementation as priority to strengthen Patient Safety service. Directorates are currently reviewing resources to enable this. Phase two requires co-production and trust wide consultation to implement. Commence October 2019.
4A	that all Incident and Serious Incident reports for submission to the CCG, NHSE, NHSi should be formally signed off by the Medical Director and Chief Nurse to ensure consistency in quality of reports.	Systems in place to facilitate this, implemented by Head of Patient Safety

No	Recommendation	Progress
4B	a strengthening of the central Trust patient safety team with the inclusion of two dedicated Process Investigation Facilitators to provide support and overview of the investigation process which will increase quality, timeliness, objectivity and trust-wide learning from the production of Investigation reports.	Business plan provided for phase one implementation as priority to strengthen Patient Safety service. Phase two requires co-production and trust wide consultation to implement. Commence September 2019.
4C	A monthly learning update for all team leaders, medical consultants, occupational therapist, psychology leaders and managers to clarify local, directorate and trust wide learning and improvements to be made.	For discussion at Learning Organisation day (25/10/19) Change from present policy, awaiting NHSE SI Framework publication (Quarter 4) for consultation and rewrite
5	it is recommended that the quality of Serious Incident reports would be improved through the consistent use of RCA methodology including Human Factors processes, the inclusion of policy, and SMART recommendations.	Draft policy completed and submitted, variation of present policy and includes good practice from NHFT policies. New policy to be consulted and written following publication of NHSI SI framework (Quarter 4)
6	It is recommended that the directorate governance staff provide regular feedback (monthly) to clinical multi-professional teams of local, directorate and trust wide learning, and quality information and data to all services to enhance implementation and embedding of learning.	Further discussions with services, and a pilot to tested in clinical divisions. Ongoing process.
7	It is recommended that all team leaders, medical, psychology and occupational therapy leaders demonstrate that learning from incidents and complaints is evident across all teams at all levels, and that they will be able to evidence this with scenario or written evidence.	For discussion at Learning Organisation day (25/10/19) Change from present policy, awaiting NHSE SI Framework publication (Quarter 4) for consultation and rewrite

8	It is recommended that a Trust wide communications strategy between Strategic and Clinical team level for information sharing and the implementation and embedding of Trust-wide recommendations is developed.	For discussion at Learning Organisation day (25/10/19) Change from present policy, awaiting NHSE SI Framework publication (Quarter 4) for consultation and rewrite
No	**Recommendation**	**Progress**
9	It is recommended that the Director of Finance employ or identify individuals who are able to analyse data and information and produce relevant graphs/run charts/spark lines or SPC.	Board development session on 30 August introduced 'plot the dots' and SPC methodologies. Head of information is developing the IQPR in line with SPC methodology
10	it is recommended that the Board of Directors determine their trust-wide approach to the analysis, and provision of data which provides assurance and is in line with quality Improvement techniques and that this forms part of the vision for quality and quality strategy for the trust.	Board of Directors workshop on QI processes Board development session on 30 August introduced 'plot the dots' and SPC methodologies. Head of information is developing the IQPR in line with SPC methodology
11	it is recommended that reports are submitted to the Quality Assurance Committee in a format that reflects the organisation and its directorates rather than separate reports.	A revised Quality Governance Structure has introduced a Quality Forum. This forum will escalate relevant reports/issues to Quality Assurance Committee.
12	it is recommended that the clinical directors provide directorate reports to the Quality Assurance Committee, using a specified template which provides relevant information including the evidence of implementation of learning from incidents qualitatively and quantitatively	The Quality Assurance Committee has revised the agenda to receive one highlight report from a directorate each month, thus 3 monthly reporting. This report is now in a quality improvement format.
13	It is recommended that the directorate governance staff provide support to front-line clinical staff to implement quality improvement processes within the clinical area to enable embedding of incident outcomes.	All directorates are now engaged in the QI knowledge hub and have introduced QI methodologies through PDSA. Staff are being trained in QI through QSIR training provided by NHFT.
14	It is recommended that all team leaders, medical consultants, occupational therapists and psychologists train in quality improvement methodology and demonstrate these skills in practice.	We are moving through a full programme of training using QSIR offered to us through NHFT. Several staff in LPT already have Masters in QI. We are launching a QI conference in 2019, and joining with UHL to deliver a QI conference in 2020.

15	It is recommended that Quality improvement is an integral part of the quality strategy under development within the Trust.	Awaiting ratification and direction Developed as part of the QI strategy
	ADDITIONAL REQUESTS	
16	Develop a Quality structure for the organization	Completed and submitted by Director of Nursing, AHP and Quality, to Board development 30 August and Formal Trust Board 1st October 2019. .
17	Investigate homicide	Ongoing, for completion mid-October, delayed start due to capacity in the Patient Safety Service
18	Analysis of aggression and violence data	Completed and submitted using data received for Head of Patient Safety
19	Paper for CEO re: case for team enhancement	Completed and submitted. Considered by Medical Director and Director Nursing September 2019, with recommendations made for development October 2019.

Following discussions between Hilary and Anna it has been agreed that a meeting will be arranged to work with the Directors and governance leads to progress the restructuring of governance processes in the organisation. This work links in closely with the work that Hilary is undertaking around SI management and the work Anna is undertaking around the restructuring of governance structures within the Directorates. The work should be completed by the end of October 2019.

Anna Pridmore

Interim Associate Director of Corporate Governance

Professor Hilary McCallion CBE

Independent Healthcare Consultant

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board 1st October 2019
Paper number	H

Corporate Governance Renewal

For approval	X	For assurance		For information	

Presented by	Angela Hillery	Author (s)	Frank Lusk

Alignment to CQC domains:		Alignment to the LPT strategic objectives:		Alignment to LPT priorities for 2019/20 (STEP up to GREAT):	
Safe		Safe		S – High Standards	
Effective		Staff		T - Transformation	
Caring		Partnerships		E – Environments	
Responsive		Sustainability	x	P – Patient Involvement	
Well-Led	x			G – Well-Governed	x
				R – Single Patient Record	
				E – Equality, Leadership, Culture	
				A – Access to Services	
				T – Trust-wide Quality improvement	
Any equality impact (Y/N)		No			

Report previously reviewed by	
Committee / Group	Date
Trust Board 30 August 2019 reviewed principles paper for approval. Governance charts have been shared for development at Executive Team meetings. Working groups such as Directorate clinical/nursing leads, and 1:1 meetings with Trust Secretary for leads.	August, September 2019

Assurance : What assurance does this report provide in respect of the Board Assurance Framework Risks?	Links to BAF risk numbers
Addressing CQC Inspection concerns for governance structures.	

Recommendations of the report
The Board is asked to approve the renewed Corporate Governance arrangements.

1. Introduction/Background

1.1 The CQC inspection in November 2018 with report published 27 February 2019 stated that 'the governance of the trust was poor' and 'did not have robust governance procedures to ensure that they could identify and address issues across the trust in a timely way'. It also stated 'the trust lacked a framework for endorsing and therefore learning from the positive quality projects taking place'.

1.2 The development of proposals for a revised Corporate Governance Structure has been discussed in the NHFT and LPT "Buddy Forum", Executive Operations meetings, the 30 August 2019 Board, and a series of meetings during September 2019. It is also reflective of the findings of the External Governance Reviews discussed earlier at this Board meeting.

2. Aim

2.1 To address the concerns outlined in the CQC report in respect of clear lines of reporting, accountability for quality, finance and performance corporate assurances up to the Quality Assurance Committee (QAC) and Finance and Performance Committee (FPC).

3. Recommendations

3.1 The Board is asked to approve the renewed Corporate Governance arrangements

4. Discussion

4.1 The Annexes illustrate the proposed corporate governance structures building upon earlier versions approved in principle at the 30 August 2019 Trust Board Development session.

4.2 The assurance is at three levels and illustrated by the colour code; highest level is the Board and its sub-committees QAC and FPC; second level is the direct reporting assurance committees/groups to QAC and FPC that are critical to determining escalation of risks/reportage to Board level; third level is the expert knowledge committees/groups.

4.3 The key changes since the August Board session reflect a deepening understanding of what is meant by the three levels of as illustrated by more appropriate colour coding, and additional input from Executive Directors.

4.4 The changes since 30 August 2019 Trust Board for the renewed Quality Governance Structure (Annex A) reflect:

a. Introduction of Joint Staff Consultative Negotiating Committee (JSCNC) reporting into the Strategic Workforce Committee. Previously the JSCNC was not captured formally in corporate governance arrangements.
b. Prescribing Group now the Medication Risk Reduction Group.
c. Introduction of the Complaints Review Group to strengthen the scrutiny of this activity.

4.5 Overall QAC has reduced its reporting-in groups from 8 to 5 groups whilst at the same time the rigour and corporate assurance covering quality matters has seen an

increase of 13 to 36 from the previous total of 23 groups/sub-groups. It is anticipated that this arrangement will eventually lead to QAC meeting on a bi-monthly basis and being more reflective of first level assurance scrutiny.

4.6 The roles of the Quality Forum and Legislative Committee will be critical to the efficacy of the new clinical governance arrangements.

4.7 The removal of MHAAC and Strategic Workforce Group as Board committees sees the release of Non-Executive and Executive Directors time.

4.8 As reported to the 30 August 2019 Trust Board the former Executive Management structure had finance and performance working groups reporting-in and would need to be considered ahead of this paper. The renewed Finance and Performance Governance have been devised by the Finance Director working with the Trust Secretary such as to remove all previous Executive Management Groups reporting into the Executive team. This arrangement had not proven to be effective for the rigour and transparency of corporate assurances needed. The renewed corporate governance arrangements for FPC are at Annex B. Key points are:

a. 7 reporting-in Committees.
b. Introduction of Transformation Committee; Waiting List and Harms Prevention Committee; and Financial Turnaround Committee. All of these committees will address "gaps" in corporate governance current arrangements.
c. Introduction of Sustainability Champions Group not previously captured formally in corporate governance arrangements.
d. The reporting-in to the Transformation Committee of all major Programme Boards pertaining to change eg Electronic Patient Record Board, All Age Mental Health Transformation Board.

4.9 The Executive Team meetings have been re-set and implemented for a cycle of Operations, strategic and Development monthly meetings.

4.10 The Quality Improvement Board, a key requirement from the CQC inspection follow-up letter, has been implemented.

4.11 Transition next steps:

October	**November**	**December**	**January**
Governance Workshop (for Chairs and governance leads) introducing changes, Board expectations for corporate assurances and information flow, and transition actions eg capturing of risks, workplans. Communication of approved structure to all Chair/leads.	Governance workshop covering changes, focus on CQC KLOEs and Step Up to Great, and Governance Pack.	Governance workshop covering changes, focus on CQC KLOEs and Step Up to Great, and Governance Pack.	Governance workshop covering changes, focus on CQC KLOEs and Step Up to Great, and Governance Pack.

October	November	December	January
Call to nominate Chairs for revised TORs, confirmation of meeting dates. Divisional governance arrangements development. QAC/FPC work programme adjustments to reflect the revised reporting-in committees so a flow of information from the levels 2 and 3 can be timetabled. Meetings commence under new structures.	Approval of TORs by lead committees. Completion of transition of Divisional governance arrangements. Meetings commence under new structures.	Approval of outstanding TORs by lead committees	Internal Audit Review of Governance Structures.

4.12 A series of "Master Classes" will be held up to the end of the year (and beyond it is expected). In addition a Governance Pack is being developed to support chairs, and available on the intranet, will comprise of standardised:

a. TORs template
b. Work programme framework
c. Agenda template
d. Front sheet and Report format
e. Highlight Report
f. Action Tracker

5. Conclusions

5.1 The new Corporate Governance Structures reflect the three tier approach to assurance, and best practice from our buddy Trust NHFT.

5.2 The structures are comprehensive in coverage and thematically collate similar areas of activity for improved oversight.

5.3 The roles of the Quality Forum and Legislative Committee will be critical to the efficacy of the new clinical governance arrangements.

5.4 A roadmap is in place for the completion and implementation of the new arrangements.

Annexes:

A. Quality Governance Structure
B. Finance and Performance Governance Structure

Level 1 Level 2 Level 3

Quality Governance Structure

Leicestershire Partnership NHS Trust

Trust Board

Quality Assurance Committee

Trust Policy Committee

Health and Safety Committee

- Moving & Handling Steering Group
- Water Management Group
- Emergency Preparedness, Resilience & Response Group

Strategic Workforce Committee

- Joint Staff Consultative Negotiating Committee
- Learning & OD Group
- Workforce & Well-Being Group
- Professional Standards & Learning Group
- Equality, Diversity & Inclusion for Staff Group
- Medical Education Group

Quality Forum

- National CQUINs & Quality Schedule Group
- Medication Management Group
  - Medication Risk Reduction Group
- Patient Carer & Experience Group
  - Equality, Diversity & Inclusion for Patients Group
- SI Oversight Group
- Complaints Review Group
- Legislative Group Agenda: Safeguarding, Positive & Safe, MCA, MHA
- Infection Prevention & Control Group
- Patient Safety & Improvement Group
  - Deteriorating Patients & Resuscitation Group
  - Medical Devices
  - Nutrition & Pressure Ulcers Group
  - Falls Group
- Learning from Deaths
  - Suicide Prevention work GP (Project GP Time Limited) Group
- Clinical Effectiveness Group
  - Care Planning Approach Group
  - Research & Development Group
  - Electroconvulsive Therapy Group
  - Clinical Audit Group

Quality Improvement Board

Learning Lessons Exchange Group

Executive Team:

Strategic Executive Meeting

Development Executive Meeting

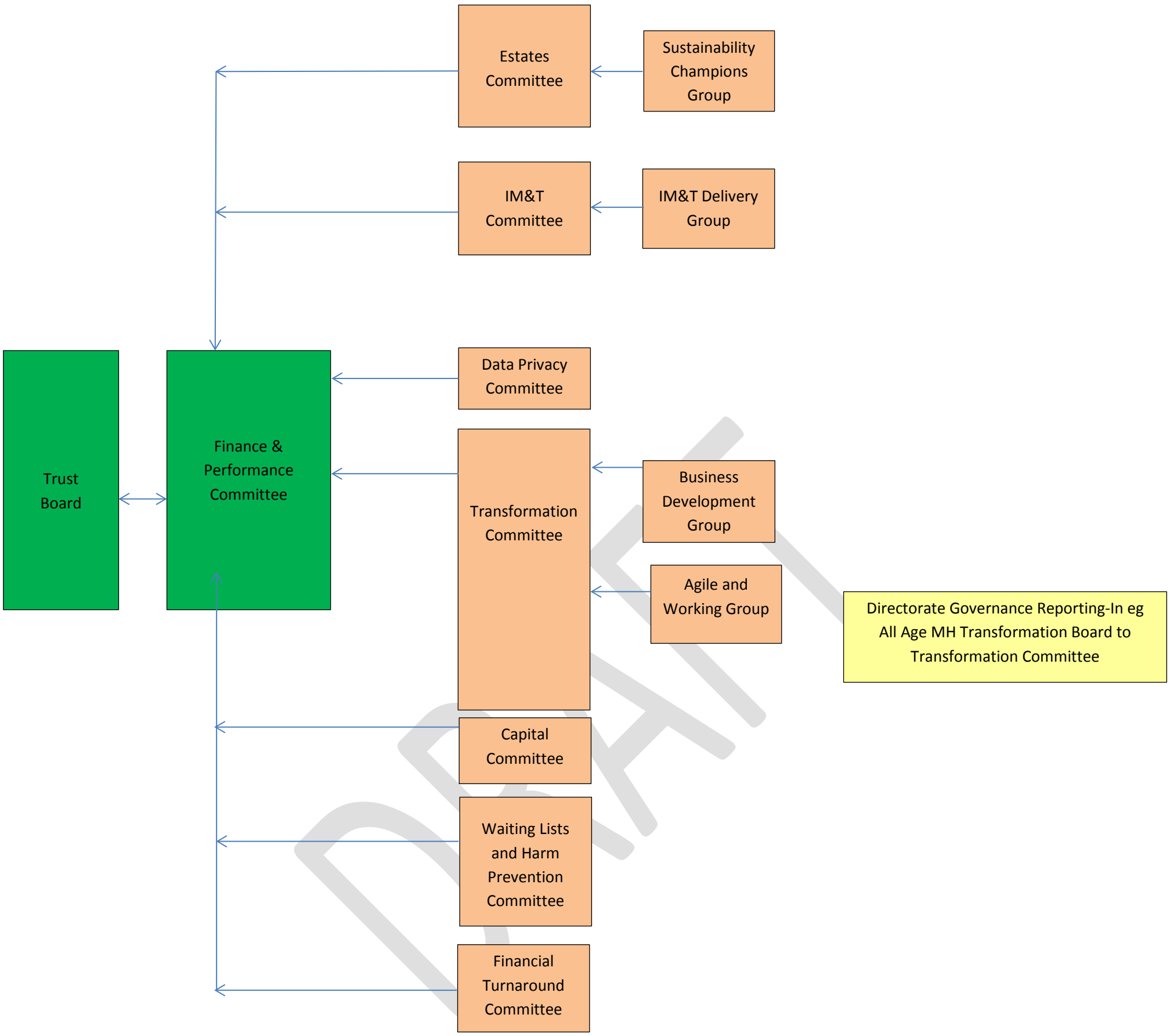
Operations Executive Team Meeting

Directorate Governance Reporting-In eg Directorate Worforce Groups to Strategic Workforce Committee

Level 1 Level 2 Level 3

Finance & Performance Governance Structure

Leicestershire Partnership NHS Trust



Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board 01.10.2019
Paper number	I

Name of Report: Better Care Together Update

For approval		For assurance		For information	Yes

Presented by	Angela Hillery, CEO	Author (s)	BCT Office

Alignment to CQC domains:		Alignment to the LPT strategic objectives:		Alignment to LPT priorities for 2019/20 (STEP up to GREAT):	
Safe		Safe		S – High Standards	
Effective		Staff		T - Transformation	Y
Caring	Y	Partnerships	Y	E – Environments	
Responsive	Y	Sustainability		P – Patient Involvement	
Well-Led	Y			G – Well-Governed	Y
				R – Single Patient Record	
				E – Equality, Leadership, Culture	
				A – Access to Services	Y
				T – Trustwide Quality improvement	Y
Any equality impact (Y/N)		N			

Report previously reviewed by	
Committee / Group	Date
N/A	

Assurance : What assurance does this report provide in respect of the Board Assurance Framework Risks?	Links to BAF risk numbers

Recommendations of the report
The Board is asked to note the Better Care Together Update Bulletin for August/September 2019.

Better Care Together Partnership update

A business update for partner boards, governing bodies and members

August/September 2019

Welcome to the business update from the System Leadership Team (SLT) of Better Care Together. The purpose of this update is to inform governing bodies, boards and members on the key business and strategic work programmes being discussed and taken forward by SLT.

Support for people with learning disabilities and/or autism

People with a learning disability and/or autism are citizens with rights, who should expect to lead happy, safe, active lives in the community and live in their own homes just as other citizens expect to. We need to reduce hospital admissions and improve and support services in the community, and improve their quality of life. In Leicester, Leicestershire and Rutland (LLR) we have been part of the national Transforming Care programme seeking to achieve these changes ensuring they become 'business as usual'.

SLT heard of achievements including extending the Learning Disability outreach team to be available seven days a week and providing a wrap-around approach as a means of trying to prevent admission and facilitating discharge out of in-patient beds.

SLT discussed the ongoing work to better understand the current and future needs of people with a learning disability and/or autism in LLR, the number of inpatient beds required and the best way to provide care in the community. Part of this approach involves the need to consider how local health and care organisations can support the development of new services to improve quality and choice. A service specification is to be written setting out what services need to be provided for people with a learning disability and/or autism who are experiencing a crisis. There is also a desire to progress the learning gained from the Learning Disabilities Mortality Review (LeDeR) programme. This is a national programme aimed at improving services based on insights into health and care from people with learning disabilities, their families and carers.

SLT members also discussed plans to develop an 'autism hub' through three-years of transformation funding. The website would help signpost families and carers to services and support. SLT was also updated on key priorities for the future which include achieving the inpatient trajectory for children and young people. A review of LLR community learning disability services is being commissioned and alternatives to inpatient provision are being explored including the availability of crisis accommodation.

SLT heard a request for more information to be provided to GPs on the wrap-around services available for people with a learning disability and/or autism. Each CCG area is served by a primary care liaison nurse in this regard. It was agreed that more information on learning disability and autism services would be provided on the PRISM information system.

SLT discussed organisation and system solutions to achieve better outcomes for service users, which meet targets including the pressing issues of identifying children early on the pathway and building a solution supported by a clinical community service for service users who have offended.

The work stream was asked to identify solutions and provide a plan and proposal to be discussed at the next SLT meeting.

Advancing mental health

SLT heard about the new Mental Health Partnership Delivery Board, formed to oversee mental health care, support and service provision in LLR. The Board, which met for the first time in June 2019, has established its terms of reference and will consider the mental health and wellbeing of local people of all ages, children and adults. It will provide the strategic direction for the implementation of mental health priorities that have been identified in the *Five Year Forward View* and *NHS Long Term Plan* across LLR.

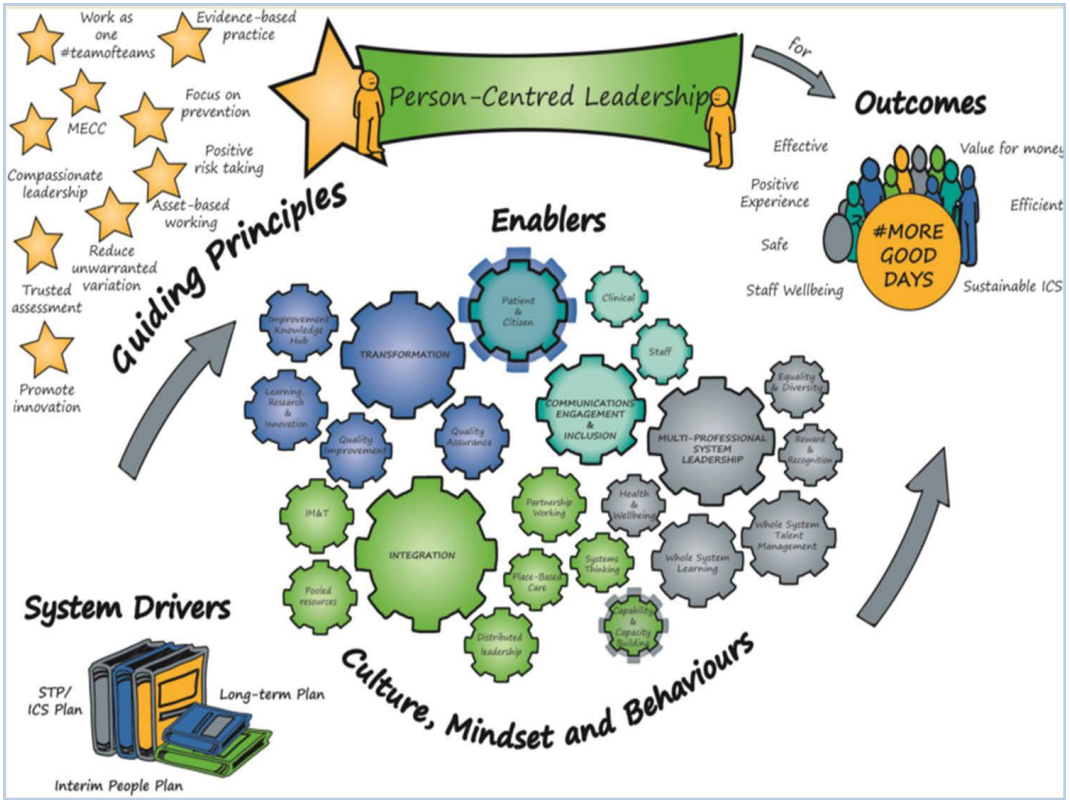
Work streams that will report into the board include groups looking at wellbeing and prevention of mental health problems, the Future in Mind programme for children and young people, the closer integration of physical and mental health care services, mental health crisis service provision, and adult complex care and rehabilitation services.

SLT discussed a key issue to be addressed by the Delivery Board which will be inpatient length of stay and the high number of out-of-area placements. Out-of-area placements impact on patient experience and affects contact with families. It is also costly to the LLR health and care system. A recovery plan has been developed to eliminate inappropriate out-of-area placements by 2021.

SLT asked the work stream to provide a bespoke report by the November meeting, discussing the approach to improve the flow of service users and identifying the request of the health and care system to support these improvements.

Putting patients and the public at the centre

As part of the local response to the *NHS Long Term Plan*, the System Leadership Team (SLT) has heard about a proposal to set up a Person-Centred Leadership Framework in LLR. It is intended that the framework is adopted across the health and care system, focusing on developing a positive culture and behaviours that support working across organisational boundaries – all for the benefit of patients.



The framework sets out four key enablers – multi-professional leadership, transformation, integration, and communications, engagement and inclusion. The aim is to deliver 'more good days' for patients, citizens and staff – that people feel listened to and their views are acted upon. Included within plans to roll out the framework are communications activities in support of the 'more good days' message.

New plan to improve urgent and emergency care

With attendances at Leicester Royal Infirmary's emergency department (ED) rising by nearly five per cent annually, health and care leaders have produced an urgent and emergency care transformation plan to address the challenges.

The plan's aim is to create a health and care system that provides responsive, accessible person-centred services as close to home as possible. It will be a model in which services will wrap care around the individual, promoting self-care and independence, enhancing recovery and reablement, through integrated health and social care services. The plan aims to develop same day emergency care services, both in hospital and in the community, to better manage patients with long term conditions, thereby reducing demand on the ED.

Key objectives for 2019-20 are to:

- Improve performance in meeting the four-hour waiting time standard in ED
- Eliminate delays in ambulance crews being able to hand over patients
- Improve the responsiveness of services including ambulance response times
- Reduce the demand on ED services by developing in and out of hospital same day emergency care services
- Reduce delayed transfers of care and reduce the numbers of long-stay patients in hospital.

A final version of the urgent and emergency care transformation plan was submitted to NHS England and NHS Improvement in August 2019 and subsequent feedback has indicated that it was the best quality plan in the region.

The plan will seek to manage demand on services in a number of key areas. These include close liaison with care homes about their residents, the potential for a GP-led facility at Leicester General Hospital for short-term observation bays, and improving awareness and understanding of the available, appropriate services among Leicester's large student population.

SLT recognised that the challenge was now in the delivery of the plan which was challenging to do alongside 'business as usual'. They generally supported the level of intensity to make this happen, but asked the work stream to define the support needed to deliver the plan and the reporting mechanism.

Getting our finances right

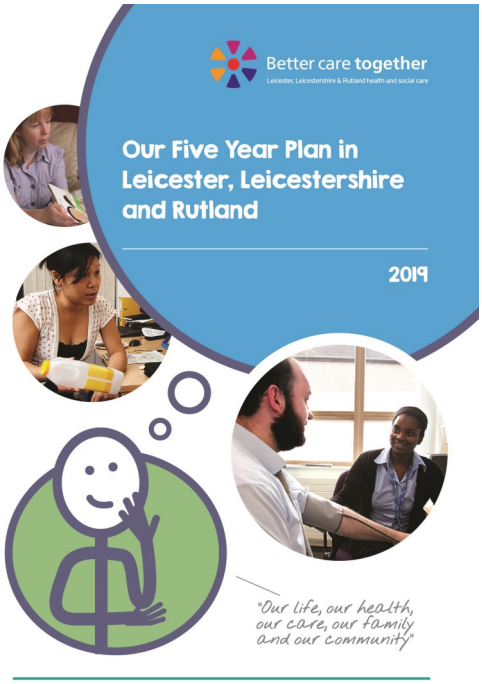
A financial recovery plan is in place for the LLR health and care economy as current figures, at this point in the financial year, point to a significant over-spend.

The plan details the scale of the challenge, the recovery actions being taken, high-level governance arrangements, and risks.

Key priorities include managing demand, particularly in urgent care and the independent sector, and controlling costs and continuing to implement cost improvement programmes. Other key areas being addressed are the need to reduce the numbers of patients being re-admitted to hospital, supporting ambulances in taking patients to appropriate services other than ED, and reducing patient admissions to hospital from care homes. A System Sustainability Group is meeting fortnightly to monitor and review the plan.

Five Year Plan addresses our key priorities

The SLT has reviewed an initial draft of the *Better Care Together* Five Year Plan, drawn up in response to the *NHS Long Term Plan*, published January 2019, setting out how health and care will be taken forward.



Better Care Together is a collaboration of partners aiming to transform health and care and create a financially sustainable health and care system for the future. The vision of the LLR Better Care Together programme is: *"to develop an outstanding, integrated health and care system that delivers excellent outcomes for the people of Leicester, Leicestershire and Rutland."*

BCT plans are based on the priorities of:

- Keep people well and out of hospital
- More care closer to home
- Care in a crisis
- High quality specialist care

The plan also addresses how organisations within LLR will seek to move towards establishing an integrated care system (known as an ICS). Our approach to developing an ICS will take place over three distinct geographical areas – across the entire LLR area, at place (local authority boundary) level, and at neighbourhood (primary care network) level.

Also in line with the NHS Long Term Plan to move commissioning to a more strategic role, the three clinical commissioning groups (CCGs) are currently considering their future form. Engagement with stakeholders and member practices will be undertaken later this year. The CCG governing bodies will then consider the outcome of the engagement and undertake formal consultation.

A draft submission of the *Better Care Together* Five Year Plan is being produced for the end of September 2019, prior to a final submission by 15 November 2019.

Ji

Leicestershire Partnership NHS Trust

TRUST BOARD –1 October 2019

QUALITY ASSURANCE COMMITTEE –20 August 2019

HIGHLIGHT REPORT

Not assured	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans
Partially assured	Amber - there are gaps in assurance but we are assured appropriate action plans are in place to address these
Assured	Green – there are no gaps in assurance

Section 1 – Assurance Topic			
Topic	**Assurance Level (RAG)**	**Rationale for Assurance Level**	**Action being taken**
Draft Integrated Quality and Performance Report (IQPR)		CPA 7 day and 12 month performance improving. Work continuing to make further improvements to systems and process.	Update on progress to QAC via the IQPR report
Care Quality Commission (CQC) Inspection 2017 and 2018 progress update		70% of the warning notices actions are complete, with minor movement on the 'should do' actions. A mapping exercise is taking place of the remaining 30% actions. Panel meetings reintroduced to monitor progress on actions and to maintain the pace of progress	Update on progress to QAC via the Care Quality Commission progress updates

Items for escalation from Safeguarding Committee Highlight report		Safeguarding Training. Risk. Lack of capacity to deliver training, which is impacting on the CQC, must do action compliance External consultant commissioned to review capacity of the safeguarding team and work continues with a task and finish group within the Trust looking at the safeguarding training offer requirements.	An update will be provided by the October 2019 via the Safeguarding Committee highlight report.
Items for escalation from Patient Safety quarter one report		A thematic review of the incidents relating to Crisis will be undertaken and with more staff engagement. Increase of aggression and violence incidents particularly on the Bradgate unit .A number of incidents been investigated internally or as a Serious Incident. Using a multi-disciplinary reflection sessions	Findings are being written up. Update to be provided by the Patient safety highlight report.
Monthly Quality Monitoring Report - Serious Incidents (SIs)		Pilot of the new SI framework taking place and due to be released in November 2019. Work to take place to ensure that LPT are the correct process in place	Update and issues to be provided to QAC via the SI report.
Mortality & Morbidity Surveillance Group-quarterly report		Currently all deaths that occur are reviewed, including those within the Community, due to the large numbers and insignificant data available, only minimal learning from these. Work taking place to improve the information	Update on progress to be provided via the Mortality & Morbidity Surveillance Group-quarterly report.

		to enable learning to be shared.	
FYPC review- clinical audit report on handovers (care plans and risk assessments) on Ward 3 and Langley.		On-going issues and concerns of quality of handovers. Action plan developed and re-introduction of the fortnightly quality ward assurance meetings Piece of work around what a good handover looks like and a quality visit on Langley ward by the patient safety team has been requested	FYPC will continue to monitor and will provide updates via the FYPC highlight reports.
Community Health Services (CHS) Directorate highlight report		Member of staff from Intensive Community support (ICS) raised concerns with the CEO regarding quality of care, safety of patients, and excessive workloads and staff morale during the transition period of Community Service Redesign. Review of all the quality and safety metrics and that all of the governance processes are continuing through the redesign. No deterioration of patient care and safety was found. A quality summit for staff has been organised.	Further work will continue over the coming months and regular Comms will be provided to the teams. An update on the position and feedback from the quality summit will be provided to QAC via the CHS quarterly highlight report.
Director of Nursing, AHP's and Quality update		The Electronic Patient Record (EPR) Project implications for the clinical staff training. Potential drop in productivity and inability to review notes during the transition. Deputy Director of	Updates on progress and issues to be raised with QAC when appropriate.

		Nursing, AHP's and Quality appointed to chair the EPR meetings	

Section 2 – Other items for Escalation			
Topic	**Level of Concern (RAG)**	**Rationale**	**Action being taken**
Quality Strategy QIP Update including CQUINS and Quality Schedule		Progress is on track, no risks identified. Quality schedule for 2019/20 agreed by LPT and East Leicester and Rutland CCG.	
Patient Experience Triangulation Quarterly report 2019-20		Well balanced report received, with notable progress being made. Work continuing within the patient experience team to improve the processes and engagement of patient and carers.	
Recommendation	The Trust Board receives the issues raised from the Quality Assurance Committee held on 16 July 2019.		
Author	Liz Rowbotham, Non-Executive Director, Chair of QAC and Deborah McMahon, PA		
Presented by	Liz Rowbotham		

TRUST BOARD –1 October 2019

QUALITY ASSURANCE COMMITTEE –17 September 2019

HIGHLIGHT REPORT

Not assured	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans
Partially assured	Amber - there are gaps in assurance but we are assured appropriate action plans are in place to address these
Assured	Green – there are no gaps in assurance

Section 1 – Assurance Topic			
Topic	**Assurance Level (RAG)**	**Rationale for Assurance Level**	**Action being taken**
Draft Integrated Quality and Performance Report (IQPR)		CPA performance requires further work to ensure consistent performance levels Patient harm indicator is not considered meaningful and other indicators may be better Revision of IQPR awaited	CPA group to consider further actions For consideration with review of IQPR
Risk Management update		New BAF/CRR expected October 2019 following significant changes to format and underlying policies. Final version expected at October QAC following October 1st board approval. New cycle of review from November onwards	New BAF/CRR to be received and reviewed at October 2019 QAC

Care Quality Commission (CQC) Inspection update		Progress is being made against actions and audits of embedded changes. Despite this much of the narrative is outdated and requires timely updates by the contributing teams. Fortnightly progress meetings now in place to oversee progress of action plan and equally preparation for next CQC inspection. Risk assessment of non achievement of actions in current plan is needed.	Continue with current actions. Reinforce the need to update the narrative in the plan Continue with the the momentum initiated for the preparation for the next CQC inspection Risk assessment to be included in the next report to QAC
Quality Improvement plan		Update received on establishment and initial areas of work in Quality Improvement Plan overseen the QIP board.	Regular updates to be received on progress
Quality governance framework		The new quality governance structure was received and discussed. Support was confirmed for the new structures. Positive feedback re the inclusion of SWG assurances. Further clarity suggested on how operational escalation will take place to the Executive. The new structure requires the establishment of a number of groups most significantly the Quality Forum	Further confirmation on the establishment of the structure required Workplan of QAC will need to be revised by November
Safeguarding committee		Concerns remain re medical leadership and representation. Capacity for training requirements of the trust is part of the	Await the outcome of the review for further actions required

		external review being undertaken. The Safeguarding Committee was closed down and responsibilities transferred to legislative committee	Risk assessment to be maintained for the service and implication re training availability
Patient Safety Improvement Group Highlight report		Reporting from sub groups improving. Concerns raised re medical devices in CHS but actions identified Policies under review but some still out of date	Continue to receive the improved reporting from sub groups and escalate areas of poor assurance Continue with policy work
Monthly Quality Monitoring Report – Serious Incidents		Reporting of Sis and associated processes improving	
IPC announced inspection report and action plan; routine IPC report and annual IPC report		The findings of the announced inspection were very disappointing. The resulting action plan addresses the specific issues. Discussion included the culture related to IPC in parts of the trust not be positive and the need to address this. The routine report highlighted the action being taken to achieve flu vaccination levels and whether these will achieve required levels. The routine report also highlighted that the Mill Lodge wall padding which has been unresolved for many months now has a temporary solution and a permanent solution	Further update to be received at QAC in October and the board in November

		agreed and funded The annual report was received and discussed	Annual report to be received by board members for information
Medicines Management Group		First report received from newly established group. The report contained specific drug related work. An update re CQC medicines management issues next month	
Director of Nursing, AHP's and Quality update		The report covered multiple areas including changes to the complaints process, the use of blanket restrictions in the trust , further work related to ligatures. A new report is to be introduced related to quality surveillance. This will integrate outcomes of external reviews and visits in future bringing together the themes and the actions being taken .	To receive further updates on work as required
ICS summit		QAC received the outcome of a quality summit re ICS concerns. The summit had been well received by the staff and a number of actions were agreed and underway	
Health & Safety Committee highlight report		Updates received related to many aspects of health and safety. Discussion on rationale for assurance levels.	Further discussion to be undertaken and assurance levels made specific. This action is part of the revisions of the quality governance structure
Clinical audit annual report		The annual report was received. The format of	The annual report to be circulated to

		the report is likely to change for the current year in line with the integration in quality improvement activities.	board members for information

Section 2 – Other items for Escalation			
Topic	**Level of Concern (RAG)**	**Rationale**	**Action being taken**
External Visits report		Currently there is minimal detail re the outcomes of external visits to the trust in the report.	Intelligence from external visits to be included in the Quality surveillance report in the future
Areas of risk highlighted in the meeting		It was agreed that the areas of risk in the meeting were the CQC action plan ; safeguarding and IPC	
Adult Mental Health and Learning Disabilities directorate highlight report	green	The report contained multiple updates and their associated actions.	The format and frequency of directorate reports may be revised in line with the changes in the new quality governance
Recommendation	The Trust Board receives the issues raised from the Quality Assurance Committee held on 17 September 2019		
Author	Liz Rowbotham, Non-Executive Director, Chair of QAC		
Presented by	Liz Rowbotham		

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board 01 October 2019
Paper number	K

Name of Report Harm Assurance Processes for Patients on Waiting Lists in LPT

For approval		For assurance	✓	For information	

Presented by	Anne-Maria Newham	Author (s)	Dr Sue Elcock

Alignment to CQC domains:		Alignment to the LPT strategic objectives:		Alignment to LPT priorities for 2019/20 (STEP up to GREAT):	
Safe	✓	Safe	✓	S – High Standards	✓
Effective	✓	Staff		T - Transformation	
Caring	✓	Partnerships		E – Environments	
Responsive	✓	Sustainability		P – Patient Involvement	✓
Well-Led	✓			G – Well-Governed	
				R – Single Patient Record	
				E – Equality, Leadership, Culture	
				A – Access to Services	✓
				T – Trustwide Quality improvement	✓
Any equality impact (Y/N)					

Report previously reviewed by	
Committee / Group	Date
Executive Management Team	16/09/2019
FPC/QAC	17/09/2019

Assurance : What assurance does this report provide in respect of the Board Assurance Framework Risks?	Links to BAF risk numbers

Recommendations of the report
o Be assured that a process is being implemented to manage the entry of patients onto waiting lists robustly. o Be assured that a process is being commenced to enable the levels of harm occurring to any patients on waiting lists to be measured. This process will continuously develop as learning occurs.

1. Introduction/Background

Waiting times have clearly been identified as a key risk area in the Trust and we have a large number of patients waiting across a large number of clinical services. NHSI have given clear guidance that we need to have robust harm assurance processes in place.

During 2018, the Trust developed and implemented a process for identifying the high risk waiting lists and agreed to prioritise actions against these waiting lists. There are 7 priority services and 8 relevant targets (as the CAMHS ED Service needs to meet two targets).

The current 7 priority services are all mental health services but there are waiting lists across the whole range of services, including physical health, provided by the Trust.

Currently, weekly meetings are held within each directorate to discuss the Patient Tracker Lists (PTL) and each directorate then monitors the waiting times for all of its services at its monthly business meeting.

There is a Trust wide Waiting Times Group chaired by the Associate Director of Business Development and Contracting. This meeting provides central oversight and interrogation into the high risk waiting times.

This meeting also decides if the prioritised service can be de-escalated due to improvements and lists now in-line with trajectory. To date, both PIER and Paediatric Psychology have been de-escalated.

Information is then presented at the Finance and Performance Committee for assurance on the processes for monitoring waiting times.

2. Aim

It is planned that LPT introduce two new processes:

- The first is to introduce a clear set of principles to which all services must adhere to when entering a patient onto a waiting list
- The second is to develop a process to undertake Harm Reviews to monitor and learn about any harms caused to patients whilst on our waiting lists and then act on the learning with a system overview

To increase the robustness of the Harm Assurance processes already in place.

3. Discussion

Proposal: The key principles that must be met to provide assurance of our process for patients being entered onto a waiting list are:

1. Robust prospective clinical triage in place in each service
2. Weekly reviews of the waiting list by service management and lead clinicians through PTLs (Patient Tracking Lists)
3. Clear process for reprioritisation if clinical presentation changes/is escalated
4. Clear information, including easily accessible formats, is provided to ensure that patients are fully aware and understand:
    - their right to have an appointment under the NHS Constitution
    - that they have been placed on a waiting list and the likely length of the wait
    - what to do if their situation changes/deteriorates
    - what to do if their situation becomes a crisis
    - what to do if they or their family/carers have any questions
    - if appropriate are signposted to supportive resources that could be accessed whilst waiting

Action: Each service will be required to review its current waiting list management to ensure it meets these principles and an assurance dashboard will be collated by the governance teams for business oversight and sharing with NHSE/I for assurance.

Proposal: The key processes to introduce and undertake Clinical Harm Reviews to monitor and learn about any harms caused to patient on our waiting lists and then act on the learning:

There are established processes to do this within acute hospitals, where waiting lists have been a focus, and a number of policies have been reviewed. There are no established formats to undertake Clinical Harm Review in mental health trusts, which are our current high risk 7 services, although a number of Trusts are now starting to plan how to do this and NHSI has also produced Best Practice Guidance for Clinical Harm Reviews.

We have agreed to work collaboratively across LLR to begin to undertake Clinical Harm Reviews into patients on our waiting lists supported by NHSE/I. This work will be in the form of a Quality Improvement project based on processes from acute trusts and early ideas from other mental health trusts. We will regularly review and refine the clinical harm review process based on PDSA methodology.

As our current 7 high risk services are mental health, the initial focus is on a process that is appropriate for these to start in October 2019 and the process for physical health services will also use the same framework to start our learning. The importance is that after this process commences, we build on it and share learning within and between other trusts.

Proposed Harm Review Process

Selection Criteria

Two selection criteria: targeted times defined by key triggers and random samples

- Targeted sample:

  - Year 1: all patients waiting over 52 weeks and then 4 monthly reviews: October 2019
  - Year 2: a % (tbd) of patients waiting over 32 weeks and then 4 monthly reviews
  - Year 3: a % (tbd) of patients waiting over 18 weeks and then 4 monthly reviews
- Random sample: 5% each month spread across all waiting lists: January 2020

The importance of using both targeted and random samples is to ensure that the process establishes if any harm is being identified in those patients on waiting lists not assessed as the current high risk.

Given the number of patients currently waiting over 52 weeks: 422, this will be the focus for year 1 in terms of the targeted sample. The timescale outlined regarding over 32 and over 18 week waits can be brought forwards should it become practical.

The timing to commence the random sampling is to allow time to focus on those waiting over 52 weeks and to finalise the planning for the random sampling harm review process.

Harm Review Tool

In acute Trusts, a number of methods are used to assess harm such as clinicians completing a Harm Review Form from the clinical records of a random sample from patients on a waiting list. Retrospective harm data can also be collated in intervention treatments e.g. surgery, by the administration of a questionnaire when attending for the treatment. Data can be used to collate and look for escalation in the form of presentation at A+E.

In mental health services, the proposal is to use a Harm Review Form that is sent to the patients on the waiting lists. This is an approach that has been considered by another Trust. The importance of asking patients directly about any potential harm shows direct patient engagement and is also a means of making contact, rather than a clinician trying to assess from clinical records the potential for harm.

Each Directorate will be responsible for implementing and managing the new processes within their own services and it is envisaged that this will primarily be co-ordinated through Business and Governance teams.

The theming of learning will use an established definition of harm and will also include qualitative information.

Definition of Harm:

Definition of Harm – A change in patient's condition due to delay in treatment based on a clinician's opinion

Death	Death whilst on the waiting list from index condition (triggering of a clinical SI)

Major	irreversible progression of disease whilst on waiting list from index condition e.g. progression of malignancy and increased risk metastases (triggering of a clinical SI)
Moderate	Increase in symptoms (physical or psychological) Increase in medication or requires a higher level of treatment
Low	prolongation of symptoms or discomfort (not requiring significantly stronger analgesia or causing psychological harm)
No Harm	patient has suffered inconvenience only

www.nrls.npsa.nhs.uk

Reporting Arrangements

It is proposed that the Harm Assurance Process is similar to the Learning from Deaths processes.

- Services will theme and identify harm and learning within the appropriately identified Service Quality Meeting.
- Directorates will then identify harm and learning wider and review at the appropriately identified Directorate Quality Meeting.
- Directorates will then report on the harm and learning to CEG (clinical effectiveness group) which is chaired by the Medical Director. This will initially be monthly for year 1 with the first report in November 2019.
- CEG will report on the overall harm and learning to the Quality Forum and the System Harm Review Panel.

The System Harm Review Panel will be a newly convened group, to ensure system oversight, learning about harms and identifying any actions that need to be taken in the event of the emergence of high level themes. The ToR will be developed collaboratively with CCG colleagues but an example would be to meet 2 monthly with an example membership from NHSI Guidance:

Provider

- External chair - commissioner
- Medical director/deputy
- Director of nursing/deputy
- Project manager?
- Administrator
- Operational representatives
- Clinical Directors
- Communications lead
- Medical records

Commissioner

- Quality lead
- Contracts lead
- Clinical representative – usually GP or specialist
- Communication lead
- Patient or patient group representative
- NHS Improvement

Next Steps

September 2019:

- The principles of the 2 components will be discussed, amended and finalised at the Operational Executive Team meeting on 16 September 2019.
- They will be submitted to the Joint FPC/QAC being held on 17 September 2019 to provide assurance that we are implementing systems to
  - introduce a clear set of principles to which all services must adhere to when entering a patient onto a waiting list
  - develop a process to undertake Harm Reviews to monitor and learn about any harms caused to patients whilst on our waiting lists and then act on the learning with a system overview
- All services will benchmark themselves and share the evidence of how the Trust Principles for entering a patient onto a waiting list are either currently being met or will be met if changes are needed.

October 2019:

- Coproduce Harm Review Forms with service users
- Agreed Harm Review Forms will be sent to all patients waiting over 52 weeks (the operationalisation of this needs agreeing).
- Commence work looking at what data is available or can be made available for electronic triangulation such as:
  - Patients on a waiting list presenting at A+E
  - Patients on a waiting list presenting to Crisis team
  - Patients on a waiting list using duty systems in specific services
- Commence work looking at how to engage other systems, such as primary care, in our harm review processes.
- Consult with partners/stakeholders re System Harm Review Panel

November 2019:

- 1st report to CEG re themes and learning from harm review forms to date then monthly
- 1st System Harm Review Panel to be held:
  - ToR
  - Processes
  - early learning
  - system assistance in triangulation and engagement planning

December 2019:

- Finalise planning for random selection sampling harm review processes

January 2020:

- Commence random selection sampling harm review process

5. Conclusion

As the Trust has waiting lists in a large number of clinical services and with some patients waiting longer than 52 weeks to receive the recommended treatment, it is necessary for the Trust to be fully assured that the risk of harm to patients from being on a waiting list is well mitigated and managed.

It has been identified that LPT needs to make its existing processes for managing harm assurance of patients on its waiting lists more robust by introducing two additional processes that will:

1. Introduce a clear set of principles to which all services must adhere when entering a patient onto a waiting list
2. Develop a process to undertake Harm Reviews to monitor and learn about any harms caused to patients whilst on our waiting lists; and then act on the learning with system overview

It is believed that by introducing these two additional processes it will enhance and support the existing processes by:

- improving the levels of involvement with patients waiting to access services;
- reduce and mitigate the risk of harm occurring to patients on waiting lists
- support the Trust's continuous Quality Improvement approach through continual learning
- meet NHSE/I expectations to have in place robust harm assurance processes

These processes should increase the level of assurance that can be provided about the care of patients whilst on Trust Waiting Lists and ensure that the Trust is meeting the expectations of NHSE/I.

This work will form a Trust Quality Improvement project and we will continuously learn and refine the process.

6. Recommendations

The Board is asked to:

- Be assured that a process is being implemented to manage the entry of patients onto waiting lists robustly.
- Be assured that a process is being commenced to enable the levels of harm occurring to any patients on waiting lists to be measured. This process will continuously develop as learning occurs.

Leicestershire Partnership NHS Trust

Meeting Name and date	**Trust Board – 1 October 2019**
Paper number	L

Name of Report Director of Nursing AHPs & Quality update report

For approval		For assurance	X	For information	X

Presented by	Anne-Maria Newham, Director of Nursing, AHP's and Quality	Author (s)	Anne-Maria Newham, Director of Nursing, AHP's and Quality

Alignment to CQC domains:		Alignment to the LPT strategic objectives:		Alignment to LPT priorities for 2019/20 (STEP up to GREAT):	
Safe	X	Safe	X	S – High Standards	X
Effective	X	Staff	X	T - Transformation	
Caring	X	Partnerships	X	E – Environments	X
Responsive	X	Sustainability	X	P – Patient Involvement	X
Well-Led	X			G – Well-Governed	X
				R – Single Patient Record	
				E – Equality, Leadership, Culture	X
				A – Access to Services	
				T – Trustwide Quality improvement	X
Any equality impact (Y/N)		No			

Report previously reviewed by	
Committee / Group	Date

Assurance: What assurance does this report provide in respect of the Board Assurance Framework Risks?	Links to BAF risk numbers

Recommendations of the report
The Trust Board is recommended to – To note the summaries of events and horizon scanning

Director of Nursing AHPs & Quality update report for September 2019 Trust Board

Welcome

Firstly I'd like to welcome the Board to my first DON AHPs and Quality update report. I started on the 1st June 2019 and it has been a whirlwind of inductions and important progressive committees and meetings. I plan to give very brief summaries of events and horizon scanning that is pertinent to the Quality agenda. This is a 3 month report, going forward it will be a monthly short report.

Quality Review Meeting 5th June 2019

This is a post CQC inspection report meeting that took place on the 5th June at the Leicester Tigers ground with a large attendance from NHSi/E, CQC, CCG, Health Education England and an expert by experience from NHSi. LPT and the CQC gave presentations both on the findings from the CQC inspection and also work we have done to date to address improvements required by the 'warning notice', which was issued on the 30th Jan 2019.

CQC unannounced Inspection 11th and 12th June 2019

The CQC inspected wards at the Bradgate unit, Willows and Stuart House. They concentrated on all the warning notice areas such as medicines management, seclusion, smoking and environment. On the 3rd day 13th June they gave informal feedback to senior leaders in the Trust. On the whole it was a very positive feedback session highlighting in particular the improvements to the environment and medicines management. There were still areas for improvement around smoking, and maintenance requests.

National Intensive Support team feedback on CAMHS outpatients and Crisis teams 27th June 2019

A feedback session from the National IST team on Core CAMHS outpatients and Crisis. This was a really mixed feedback session giving lots of great examples of improvement as well as some areas for improvements particularly around our workforce and how it feels to work in LPT.

Inaugural LPT Sexual Safety workshop 1st July 2019

The Nurse lead for MH and LD chaired the first meeting to address the national findings and recommendations from the CQC sexual safety report. There was attendance from all MH LD clinical areas across the Trust. It showed there is national evidence of under reporting which is multi factorial but also a sense of 'it's the norm when working in MH'. Some clear pieces of work will be started to address this within LPT. LPT are now part of a National Pilot looking at sexual safety in MH wards.

9th July Leadership Joint Oversight Board

This Board is an opportunity for UHL, LPT and University of Leicester to meet and discuss our working arrangements for students and placements. This Board has been running for some time, and drives an important agenda around the quality of the training and placements our future workforce receive. University of Leicester recently started the first Masters programme for Nursing and Leadership component over 4 years across England. This year they received 357 applications for the degree, 100 shortlisted and 49 offered.

9th July 360 Internal Audit meeting

We have agreed with Internal Audit to undertake an audit on our seclusion practices, procedures and policies. This audit will start in Q2 of this financial year, TOR have been agreed and signed off. We now have in post a 0.5wte lead for positive and safe (Rachael Shaw) who will lead this work. The report will be available from the end of October 2019.

22nd July Inaugural Buddy Forum and 16th August 2019 – Buddy Forum (at Berrywood)

The buddy forum is a formal agreed forum with NHFT and LPT senior members. This was the first meeting of the buddy arrangement with NHFT. This included the Trusts Chairs, CEO, Directors of Nursing, NHSi support and Chairs of the Quality Committees. We have had confirmed that £150k is available which has been clearly badged against, Organisational development, Pathway and Project Management Support. The MOU for the buddy arrangements is now complete and signed off. Good discussion on the fact that this is a two way buddy offer and we also have much that NHFT can gain from our developments. A JD has been drafted for a Project Management Officer (PMO) who will oversee the developments of the step up to great 9 bricks. Agreed to develop our risks in line with NHFTs model. Combining the BAF and Risk Register together. We have agreed to draw together all the intelligence and reviews into a quality surveillance report similar to what NHFT have in place. We agreed a name for this relationship #BuddyUP.

23rd July Inaugural Strategic Improvement and Assurance Meeting (SIAM) and 27th August 2019 –

This meeting was required on the back of our CQC report in which we received 'inadequate' for well led and 'inadequate' for safe. Attendees are from NHSi, CCG and LPT. This is a monthly meeting of which I am the executive lead. There was much discussion in getting the TOR right. We have agreed a list of deep dives they would like to see the first one in September on the CAMHS Eating Disorders service in particular the waits and any harm caused. There was a lot of discussion in relation to our knowledge of levels of harm of patients waiting for care and treatment. We have been tasked to develop a tool that can understand harm for those waiting.

The 27th August meeting concentrated on the following areas.

- 52 week waits - access and waiting for treatment / intervention ie to include 'hidden waits'
- Highest risk of harm services – Trust process of assessment / risk stratification and outcomes
- Divisional reporting information for the highest risk of harm services, including 'keep safe today' metrics
- Harm review assurance - process and compliance

Several documents have been shared with LPT in relation to potential harm for patients whilst on the waiting list. This has been a very clear focus from NHSI to understand our approach to the patients waiting and what we know about them. NHSI also felt that the Board were not sighted enough on our waiting lists. They want to know what are our longest waits, where are people waiting and for what reason.

26th July Leicester Leicestershire & Rutland Safeguarding Alliance

This was attended by all Chief Nurses and Directors of Nursing across LLR CCGs and Providers. This is being commissioned by NHSE and facilitated by an external Consultant. We are working towards a better understanding of a Safeguarding Collaborative. This means what is there we can do together better. We have agreed to bring all the safeguarding teams together to an event on the 27th September to look at 'high performing teams'.

8th August 2019 – Meeting UHL in relation to Quality Improvement (QI).

This was a really helpful opportunity to hear from UHL in their approach to QI. They have recently received £1.4 million investment to ensure they have embedded QI across the organisation. They have appointed an external senior QI lead who heads up 5 x 8a improvement specialists who are working on essential improvement projects. They have prioritised 14 medical sessions, a comms lead and OD support. They have now put 200 staff through taster days to understand the QI methodologies. We have agreed to work more collaboratively together, looking at a joint QI conference in 2020, Lyn Williams will attend UHL's training sessions, and we will both use the life QI platform to manage our QI developments.

Reviews undertaken by external experts

We have agreed a programme of reviews to be undertaken by external experts.

Mixed Sex Accommodation review of CHS wards – UHL September 2019
Infection Prevention Control Review – NHFT Jenny Boyce IPC lead
Ligature review – NHFT
Seclusion review – NHFT
Mental Health Wards environment, Clinics, Seclusion, MSA – Amanda Proud (external CQC SPA)

These reviews have been prioritised based on concerns raised by the CQC, MHA CQC inspections and NHSi external inspections.

9th August 2019 – New independent chair of Adult City and County Safeguarding Board

I met with the new independent chair called Fran Pearson. Interestingly I have worked previously with Fran when she was an independent author for a complex Serious Case review. She is keen to change how organisations report to the Board moving away from updates and more to what are the priorities and are they still relevant.

9th August 2019 Regional Chief Nurse tele call

Siobhan Heafield (regional chief nurse) has started a fortnightly tele call with all Director of Nursing/Chief Nurses across midlands and east. This is arranged following her briefing from Ruth May (England CNO). It is a confidential space to also raise issues and concerns, information given to us was:

There are more university places than in the last 9 years. There is a national target for I7,500 Nursing Associates we need to model how many we can take in LPT. NHSi are recruiting short term pharmacists to prepare for a no deal Brexit. Medications will be prioritised for transport as over 75% comes from the EU.

Flu campaign is being run by Public Health not NHS Providers as previously. They do forsee a problem with supply of the vaccine for over 65years. The target this year has increased. We were in the bottom quartile last year I therefore want to see a great improvement this year through the support and promotion by the Board.

Complaints

At the strategic executive Board on the 9th August we have agreed a new approach to complaints. Our response rate is poor and this contributes to out well led CQC domain. For 18/19 this was 74%, it is currently at 64%. I have agreed that from the 1st October 2019 our target will be 25 days as a response rate for all complaints unless there are extenuating circumstances. I have asked directorates to pay attention to this area and focus improvement plans around the target.

CQC Brief guides.

The CQC produce a raft of brief guides which are excellent for staff to understand expectations from inspections. One of the areas I've highlighted to staff is something called 'blanket restrictions'. The Mental Health Act Code of Practice defines blanket restrictions as "rules or policies that restrict a patient's liberty and other rights, which are routinely applied to all patients, or to classes of patients, or within a service, without individual risk assessments to justify their application." The reason I have highlighted this is because I feel we have some areas in the trust that are applying blanket restrictions without fully understanding the implications or without carrying out risk assessments as required. I have therefore agreed to focus on one CQC brief per CQC progress meeting.

22nd August 2019 – Intensive Community Support (ICS) team Quality Summit

Myself and Rachel Bilsborough facilitated a half day meeting with approximately 25 staff from ICS and also Community staff. There was a full paper to 17th September QAC.

28th August 2019 – Quality Improvement Core Group.

This is a group chaired by Sue Elcock. We have agreed to fund a Project manager to support the knowledge improvement Hub. We agreed to use the Life QI platform, which will help us to monitor and support all developments/projects. Agreed a communication strategy which includes commissioning a company called 'alive with ideas'. Staff currently accessing QSIR training through NHFT.

28th August 2019 – discussion on ligatures.

Ligatures have been highlighted consistently by CQC as an area of concern; in 2018 they found somethings wrong that had previously been ok, risk assessments, and a few areas like taps. I called a meeting to discuss how we currently assess risk around ligatures and who leads this work. We don't have a trust wide lead but what we do have are a few experts in this area, Bernadette Keavney and Michelle Churchard Smith. Currently risk assessments are done by Health and Safety (H&S) and the ward manager. There is a database of every ligature which is held by H&S. There is a weekly audit on every MH ward as part of the environmental check. We discussed concerns around 'deregation' which is what the trust chooses to accept as a risk. An example of this is when it competes with the cost of making the change. We have suggested a paper comes to H&S Group and Pt Safety in Nov and Dec in order for us to be sighted on the current deregations that we have in the organisation.

29th August 2019 – City Health and Oversight Scrutiny Committee

This was attended by myself, Angela Hillery and Rachel Bilsborough in relation to the update from our CQC ratings and inspections. It generated a lot of questions around, leadership, why Northants, ligatures, estate and dormitories. Angela answered the questions really well and whilst the committee were extremely challenging they seemed prepared to wait and see if we could bring about the changes we have described.

Evidence-Based Interventions and private practice

As you maybe aware, in November 2018 NHS England and NHS Improvement - in partnership with the Academy of Medical Royal Colleges, NHS Clinical Commissioners and NICE – published statutory guidance to the system concerning 17 interventions which should no longer be provided by the NHS, or only provided when specific criteria were met.

This guidance was issued to contribute to the aim of reducing the number of inappropriate interventions provided on the NHS. The primary goals of the Evidence-Based Interventions programme are to avoid the possibility of needless harm to patients and free-up scarce professional time for performing other interventions - including creating additional headroom for proven innovations.

The recommendations to stop or set activity goals to reduce inappropriate use of the 17 interventions included in the statutory guidance (made under Section 14Z8 of the NHS Act 2006) were based on the best available clinical evidence and advice from specialist societies and clinicians, two equality impact assessments and a public consultation, and have been reinforced through the NHS Standard Contract (Service Condition 29).

NHS England and NHS Improvement expect NHS trusts to be evidence-led in everything they do. These interventions were identified in partnership with the Academy of Medical Royal Colleges and NICE, then withdrawn or restricted on the advice of clinical experts, because the evidence shows that in most cases the benefits don’t justify the risk and opportunity cost involved.

The guidance therefore also makes it clear that we do not expect NHS providers to offer these interventions privately.

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board 1st October 2019
Paper number	M

Name of Report Care Quality Commission (CQC) progress Action Plan

For approval	✓	For assurance	✓	For information	

Presented by	Anne-Maria Newham, Director of Nursing, AHP's and Quality	Author (s)	Kate Dyer, Head of Assurance

Alignment to CQC domains:		Alignment to the LPT strategic objectives:		Alignment to LPT priorities for 2019/20 (STEP up to GREAT):	
Safe	✓	Safe	✓	S – High Standards	✓
Effective	✓	Staff	✓	T - Transformation	✓
Caring	✓	Partnerships	✓	E – Environments	✓
Responsive	✓	Sustainability	✓	P – Patient Involvement	✓
Well-Led	✓			G – Well-Governed	✓
				R – Single Patient Record	✓
				E – Equality, Leadership, Culture	✓
				A – Access to Services	✓
				T – Trust-wide Quality improvement	✓
Any equality impact (Y/N)		No impact on equal opportunities			No

Report previously reviewed by	
Committee / Group	Date
Quality Assurance Committee	17 September 2019

Assurance: What assurance does this report provide in respect of the Board Assurance Framework Risks?	Links to BAF risk numbers
The paper provides the Trust Board a progress report on the implementation of actions resulting from the last CQC inspection. An excerpt from the action plan has been provided in the Board information pack.	Whole BAF

Recommendations of the report
The Trust Board is asked to note the information included in the report and take assurance that work to implement actions is progressing.

Leicestershire Partnership NHS Trust

Care Quality Commission Report

1. Aim

1.1 To provide an update on Care Quality Commission (CQC) related activity, including delivery against the actions identified following the 2018/19 inspection findings.

2. Introduction / Background

2.1 The CQC report published in February 2019 relates to the inspection dated 19th November 2018 to 13th December 2018. The report describes the CQC's judgement of the quality of care provided with respect to the Trust's well led framework and an inspection of five of our core services. The CQC issued a Warning Notice to the Trust on the 30th January 2019.

3. Discussion

3.1 There are currently 91 actions on the CQC element of the regulatory action plan (three more than last month due to a number of actions being separated out for clarity). Of these, 66 are classed as warning notice or must do actions; the remaining 25 are classed as should do actions.

Actions complete – September 2019

- Warning notice and must do actions are 83% complete (last month was 70%)
- Should do actions are 36% complete (last month was 8%).

Spot checks complete – September 2019

- Warning notice and must do spot checks are 47% complete (last month was 38%).
- The Trust has not yet completed any should do spot checks.

3.2 Further detail is provided in the tables below.

Table 1: Warning notice and must do actions (as at 6th September 2019)

Theme	Warning Notice and Must Do %	
	Action Complete	**Spot Check Complete**
Access	75%	50%
Care planning	100%	0%
Environmental / estates	60%	20%
Fire safety	86%	43%

Governance	50%	0%
Infection Control	80%	60%
Medicines mgt / medical devices	86%	57%
Physical healthcare	100%	40%
Privacy and dignity	100%	100%
Risk assessments	100%	50%
Seclusion environments/ paperwork	88%	25%
Total number (%)	55 / 66 (83%)	29 / 62* (47%)

*Four actions do not require a spot check

Table 2 Should do actions (as at 6th September 2019)

Theme	Should Do %	
	Action Complete	**Spot Check Complete**
Access	0%	0%
Care planning	100%	0%
CTO	0%	0%
Environmental / estates	50%	0%
Fire safety	100%	0%
Governance	100%	0%
Medicines mgt / medical devices	50%	0%
Meet diverse need	0%	0%
Patient involvement	33%	0%
Physical healthcare	0%	0%
Safeguarding	0%	0%
Workforce	38%	0%
Total number (%)	9 / 25 (36%)	0 / 25 (0%)

3.3 CQC Progress Meeting

The Trust has implemented a CQC progress meeting on a bi-weekly basis. This aims to address overall improvement and pace of delivery from the 2018/19 inspection, and preparedness for the forthcoming inspection for 2019/20. This will be followed by a bi-weekly CQC newsletter for the dissemination of key messages across the Trust.

3.4 2019/20 Inspection

The 2019/20 Provider Information Request (PIR) is anticipated at any time. Preparation is underway for this.

4. Compliance with fundamental standards

The latest poster continues to contain an inaccuracy. The rating for wards for people with a learning disability or autism has a ‘not rated’ section on the poster for the Well Led component of the inspection. In the report this had been rated as ‘requires improvement’.

The latest poster is displayed at each premises where a regulated activity is being delivered (including main place of business and our website).

5. Conclusion

The Trust continues to make progress against the CQC inspection action plan. The Trust has implemented a CQC progress meeting to address pace and preparedness for the forthcoming inspection.

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board 01 October 2019
Paper number	Ni

Name of Report Mortality Surveillance Group Quarterly Review 2018/19 Quarter 4

For approval		For assurance	✓	For information	

Presented by	Anne-Maria Newham	Author (s)	Professor Al-Uzri

Alignment to CQC domains:		Alignment to the LPT strategic objectives:		Alignment to LPT priorities for 2019/20 (STEP up to GREAT):	
Safe	✓	Safe	✓	S – High Standards	✓
Effective	✓	Staff	✓	T - Transformation	
Caring	✓	Partnerships		E – Environments	
Responsive	✓	Sustainability		P – Patient Involvement	
Well-Led				G – Well-Governed	
				R – Single Patient Record	
				E – Equality, Leadership, Culture	
				A – Access to Services	
				T – Trustwide Quality improvement	✓
Any equality impact (Y/N)		No			

Report previously reviewed by	
Committee / Group	Date
QAC	20/08/2019

Assurance : What assurance does this report provide in respect of the Board Assurance Framework Risks?	Links to BAF risk numbers

Recommendations of the report
1. Receive the information related to all deaths in scope for Q4 20 18/19 2. Note the priorities for further work as set by MSG

Leicestershire Partnership NHS Trust

Introduction/Background

In July 2017, NHS Improvement produced a document titled **"Implementing the Learning from Deaths framework: key requirements for trust boards**". This introduced a number of new requirements on Trusts in relation to the Learning from Deaths framework. These included:

a) A System in place to report, review and report all deaths from services in scope so that the organisation can learn from these leading to quality Improvement.
b) An Updated policy on the intranet.
c) To Publish information on deaths; reviews and investigations via a quarterly agenda item and paper at the Trust's public board meetings.
d) From June 2018 onwards, to publish an annual overview of this information in Quality Accounts.

The above is now all in place at Leicestershire Partnership Trust and is overseen by the Mortality Surveillance Group which meets quarterly.

Please note: this group is to become known as The Learning from Deaths Group as it is felt that this better promotes the notion of sharing knowledge and learning from peers and colleagues.

Aim

The effective review of mortality is an important element of the Trust's approach to learning and ensuring that the quality of services is continually improved.

Progress update since Q3 2018/19

1. The policy, now to be known as the Learning from Deaths Policy, has been agreed in principle and only requires proper formatting and proof reading. This should be complete by end of August 2019. It will then be published and implemented within the Trust.

2. All actions from the 360° Assurance Internal Audit are expected to be complete by 08 November 2019. The last remaining action relates to ensuring that all deaths are captured by cross referencing and methodical checking of the Spine. The technical and resourcing issues are being addressed.

3. From 01 August 2019 all directorates will be uploading completed Care Case Reviews to Ulysses. The resource to upload the backlog is still being identified.

4. The quality of the Quarterly Report of Death Reviews for the Mortality Surveillance Group continues to improve as it becomes more standardised and better understood across the directorates.

5. The Trust expects to receive the first written report from LeDeR by the end of Sept 2019 and the learning will be disseminated accordingly both within the immediate Learning Disability Team and then across the whole Trust where appropriate. The mechanisms for the dissemination are still being identified.

6. The newly formed Suicide Prevention Group will meet for the first time in August and monthly thereafter. This will be chaired by Dr Avinash Hiremath in his capacity as Associate Medical Director for Quality.To begin with, the Suicide Prevention Group will be looking to develop the Trust's Strategy and Policy on Suicide Prevention; Self Harm Management and the implementation of the Trust's Zero Tolerance Ambition for Inpatient Suicides.

Priorities for QI 2019/20

1. Resolve issues of timeliness relating to the provision of information to both CQRG and the Quality Account.
2. Improve the Directorate Quarterly Reporting Template to indicate flow of work and better identify backlogs.
3. Develop better consistency across the three directorates with regards resources allocated and the quality of the reporting.
4. Complete the implementation of the recommendations from the 360° Assurance Internal Audit.

Recommendations

- Receive the information related to all deaths in scope for Q4 20 18/19
- Note the priorities for further work as set by MSG

Adult Mental Health & Learning Disability (AMH&LD) Services
Mortality Surveillance Sub-Group (MSSG)

<table>
<tr><th>Report: Quarter 4.</th><th>Total n^o of deaths meeting threshold</th><th>N^o of deaths subject to case review (desktop-review of case notes using a structured method)</th><th>N^o of case reviews completed within the Quarter</th><th>N^o of deaths subject to Incident Investigation process</th><th>No of deaths not yet reviewed as waiting for more information</th><th>N^o of deaths reviewed and, as a result, considered more likely than not to be due to problems in care</th><th>Themes & issues identified as part of the review/investigation including examples of good practice</th><th>Actions taken in response to identified themes & issues; actions planned and an assessment of the impact of actions</th></tr>
<tr><td rowspan="3">Q4, 2018/19</td><td>29</td><td>16</td><td>9</td><td>13</td><td>7</td><td>0 to date</td><td rowspan="3">Neither AMH&LD MSSG, nor LPT Patient Safety Team currently has capacity to perform ongoing administrative and support tasks required for information collection and data recording & analysis necessary for robust procedures & governance to ensure compliance with requirements of national Learning From Deaths framework.</td><td rowspan="3">Concerns re: gaps to be raised with: LPT Mortality Surveillance Group; and AMH&LD SMT.

Meeting to be arranged with UHL’s Head of Outcomes & Effectiveness to share experience of implementing framework.</td></tr>
<tr><td colspan="2" rowspan="2">Not meeting threshold:
• LD patient deaths that occurred after Jan 2019 - now all routinely subject to LeDeR.
• Patients with whom AMH&LD had not had involvement for a significant period of time.</td><td>Including deaths in Jan 2019 of three LD patients.</td><td></td><td></td><td rowspan="2">Further to MSSG review findings only (not contributory concerns identified through incident investigation process).</td></tr>
<tr><td colspan="3">One death has so far been subject to both review by the MSSG and incident investigation.</td><td></td></tr>
</table>

Report: Quarter 4.	Total n° of deaths meeting threshold	N° of deaths subject to case review (desktop-review of case notes using a structured method)	N° of case reviews completed within the Quarter	N° of deaths subject to Incident Investigation process	No of deaths not yet reviewed as waiting for more information	N° of deaths reviewed and, as a result, considered more likely than not to be due to problems in care	Themes & issues identified as part of the review/investigation including examples of good practice	Actions taken in response to identified themes & issues; actions planned and an assessment of the impact of actions
							Process is required to facilitate notification when MSSG review identifies issues relating to care from other providers.	UHL: contact identified, process for sharing to be agreed (see above re: meeting). Other providers: Head of Patient Safety requested to facilitate solutions .

Report: Quarter 4.	Total n° of deaths meeting threshold	N° of deaths subject to case review (desktop-review of case notes using a structured method)	N° of case reviews completed within the Quarter	N° of deaths subject to Incident Investigation process	No of deaths not yet reviewed as waiting for more information	N° of deaths reviewed and, as a result, considered more likely than not to be due to problems in care	Themes & issues identified as part of the review/investigation including examples of good practice	Actions taken in response to identified themes & issues; actions planned and an assessment of the impact of actions
							At present the AMH&LD MSSG is not always able to complete informed reviews of deaths for which formal Cause of Death information is not available; having this information can help a better understanding, for example if related to prescribed medications or pre-existing conditions.	Head of Patient Safety looking into ways CoD might be obtained (eg locally via UHL Medical Examiner or GP records on SystmOne; nationally via General Register Office death records).

Report: Quarter 4.	Total n° of deaths meeting threshold	N° of deaths subject to case review (desktop-review of case notes using a structured method)	N° of case reviews completed within the Quarter	N° of deaths subject to Incident Investigation process	No of deaths not yet reviewed as waiting for more information	N° of deaths reviewed and, as a result, considered more likely than not to be due to problems in care	Themes & issues identified as part of the review/investigation including examples of good practice	Actions taken in response to identified themes & issues; actions planned and an assessment of the impact of actions
							Suspected suicide (confirmed CoD not available) was not subject to formal incident investigation as patient had yet to be seen by CMHT. MSSG review identified no contact with patient or appointment arranged, following referral acceptance.	Further service review of incident requested. Review of CMHT administration currently in progress; learning to be shared across all services.

Report: Quarter 4.	Total n° of deaths meeting threshold	N° of deaths subject to case review (desktop-review of case notes using a structured method)	N° of case reviews completed within the Quarter	N° of deaths subject to Incident Investigation process	No of deaths not yet reviewed as waiting for more information	N° of deaths reviewed and, as a result, considered more likely than not to be due to problems in care	Themes & issues identified as part of the review/investigation including examples of good practice	Actions taken in response to identified themes & issues; actions planned and an assessment of the impact of actions
							MSSG reviews of unexpected deaths of AMH community patient identified concerns re: adherence to clinical policies & procedures on assessment, risk, care planning & record keeping.	Further service reviews of incidents requested. Review of CMHT administration currently in progress; learning to be shared across all services.
							Reviewing deaths of patients seen for Mental Health Triage Team (MHTT) at LRI, concerns raised re: gaps in recording and completing actions identified at assessment.	MHTT to arrange access to scanning facility to enable documentation to be saved onto EPRs. Further service reviews of incidents requested.

Report: Quarter 4.	Total n° of deaths meeting threshold	N° of deaths subject to case review (desktop-review of case notes using a structured method)	N° of case reviews completed within the Quarter	N° of deaths subject to Incident Investigation process	No of deaths not yet reviewed as waiting for more information	N° of deaths reviewed and, as a result, considered more likely than not to be due to problems in care	Themes & issues identified as part of the review/investigation including examples of good practice	Actions taken in response to identified themes & issues; actions planned and an assessment of the impact of actions
							When a patient DNA'd appointments just prior to his death, Team could not contact NoK as no details on EPR (NB Did not contribute to patient's death).	Feedback given to Team.
							GOOD PRACTICE: Comprehensive care plans - and communication of these - clearly recorded on EPR of patient who died at Mill Lodge.	
							GOOD PRACTICE: Good discharge plan & support from Stewart House to nursing home; and regular communications re: patient between LRI, Stewart House & Liaison Psychiatry Team.	

Leicestershire Partnership NHS Trust

Mortality Surveillance Group

Directorate Reports

Directorate: **FYPC** **Year: 18/19**

Quarter	Total number of deaths meeting threshold	Number of deaths subject to case review (desktop review of case notes using a structured method)	Number of cases reviewed within the Quarter	Number of deaths subject to an SI investigation	Number of deaths reviewed/investigated and as a result considered more likely than not to be due to problems in care	Themes and issues identified as part of the review/investigation including examples of good practice	Actions taken in response to identified themes and issues, actions planned and an assessment of the impact of actions
4 (18/19)	10 (all child deaths)	10 child deaths (6 expected 4 unexpected)	1 (expected death reviewed at FYPC M&M)	0	0	No themes from CDOP. One expected death was discussed at the FYPC M&M in Q4. Outcomes were positive feedback from the family regarding the end of life pathway.	Nil

Leicestershire Partnership NHS Trust

Mortality Surveillance Group

Directorate Reports

Directorate: CHS **Year: 2018-19**

Quarter	Total number of deaths meeting threshold	Number of deaths subject to case review (desktop review of case notes using a structured method)	Number of cases reviewed within the Quarter	Number of deaths subject to an SI investigation	Number of deaths reviewed/investigated and as a result considered more likely than not to be due to problems in care	Themes and issues identified as part of the review/investigation including examples of good practice	Actions taken in response to identified themes and issues, actions planned and an assessment of the impact of actions
4	67	64	69* * 29 reviewed from Q3 and 40 reviewed from Jan 19 (Q4)	3	0	1. EOL paperwork was initiated in 95% of all deaths considered this quarter 2. There has been 190% increase in EOL paperwork documentation compared to Q4 2017 3. Confusion in care seen in patients receiving last days of life care and EOL care 4. Recording of observations on Nerve Centre not always merited but still carried out 5. Due to lack of	1. EOL champions continue their work in spreading the message on 'quality of death' 2. M&M Board learnings are now more locally delivered to grass root staff where robust discussions about last days of life and EOL are taking place. 3. IM&T strategy Board to take up
						communication between the two Nerve Centres at UHL and LPT, transfer of care paperwork between organisations remains an issue for late discharges (OOH) at UHL	the issue of Nerve centre stream-lining between the two organisations

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board – 1st October 2019
Paper number	Nii

Name of Report: Mortality Surveillance Group Quarterly Review 2019/20 Quarter 1

For approval		For assurance	✓	For information	

Presented by	Sue Elcock	Author (s)	Tracy Ward, Trust Patient safety lead

Alignment to CQC domains:		Alignment to the LPT strategic objectives:		Alignment to LPT priorities for 2019/20 (STEP up to GREAT):	
Safe	✓	Safe	✓	S – High Standards	✓
Effective	✓	Staff	✓	T - Transformation	
Caring	✓	Partnerships		E – Environments	
Responsive	✓	Sustainability		P – Patient Involvement	
Well-Led				G – Well-Governed	
				R – Single Patient Record	
				E – Equality, Leadership, Culture	
				A – Access to Services	
				T – Trustwide Quality improvement	✓
Any equality impact (Y/N)		No			

Report previously reviewed by	
Committee / Group	Date
QAC	20/08/2019

Assurance : What assurance does this report provide in respect of the Board Assurance Framework Risks?	Links to BAF risk numbers

Recommendations of the report
1. Receive the information related to all deaths in scope for Q1 2019/20 2. Note the priorities for further work as set by MSG

T11b: Mortality Review- Q1 August CQRG

1. Introduction

Leicestershire Partnership Trust has recently reviewed their internal governance arrangements in relation to Learning from Deaths. Responsibility for monitoring this agenda was previously in the portfolio of the Head of Assurance and Governance however, on review this has now been transferred to the Head of Patient Safety. This report has been reformulated for quarter 1 2019/20. The aim of this revised report is to give a more timely and accurate report of the Trusts current position. This report will also contain the LeDer recommendations and LLR response. Leicestershire Partnership Trust's response to the recommendations will be detailed in the Q2 report. This report will include information required for the LPT Quality Schedule indicator T11b.

2. Mortality Data

The Trusts mortality figures are detailed in table 1 below. This contains information covering a rolling year, commencing from Q2 2018/19 to Q1 2019/20. This will be updated in each quarterly report.

Currently LPT is in the process of updating their Learning from Deaths Policy. This is in response to a 360° audit. The revised policy will be presented at LPT Quality Assurance committee in July 2019. The current and draft revised policies identify which patient under LPT care are 'in scope' and 'out of scope' for the purposes of Learning from Deaths. This policy will be shared with commissioners via the Clinical Quality Review Group (CQRG).

Table 1.

Number of its patients who have died during 2018/20					
	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Rolling total
Expected	96	83	82	67	328
Unexpected	35	37	45	35	152
Totals	131	120	127	102	480
Number of Child death overview panel (CDOP)					
Totals	15	10	10	Data available in Oct 2019	35
The number and percentage of deaths subjected to a case record review					
Numbers completed	83	93	CHS- 69 AMH- 29	0	274
Percentage completed	65%	78%	77%	Data available Oct 2019	
Numbers outstanding			CHS- 23 outstanding from Q3 were reviewed in Q4	0	
The number and percentage of unexpected deaths subjected to an SI investigation					
Numbers completed			16	11	

The number and percentage of deaths subjected to an SI and case record review					
Numbers completed				Data available Oct 2019	
Numbers outstanding				Data available Oct 2019	
The number of deaths more likely than not to have been due to problems in the care provided					
	0	0	0	Data available Oct 2019	

The table above demonstrates that the trust is on average …. behind with reviews.

3. Learning from Deaths

3.1 Learning from SIs

3.2 Learning from LeDeR

The third annual National LeDeR Report was published in May 2019 the below were the key findings from the deaths in scope below:

Table 1: Number of in-scope notifications of deaths of people with learning disabilities aged 4 years and over, by NHS England region

1st July 2016 – 31st Dec 2016	1st Jan 2017 – 31st Dec 2017	1st Jan 2018 – 31st Dec 2018	Estimated number of deaths in 20189	Percentage of notifications to estimated number of deaths in 2018	Total deaths notified 1st July 2016 – 31st Dec 2018
North	56	565	813	1,071	76%	1,434
Midlands & East	*	268	948	1,079	88%	1,217
South East	27	134	587	483	122%	748

South West	14	126	254	361	70%	394
London	*	181	324	419	77%	509
Total	102	1,274	2,926	3,413	86%	4,302

Since the start of LeDeR, the programme Bristol has been notified about the deaths of 4,302 people with learning disabilities.

By the end of December 2018:

•A quarter (25%) of the deaths notified had been reviewed.

•Over a third (37%) were in the process of being reviewed.

•Over a third (38%) were waiting to be allocated to a reviewer.

The Midlands and East has the highest numbers of deaths waiting for reviewer allocation at 49%. The reviews should be finished within 6 months of being told about the death.

Of the notified deaths the following are reported:

- Males 58%; females 42% (n=4,290)
- White ethnic background 90% (n=3,815)
- Level of learning disabilities (n=1,719):
  - •Mild 27%
  - •Moderate 34%
  - •Severe 27%
  - •Profound or multiple 12%

- Place of death: 62% in hospital compared to 46% in general population.
- Deaths reported to coroner: 31% compared to 43% in general population.
- 19 reviews reported that the term ‘learning disabilities’ or ‘Down’s syndrome’ was given as the rationale for Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) order.
- 19% of adults were usually prescribed antipsychotic medication.

- Youngest aged 4 years; oldest aged 98 years.
- Median age at death 59 years (n= males 60 years, Females 59 years)
- Disparity between age at death in people with learning disabilities (aged 4 years and over) and the general population (all ages)
  - 23 years for males
  - 27 years for females.

- Most common conditions mentioned in Part I of the Medical Certificate of Cause of Death (n=1,938)
  - Pneumonia 25%
  - Aspiration pneumonia 16%
  - Sepsis 7%
  - Dementia (syndrome) 6%
  - Ischaemic heart disease 6%
  - Epilepsy 5%

- A third (33%) of reviews reported example(s) of best practice.
  These were mostly in relation to:

  - Strong, effective inter-agency working.
  - Person-centred care.
  - End-of-life care.

- 11% of reviews noted that concerns had been raised about the person's death.
  These were mostly in relation to:

  - Delays in diagnosing and treating illness.
  - The quality of care received by the person.

The recommendations from the National LeDeR Report are shown in appendix 1.

The LLR findings

There have been 22 completed reviews since 2017, 14 adults and 8 children.

- For the adults there were:
  - 7 in Leicester
  - 4 in Leicestershire
  - 1 in Rutland

  - 12 were single
  - 1 widowed
  - 1 married

  - The mean age of death was 67.
  - 9 out of 14 died in hospital, the rest where they lived.
  - 75% were identified as on End of Life Pathway
  - 100 had DNACPR orders in place

- The main causes of death were as the national findings but other secondary conditions were:
  - Chronic renal failure
  - Prostate Cancer
  - Cellulitis
  - Limb ischaemia
  - Obstructive Uropathy
  - Severe aortic stenosis

There were multiple references to sepsis, Dementia, Downs Syndrome with 65% having a cause of death documented as Pneumonia.

- 10 out of the 14 adult deaths identified some good practice, 3 identified issues with organisational systems and processes and 1 out of the 14 identified the death as possibly being attributed to abuse/ neglect – this was not in an inpatient LPT area.

Next steps for the LLR LeDeR Steering Group

The group are currently meeting with reviewers to complete a thematic review of the learning from deaths so far; this has involved a confirm and challenge session and further analysis and investigation for some reviews. Analysis and learning from the reviews will be shared in August 2019 with partner organisations and will feed into the strategic planning for the LLR LD Transforming Care Board.

Insert paragraph from the recommendations report.

3.3 Learning from CDOP

There was no learning identified through the CDOP process.

3.4 LPT Learning from Deaths - merge directorate data

The Mortality Surveillance Group are working with Directorates to identify their learning and what constitutes learning as part of the mortality reviews.

4. Learning from the process

There are some issues which have been identified which are currently under review internally.

- LPT are unable to identify all deaths which have been notified from the NHS national Spine data.

- Difficulty in establishing cause of death for patients not known to the coroner.
- No access to GP records for patients who have not given prior permission to share their data on Systm1
- There are currently different systems for the review of deaths between directorates
- National policy currently allows for some variation in the deaths that are considered to be in and out of scope
- Timescales for reports internally for appropriate governance routes requires review to align with quarterly reporting schedules

5. Actions

5.1 Meeting arranged with the Head of Effectiveness at University Hospitals of Leicester. The aim of this meeting is to enable closer working relations where the patient has been under the care of both organisations.

5.2 Review and mapping for internal governance meetings to achieve a more timely reporting of data.

5.3 Review of national policy in relation to patients who would be in and out of scope for review.

5.4 Review the way in which LPT can more accurately identify patients via the NHS spine data.

Progress with these actions will be reviewed at the LPT October 2019 Mortality Surveillance Group.

6. Conclusion

This report has identified the changes in responsibility for Learning from Deaths. Data has been provided for a rolling years deaths and the numbers of reviews completed. The report includes the LeDeR recommendations and in Quarter 2 the LPT response will be included. The report details learning from deaths, deaths investigated as Serious Incidents and CDOP learning.

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board – 1 October 2019
Paper number	O

Name of Report: Patient Safety Quarter One Report

For approval	X	For assurance	X	For information	

Presented by	Anne-Maria Newham	Author (s)	Jo Nicholls, Tracy Ward

Alignment to CQC domains:		Alignment to the LPT strategic objectives:		Alignment to LPT priorities for 2019/20 (STEP up to GREAT):	
Safe	X	Safe	X	S – High Standards	X
Effective	X	Staff		T - Transformation	
Caring	X	Partnerships	x	E – Environments	x
Responsive		Sustainability		P – Patient Involvement	
Well-Led	X			G – Well-Governed	
				R – Single Patient Record	
				E – Equality, Leadership, Culture	x
				A – Access to Services	x
				T – Trustwide Quality improvement	X
Any equality impact (Y/N)					

Report previously reviewed by	
Committee / Group	Date

Assurance : What assurance does this report provide in respect of the Board Assurance Framework Risks?	Links to BAF risk numbers

Recommendations of the report
The QAC is recommended to receive the Q1 update

Leicestershire Partnership NHS Trust

PATIENT SAFETY REPORT

Q1 2019/20

CONTENTS

15	Never Events	34
16	National Developments	34

1. EXECUTIVE SUMMARY

Previously this quarterly report has included learning from Trust wide Serious Incidents only. This report is being developed to provide an overview of incidents across the organisation and key learning identified.

This report outlines performance and progress in relation to reporting, investigating and learning from Serious Incidents (SI's). The information detailed in this report is examined quarterly within the Patient Safety Improvement Group (PSIG) and learning and emerging themes are discussed, addressed and or escalated as required.

This style of report was trialled for Q4 and feedback was positive. Long term sickness in the Patient Safety Team has challenged further development however it is expected that this report will develop over time as the PSIG develop and in response to feedback of its usefulness.

During Q 4 we discussed the increase in deaths under the care of the Crisis team. We have commissioned an external Crisis Consultant to re review initially one Serious Incident where a patient took their own life while under the care of the crisis team. On completion of this he has also been asked to consider our model of care to ensure that we are maximising the usefulness of the resource that we have. Particularly around continuity of care/carer.

The Associate Medical Director for Quality is now in post and will lead the Trusts work in relation to our zero tolerance approach to in patient suicide (which includes patients on authorised leave and absent without leave) We are also looking to recruit a clinician to

drive forward this important agenda. It is anticipated that this work will spread as it develops. The refreshed suicide prevention group will meet in August and will include considering what is required to develop and model/approach to self harm.

NHSI have developed guidance published in June 2018 which was focused on identifying the learning from incidents, therefore Pressure Ulcers are no longer categorized as avoidable or unavoidable and as such will all be investigated to consider any learning. We have agreed that Grade 4's will be reported as a Serious Incident due to the degree of harm. Those that we have reported during Q1 are all patients in the community. Due to the nature of this group of patients their care is delivered by a variety of people. Carers, family, care home staff or only the patient themselves. The approach we are taking is to consider 'what needed to happen to stop the patient developing a pressure ulcer' this way we hope to obtain the learning for the health economy. Early learning identified is around education of patients in relation to the development and consequence of pressure ulcers to support their decision making, as well as compliance with the SSKIN bundle designed to assess risk and develop care plans.

During Q4 we described an increase in intensity of aggression and violence particularly on the Bradgate Mental Health Unit. During Q1 the patient safety team requested that some of these more serious incidents have full internal incident investigations; to understand the factors that may be contributing to this increase in violence and aggression. Having reviewed some of these incidents it was felt that this methodology was not looking widely enough across the system. A further incident occurred and the decision was made that due to the opportunity for learning we would report this as a Serious Incident and investigate using a multi disciplinary reflection and two meetings were held to maximise opportunity for attendance. Staff have contributed some very useful suggestions and this report is being written up currently.

National Patient Safety Strategy

The new patient safety strategy (NHSE/I) was launched at Patient safety Congress in April 2019

This was developed following extensive consultation which we had the opportunity to input to.

It describes;

Patient safety is about maximising the things that go right and minimising the things that go wrong. It is integral to the NHS' definition of quality in healthcare, alongside effectiveness and patient experience.

To continuously improve patient safety. The NHS will build on two foundations: a **patient safety culture** and a **patient safety system.**

Three strategic aims will support the development of both:

• improving understanding of safety by drawing intelligence from multiple sources of patient safety information **(Insight)**

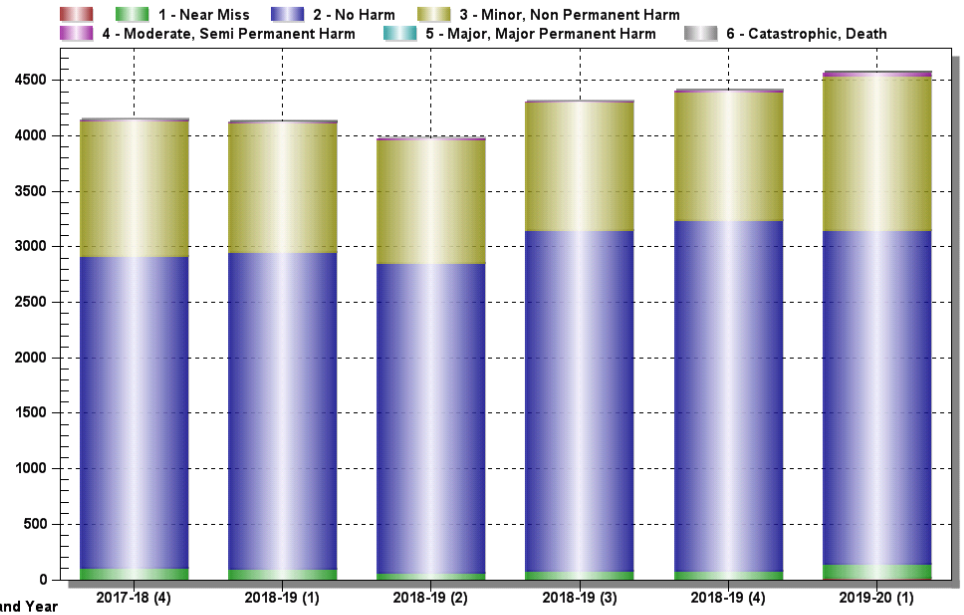
• equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system **(Involvement)**

• designing and supporting programmes that deliver effective and sustainable change in the most important areas **(Improvement)**

More information can be found in section 15 of this report with a link to the full document. Future Quarterly reports will consider our response to the different relevant sections of the strategy.

2. TRUST WIDE INCIDENT DATA

Fig 2.1 Trust Harm Profile



Month and Year	2017-18 (4)	2018-19 (1)	2018-19 (2)	2018-19 (3)	2018-19 (4)	2019-20 (1)
	0	0	0	0	0	1
1 - Near Miss	94	86	49	63	69	132
2 - No Harm	2814	2859	2790	3075	3157	3006
3 - Minor, Non Permanent Harm	1220	1164	1121	1163	1162	1391
4 - Moderate, Semi Permanent Harm	6	10	13	6	14	34
5 - Major, Major Permanent Harm	0	1	0	0	0	1
6 - Catastrophic, Death	6	3	0	0	1	2

Figure 2.1 above highlights the quarterly data with regarding to numbers of incidents reported by LPT since 1st January 2018. The data shows that there has been an overall increase in reportable incidents from 4,403 in quarter 4 2018/19 to 4,567 in quarter 1 2019/20.

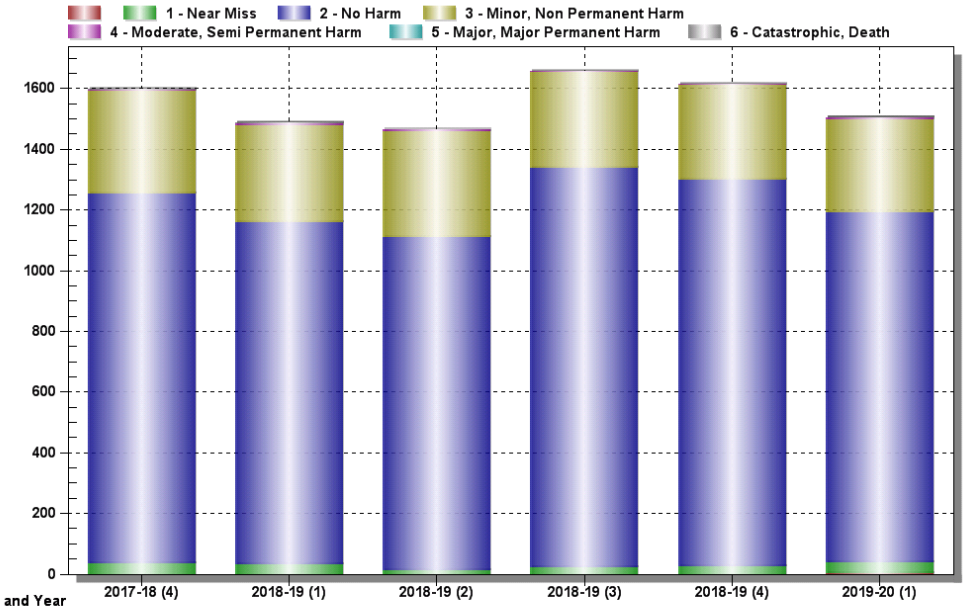
Safe organisations are identified as those that are high reporters of incidents with low harm.

See section 3 for a breakdown of incidents reported by directorate.

3. DIRECTORATE INCIDENT DATA AND LEARNING

3.1 Adult Mental Health and Learning Disabilities

Fig 3.1.1 AMH/LD Harm Profile



Month and Year	2017-18 (4)	2018-19 (1)	2018-19 (2)	2018-19 (3)	2018-19 (4)	2019-20 (1)
	0	0	0	0	0	1
1 - Near Miss	35	32	12	21	26	35
2 - No Harm	1217	1126	1097	1315	1273	1155
3 - Minor, Non Permanent Harm	339	320	348	318	312	306
4 - Moderate, Semi Permanent Harm	4	5	6	3	5	6
5 - Major, Major Permanent Harm	0	1	0	0	0	1
6 - Catastrophic, Death	4	2	0	0	0	1

Figure 3.1.1 above highlights the quarterly data with regarding to numbers of incidents reported by AMH&LD since 1st January 2018. The data shows that there has been an overall decrease in reportable incidents from 1,616 in quarter 4 2019/20 to 1,505 in quarter 1 2019/20.

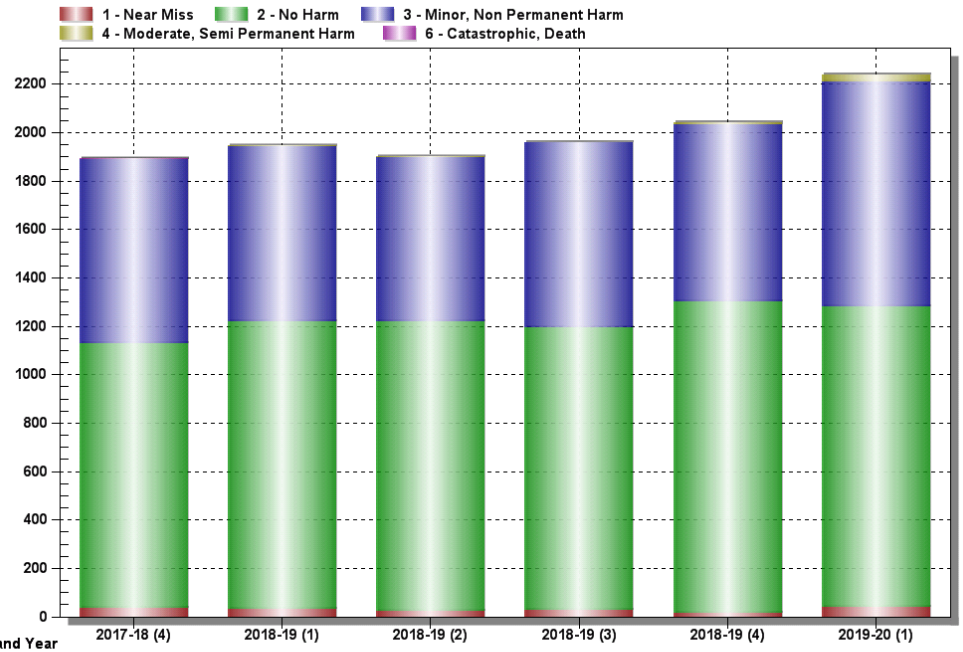
3.1.2 Learning

In Q4 AMH/LD describe the two highest reported incidents as violence and aggression and self harm. As described in other parts of this report there are pieces of work underway to reduce these incidents.

Locally the wards are introducing an initiative called safe wards which involves a series of 10 core interventions. Evidence from other early adopters is that when fully implemented it can result in a 20% decrease in violence and aggression. It is too early in the implementation process to expect discernible results.

3.2 Community Health Services

Fig 3.2.1 CHS Harm Profile



Month and Year	2017-18 (4)	2018-19 (1)	2018-19 (2)	2018-19 (3)	2018-19 (4)	2019-20 (1)
1 - Near Miss	34	29	21	27	16	39
2 - No Harm	1095	1192	1198	1166	1284	1241
3 - Minor, Non Permanent Harm	760	722	679	767	732	932
4 - Moderate, Semi Permanent Harm	2	3	4	1	8	27
6 - Catastrophic, Death	1	0	0	0	1	1

Figure 3.2.1 above highlights the quarterly data with regard to numbers of incidents reported by CHS since 1st January 2018. The data shows that there has been an overall increase in reportable incidents from 2,041 in quarter 4 2019/20 to 2,240 in quarter 1 2019/20. There has also been an increase in 'moderate harm' incidents from 8 in quarter 4 2018/19 to 27 in quarter 1 2019/20. This increase in moderate incidents is related to the change in reporting of pressure ulcers relating to their harm.

3.2.2 Learning

Investigations relating generally to pressure ulcers Identified that staff had a knowledge gap in relation to the lower limb pathway. A further spot check identified that only 25% of staff interviewed were aware of the process for referral and service offered. This knowledge gap is being addressed.

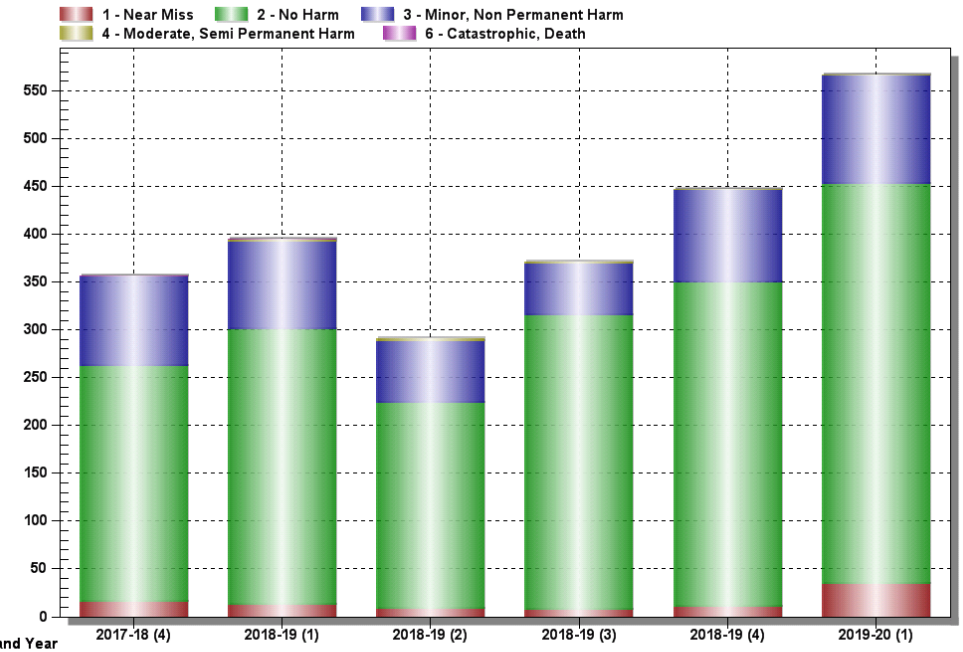
Investigations have also identified that sometimes patients find their airwave mattresses uncomfortable which means they are reluctant to use them and that some of the replacement cushions cause patients to feel unsafe and as though they may fall out of the chair (particularly smaller framed patients). Again this results in poor compliance. Both of these issues will be discussed with the medical devices group.

In relation to the learning from Grade 4 pressure ulcers the early learning relates to staffs consistent compliance with the SSKIN bundle designed to support the holistic assessment of pressure areas and bespoke plan of care. In addition some reports have identified that there is further improvement required to the information provided to patients around their role in reducing the risk of pressure damage.

In relation to falls prevention the use of post fall huddles has been trialled so that staff can immediately discuss the patients care and new risks to implement further fall reduction strategies to reduce the risk of further falls.

3.3 Families, Young People and Children Services

Fig 3.3.1 FYPC Harm Profile



Month and Year	2017-18 (4)	2018-19 (1)	2018-19 (2)	2018-19 (3)	2018-19 (4)	2019-20 (1)
1 - Near Miss	15	12	8	7	10	34
2 - No Harm	247	288	215	308	339	418
3 - Minor, Non Permanent Harm	93	92	65	54	97	114
4 - Moderate, Semi Permanent Harm	0	2	3	2	1	1
6 - Catastrophic, Death	1	1	0	0	0	0

Figure 3.3.1 above highlights the quarterly data with regard to numbers of incidents reported by FYPC since 1st January 2018. The data shows that there has been an overall increase in reportable incidents from 447 in quarter 4 2018/19 to 567 in quarter 1 2019/20. Some of this is accounted for a change in reporting in relation to the making of safeguarding referrals

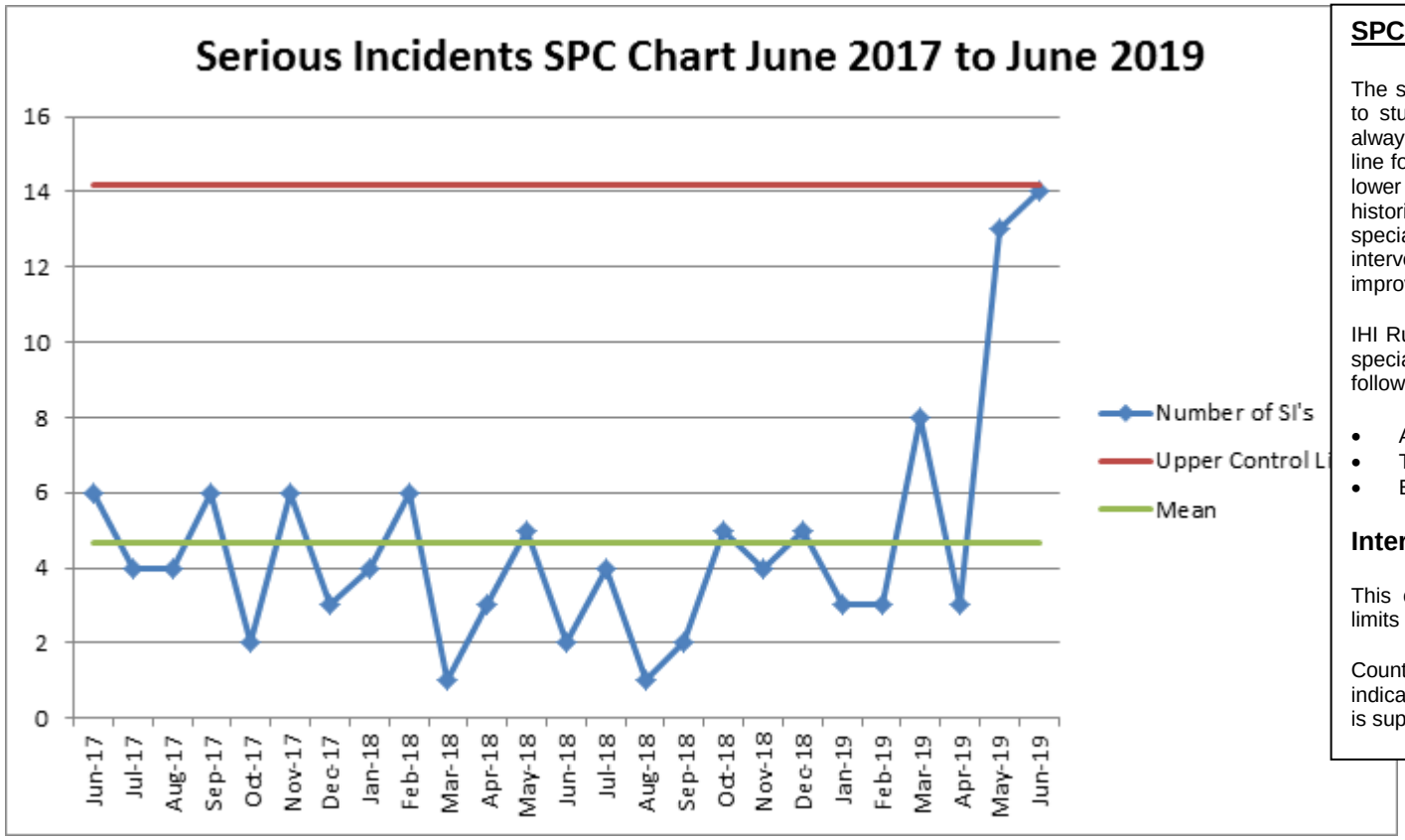
3.3.2 Learning

Both internal and serious incidents undertaken have identified that staff are not consistently following the ethos of the whole family approach. Whilst staff have attended training the style of the training doesn't seem to be supporting them to translate this training into real situations when working with families. Feedback and suggestions for improving the relevance of the training have been made to the safeguarding team responsible for the training.

One serious incident investigation identified that there was a discrepancy between to pathways essentially for the same condition of poor diet intake. These have now been aligned.

4. SERIOUS INCIDENT DATA TRUST WIDE

In quarter 1 2019/20 there were 30 SIs that met the reporting criteria for escalating to the Clinical Commissioning Group (CCG).



SPC Chart

The statistical process control chart is a graph used to study how a process changes. A control chart always has a central line for the average, an upper line for the upper control limit and a lower line for the lower control limit. These are determined from historical data and allow us to analyse common and special variation. It also enables us to identify interventions made to the process and assess for improvement.

IHI Rules (minimum of 20 data points required) state special cause variation is identified if any of the following apply:

- A single point outside the control limits
- Two of three points outside the two sigma limit
- Eight in a row on the same side of centreline

Interpretation

This chart demonstrates the trust is within control limits for SIs for this period.

Counting numbers of incidents is not a good indicator and further analysis of themes and learning is supplied.

The above SPC chart highlights the monthly data with regard to numbers of serious incidents reported by LPT since 1 June 2017. The rise in Sis for May 2019 was due in part to the reporting of pressure ulcer Grade 4 onto STEIS which were previously reported on using different criteria. The highest type of Serious Incident reported during quarter 1 2019/20 is Pressure Ulcer Grade 4 (36%).

4.1 New SIs reported and actions taken to reduce immediate risk Q1 2019/20

STEIS No	Department	Incident	Incident Description	Action taken to reduce immediate risk
2019/9891	PIER Team	Suspected Suicide	Whilst in Police custody a patient open to the PIER Team ligated, he was taken from there to LRI where a decision was made to switch off his life support.	No immediate actions identified Section 42 Inquiry in progress
2019/9911	Assertive Outreach	Suspected Suicide	A patient was found having ligated at his home address. He was declared deceased at the scene.	No immediate action identified
2019/9920	ICS East South	Sub optimal care of the deteriorating patient	A patient was visited by a District Nurse and it was noted that her SATS were low at 77%, her RPM were high and her pulse rapid and irregular. The DN did not call for an ambulance as the patient was able to speak but instead called the GP. The GP was not available so the nurse said she would call back the next day. Subsequently the GP spoke to the patient and called an Ambulance and the patient died in the acute hospital.	Clinical supervision and reflection session held with staff and review of clinical case load
2019/10146	Charnwood CMHT	Suspected Suicide	A patient's ex-husband contacted the police to say that he hadn't been any communication from the patient for 2 days which was unusual. The Police attended the patient's address and found her deceased at the property. The Coroner confirmed the cause of death as drug toxicity.	No immediate action identified
2019/10147	AMH City East CMHT	Suspected Suicide	A patient's brother who lived with him called an ambulance and when the paramedics arrived the patient was deceased. The Coroner confirmed the cause of death as multiple drug toxicity.	No immediate action identified
2019/10329	AMH City Central OPD	Suspected Suicide	A patient's mother made a complaint to LPT regarding her Son's treatment. At the time this hadn't	No immediate action identified

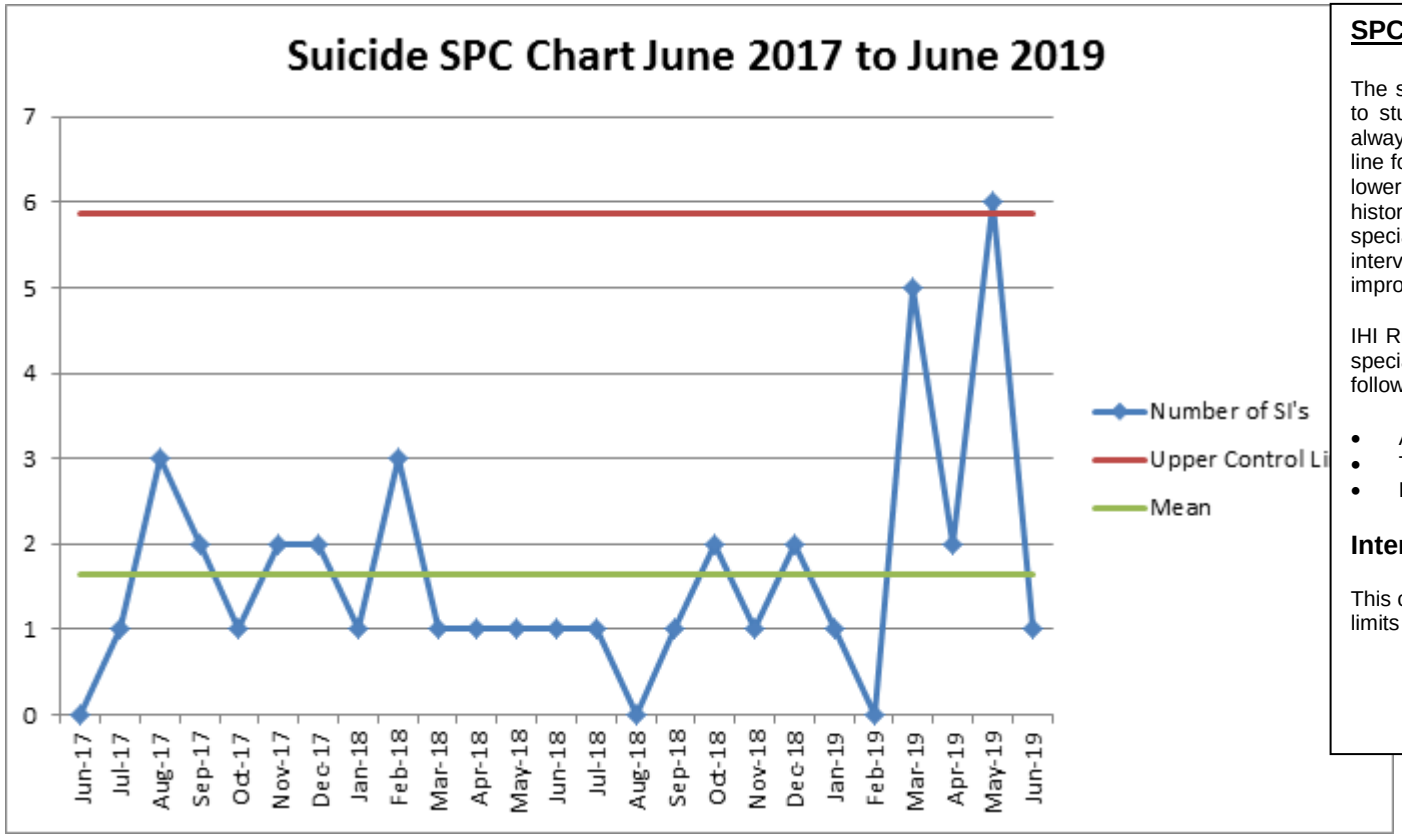
			been investigated as an SI as it fell outside of the Criteria however further information from the patient's mum suggested the patient had been in contact with services within the 6 months before his death. An SI was commissioned and the Coroner confirmed the patient had died of drug toxicity.	
2019/10716	Merlyn Vaz District Nurses	Pressure Ulcer grade4	The patient developed a pressure ulcer grade 4 to their natal cleft whilst under the care of LPT.	Regular staff are now provided with electronic access to the full clinical records
2019/11014	Crisis	Suspected Suicide	A telephone call was received by the service informing them that a patient under their care had driven his car into a tree and had been pronounced deceased.	No immediate action identified
2019/11034	City Central CMHT	Suspected Suicide	The patient's relatives informed the team that the patient had passed away and the Coroner confirmed that the cause of death was multiple drug toxicity	No immediate actions
2019/11258	Eating Disorders OPD	Sudden unexpected death	A patient open to LPT was admitted to LRI following collapse at home she later died in LRI and the cause of death was given as anorexia nervosa.	No Immediate actions identified
2019/11375	Braunstone HSC District Nurses	Medication incident	A patient was given an extra dose of insulin that resulted in the need for them to be admitted to LRI for further treatment.	Medication error documentation completed record keeping for staff member update don ULearn
2019/11673	Melton District Nurses	Pressure Ulcer grade 4	The patient developed a pressure ulcer grade 4 to their sacrum and shoulder whilst under the care of LPT.	Clinical supervision to be conducted with the staff
2019/12093	Bosworth Ward	Self harm	A patient used a razor blade to make an extensive cut to his throat which required surgery to close the wound.	Staff reminded of need to adhere to policy in relation to sharps management
2019/12396	Early Start City	Safeguarding Vulnerable Child	A 9 month old baby suffered multiple fractures that were caused by non-accidental injury.	

2019/8504	City West CMHT	Suspected Suicide	A patient was found at his home address having ligated in his garden he was declared deceased at the scene.	Investigation to consider action taken in relation to DNAs.
2019/13169	Merlyn Vaz District Nurses	Pressure Ulcer grade 4	Patient had a grade 3 pressure ulcer on her coccyx that deteriorated to a grade 4	Wound assessment updated and referred to physio for appropriate chair
2019/8536	Griffin Ward	Alleged abuse of a patient	Allegations were made against staff by a patient where the patient was verbally threatened with inappropriate sanctions and restricted to her bedroom.	Temporary reduction in bed status and additional staff secured.
2019/14284	The Willows	Unexpected death of an In Patient	A patient who was detained under the Mental Health Act collapsed and died. The patient had recently had investigations for cardiac issues.	No immediate actions identified
2019/13213	Memory Service	Unexpected death of a community patient	A patient open to the memory service died in a fire at his home. It had been identified in an earlier assessment that there was a fire risk at his property because of his hoarding behaviour	No immediate actions identified
2019/7910	City West OPD	Suspected Suicide	The patient hadn't been seen for a number of days and when the Police attended they found the patient deceased the Coroner confirmed cause of death as multiple drug toxicity.	No immediate action required
2019/14123	Loughborough District Nurses	Pressure Ulcer grade 4	Patient developed a pressure ulcer grade 4 to their foot whilst under LPT care	Frequency of dressings changes increased
2019/14116	Springfield Road HC District Nurses	Pressure Ulcer grade 4	A pressure ulcer deteriorated to a grade 4 whilst the patient was under LPT care	Wound assessment updated
2019/12835	Beaumont Ward	Self Harm	Phone call received from Guy and St Thomas's Hospital in London regarding patient who had gone AWOL and was currently under their care. Staff from the hospital said that the patient had presented having taken an overdose of aspirin and ibuprofen. They stated that the patient had deteriorated in their	Patient has been detained under the MHA following her discharge from UHL

			physical health and had had a prolonged seizure. Staff from the hospital said that she was currently in intensive care, unconscious and ventilated.	
2019/12414	Crisis	Suspected Suicide	The police have received a telephone call from East Midlands ambulance service (EMAS) to report that they are currently with a deceased male who appears to have sadly taken his own life. Male appears to have ligated was found by his brother.	No immediate actions identified
2019/13745	Charnwood District Nurses	Pressure Ulcer grade 4	TVN visited a patient to review a pressure ulcer which had deteriorated to a grade 4 whilst in LPT care.	All assessments complete and up to date. Patient has declined advice re using pressure ulcer equipment. Advice given again by nurses
2019/13488	Charnwood Mill District Nurses	Pressure Ulcer grade 4	Patients wound was reviewed by TVN specialist and has now been graded as a cat 4 pressure ulcer to sacrum from a grade 3.	Missing equipment put into place
2019/13453	Loughborough District Nurses	Pressure Ulcer grade 4	Routine visit to redress category 3 pressure sore to right outer foot. This has had deteriorated to a grade 4,	Clear assessments and personalised care plans are already in place and the MDT are working to support the patient
201913397	Braunstone HSC District Nurses	Pressure Ulcer grade 4	Patients wound was reviewed and had deteriorated to a grade 4 from a grade 3	Guidance on correct use of a wedge given to care home
2019/13337	Merlyn Vaz District Nurses	Pressure Ulcer grade 4	A patient developed a grade 4 pressure ulcer whilst in LPT care	Bed extension ordered for the patient, LPT repositioning charts issued to the care home.
2019/13313	Hinckley and Bosworth District Nurses	Pressure Ulcer grade 4	A patient developed a grade 4 pressure ulcer whilst in LPT care which had deteriorated from a grade 3.	Clear assessments and personalised care plans are already in place and the MDT are working to support the

				patient

5. SUICIDE DATA TRUST-WIDE



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- A single point outside the control limits
- Two of three points outside the two sigma limit
- Eight in a row on the same side of centreline

Interpretation

This chart demonstrates the trust is just within control limits for suspected suicides for this period.

The above SPC chart highlights the monthly data with regard to numbers of suspected suicides reported by LPT since 1 June 2017. The number of suicides reported in May 2019 reflects the date that these were reported onto STEIS and not all of these deaths happened in May. The reason for late reporting was because we were only aware of the deaths because the Coroner had informed us of the death. There are ongoing issues with the Trust being able to gather information from deaths from the national spine and this is currently being addressed. Some incidents are reported some time from the death due to awaiting toxicology for example

5.1 Suspected Suicide SIs reported in Q1 19/20 – This information will be available in future reports

STEIS No	Incident Date	Gender	Age	Service	Locality	Method	Diagnosis	Time in service	Ethnic Origin	Marital status	*Inquest verdict*

NB this data is recorded by reported date rather than actual incident date. Some incidents are reported some time from the death due to awaiting toxicology for example

The patient safety team will work when they have resource to re base the data each quarter to reflect the month the death occurred rather than the month reported.

There has been an increase noted in deaths of patients under the care of Crisis Team with six having been reported in the six months of 2019 compared to a total of three for the whole of 2018. Looking at the National Confidential Inquiry data there has also been a national increase noted. This increase will be reviewed for themes/trends and findings shared.

Calendar year	On the ward	Off ward on planned leave	Off ward unplanned leave/AWOL	Community Treatment Order	Within 10 days of discharge	Under the care of crisis team	Within 5 days of discharge from Crisis	Community suicides
2015	0	1	0	0	0	3	0	21
2016	1	1	0	0	2	2	0	12
2017	0	3	0	0	0	2	0	13
2018	0	0	1	1	2	3	0	10
2019	0	2	0	1	0	4	1	11

Suicide Reduction

LPT are part of the LLR multi agency approach to suicide prevention which focusses on patients in the community.

Numbers of suicides in young people are very low and over the year there has been one, which was a CAMHS Out Patient. FYPC have organised a multi agency conference to consider 'why young people take their lives'. This conference took place on Wednesday 8th May 2019 and was very well attended.

Zero Tolerance approach to in-patient suicide

NHSE have tasked trusts to develop a zero tolerance approach to in-patient suicide plan. This includes patients on authorised and unauthorised leave. Whilst developing this and on review of our local data we are extending the focus of this work to include patient's within 10 days of discharge and patients under the care of the Crisis team. The plan will be extended next year to begin the work towards Zero Suicide in all patients under the care of LPT.

As this plan develops and learning is identified this approach will be widened.

The plan will be held by the Suicide Prevention Group and monitored against progress by the Mortality Surveillance Group.

The Trust will also be developing a strategy for the management of self harm.

The full plan will be embedded in the Q2 report for 2019/2020.

The Trust has now appointed an Associate Medical Director for Quality who will also lead on Suicide Prevention.

A job description has been developed for a dedicated .5 WTE clinician

6. INCIDENCES OF FAILURE TO PRODUCE AN APPROPRIATE BED FOR PATIENTS UNDER THE AGE OF 16

There was one incident of failure to provide an appropriate bed for patients aged 16/17 in quarter 1 2019/20. The patient was transferred from CAMHS Ward 3 following him assaulting several members of staff and attempting to assault other patients. It was considered that the level of violence being exhibited by the patient was not manageable on Ward 3. A specialist bed was not available so for his safety and the safety of the other patients he was moved to the seclusion room on Bosworth Ward whilst awaiting a specialist bed. There was a significant delay which is being considered by the investigator, from NHSE and private providers in providing a suitable placement.

7. PERFORMANCE

7.1 Quality of Investigation Reports

	No. CCG feedback received	No. SIs closed	No. SI action plans requiring amendment as a result of CCG feedback
Qtr 1 – 19/20	18	9 (50%)	0 (0%)
Qtr 4 – 18/19	15	8 (53%)	2 (13%)
Qtr 3 – 18/19	15	9 (60%)	0 (0%)
Qtr 2 – 18/19	15	10 (67%)	0 (0%)

7.2 SI reporting target (≤ 2 working days) and Notification to commissioner

Submission	Total No. of SIs reported	Q1 – 19/20	Q4 – 18/19	Q3– 18/19	Q2– 18/19
Green (within timeline)	30	93%	100 %	93%	100%
Amber (breached ≤ 7 days)	1	1	0	0	0
Red (breached ≥ 8 days)	1	1	0	1	0

* The number of SIs reported onto STEIS during, Q2 Q3 & 4 18/19.

During quarter 1 2019/2020, thirty external SIs were reported and twenty eight (93%) were reported within 2 working days of the Trust becoming aware.

The two late reports were due to delay in the service letting the Patient Safety Team know that there were two confirmed Pressure Ulcers meeting the SI criteria.

The one late report in Q3 was the report into the Fire on Beaumont ward, the reporting was delayed as staff had not felt that it met the criteria for a Serious

Incident due to the fact that there was no harm. The scale of the fire was not known at the time of reporting and when this was known the incident was escalated.

7.3 Final report submission (≤ 60 working days)

A total of sixteen incident investigations were concluded and 5 (31%) were submitted to the commissioners by the target date.

Submission	Q1 19/20	Number	Q4 18/19	Number	Q3 18/19	Number	Q2 18/19	Number
Green (within timeline)	31%	5	57%	4	100%	8	92%	12
Amber (breached ≤ 7 days)	38%	*6	29%	*2	-	-	8%	1
Red (breached ≤ 8 days)	31%	*5	14%	*1	-	-		-

*The reason for late submissions was due to the capacity of senior staff to write up reports.

Implementation of a new Executive Sign off stage in the process.

Having been reviewed by the Head of Patient Safety some were not considered to a standard that could be submitted to the CCG.

Actions are being put into place going forward to improve the quality of investigations and the reduction in internal timescales to facilitate robust internal sign off. The Executive sign off is now incorporated into the process to allow at least 5 days for comment.

8. DUTY OF CANDOUR

There were zero duty of candour breaches in quarter 1 2019/20. The Patient Safety team have also been monitoring the quality of the Duty of Candour response and making suggestions for improvement where required.

9. SI ACTION PLAN TRACKER – Q1 19/20

There were ten action plans due for completion in quarter 1 2019/2020 all ten met timescales.

9.1 SI ACTION PLANS MONITORING OF EMBEDDEDNESS

FYPC embeddedness of learning

Following a Serious Incident that took place in December 2018 where it was identified that in relation to the Whole Family approach communication factors between LPT services and with social care were a contributory factor with staff demonstrating differing practice in relation to their application of the whole family approach.

The Governance Manager has planned to undertaken a pre-test/ post-test review of health visiting practice in relation to their individual application.

A survey-monkey review was undertaken with the results demonstrating that there needs to be an increased focus on liaison between services and situations to liaise in relation to, as only 1/3 of staff responding indicated they would liaise for either parent/ family member.

A training presentation will be circulated over August and September 2019 and a post survey will be repeated in December 2019. The results will be considered as to the effectiveness of this approach and a decision made how to improve training and understanding for staff going forward.

MHSOP

Learning from fall incidents was spot checked with good results. Knowledge of appropriate assessments was good and the paperwork to use. 10 records were checked and found to be appropriately completed. Knowledge of availability and appropriate use of equipment was also good.

10. INTERNAL ROOT CAUSE ANALYSIS INVESTIGATION DATA AND LEARNING

Incident No	Department	Incident	Incident Description	Action taken to reduce immediate risk

This information will be available in future reports

11. PREVENTING FUTURE DEATHS AND RESPONSES

During Q1 no preventing future deaths reports have been received by the Trust. Future quarterly reports will consider previous actions and assurance of actions.

12. PRESSURE ULCERS

In August 2018 Leicestershire Partnership Trust (LPT) re-established its Pressure Ulcer Ambition group with the purpose of ensuring we are creating best practice guidance for preventing pressure ulcers and learning from those that do occur to ensure patients get the right treatment. This included reviewing the current pressure ulcer policy along with reporting systems to ensure they were fit for purpose.

The group's first priority was to review and change the Ulysses incident reporting system in relation to pressure ulcers to ensure we were in line with the new national Pressure Ulcer reporting guidance (NHS Improvement Pressure Ulcers: revised definition and measurement June 2018). This guidance is aimed to ensure a "better understanding of pressure damage will enable trusts to learn from incidents and design appropriate improvement work in response to their profile"

From this review of the Ulysses system we ensured the correct information was being captured so we could understand why the pressure ulcer had occurred and establish lessons to be learned. A new Pressure Ulcer Scrutiny Template was designed to enable us to capture learning and actions from all pressure ulcer incidents that have developed or deteriorated in LPT care. This system went live on 1st April 2019 and the first review of extracted data being captured was positive as it demonstrated to the group that we would be able to review lessons learned themes. At July's meeting the group reviewed the quarter's data and identified themes which will enable us to reduce the risk of occurrence.

The next priority for the group is to identify the improvement journey we need to take to reduce the number of pressure ulcers developing in our care along with how we measure this.

Grade 4

Month developed Grade 4	Number on STEIS Community	Number on STEIS In patient	Number awaiting confirmation from TVN
April	0	0	0
May	7	0	0
June	11	0	0

NB When there are enough data points and there are actions in relation to the learning this data will be converted into an SPC chart in order to monitor the trajectory to ensure there is a sustained downward trend.

Analysis of Pressure ulcer themes and trends identified during quarter 1 and lessons learned

The category 4 pressure ulcer serious incidents reported during quarter 1 (total 18) are spread across 7 of the 8 community nursing hubs, with Charnwood hub reporting 4 of these. A discussion is planned at the next Community Services Matron hub to understand why Charnwood hub had so many category 4 incidents and why Northwest hub have had zero so we can understand if we can learn from these areas. Five category 4 pressure ulcers serious incident investigations have been completed and reviewed at Community Health Services (CHS) directorate serious incident sign off meeting which is incorporated into the Senior Clinical Team meeting. Early lessons have been identified and will be shared with staff, these include: increased understanding of the process of referral or when to refer to Podiatry Services, being aware of the risk to patients of relatives using cushions to support them resulting in increased pressure. Learning is also emerging around the need to support staff to raise concerns re carers and care homes.

The new Pressure Ulcer Scrutiny Template has enabled LPT to capture themes from lessons learnt for all pressure ulcers developed / deteriorated in our care during quarter 1, (394 completed templates in total) with the Top 2 being:

- Lack of SSKIN / elements of SSKIN / review of SKKIN (29%)
- Patient education / information (25%)

Within Community Nursing Services the matrons are currently identifying quality improvement projects to test their ideas using PDSA (plan do study act) technique to see it they make the difference. Within the East South hub they are focussing their PDSA around reducing category 2 pressure ulcers in new patients by improving patient education.

Hinckley & Bosworth hub noted they had an increase in category 2 pressure ulcers which have deteriorated from moisture associated skin damage, so arranged training sessions from the Tissue Viability Nursing (TVN) service to ensure staff understand how to prevent, treat and correct categorisation.

City East hub have identified the following 2 themes; SSKIN being completed but not Waterlow and SSKIN & Waterlow not being completed at routine catheter changes and B12 injection visits, therefore it is hard to ascertain if subsequent pressure area breakdown could have been prevented. The Senior District Nurse has held a training session with the team to highlight the importance of fully completing the appropriate records ensuring all information is captured and putting in place appropriate measures in relation to any assessed risks.

Within Community Hospitals reporting has remained consistent. From review of these cases it has been identified that the wards are receiving increasingly complex, co-morbid and frail patients during quarter 1. This has been demonstrated in the following examples. Firstly, via the number of category 2 pressure ulcers which have deteriorated from moisture associated skin damage. Appropriate interventions were put in place which has resulted in these being healed upon discharge for these patients.

Secondly, one Community Hospital Ward had two complex patients that were admitted following a “long lie” at home prior to admission and a patient who had received no formal care prior to admission into hospital. These patients were identified as high risk on admission to the ward, all prevention strategies were in place and reviewed by TVN team as appropriate, but one of these still deteriorated. The investigations did not find any care recommendations.

Thirdly it was noted that more of the community hospital patients with pressure ulcers were receiving end of life care, the review has identified that all preventative strategies were put into place to support their care in the last days of life and prevent any further deterioration.

Finally there has been an increase in suspected deep tissue injury in LPT care in community hospitals, the reviews have identified that all appropriate measures were put in place but the clinical record did not capture the detail around patient education and information provided. Ward sisters and therapy leads to review the current process of patient involvement and education via discussion at the July clinical network meeting.

13. FALLS

Over the past year we have been reviewing how we scrutinise the data we review at Falls Steering Group – it had been custom to look at very high level incident data and review SIs at the meeting – it was clear this wasn't effective in identifying clear themes and associated actions. So below are key initiatives we have put in place to improve our analysis and direct our work plan but also to encourage directorates to own and identify themes and actions (work in progress so not finite).

- As well as the expected local scrutiny at team and directorate level, we introduced Inpatient Falls Forum where community / AMH /LD reps(falls champions) from the wards discuss falls incidents and share learning and good practice and identify themes – this is where the need for socks were identified.
  (AMH/LD also started a falls forum to reinvigorate the falls agenda in the directorate and support a new cohort of falls champions)

- We have changed the codes on Ulysses so we can now differentiate those falls that are first falls and repeat falls with the purpose of identifying any difference in themes for those scenarios and demonstrating the effectiveness of our interventions - Huddles were introduced to reduce repeat falls

- We have recently agreed directorate specific reports on falls incidents (CHS governance are collating) to provide better level of scrutiny and are asking the directorates to provide the narrative for discussion at steering group e.g. story/actions/learning behind a repeat faller. To support and encourage identification of themes at directorate level

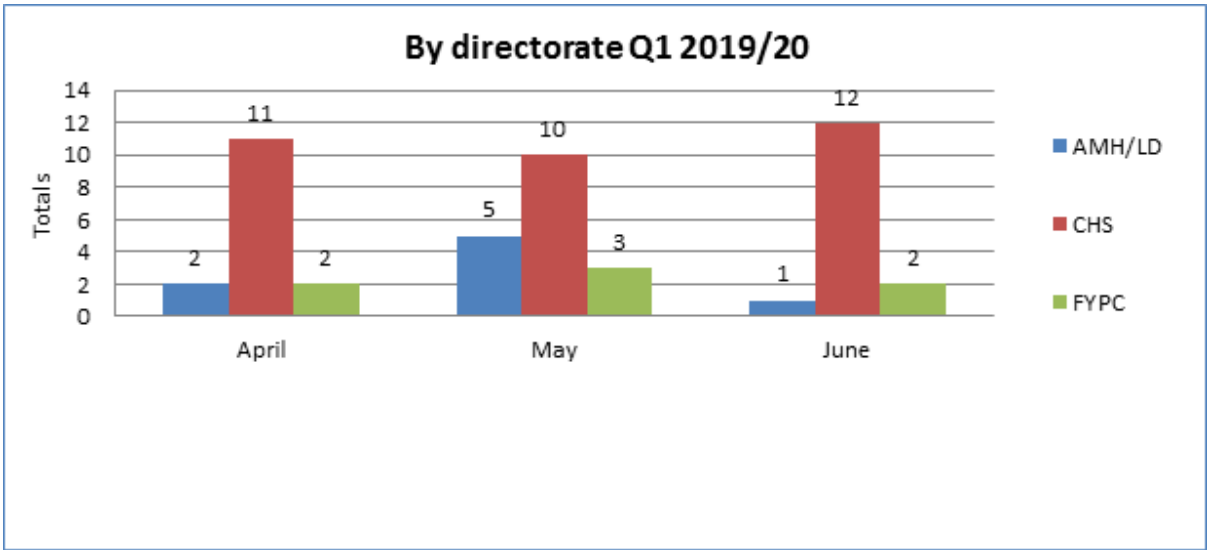
- Recent incidents have identified lack of clarity around moving patient post fall so we plan to update policy and cascade training

13.1 Falls Data

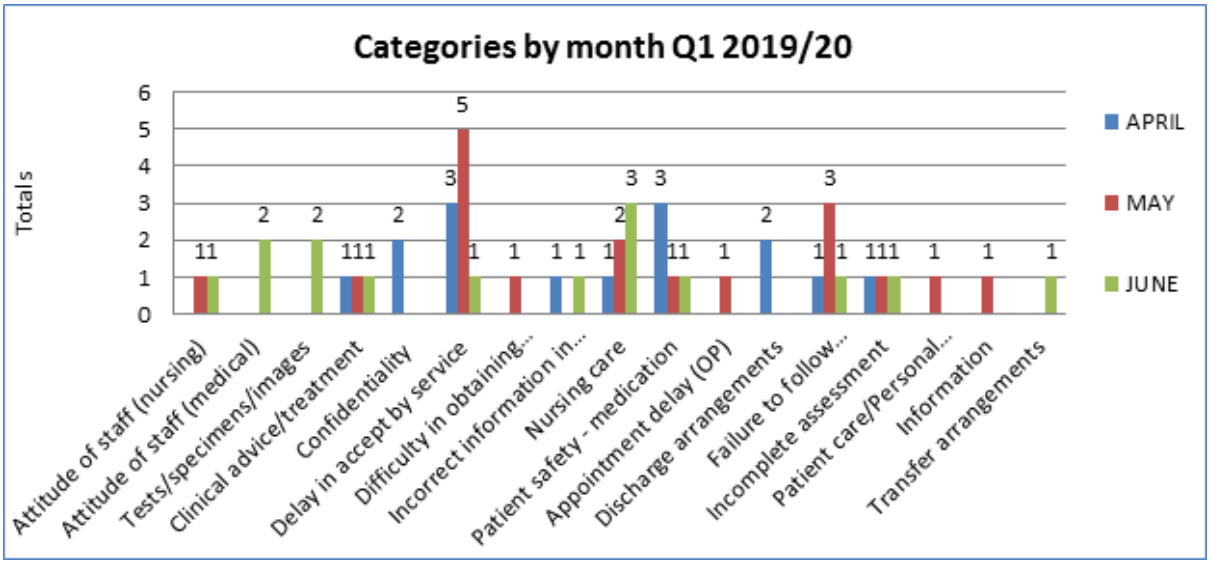
	17/18 Q1	% of total	18/19 Q1	% of total	18/19 Q2	% of total	18/19 Q3	% of total	18/19 Q4	% of total	19/20 Q1	% of total
1 – Near miss	7	1%	2	0.40%	0	0%	0	0%	1	0.20%	**2**	**1%**
2 – No harm	291	59%	307	69%	307	68%	293	67.70%	262	69.50%	**201**	**65%**
3 – Minor, non-permanent Harm	189	38%	136	30%	139	31%	138	31.80%	109	30%	**100**	**32%**
4 – Moderate, semi-permanent harm	4	1%	3	0.60%	4	0.90%	2	0.50%	5	1.30%	**6**	**2%**
Total falls	491	100%	448	100%	450	100%	433	100%	377	100%	**309**	**100%**

14. LEARNING FROM CONCERNS RAISED VIA THE TRANSFERRING CARE SAFELY PROCESS (TCS)

During Q1 49 concerns were received with the majority being for Community Health Services (CHS)



Below is a breakdown of the categories used and demonstrating small numbers in the majority of categories



Learning (actions taken by LPT)

Difficulty/Delay in being accepted by a service

Referral to Speech and Language Therapy (SALT) team delayed. Action has been taken to change wording on the referral form to provide more clarity on the referral process.

Nursing care

INR dosage monitoring referred to GP on a Good Friday. Action taken: Advanced Nurse Practitioners team informed of the importance of forward planning when informing the GP they will take over the monitoring of INR dosage.

Patient safety

UHL service concern: TTO letter not clear regarding medication during inpatient stays in different LPT community hospitals. Action taken: Provide more clarity as to why change in medication and ensure TTO is more explicit.

15. NEVER EVENTS

No Never Events were reported for Q1.

16. NATIONAL DEVELOPMENTS

Patient Safety Strategy

In April 2019 at the Patient Safety Congress Aidan Fowler, National Director of Patient Safety introduced the NHS Patient Safety Strategy. https://improvement.nhs.uk/documents/5472/190708_Patient_Safety_Strategy_for_website_v4.pdf

Patient safety is about maximising the things that go right and minimising the things that go wrong. It is integral to the NHS' definition of quality in healthcare, alongside effectiveness and patient experience.

To continuously improve patient safety.

The NHS will build on two foundations: a patient safety culture and a patient safety system. Three strategic aims will support the development of both:

• improving understanding of safety by drawing intelligence from multiple sources of patient safety information **(Insight)**

• equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system **(Involvement)**

• designing and supporting programmes that deliver effective and sustainable change in the most important areas **(Improvement)**

Insight

• adopt and promote key safety measurement principles and use culture metrics to better understand how safe care is

• use new digital technologies to support learning from what does and does not go well, by replacing the National Reporting and Learning System with a new safety learning system

• introduce the Patient Safety Incident Response Framework to improve the response to and investigation of incidents

• implement a new medical examiner system to scrutinise deaths

• improve the response to new and emerging risks, supported by the new National Patient Safety Alerts Committee

• share insight from litigation to prevent harm

Involvement

• establish principles and expectations for the involvement of patients, families, carers and other lay people in providing safer care

• create the first system-wide and consistent patient safety syllabus, training and education framework for the NHS

• establish patient safety specialists to lead safety improvement across the system

• ensure people are equipped to learn from what goes well as well as to respond appropriately to things going wrong

• ensure the whole healthcare system is involved in the safety agenda.

Improvement

• deliver the National Patient Safety Improvement Programme, building on the existing focus on preventing avoidable deterioration and adopting and spreading safety interventions

• deliver the Maternity and Neonatal Safety Improvement Programme to support reduction in stillbirth, neonatal and maternal death and neonatal asphyxial brain injury by 50% by 2025

• develop the Medicines Safety Improvement Programme to increase the safety of those areas of medication use currently considered highest risk

• deliver a Mental Health Safety Improvement Programme to tackle priority areas, including restrictive practice and sexual safety

• work with partners across the NHS to support safety improvement in priority areas such as the safety of older people, the safety of those with learning disabilities and the continuing threat of antimicrobial resistance

• work to ensure research and innovation support safety improvement

There is a lot of detail in the report about specific areas of work that will be relevant to us including medicines safety, recognition of deterioration and treatment of Sepsis. In addition there is a section focussed on Mental Health specifically

In The state of care in mental health services 2014-2017, CQC identified safety as the biggest concern for mental health services. The MHSIP aims to provide both bespoke support to mental health trusts on their individual safety priorities as well as support around challenges that are common across many or all local systems.

The MHSIP works with the 54 NHS trusts providing mental health services in England, and closely with CQC centrally and with CQC and NHS Improvement teams regionally. The programme is delivered by a team of experts in mental health, some of whom have board-level and quality improvement professional experience and some lived experience of our services, either as a service user or as a carer of someone who has used services.

This programme has two main components.

The trust engagement programme

The MHSIP team meets every trust executive team after CQC reports on its inspection of the trust. Before this meeting the MHSIP team will have met the regional CQC and NHS teams to develop a shared understanding of each organisation’s safety concerns. We work collectively to determine what a trust’s priorities are and to devise an improvement plan accordingly. We aim to develop a safety improvement plan for each trust by April 2020.

Once complete we will move resources from the engagement programme to supporting the improvement collaborative programme

The improvement collaborative programme

This component concerns the complex safety problems in mental health. It uses quality improvement for testing, measuring and improving. Work is already underway to reduce restrictive practice (restraint, seclusion and rapid tranquilisation) by a third by April 2020. A collaborative to improve sexual safety is being designed and will launch at the end of this year. We are inviting all NHS mental health inpatient providers to nominate a ward to participate in this improving sexual safety collaborative.

LPT response

LPT's patient safety plan was developed based on these principles a culture that has a clear vision of the quality of care we aim to deliver and is based on learning and not blaming. This means creating a culture where we create systems collaboratively with patients and staff that make it easy to care for patients, whilst being open and transparent when things go wrong with a commitment to learn. As the detail of the initiatives are developed we will update as appropriate.

Patient Safety Congress

The Head of Patient Safety was fortunate to have been able to attend Patient Safety Congress in April. It was great to hear Aiden Fowler vision for the above Patient safety strategy. The audience all welcomed the focus on systems and the stronger links that we are forming with safety scientists (Human Factors, Ergonomists)

There were again however too many patient speakers with very powerful and distressing stories of how the NHS has failed to be open and transparent and engage with them when things have gone wrong. A number of these patients have gone on to develop careers in patient safety. There was an overwhelming plea from the audience to drive forward the just Culture approach as for any patient safety initiative to be successful this was essential.

There were also a number of sessions that focussed on 'work as imagined vs work as done' this describes the situation where there is a vision/view held by managers and policy makers around how work is done and this is described as 'imagined' and then the actual work undertaken by those involved as 'work as done' These sessions focussed on the need to work with frontline staff and patients to design safe systems of work collaboratively rather than these being designed remotely.

Safe staffing also featured with a challenge from the audience around degree only nursing degrees, Ruth May was very clear that this would not change to a bursary

style training as the evidence is overwhelming that well trained staff delivering high quality care.

There were also a number of sessions that discussed the ‘civility saves lives’ work. This describes the loss of cognition when staff are either responded to with incivility or witness others. This work is aimed at frontline staff but in fact in patient safety it is important to flatten hierarchies and ensure that all staff are encouraged to contribute and when they do they are treated with Civility

The Head of Patient safety will be happy to expand on any of the above and further detail in relation to the progress will be included in future reports.

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board – 1 October 2019
Paper number	P

Name of Report: Complaints Annual Report 2018/2019

For approval	x	For assurance	x	For information	

Presented by	Anne-Maria Newham, Director of Nursing AHPs and Quality	Author (s)	Matthew Smith, Complaints Manager

Alignment to CQC domains:		Alignment to the LPT strategic objectives:		Alignment to LPT priorities for 2019/20 (STEP up to GREAT):	
Safe	X	Safe	X	S – High Standards	X
Effective	X	Staff		T - Transformation	X
Caring	X	Partnerships	X	E – Environments	X
Responsive	X	Sustainability		P – Patient Involvement	X
Well-Led	x			G – Well-Governed	X
				R – Single Patient Record	
				E – Equality, Leadership, Culture	X
				A – Access to Services	X
				T – Trust-wide Quality improvement	X
Any equality impact (Y/N)		No impact on equal opportunities			No

Report previously reviewed by	
Patient and Carer Experience Group Quality Assurance Committee	Date: 2 July 2019 20 August 2019
None	

Assurance: What assurance does this report provide in respect of the Board Assurance Framework Risks?	Links to BAF risk numbers
This document links across the framework. There is particular reference in 1d 'continually improving our standards so we can demonstrate compliance with CQC standards and NHS Licence conditions'.	Whole BAF/ **1d**

Recommendations of the report

Leicestershire Partnership NHS Trust

Annual Complaints Report for 2018-19

Introduction

The Trust values the feedback it receives from patients, carers and their relatives and continues to use complaints as an effective measure of our patient experience and an opportunity to learn and improve the services it provides.

The service has continued to support people to access the Trust complaint process which is felt to be reflected in the increased number of registered complaints this financial year. There were a number of staff changes within the complaints team in 2018-19 with the introduction of a new Complaint Facilitator in July 2018 and a Complaint Manager in February 2019.

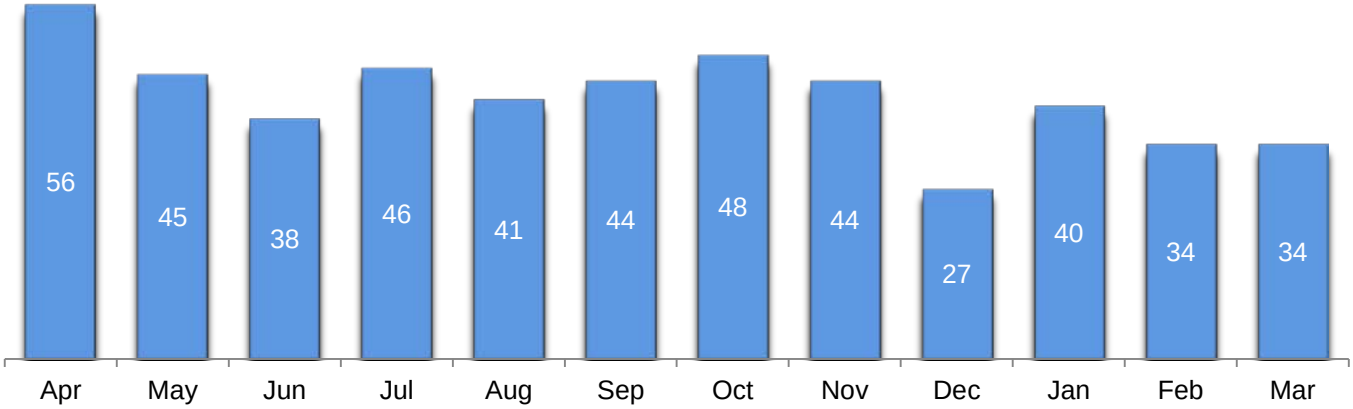
This report aims to provide a detailed insight into the Trust performance for complaints in 2018-19 and give examples of how we have used our patient experiences to improve the service for all accessing care.

Performance Overview

- **497** The number of complaints formally registered
- The percentage of complaints responded to in the agreed timeframe **74%**
- The percentage of complaints registered against patient activity **0.07%**
- **59** The number of complainants that were unhappy with their response
- **100%** The Percentage of complaints acknowledged within 3 working days
- The percentage of complaints we upheld or partly upheld **60%**
- The percentage of complaints we resolved in 10 working days **23**
- **1** The number of complaints that were formally investigated by the Parliamentary & Health Service Ombudsman

Complaints Received

During the period 1 April 2018 to 31 March 2019, the Trust registered 497 formal complaints. This was a six percent (31 complaints) increase on the previous year and twenty five percent (125 complaints) increase on 2016-17. Below is a breakdown of complaint received by month:



The Adult Mental Health and Learning Disabilities (AMHLD) directorate received the highest number of complaints in 2018-19 with 198. This was closely followed by Community Health Services (CHS) and then Families Young People and Children's (FYPC) Services. Below is a breakdown of complaints received in 2018-19 by to directorate compared to the previous 3 years:

	2018-19	2017-18	2016-17	2015-16
Total Complaints Registered	**497**	**466**	**370**	**344**
Adult Mental Health and Learning Disabilities	198	201	188	162
Community Health Services	174	150	111	117
Families, Young People and Children	119	107	66	61
Other	6	8	5	4

AMLD has consistently received the highest number of complaints compared to other directorates. The exact reason for the high numbers received is not known but it is believed to be due to the complex nature of the issues raised by the service user and staff encouraging patients to access the Complaints Services.

There has been a noticeable increase in the number of complaints received for CHS and FYPC compared to the previous year. The number of complaints received by the District Nursing service in 2018-19 increased by 29 and is felt to have accounted for the difference in the number received for CHS compared to 2017-18.

FYPC saw an increase in the number of complaints received for the Diana Service. 10 complaints were received between April – June 2018 relating to a change in the Rapid Response Service and this no longer being available. All 10 complaints related to the service no longer being in place. 27 of 497 complaints were withdrawn across all directorates. (11 = AMHLD, 13 CHS and 6 FYPC).

Case Summary 1

Mrs X complained about the appointment process within the Asperger's clinic and that staff had not followed process when requesting her to book a second appointment. Mrs X was also unhappy with the insensitive nature of the member of staff when they rang the service.

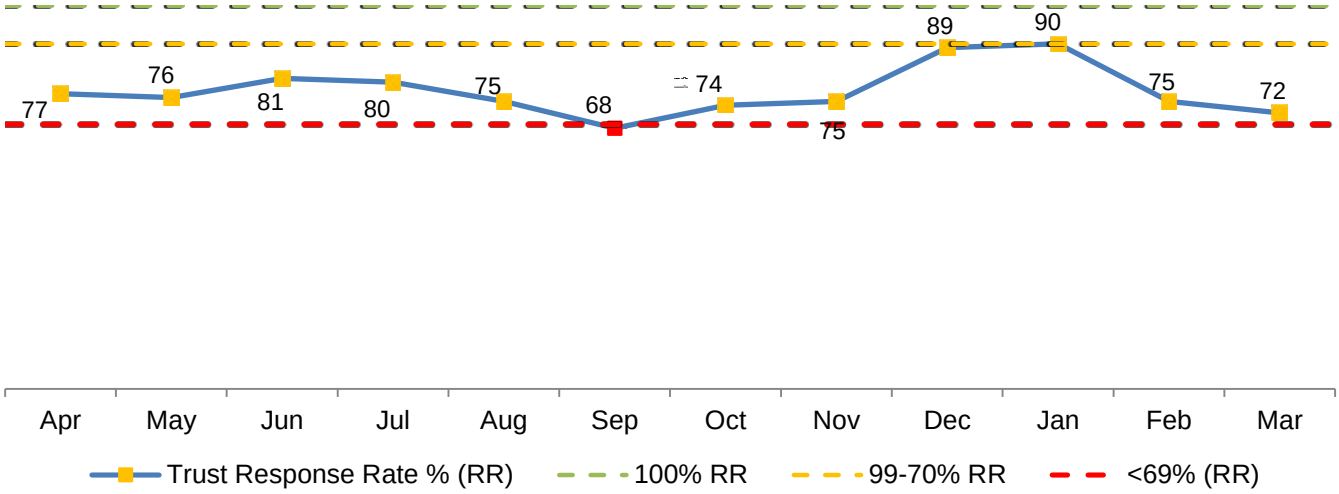
> **The standard process that the member of staff seems only to be able to adhere to was not followed in my case**

We looked into what had happened and acknowledged the appointment process had not been clearly explained to Mrs X on their first appointment. As a result we apologised for misinforming Mrs X of the appointment process. We advised that a review of the current leaflet provided to all patients and discussed in their first appointment would be undertaken and changes made to the information provided on the appointment process. A copy of the new leaflet was also sent to the complainant.

Complaints Response Rate

The timescale to provide our complaint response is made in agreement with the complainant. The investigator will make contact with the complainant to discuss their concerns, understand what they hope to achieve from the complaint and how they would prefer to receive the findings of our investigation.

It is at this point that a timeframe to provide our response is also agreed and fully explained. The timescales for response are 10, 25, 40 or 60 working days. Complaints can be responded to verbally, through a face to face meeting or by written response. The chart below shows the Trusts performance by month.



For 2018-19, the Trust responded to 74% of complaints within the agreed timescale compared to 80% the previous year. The AMHLD directorate responded to 68% of complaints within the agreed timescale. Community Health Services and the Families, Young People and Children's Services responded to 82% and 81% respectively.

> **62% of complainants felt their complaint was dealt with within a reasonable timeframe[1]**

The reduction in the number of complaints responded to within the timescale was felt to be due to the increased number received compared to the previous year alongside the increasing complexity of the issues especially those received by the Adult Mental Health and Learning Disabilities directorate. This means that greater time is needed to ensure we fully understand and investigate all the issues and provide an appropriate response to the complainant. The Complaints Service is working with the AMHLD directorate to improve compliance and offer support with handling and responding to complaints.

Case Summary 2

Father complained about their daughter's inpatient treatment specifically the lack of clinical oversight, continuity of consultant and direction of care and, concerns regarding staff awareness of patient's specific health and environmental needs relating to autism diagnosis.

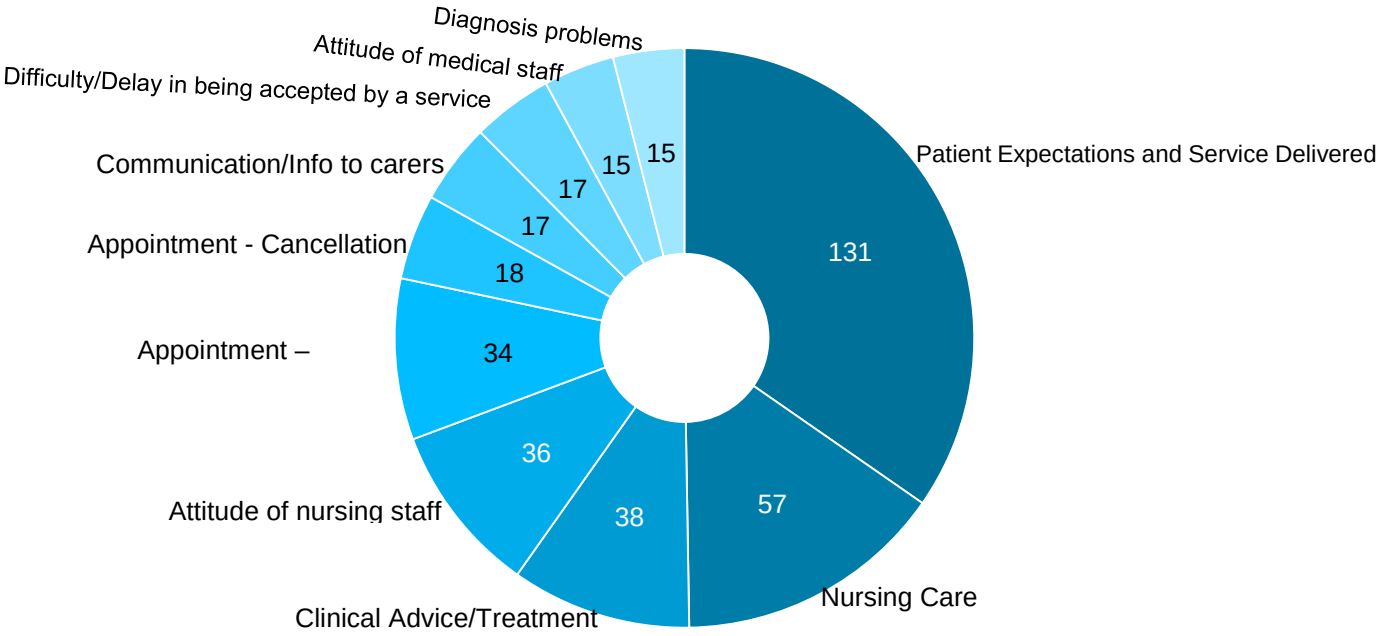
Matron met with patient and family on a weekly basis on the ward until patient was discharged. The issues of the complaint were established, an apology given and family reassured that these issues had been shared with the appropriate staff and care team. Importantly the weekly meetings were to establish a collaborative approach to the care with patient and family fully involved.

Matron highlighted there had not been an appreciation and consideration of specific health and environmental needs for patient who had autism. This was addressed as part of autism awareness training with the patients specific needs also assessed.

[2] Results from complainants surveyed in 2018-19

Complaint Themes

Upon receipt of every complaint the content is reviewed and the primary issue from the complaint logged onto our complaint management system. The chart below identifies the top 10 primary complaints themes for 2018-19.



The main theme of complaints was 'Patient Expectations and Service Delivered' with 131 complaints. This was a significant increase on the previous year and was felt to be due to limited categories that the issues could be attributed to.

A complaint logged under this category is defined as a concern with the service provided against the service user's expectations. This could be, for instance, the frequency of appointments given against what the service user was expecting.

"I am not aware of when nurses will next attend to my mum to help with her care at home"[2]

Nursing Care received the second highest number of complaints with 57 which was consistent with 2017-18. Of the 57 complaints, 77% were recorded against the District Nursing service. A review of these complaints highlighted there were a number of concerns relating to appointments (failing to attend and their frequency) and the communication of staff with the patient, relative or their carer. All relevant complaints have been shared with the service and directly with staff involved. Complaints are also regularly discussed in directorate meetings.

An analysis of the 'Patient Expectations and Services Delivered' category identified specific issues relating to patient appointments, particularly a delay receiving a date and communication as the stand out themes. These were in very small numbers and there was no specific trend, area or team associated with these concerns.

It was recognised that identifying trends and themes using the current categories particularly 'Patient Expectations and Service Delivered Category' was very difficult. We have learnt from this and have since undertaken a review of the categories.

The main finding of the review was that there were limited categories and as such we may not have been recording issues accurately. The issues attributed to 'Patient Expectation and Service Delivered' particularly should have been recorded under a more appropriate category. We have since revised the categories and they are now in line with the

1. Comment received on a survey received in September 2018

KO41a which is a national return for complaints. Our quarter 1 report for 2019-20 will reflect these changes.

Case Summary 3

We assisted with a joint complaint response in which relative of the late Mr T complained about the care provided and number of transfers.

We found that on each presentation the decision to transfer Mr T back to the acute setting was correct based on the clinical symptoms at the time. We recognised however that had staff reviewed previous presentations and admissions, it may have been possible to put a plan in place and prevent two admissions to the acute setting.

A meeting was held with family members where the findings of our investigation were gone through in detail and we sincerely apologised and acknowledged the failings. We advised that as a result the finding had been feedback to the relevant staff so they could appreciate the care. A workshop was also created where the records would be reviewed and the admissions to ensure staff considered appropriate actions, including escalation planning, early on during a patients stay. This will be applied to future practice.

Complaint Demographics

We use service user details to monitor the demographics accessing the complaints service. This data is produced at the end of each financial year by our Equality and Human Rights Team and gives the gender, age and ethnicity of the service users accessing complaints/that the care relates to. A breakdown is below:

Age	
0-9	39
10-19	77
20-29	60
30-39	49
40-49	54
50-59	55
60-69	43
70-79	33
80-89	49
90 and above	20
Unknown	16

Ethnicity	
White: British	299
White: Any Other White Background	8
Asian or Asian British: Indian	37
Asian or Asian British: Pakistani	2
Asian or Asian British: Any Other Asian	9
Black or Black British: African	3
Black or Black British: Caribbean	7
Black or Black British: Any Other Black Background	4
Mixed: White and Asian	4
Mixed: White and Black African	5
Mixed: White and Black Caribbean	6
Unknown	97

Sex	
Female	256
Male	222

The data highlighted that we received the highest proportion of complaints relating the care of White British Females. Concerns relating to the care of patients within the 10-19 age bracket was apportioned to the highest within the age demographic.

The lowest number of complaints were received relating to care of patients with Asian or Asian British: Indian ethnicity more specifically females as there were none. The lowest age population of complaints were registered relating to care of the 90 and above age range.

[2] Results from complainants surveyed in 2018-19

Case Summary 4

Mr X complained to his MP regarding the management of his leg wounds and difficulty obtaining compression stockings.

We found that on each occasion Mr X had accessed the service, the wounds had healed to good effect. However, there was a lack of communication and clarification from staff to Mr X on who would supply the compression stocking once discharged from the service.

We identified that there were missed opportunities within the care to have communicated to Mr X the correct process which in turn resulted in a delay obtaining leg compression stockings.
We could have also worked in partnership with the GP practice to ensure provisions were also made available to Mr X. This was due to a lack of awareness by staff about how the service is funded and organised to deliver lower limb care.

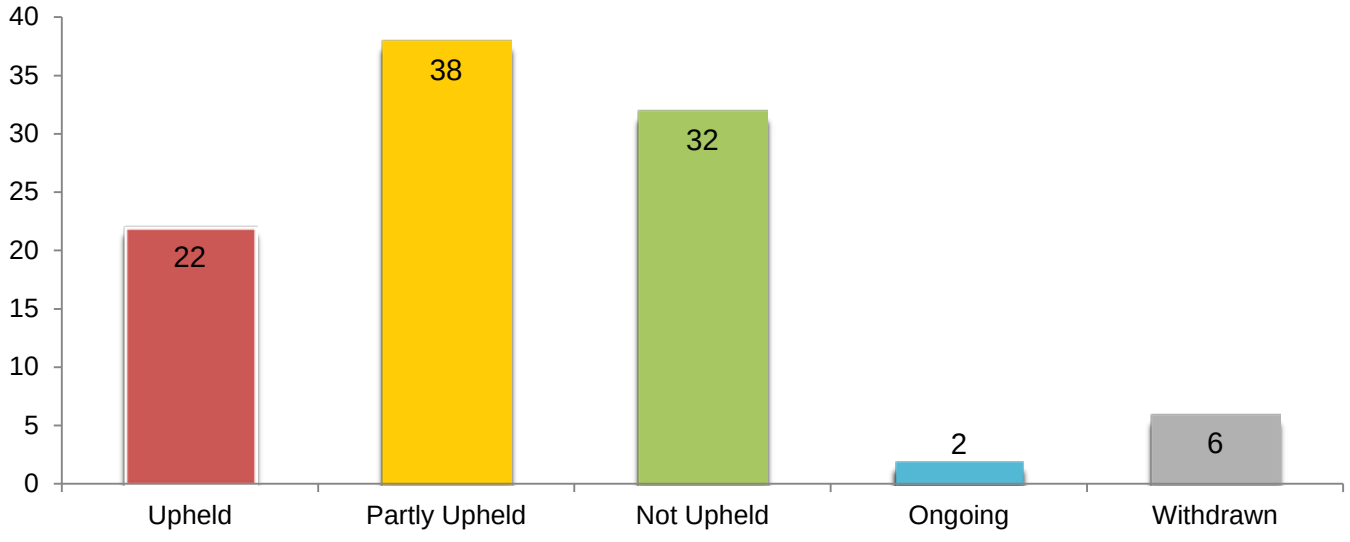
As a result of the complaint a letter was developed that can be sent with both the patient and to the GP practice detailing discharge from the service and ongoing management responsibilities. A review of the triage guidance has also taken place to ensure it captures the lower limb pathways and this has been reiterated to staff within the service.

Outcomes of Complaints

The outcome from a complaint is categorised in line with the KO41a national return requirements and can be upheld, partly upheld or not upheld.

Upheld	All issues of the complaint are fully substantiated and that there are shortcomings in the care and treatment provided
Partly Upheld	Some of the issues of the complaint are substantiated.
Not Upheld	The issues of the complaint are not substantiated and the care was appropriate and according to process or guidelines.
Ongoing	The complaint is under investigation.
Withdrawn	The complainant no longer wishes to progress their complaint or require a response.

The chart below shows the percentage of outcomes (this does not include those complaints that were withdrawn or are currently ongoing).



Between 1 April 2018 and 31 March 2019, we upheld or partly upheld 60% of our complaints (299 of 497 received) which is a marginal increase compared to 58% the previous year.
In these cases we found that there was a failing and there was an opportunity for learning. In addition to an apology being given, and an explanation for what went wrong, we also detailed how we would learn from the experience and the action that would be taken. There were also 11 cases outstanding and in need of an outcome when writing this report.

We upheld or partly upheld 60% of our complaints

There was a marginal increase in the percentage of complaints that were partly upheld in 2018-19 compared to the previous year (from 33% to 38%).

Case Summary 5

Mr C complained that a letter had been received for his son and the label on the back identified that his son accessed the speech and language service.

> **Now everyone knows my son accesses this service**

We established the label referred to by Mr C was a pre-printed return label to advise where the letter should be sent if it was undelivered.

We apologised for the upset the pre-paid label had caused. Specialist advice was sought and it was advised that best practice would be to use a unique identification number for the speech and language service letters to be returned to, if undelivered. This would also enhance confidentiality. All letters from this service now do not identify the letter as being from the specific service and they use a unique identification number.

Further Local Resolution

Between 1 April 2018 and 31 March 2019, 59 complainants got back in touch as they were unhappy with their initial response, compared to 47 the previous year. The table to the right shows a breakdown of why complainants were unhappy with their response. The complaints were reopened for further investigation.

Reason	
Response did not address all issues	17
Disputed the information provided	13
Unresolved issues	12
Complainant raised further issues	8
Requested meeting to clarify response	9

Of those that got back in touch, the Trust assisted with the outstanding issues by facilitating either a further written response or a face to face meeting. This approach has been successful with only one complaint referred to the Parliamentary and Health Service Ombudsman in 2018-19.

Learning from Complaints

It is important that we recognise when a patient's care has gone wrong and use their experience to learn and make improvements. This is so that the care and treatment we provide for everyone accessing the service is optimised. Complaints are a valuable source of feedback and an opportunity to bring about positive change. Throughout the report are examples of how we have used complaints received to make changes to the service we provide and positively influence

[2] Results from complainants surveyed in 2018-19

care to everyone accessing that service. In addition to sharing complaints directly involved with the staff involved in the care, complaints are shared at directorate Governance meetings which feeds into our Patient Carer and Experience Groups and then to our Quality Assurance Committee and Board.

Moving forward we are going to implement a new Complaints Review Committee which will oversee the Trust's management of complaints but importantly ensure that processes and learning are effectively monitored and embedded within the Trust.

Case Summary 6

Mother complained that a letter was received advising her child was overweight and they needed to participate in a healthier lifestyle or club for child. This was part of the NCMP programme. Mother was unhappy that staff had not appreciated her child had a growth disorder.

We found that the practitioner, who had undertaken the assessment, had recorded on the form that the child had a medical reason for their height and weight measurements. However, administration staff had overlooked this information before sending out the letter to the parents.

As a result administration staff were urgently reminded of the importance of following the standard operating procedure and checking any messages/notes on the assessment form before downloading the measurements and generating letters. The service has also changed their process so that a standard message is entered on all assessment forms that 'child weighted and measured, do not send a letter'. Where children have a medical reason underpinning an adverse result, the school nurse in the local team will personally ring the parent to inform them of the result and offer a more personalised service and support.

> **The school nurse will personally ring parents to inform them of their child's results and offer a more personalised service**

The Adult Mental Health and Learning Disabilities Service also recognised the high number of complaints received regarding administration staff. As a result, a bespoke training package is currently being developed and is trialled with 20 staff with a view to rolling this out to all administration staff across the directorate. The training will provide staff with a greater understanding of mental health conditions and how this may impact a person's communication. It will also offer support surrounding managing difficult conversations.

Parliamentary and Health Service Ombudsman (PHSO)

During 2018-19 one complaint was referred to the PHSO which was returned as not upheld. We also received the final decision on a complaint from 2017-18 in November 2018 and below are the details:

Mr X complained that it took too long to send a physiotherapist to the patient's home to assess their needs. As a result, the family paid for a private physiotherapist. Mr X believes that the patient would have improved more, had they received earlier physiotherapy. Mr X also believes that without input from the private physiotherapist the patient would have deteriorated further.

The ombudsman decided to uphold the complaint. They found there was a delay in the patient being seen by an NHS physiotherapist in the community. They did not feel being seen sooner would have changed the outcome but the small improvement seen could have been made sooner. It was felt the Trust did not take proactive steps to try and address the delay when it was made aware.

The ombudsman recommended that the Trust send a personal apology to Mr X and his family acknowledging the 8 months delay to receive physiotherapy and that we did not proactively take steps once the delay was known. We should also apologise for the distress caused that family needed to chase the physiotherapy. The Trust was recommended to pay £1740 to cover the expense incurred from private physiotherapy. We should also devise an action plan to detail how we propose to learn from the experience. Both the apology letter, action plan and payment have been completed and sent to the relevant persons.

Learning implemented from our Ombudsman case

Recommendation	Agreed Action	Evidence
Review and agree the process for patients seen as a planned 3 day response and whether after the urgent/vital needs have been met they are placed back on to the 20 day waiting list or treatment is continued.	Patients will receive ongoing rehabilitation and will not be placed back on the waiting list. Wider dissemination across Community Health Service Therapy Services.	Discuss and agreed at Community Integrated Neurology & Stroke Services (CINSS) Clinical and Operational Leadership meeting. Communicated in staff meeting.
Therapists who work with another professional in an advisory role will clearly communicate to patients and family and document accordingly.	Therapists who work with another professional in an advisory role will clearly communicate to patients and family and document accordingly.	Discuss and agreed at CINSS Clinical and Operational Leadership meeting. Communicated in staff meeting.
Continuous improvement of the integrated offer.	CINSS leaflet and patient letter updated to reflect integrated service offer.	Completion of CINSS leaflet and patient letter.
Continuing HealthCare (CHC) Funding Clarify and explore how CINSS contribute to the CHC checklist determine trust process.	Discuss policy/process with CHC Leads in the Trust.	Clinical Services Manager discussed with CCG.

Focusing on the future

The focus of the Complaints Team for 2019-20 will be to:

- Undertake a self-assessment of the current complaints process using the NHS Patient Experience Improvement Framework to benchmark our current position.

[2] Results from complainants surveyed in 2018-19

- Undertake a review of the Trust's current complaints process, considering the 'PHSO - My expectations to raising concerns and complaints report' and 'NHS England Complaints Tool Kit'.
- Review our reporting of complaints to ensure the information we provide is enriched with examples of learning and the actions we have taken from complaints.
- Reinvigorate our complaints peer review process so that the experience our service users have, when accessing the complaints process, is regularly reviewed and improvements are made.
- To develop and implement a Trust wide training programme to support staff in managing and responding to complaints and also support those staff who are involved in providing information for the complaints investigation process.
- Complaints Review Committee which will oversee the Trust's management of complaints but importantly ensure that processes and learning are effectively monitored and embedded within the Trust.

Leicestershire Partnership NHS Trust

Meeting	Trust Board
Date of meeting	1 October 2019
Paper number	Q

Name of Report
NHS England & NHS Improvement Infection Prevention visit report and action plan

For approval	☑	For assurance	☑	For information	

Presented by the Accountable Director	Anne-Maria Newham	Author (s)	Emma Wallis

Alignment to CQC domains:		Alignment to the LPT strategic objectives:		Alignment to LPT priorities for 2019/20 (STEP up to GREAT):	
Safe	☑	Safe	☑	S – High Standards	☑
Effective		Staff		T - Transformation	
Caring		Partnerships		E – Environments	
Responsive		Sustainability		P – Patient Involvement	
Well-Led				G – Well-Governed	☑
				R – Single Patient Record	
				E – Equality, Leadership, Culture	
				A – Access to Services	
				T – Trustwide Quality improvement	

Report previously reviewed by		
Committee / Group	Date	Assurance obtained (Significant/Limited/None)
Quality Assurance Committee	17 September 2019	Limited

Assurance: What level of assurance does this report provide in respect of the Board Assurance Framework Risks? (Significant / Limited / No Assurance)	Links to BAF risk numbers
Limited; There is a risk that the Trust's systems and processes for the management of patients may not be sufficiently effective and robust to provide harm free care on every occasion that the Trust provides care to a patient.	

Recommendations of the report
To inform and assure the Trust Board actions taken in response to the NHSE & I Infection Prevention visit are robust and to approve recommendations for future monitoring and assurance.

Leicestershire Partnership NHS Trust

TRUST BOARD – 1 OCTOBER 2019

NHS ENGLAND & NHS IMPROVEMENT INFECTION PREVENTION VISIT REPORT AND ACTION PLAN

Introduction/Background

1. Dr Debra Adams, Senior Infection Prevention and Control Advisor, NHS England & Improvement, Midlands and East, visited the Trust on 7 August 2019 following the findings identified in the CQC report dated February 2019 in relation to Infection Prevention and control. As such, the Trust was assessed as NHSEI IP internal escalation level RED.

2. Dr Adams was accompanied by Vanessa Wort, Senior Clinical Lead NHSEI and Zoe Green, IPC lead CCGs.

3. The visit consisted of;
    - A review of key IPC Trust documents.
    - Discussions with staff.
    - Visits to three clinical areas; Rubicon Close, Agnes Unit and Westcotes House.

Aim

4. The aim of this report is to provide the Trust Board with a robust action plan in response to the recommendations from the visit and outline the monitoring and assurance processes. This report was reviewed at QAC on 17 September 2019

Report post visit

5. Dr Adams submitted a report to Anne-Maria Newham, Director of Nursing, AHPs and Quality and Trust Director of Infection Prevention and Control (DIPC) on the 8 August 2019 outlining the key findings and recommendations (Appendix 1).

6. To summarise; the key changes and actions required include; completion of a gap analysis against the “hygiene code”, reviewed governance systems and strengthening of the internal assurance processes.

7. An action plan in response to the report has been developed with the Associate Director of Nursing and Professional Practice, Infection Prevention and Control Lead Nurse, Infection Control Team, Property Manager - Estates & Facilities and the three Directorate IPC leads with oversight and scrutiny from the Trust DIPC (See Board information pack).

Monitoring and Assurance

8. The actions have been added to the Trust CQC/regulatory action plan and to the SIAM (System Improvement Assurance Meeting) with an agreed cycle of reporting to monitor progress.

9. From November 2019 the Trust Board will receive a six monthly IPC report to include the gap analysis against the hygiene code, progress against the NHSEI action plan and IPC work plan and strategy.

10. The action plan will be monitored through the IPC Committee and referenced within the quarterly QAC highlight report (next report due December 2019).

11. Following the visit, the escalation level has been reviewed and de-escalated to AMBER in response to the renewed focus placed on Infection Prevention and Control by Anne-Maria Newham as Director of Nursing, AHPs and Quality and the Trust DIPC, to drive the changes required.

12. The Director of Nursing AHPs and Quality has commissioned an external review of IPC to be completed by Jenny Boyce, IPC Lead, Northamptonshire Healthcare Foundation Trust in October 2019.

13. Dr Adams will undertake a follow up visit in January 2020.

Recommendations

14. The Trust Board is asked to review the action plan in response to the recommendations and approve the governance framework, cycle of reporting, monitoring and assurance.

Presented by:	Anne-Maria Newham, Director of Nursing, AHPs and Quality
Author:	Emma Wallis – Associate Director of Nursing and Professional Practice

Appendix 1

Birmingham Office
St Chads Court
213 Hagley Road
Birmingham

8th August 2019

Anne-Maria Newham: Chief Nurse
Leicestershire Partnership NHS Trust
Riverside House
Bridge Park Plaza
Bridge Park Road
Thurmaston
Leicester
LE4 8PQ

Dear Anne- Marie
Re: *NHS Improvement Infection Prevention (IP) visit; 7th August 2019.*

I would like to thank you for organizing the visit to Leicester Partnership NHS Trust on the 7th August 2019. The visit was requested following the findings identified in the CQC report dated February 2019 (Appendix 1). As such, the Trust was assessed as NHSEI IP internal escalation level RED.

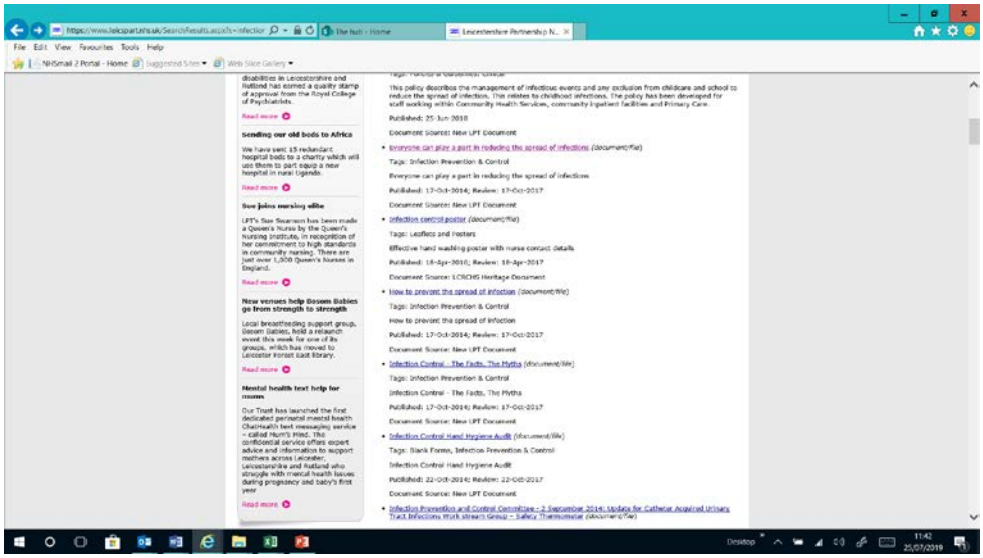
I was accompanied today by Vanessa Wort: Senior Clinical Lead NHSEI and you invited Zoe Green IP lead from your CCG. Following this visit the escalation level has been reviewed and de-escalated to AMBER. Vanessa and I felt that the renewed focus placed on IP by yourself (new in post) will drive the changes required. As discussed this will require a gap analysis against the "hygiene code" (tool provided as an example), reviewed governance systems and strengthening of the internal assurance processes. You agreed that this would be added to the SIAM (system assurance and improvement meeting) with an agreed cycle of reporting to monitor progress and that I would undertake a follow up meeting in January 2020.

Summary of visit.
The visit consisted of a review of:

- Key IP Trust documents.
- Discussions with staff.
- Visits to the clinical areas

Documentation review:

1. Web Page	Unable to locate the DIPC annual report as required in Criterion 1 of the "Hygiene Code". Last available version was from 2015-16. However, I did locate a variety of out of date guidelines which need to be reviewed as they expired 2 years ago: see screen shot below. **Q:** Has the trust board received assurance of compliance against the Hygiene Code as DIPC report has not been published since 2016. **Q:** How are IP guidance documents reviewed to ensure in date and effective governance? **Advise:** that oversight and governance is strengthened.

	Advise: that a GAP analysis is undertaken and present to the board. On a search of flu advice; the latest was from 2015. **Q;** is the Trust on board with the national flu campaign? HCW uptake 2018-19 was 54.7% which was below the anticipated uptake of 75% for 2018-19 .https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/804885/Seasonal_influenza_vaccine_uptake-HCWs-2018_Final.pdf. **Advise:** that the public facing web site is reviewed to ensure that the public can easily access IP data as required in Criterion 4. 
2. Latest IPC Annual Report.	Annual Report 2018-19. 4.2; Meticillin spelt incorrectly. Provides re-assurance but not assurance e.g. 4.2.1 states MRSA screening undertaken but not the compliance. Talks about compliance with the Hygiene Code but does not provide assurance that it is compliant. From reviewing the web page I am not sure the Trust is fully compliant and would advise a gap analysis is undertaken. **Advise:** Need to provide assurance against the "Hygiene Code" criterion to ensure all assurance is captured. At present the report provides reassurance and not assurance as outcomes are not noted e.g. cleanliness scores (Criterion 1.7 and 2), audit outcomes, antimicrobial compliance (Criterion 3) etc. There is no mention of the actions undertaken to deliver the National Gram negative ambition, which will need to be included. Clear identification of who the DIPC is this does not appear to be identified.
3. IPC compliance with hygiene code/outcome 8.	The information provided is not the Trust assessment for compliance with the "Hygiene Code": **Summary of compliance for Quarter 2 / 3 – 2019/20** **Q:** Has the Trust Board received a GAP analysis against the Code for assurance.

	Q: How is the Trust board assured of compliance? Advise: action as per point 1.
4. HCAI plan/ IPC Annual work plan/ audit plan.	**Q:** How is the trust demonstrating compliance with the Gram negative ambition. The document does not include the new definitions of C. difficile infection and impact on numbers. Does not state who the DIPC is. Does not mention about water safety. **Advise**: that the criterion identified in the Hygiene Code are captured to ensure everything is covered. **Q.** Does not mention the NHS Long Term plan and actions that will be taken by the trust to deliver. Is the Trust Board cited on this document via briefings from the IP Committee? **Q**. Flu ambition states 70% it was 75% last year and is now 80%. Has this document been updated for 2019-20?
5. Policies	MRSA in date. CDI in date; the Trust may wish to update following the 2019-20 CDI plan which has introduced new definitions of what is trust attributable. Hand Hygiene in date. Urinary Catheter in date. **Q:** the policy does not appear to include triggers for staff to question the need for the patient to have a catheter e.g. HOUDINI. How is the trust assured that this is being actioned?
6. Compliance data to all IPC KPI e.g. saving lives, essential steps, hand hygiene, environmental cleaning etc. for last 3 months.	Sepsis; no compliance data provided. Action plan sent but not updated, no times to achieve, not RAG rated; one action due 2017. **Q:** how is the trust assured? Cleaning; deep clean timeline provided but no assurance as to whether this is on target for achieving. Cleaning audits provided. **Q;** what audit tool is used. **Q:** when there are consistently poor outcomes e.g. Sothland/St Phillips etc what actions undertaken as these do not appear to be improving. Cleaning meeting; no roles next to names so unsure who has attended. It states DRAFT but these are from May 2019; no date has been arranged for follow up meeting. **Q**: Are poor scores discussed at this meeting? Are staff held to account and expected to deliver an action plan to this meeting? Hand hygiene: no compliance data provided as requested. Received: April and May 4/16, June: 6/16, July 3/16 units submitted data. **Q:** how is the trust assured as audits are not being received. AMH/LD- wards are failing to submit HH audits each month; e.g. Cedar MHSOP appear to submit each month.

	IPC audits: no compliance data provided. **Q:** Is the trust Board receiving assurance as only limited assurance data has been provided
8. IPC committee; structure, IPCC minutes for last 3 meetings +TOR + membership.	Nov 2018- noted as not quorate. **Q:** Who is the DIPC as not noted. February 2019; was this quorate as per ToR as there did not appear to be representation from all divisions? **Q:** Who is the DIPC as not noted. May 2019: appears quorate. **Q:** The new CDI definitions were introduced to commence April 2019- how was the Trust Board informed of this – there was not evidence of discussion in this meeting or the previous one. **Q:** Where is the evidence of discussion on the national Gram negative ambition and how is this captured? ToR received.
14. Last Trust Board IPC paper.	June 2019 Trust Board paper only provides an update on the CQC findings. There is no assurance on the compliance with the "Hygiene Code" **Advise:** The Trust board needs to be sighted on compliance with the Hygiene Code. The IP committee meets quarterly - from reading the last three meetings minutes only 1 out of the three meetings was quorate. In addition, as identified above some of the oversight and governance needs to be strengthened in order that the Board can be assured.
15. Estates information.	See below

	Authorizing Engineer/organisation. Show appointment letter.	Authorised Person	Competent Person/trained?	Director with Board responsibility	Send last set of minutes for meeting:
HTM01-01 (Decon)	Milton Management Services – Andrew Birch (Appointed through UHL)	**Q :** who	Avensys Medical – David Gibb	DIPC : **Q** :who	Decontamination: CHS Highlight report ; NOT RECEIVED
HTM 03-01 (ventilation)	GPT Consult LLP – Graham Taylor	Martin Owen/ Steve Farmer	Air Projects – validation RW Veasey – projects UHL estates staff	DIPC	
HTM04-01 (water)	Hydrop – Gavin Wood	UHL estates Peter Pierce /	GES – testing UHL estates staff	DIPC	Water Quality: NOT RECEIVED

		Steve Harrison, LPT policy Andy Donoghue			

Clinical visits;
Themes for attention (some of which were identified previously by the CQC but had not been actioned):

- Body fluid ingress e.g. chair cushions, mattresses.
- Out of date products.
- Lack of eye protection.
- SOP: laundry, carpet spills.
- Toy cleaning schedules.

Visit areas chosen by the Trust.
Westcotes House: CAMHS
Positive Observations

- Bare below the elbows (BBE).
- Hand hygiene.
- PPE.
- Cleaning schedule.
- Fan clean.
- Water flushing

Observations Requiring Attention.

- Cleaning SOP required for carpets and soft furnishing.
- Spills kit required.
- Eye protection required.
- Radiators dirty
- General estates issues; acknowledging that these are on planned rectification.
- Cleaners room dirty.
- No hand sanitizer in cleaners' room.
- To develop toy leaning assurance process.

Agnes Unit.
Positive Observations.

- BBE.
- Hand hygiene.
- PPE.
- Cleaning schedule.
- Hand sanitizer available.
- Sharps box signed for.
- Sharps safety devices available.
- Link nurse post

Observations Requiring Attention.

- Out of date hibiscrub-2013.
- Out of date saline 2012.
- Out of date BNF 2018.
- Gross body fluid ingress on mattress in "clean room".
- Kit under U bend; hand towels.
- Advise danicentre in clinical room.

- Dining table dirty.
- Damaged tap.

Rubicon Unit.
Positive Observations.

- BBE.
- Kitchen clean.

Observations Requiring attention.

- Cleaning schedule.
- Laundry shared with sluice. Process needs full review and risk assessment.
- Laundry floor dirty.
- Linen airer very dusty.
- Suction machine very dusty - no assurance process.
- Torn bed bumpers.
- Dirty bed bumpers.
- No toy cleaning schedule.
- Toys dirty.
- Toilet rolls do not fit dispenser.
- Toilet roll dispenser soiled.
- Pull cord very dirty.
- Inappropriate posters in toilet used by relatives.
- Rusty shower chair.
- Fan dirty.
- Dirty equipment trolley in bathroom.
- Kit under U bend.

NHSEI:

- If we can support you in any way please do not hesitate to contact us.
- I have forwarded a Hygiene Code assessment tool as requested.

Next Steps

- Develop an action plan to support the delivery of IP across the Trust; consider working with your communications team to rebrand IP.
- Incorporate IP into the SIAM.
- A review visit 7th January 2020.

Kind regards

Debs

Dr. Debra Adams | Senior Infection Prevention and Control Advisor (Midlands and East).

T 07972 589189

E Debra.adams2@nhs.net | W improvement.nhs.uk

Birmingham Office | St Chads Court | 213 Hagley Road | Edgbaston | Birmingham | B16 9RG

C.C.

- NHS Improvement.

Appendix 1: IP concerns identified within the CQC report

CQC findings:

Wards for people with a learning disability or autism:

• The trust must ensure that staff adhere to infection control principles and that items such as hairbrushes are not used
for different patients. Regulation 12 (2)(h).

Specialist community mental health services for children and young people

• The trust must ensure children and young people's service staff follow the trust's infection control procedures and
processes. Regulation 12 (1) (2)(a)(b)(h).

Staff did not ensure infection control measures were effective in two services we inspected. This included toy cleaning, play equipment and handwashing facilities in specialist community mental health services for children and young people, and unlabelled hairbrushes at Rubicon Close. The short breaks service did not always adhere to infection control principles. We found a jug on the edge of the bath at Rubicon Close containing several used hair brushes, labelled with the name of the service.

There were hazards in the short breaks services which could compromise the safety of patients. These included broken items of garden furniture and uneven pathways. The keys to the 'Control of Substances Hazardous to Health (COSHH) cupboard had been left in the door and the door had been left open. Staff did not always manage medicines safely or adhere to infection control principles. Managers did not have sufficient oversight of these issues.

The trust had not ensured adequate higher management leadership and governance to address all actions from our previous inspections. Some issues particularly relating to the management of staff resources, waiting lists and the environments for example, infection control procedures, still posed a risk for the service. The CQC had found some of these risks since 2015. Whilst we noted the trust had made changes to the service, we had concerns about the slow pace of change as patients still faced long waits for assessment and treatment.

The trust had not fully ensured since our 2017 inspection that clinical premises where patients received care were safe, clean, well equipped, well maintained and fit for purpose. The trust's infection control processes were not robust as most sites did not have cleaning rotas for treatment rooms and toys. The trust had not ensured that Westcotes House reception was fully private and confidential as visitors could overhear the receptionist conversations and trust information.

Managers did not have oversight of some issues affecting the short breaks services, for example medication errors and infection control issues. Managers did not have a robust system to ensure that essential information, such as learning from incidents and complaints, was shared and discussed with all staff, including healthcare assistants.

Community Based for older people:
All areas were clean and well maintained and we observed staff adhering to infection control principles including handwashing.

Community based CYP:
Staff did not always follow the trust's policy for infection control as they had not ensured that toy and clinic cleaning rotas were available or routinely completed across all sites. Fabric beanbags in Westcotes House's group room had

Well led:
The trust had not ensured adequate higher management leadership and governance to address all actions from our previous inspections. This included management of staff resources, waiting lists and the environmental infection control procedures, still posed a risk for the service.

Appendix 2: Agenda.

7 August 2019 - Schedule			
Time	Venue	Visiting whom	Notes
9:00am	NSPCC – Room 9	AH/EW/AP	Setup room
9:10am	Train station	DA	Dr Debra Adams arrives at train station
9:30am	Taxi to LPT Education and Training Centre Beaumont Leys (NSPCC) 3 Gilmour Close, Leicester, LE4 1EZ	DA	Dr Debra Adams gets taxi to NSPCC. **Please note:** Go through the NSPCC front doors, walk straight through to the outside and the LPT building is straight in front of you.
10:00am	Dr Debra Adams arrive at NSPCC and welcomed by Anne-Maria Newham	DA/AH/EW/AM-N	Dr Debra Adams arrives at NSPCC
10:30am	Leave NSPCC – no later than 11am	Jane Martin / John Barnes	Drive to Rubicon Close
11:00am	**Rubicon Close** 3 Rubicon Close Linkfield Road Mountsorrel Leics LE12 7DJ	Jane Martin / John Barnes	
11:45am	Leave Rubicon Close	Vicki Elliott	Drive to Westcotes House
12:15pm	**Wescotes House** Westcotes Drive Leicester	Vicki Elliott	

7 August 2019 - Schedule			
Time	Venue	Visiting whom	Notes
	LE3 0QU		
1:00pm	Leave Westcotes House	Judith Pither / Francine Bailey	Drive to Agnes Unit – POD 2
1:00pm	**Agnes Unit** The Pods – POD 2 Anstey Lane Leicester LE7 7GL	Judith Pither / Francine Bailey	Drive back to NSPCC for lunch and feedback
1:45pm	Leave Agnes Unit		Drive back to NSPCC for lunch and feedback
2:00pm – 3:00pm	Lunch & feedback	AH/EW/AP/HW/DA/ZG/Guest	
3:00pm	Dr Debra Adams leaves		

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Leicestershire Partnership NHS Trust

TRUST BOARD – 1st October 2019

Guardian of Safe Working Hours Quarterly Report
May 2019 to July 2019

1. Introduction

The Report:

i) Provides assurance to the Trust Board that doctors in training in LPT are safely rostered and have safe working hours that comply with the Terms and Conditions of Service

ii) Shows that 3 exception reports have been raised in this period

iii) Gives information on work schedule reviews and rota gaps.

iv) Provides information on the implementation of changes to the 2016 TCS as implemented in August 2019

2. Recommendations

The Report is to provide assurance to the Board.

3. Transfers to the 2016 TCS

Implementation of the new TCS for Junior Doctors is well established after beginning in December 2016. There are 86 trainees employed on the 2016 contract. The remaining 3 trainees are likely to remain on their existing 2002 TCS until they complete training.

4. Work Schedules

As required under the TCS, generic and personalised work schedules continue to be provided to trainees in accordance with the code of practice and outline the working pattern; pay; training opportunities; key contacts and time for education, handovers, breaks and rest periods.

5. Exception Reports

Exception reporting is the mechanism for all doctors employed on the 2016 Junior Doctors Contract to inform the Trust when their day to day work varies significantly and/or regularly from the agreed work schedule. The reports are raised electronically using the “Allocate” rostering system and there is a robust system in place to manage exception reporting.

Three exception reports have been received in this quarter. One report concerns a variance from the work schedule, one is about a difference in the pattern of hours worked resulting in a breach in rest time. A request has been made for additional information for both reports.

The third report is in relation to support available whilst on call and covering an absent duty doctor. A request has been made for further information. However, the trainee is currently absent from work and a review meeting will be set up on their return.

6. Rota Gaps and re-design

Gaps in the current rotation (August 2019 – December 2019);

- CT1-3 x 1 One post covered by LAS
- StR Adult x 6 no cover
- StR OA x2 no cover
- StR CAMHS x3 no cover
- StR LD x 2 no cover

Each service area is managing the gaps in Junior Doctor placements to meet clinical need.

7. Implementation of changes to the TCS from August 2019

A number of changes have been introduced nationally to the TCS, some of which are to be phased in over the next 12 months. The changes relate to working patterns, exception reporting, pay and allowances. Changes have been made in ESR to pay and working patterns will be assessed over the coming months to ensure compliance with the new requirements.

We have recently received £60k to improve the working conditions of junior doctors. Discussions have taken place with trainees to develop a list of priorities and following consultation it has been agreed that laptops will be purchased for Core Trainees and the Bradgate on call room will be refurbished.

8. Engagement

Continuing efforts to engage the junior doctors has taken place through the following measures:

- Meet new trainees at the Junior Doctor Induction Day explaining the role of guardian - ongoing
- Regular attendance at Junior Doctor Forum meetings - There has been an increase in attendance by medical trainees at the last couple of JDF meetings. There is also an increased use of emails by trainees to raise issues at the JDF when they are unable to attend.
- Email and telephone access to trainees to discuss issues outside of exception reports if needed
- Develop links with Clinical and Educational supervisors to support Junior Doctors with exception report when problems arise- ongoing.

Presenting Director: Dr Sue Elcock, Medical Director
Authors: Dr Amala Maria Jesu, Guardian of Safe Working Hours
Angela Salmen, Medical Staffing Manager

Appendices

Appendix A	Locum Hours – Internal Bank and Agency (1st May 2019 – 31st July 2019)
Appendix B	12 month summary data Exception reports

Appendix A

Locum Hours (Internal Bank and Agency)
1st May 2019 – 31st July 2019

Locum bookings by Rota				
Rota	Number of shifts vacant	Number of shifts filled by Internal Bank	Number of shifts given to agency	Number of shifts filled by agency
Bradgate / Bennion	40	40	Nil	Nil
Evington	42	42		
Central Duty Rota	22	22		
StR East	5	5		
StR West	20	20		
Total	129	129		

Locum bookings by reason				
Reason	Number of shifts vacant	Number of shifts filled by Internal Bank	Number of shifts given to agency	Number of shifts filled by agency
Vacancy *	96	96	Nil	Nil
Sickness	31	31		
Maternity				
Special Leave	2	2		
Temporary removal of trainee from rota**				
Total	129	129		

* includes Less Than Full Time (LTFT)

** may be due to reasonable adjustments recommended by Occupational Health or Heath Education East Midlands/Associate Director for Medical Education

Appendix B

12 month summary data

Exception Reports

Reason for exception report	Aug'18 – Dec'18 rotation period	Jan'19 – Apr'19 rotation period	May'19 – July'19 Rotation period
Working Hours	0	1 (rest, TOIL)	2
Training issue	0	0	0
Other reason	0	0	1
Total	0	1	3

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Leicestershire Partnership NHS Trust

TRUST BOARD – 1 OCTOBER 2019

FINANCE AND PERFORMANCE COMMITTEE AND QUALITY ASSURANCE COMMITTEE JOINT MEETING – 17 SEPTEMBER 2019

OVERVIEW REPORT TO BOARD

The key headlines/issues and levels of assurance are set out below, and are graded as follows:

Assurance level	Colour to use in 'Assurance level*' column below
Not assured	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans If red, commentary is needed in "Next Actions" to indicate what will move the matter to "full assurance"
Partially assured	Amber - there are gaps in assurance but we are assured appropriate action plans are in place to address these
Assured	Green – there are no gaps in assurance

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
Scope of Work 		FPC agreed the revised scope of work on how FPC and QAC would work together taking account of comments made by committee members at the June meeting. The committee noted the work progamme needed further development and agreed it would be presented to the FPC and QAC meetings in October for approval.	A review of the scope would be undertaken at the next joint meeting in December	December 2019
Estates Strategy 2020 to 2025 		The committee received the draft high level Estates Strategy, key points were; • The strategy linked to LPT and system-wide priorities as well as Step up to Great. • Specific focus had been given to transformation schemes, all age mental health and community services redesign. • There was acknowledgement within the strategy for ongoing alignment with the wider system key projects, within that were CAMHS and the Hinckley and Bosworth business case. LPT anticipated bidding for capital from Wave 5 when available. • Emphasis had been given to LPT's aims for its estate to have safe buildings, effective facilities, caring environments, responsive and well led services.	The Committee noted the contents and agreed recommendation to Trust Board on 1 October subject to additions highlighted	

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
		• There was acknowledgment that investment in the infrastructure was required. • Elimination of dormitory accommodation was also a key feature, the expectation was that an interim solution would be available by December 2019. • An implementation plan was included that indicated when delivery of key aspects was expected to be. • The facilities management review was coming to an end. Concern was raised that the target date for implementation April 2021 was too far ahead. Confirmation was received that discussion had been held with UHL who would assist in accelerating changes. It was recognised a minimum period of notice may need to be given. FPC highlighted that significant changes needed to be made in the 18 month interim period and the strategy needed to state what action would be taken to raise the standard in the current model. • The meeting noted the benchmarking data and requested that themes and LPT's position were highlighted. • Greater emphasis on transforming care for people with learning disabilities and particularly autism in the design of future buildings was suggested. • The committee requested more narrative on the emerging STP vision and how it would drive a LLR estates strategy.	Further discussion about the interim solution would be held at the main FPC meeting.	
Waiting Times Improvement 		The committee received an update on Trust performance against local and national waiting time targets. Key points to note were; • Waiting times performance was monitored by directorate level performance groups and the overarching waiting times group. • There was no-one waiting more than 52 weeks for a first appointment. • 7 high risk services had been agreed as the priority. • Assurance was received on the work taking place in directorates on the non-priority services and the methodology used to prioritise services that were most likely to result in harm to patients.		

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
LPT's Proposed Harm Assurance Processes		A process for managing the impact to patients and potential harm whilst waiting for treatment was presented. Key points to note were; • The LPT System Assurance Meeting (SIAM) led by NHSE/I had been clear that a harm assurance process needed to be in place as soon as possible. The process would have two elements, the first related to LPT's principles that needed to be met for a patient put on a waiting list and the second was the process for patients already on a waiting list. Year one would focus on the patients already identified as waiting for follow up from the first appointment. • Reporting would be through the Clinical Effectiveness Group. • A System Harm Review Panel would be set up to consider the themed learning.	FPC/QAC received assurance that a process had been started. The committee approved the process with the addition of Experts by Experience and diversity aspects and agreed it would be presented to the next SIAM meeting on 24 September. Governance would be by QAC.	

Recommendation	The Trust Board receives and notes the issues raised in the highlight report
Author	Geoff Rowbotham, Non-Executive Director Liz Rowbotham, Non-Executive Director Sharon Murphy, Deputy Director of Finance and Procurement Val Glenton, PA to Director of Finance, Business and Estates
Presented by (Chair of committee)	Geoff Rowbotham, Non-Executive Director

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Leicestershire Partnership NHS Trust

TRUST BOARD –1 OCTOBER 2019

FINANCE AND PERFORMANCE COMMITTEE – 20 AUGUST 2019

OVERVIEW REPORT TO BOARD

The key headlines/issues and levels of assurance are set out below, and are graded as follows:

Assurance level	Colour to use in 'Assurance level*' column below
Not assured	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans If red, commentary is needed in "Next Actions" to indicate what will move the matter to "full assurance"
Partially assured	Amber - there are gaps in assurance but we are assured appropriate action plans are in place to address these
Assured	Green – there are no gaps in assurance

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
The focus of this FPC meeting was a deep dive into four specific topics; Estates Strategy; internal financial turnaround; waiting times; and Performance Management Framework. It was agreed ,due to the reported further deterioration in the monthly financial position, to allocate additional time within the agenda to this item.				
Waiting Times 		Key points to note included; • A significant improvement in CAMHS backlog for access was starting to be seen. CAMHS treatment backlog was reporting an improved position in numbers waiting for over twelve months for treatment however, numbers waiting less than one year had increased. • Consultant led national targets in AMH for Adult ADHD and Adult ASD were challenging. • Clarity was received on 52 week waiters which were not nationally reported. As at 30 June 2019 the Trust had no-one genuinely waiting for a first appointment. • Work undertaken by directorate business teams had identified the majority of over 52 week waits were in AMH/LD, none had been identified in FYPC or CHS but some data quality issues in FYPC had been found which were being resolved. • Discussion focussed on the demand and capacity review which had established that the amount of capacity in the system was generally right but the challenge was in having a system	The Trust was monitoring the position internally Trajectory for Adult ASD and action plan was requested at the October meeting	September 2019 October 2019

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
		to access capacity. Work was being carried out with consultants to plan their activity in a consistent way so that there was a robust process in place. A number of options were being progressed including reviewing whether consultant job plans needed adjusting • Concern was raised that three out of four national targets were failing. • FPC asked for clarity around what the Trust needed to deliver nationally as well as what the Trust was doing to improve quality of care and deliver local based targets. • The committee agreed it would be appropriate to understand how a 'harm based' process was being incorporated within the present risk assessment.	Discussion would be held at the joint FPC/QAC meeting in September about a harm based approach to prioritising waiting times.	September 2019
Estates Strategy 		The first draft of the Estates Strategy was presented for comment, the key points were; • A review of facilities management arrangements was being undertaken to ensure that LPT's estate remained clean and safe on a day to day basis. Recommendations on the preferred model on future delivery would be made to Trust Board at its November meeting. The plan was to give notice on existing arrangements by March 2020 at the latest. • Progress had been made on the all age SOC, key stakeholder meetings had been held, a shortlist was now available. Consideration was being given to a requirement of 299 beds or 314 if CAMHS was included. A cost of between £300m and 400m had been identified for the work. A capital template had been submitted to NHSI for the SOC. • An initial review of dormitory accommodation was complete, a sub-group of the Estates Medical Equipment Strategy Group was being formed to drive the work forward. The scope and indicative cost was expected to be available by December 2019 so that it could be included in the capital plan for next year. • The CCG had completed the pre-business case consultation for the Hinckley scheme. An issue for LPT had arisen around accommodation for MSK at the Hinckley and District Hospital	The final document would be presented to the joint FPC/QAC meeting in September and then to Trust Board.	September 2019

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
		site as it was not now included in the project. There were also some unresolved issues around capital. • FPC was assured that work was taking place between CHS and Estates teams around community services redesign and where services would be co-located in eight hubs. Discussion took place around how agile working would develop in the future in terms of transformation of services and location of hubs. • FPC agreed there was more focus on engagement with district councils in the document as they had facilities that would allow LPT to rationalise its estate. • In terms of the Carter Review, there was recognition that estates performance needed to be more effective and work was taking place with Cathy Geddes, Interim Director of Improvement and Quality for NHSE/I about key performance indicators for estates. • Staff retention issues were raised at the Hinckley sites which was a concern as completion of work was not until September 2021. Further discussion would be held on this matter.		
Internal Financial Turnaround and Recovery Plan 		The finance report for month 4 2019/20 was presented, key points to note were; • Operational budgets were currently overspending by c£1.5m. The run-rate overspend had reduced in month 4 but it was still at a very high level. The year end forecast, overspend had increased from the £3.4m reported last month, to £3.9m. • AMH services' budgets showed the highest level of overspend mainly due to out of area placements and overspends on Belvoir Ward. Community teams were breaking even but an underspend had been reported the previous year at this point. • FYPC services were currently overspending by£248k and were forecasting £600k overspend at year end due to ward under occupancy and higher staffing ratio because of the number of acutely unwell patients. There was also a potential overspend on the CAMHS waiting list initiative. The forecast was expected to reduce and was being monitored closely.	Chair agreed to request the committee's concern around the present position was both highlighted and discussed at the next Trust Board Meeting.	

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
		• CHS directorate was forecasting an overspend of £450k at year end, the directorate had a very large vacancy rate on inpatient areas and high bank and agency spend. There was also a high number of acutely unwell inpatients. • Estates services were forecasting an overspend of £1.6m at year end. There was also a significant risk with the UHL SLA, due to a discrepancy in budget spend. • Enabling services were holding steady on a £225 underspend and partially offsetting some overspends. • CIP schemes were currently under delivering, the year end forecast for operational schemes currently showed 65% achievement which was the lowest it had been. £1.5m CIP still needed to be identified. • At month 4, total Trust agency overspend was forecast at £9.3m. Agency spend had reduced slightly from month 3 in AMH and FYPC services. • Closing cash for July stood at £10.7m. This equated to 14.5 days' operating costs, and was above the planned cash level of £8.3m for July. A closing balance of £7m was expected for year end. • Capital spend for July was £1,765k, which was within limits. NHSI had given approval for the Trust to spend its capital resource limit of £1.6m. Key points of the Framework for Financial Turnaround - Approach to Financial Recover y were; • The level of financial recovery required was c£2m. ET had discussed the communications around the launch of the turnaround as the timing coincided with the Step up to Great launch. • Initial steps had been taken to improve the position. An executive director was being allocated for each recovery scheme and to provide operational management support. Financial Turnaround Groups had been convened and would meet weekly and report into the Operational Strategic Executive Team meeting. • Consideration was being given to having NED engagement to give some confirm and challenge. Trust leadership		

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
		requirements would be reviewed also. • Discussion at the System Sustainability Group had confirmed commissioners were keen for provider Trusts to retain their PSF funding which was a positive step however, LPT would need to deliver its control total to achieve this. The committee acknowledged the financial position for the Trust was very serious and by month 8, LPT would need to declare it would not achieve balance at year end if it did not improve. Although a turnaround process was in place, the committee was not assured due to the present inability to share a detailed set of recovery plans. It was agreed the committee's present lack of assurance would be escalated immediately to the next Trust Board meeting		
Performance Management Framework 		An update on how performance was currently being overseen in the organisation was provided. Key points to note were; • A Quality Improvement Board had been established chaired by the CEO and reporting into Trust Board via its committees. • The Quality Improvement Plan (QIP) was being formally managed as a progamme Funding had been secured from NHSI to appoint a senior PMO manager to support the work. • A formal launch of Step up to Great was planned for September, ET was working on the KPIs and reporting structure. Work was also taking place with Anna Pridmore, Interim Associate Director of Corporate Governance to identify risks to delivery through the new corporate risk register and Board Assurance Framework. • The new structure for ET meetings to provide oversight of operational business was explained. • A team of LPT representatives would be visiting Worcestershire Acute Hospitals NHS Trust on 4 September to look at the reporting and monitoring systems they had in place. • A review of total Trust capacity and data gathering processes was due to commence in September supported by NHSI Corporate Benchmarking. • FPC recognised a first KPI draft was proposed for December 2019. It was		

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
		concerned about how it and other committees would receive assurance around the KPI's aligned to the Step up to Great priorities prior to agreeing the draft.	DC agreed to bring an interim proposal to the October meeting	

Recommendation	The Trust Board receives and notes the issues raised in the highlight report
Author	Geoff Rowbotham, Non-Executive Director Danielle Cecchini, Director of Finance, Business and Estates Val Glenton, PA to Director of Finance, Business and Estates
Presented by (Chair of committee)	Geoff Rowbotham, Non-Executive Director

TRUST BOARD –1 OCTOBER 2019

FINANCE AND PERFORMANCE COMMITTEE – 17 SEPTEMBER 2019

OVERVIEW REPORT TO BOARD

The key headlines/issues and levels of assurance are set out below, and are graded as follows:

Assurance level	Colour to use in 'Assurance level*' column below
Not assured	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans If red, commentary is needed in "Next Actions" to indicate what will move the matter to "full assurance"
Partially assured	Amber - there are gaps in assurance but we are assured appropriate action plans are in place to address these
Assured	Green – there are no gaps in assurance

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
Director of Finance Report 		• LPT's summary planning timeline for its 5 year and 1 year operational plan drafting and submission was presented to the committee having been presented to the Executive Team on 16 September. In order to support LPT's improvement journey, a new organisational Five Year Plan needed to be developed to drive the delivery of the LPT elements of the system plan as well as organisational priorities. • The LPT EU Exit group restarted its regular meetings in September in preparation for a 31 October leave date. The group reviewed the risk and action log against new information and was confident that it had done everything it needed to do at the current time. However, one concern was that the new exit date was leading into winter and could add to existing winter pressures. • The Business Development Group was working on a business case approval process which would be presented to its next meeting for approval. Work was also taking place with CCGs to agree the business case / contract for the transfer of community paediatric services in Leicestershire and Rutland.	Trust Secretary to be informed of key planning and submission deadlines for Trust Board agenda setting.	
LPT Winter Arrangements 2019 / 20		Key changes to the plan were highlighted. FPC received assurance that LPT had sufficient procedures in place to maintain	This plan would form part of the LLR Urgent Care	

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
 Emergency Preparedness, Resilience Response (EPRR) Core Standards 2019/20		service delivery throughout winter 2019/20. Brexit was acknowledged as a potential risk but the position would be monitored closely through the EU Exit Group. FPC approved the Winter Arrangements 2019/20. The committee received an update on how LPT rated itself as fully compliant against the NHS England EPRR Core Standards 2019/20 by conducting a self-assessment against 54 core standards applicable to the Trust set out across 10 domains. FPC reviewed and noted the submission to NHSE/I and would review the position in January 2020.	Winter Plan 2019/20 Validation and scrutiny would be undertaken on 8 October 2019 by an NHSE/I review panel. The outcome was expected by 31 December 2019	
Mental Health Inpatient - Strategic Outline Business Case (SOC) 		The draft SOC for acute inpatient mental health and learning disabilities accommodation was presented. Three sites had been shortlisted, all would have phased implementation and cost c£500m over a 10 year period to carry out the full scope. The next step would be development of an OBC to set out the full vision, cost to be finalised. FPC was informed that discussion had been held at ET around balancing pace with available capital, concern had been raised about the length of time and cost the build would take as scoped in the SOC. FPC supported the key points highlighted by ET and discussion focused on the risks, potential funding sources and how to make the build a STP and national priority.	FPC agreed Trust Board would be asked to; 1. Consider that intermediate or reduced models were developed at OBC, given the pace and cost of the full scope. 2. To approve development of submis-sions for Wave 5 capital bids. 3. To consider proceeding at risk spend for development of the OBC.	
Estates and Facilities Management Update 		An update on progress was presented, key issues were; • CAMHS building works were progressing well and on programme. Spend to date (c£780k) was in line with original cash flow projection. • The committee recognised the work undertaken in developing the draft Estates Strategy and SOC within the agreed timescales. It thanked all those involved. • A facilities management customer survey had now been introduced alongside the KPIs reported.		October 2019

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
		• FM performance was flat lining over the year and remained red. • KPIs for cleaning were positive however, an NHSI infection prevention inspection in August had identified a number of areas where cleaning standards were poor. • Concern had been raised at the joint FPC/QAC meeting that although there was a timeline for management of facilities up to April 2021, there was not a clear view on how to manage the interim period. • FPC acknowledged the difficulties experienced in working with UHL for provision of its FM services despite regular meetings with them. • The committee recognised the potential risk associated generally when there was a change of provider as a result of disengagement by staff.	FPC asked for an understanding of the difference between what the KPIs were showing and what actions were proposed during the interim period to improve current FM service performance. Supported the development of a BAF risk around service transition.	
Board Assurance Framework and Review of Corporate Finance Risk Register G Well-governed		ET had received for review the draft corporate risk register at its meeting on 16 September. Risks were being finalised before being presented to Trust Board on 1 October. ET had agreed the minimum update to committees would be quarterly but SROs could escalate risks in the interim if necessary. Management of the risk system would be the responsibility of the Head of Assurance.	FPC to receive the updated risk register at its next meeting for review.	October 2019
Information Governance Six Monthly Review and GDPR Monitoring G Well-governed		The committee received an update of the Trusts work plan in relation to the data privacy agenda for 2019/20 which included GDPR compliance monitoring. Key points to note were; • Compliance with data subject access requests to meet 30 days was around 96%. There had been two complaints to the Information Commissioner's Office (ICO) and positive responses had been received. • Work was taking place with a company commissioned by NHS Digital on the unified cyber risk framework to look at LPT's cyber risk profile. Training would be provided by them. • Two reportable data breaches had been received in Q1, one had been in relation to auto-forwarding of e-mails.	A deep dive on information governance would be added to the FPC work plan to allow more time for discussion on all IG aspects.	

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
		The ICO was satisfied with LPT's response and shared learning across LLR had been carried out. • Compliance with the mandatory information governance training was expected to be 95% at the end of March. Assurance was received that staff were finding the new e-module more user friendly. • Progress of the Trust on compliance to GDPR was monitored through the Data Security and Protection Toolkit and presented to the Data Protection Group at each meeting.		
Finance Report Month 5 2019/20		• Operational budgets continued to overspend with a negative movement of £486k compared to month 4. The forecast outturn also increased by £300k to £4.3m overspent at year end. The deterioration in month 5 position was primarily due to AMH pressures, in particular the high levels of out of area placements. • The value of the turnaround plan had gone up from £1m at month 4 to £1.9m in month 5, the reason being the Trust had agreed it would achieve the stretch target and this was being reported to NHSI. • Progress on the turnaround had been slow but was now building momentum, regular meetings with execs and service leads were taking place. There was an unidentified scheme line of £600k which was a concern. • The year end CIP delivery predicted performance was significantly lower than plan - 67%. • Agency spend had reduced by £60k the forecast outturn had also reduced. Agency spend was the biggest material item in the turnaround plan of c£1m • Closing cash for August stood at £13.0m. This equated to 17.6 days' operating costs, and was above the planned cash level of £8.4m for August. • Capital expenditure was on target year to date, c£1m slippage had been identified following approval of the CRL. The Capital Management Group had re-prioritised some key schemes that had been slipped into 2020/21. • The BPPC target had slipped slightly in month 5 due to late receipt of estates' invoices but there were no major concerns.	FPC recognised the introduction of the turnaround process and associated improvement in the recovery scheme position. It was less assured on the financial position than it had been the previous month as there was still a gap in level of schemes and the under-lying trend was deteriorating. The Trust Board may need to consider potentially in the next 2 months reporting the risk / impact of not meeting its projected outturn position for 2019/20. Trust Board would be asked to consider using some of the slippage to support the development of the OBC for the Mental Health Inpatient Unit	October 2019

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
AMH/LD Finance Summary-		• The financial forecast had moved adversely in month 5, August saw the highest out of area bed days ever recorded. A robust out of area recovery plan was in place and the directorate was now ahead of trajectory. • Work had been taking place with UHL to try and reduce agency spend for support to people with mental health needs in the acute sector. • Funding had been made available for the Crisis Home Treatment Team. £500k to develop the core 24 offer would also be available from 1 April 2020 which would be linked with the Crisis Home Treatment Team.		October 2019
FYPC Finance Summary		• The run rate had improved in month 5 but non pay budgets were overspent by £154k. • Income budgets were under recovered by £130k, linked to occupancy levels on the wards.		October 2019
CHS Finance Summary		• The CHS directorate was reporting an overall overspend of £263k for the first five months of this year, presenting an adverse movement of £44k during the month. Nursing supply was the main reason for the deterioration in position. However, the use of Thornbury for health care support workers had ceased across the board which was expected to have a positive impact on agency costs.		October 2019
Integrated Quality and Performance Report (IQPR) 		The IQPR end of August 2019 position was presented. Key points to note were; • Out of area placements had increased, FPC agreed that exception reports would be provided in future reports. • Benchmarking information showed an improvement in CPA 7 day and a significant improvement in gatekeeping reporting. • Mental Health detoc had been reported as very high at the September Trust Board. An issue in reporting had been identified and the figure had dropped significantly since April.	A first draft of a report highlighting KPIs around the Step up to Great priorities was being reviewed at the next meeting.	October 2019
Electronic Patient Record Project Progress Report		An update of progress of the processes in place to managing the issues, risks and deliver mitigations as well as the overall progress and management of the project was presented. The main risks were; • The first cut of testing on data	A deep dive on EPR and associated risk within the corporate risk register would be	

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
		migration had been done, a 5% error rate had been found which was positive. Lessons learned were being themed. Assurance was received that following recruitment of staff, there was adequate resource and the plan was on track. • The Deputy Director of Nursing was working with the training sub group on the training plan. Assurance was received that the plan was on track and would be received at the next meeting of the sub group in October. • There was some concern around reporting, FPC was informed that testing had not been possible yet, but there was awareness of the issues with multiple modules. LHIS was working with the Information Team on requirements for reporting. A template had now been implemented for reporting to CCGs and external stakeholders. • The true understanding of the reporting impact would not be possible until after November 2019 when LPT was allowed to run data extracts from the migrated data to test.	added to the FPC work plan to allow more time for discussion around assurance of the project	

Recommendation	The Trust Board receives and notes the issues raised in the highlight report
Author	Geoff Rowbotham, Non-Executive Director Sharon Murphy, Deputy Director of Finance and Procurement Val Glenton, PA to Director of Finance, Business and Estates
Presented by (Chair of committee)	Geoff Rowbotham, Non-Executive Director

Leicestershire Partnership NHS Trust

Meeting Name and date	**Trust Board, 1st October 2019**
Paper number	**U**

Name of Report: **Finance Report Month 5**

For approval		For assurance	X	For information	X

Presented by	Danielle Cecchini, Director of Finance	Author (s)	Chris Poyser, Head of Corporate Finance

Alignment to CQC domains:		Alignment to the LPT strategic objectives:		Alignment to LPT priorities for 2019/20 (STEP up to GREAT):	
Safe		Safe		S – High Standards	
Effective		Staff		T - Transformation	
Caring		Partnerships		E – Environments	
Responsive		Sustainability	X	P – Patient Involvement	
Well-Led	X			G – Well-Governed	X
				R – Single Patient Record	
				E – Equality, Leadership, Culture	
				A – Access to Services	
				T – Trustwide Quality improvement	
Any equality impact (Y/N)		N			

Report previously reviewed by	
Committee / Group	Date
Finance & Performance Committee	17/09/2019

Assurance : What assurance does this report provide in respect of the Board Assurance Framework Risks?	Links to BAF risk numbers
Provides assurance that the Trust financial position is intensively monitored and managed, with any perceived adverse impact immediately and clearly highlighted to senior management	All FPC finance risks

Recommendations of the report
The Trust Board is recommended to accept the reported financial position, and to support any further actions designed to improve the year end forecast as agreed / discussed during the meeting.

Leicestershire Partnership NHS
NHS Trust

Finance Report for the period ended
31 August 2019

For presentation at the
Trust Board
1 October 2019

Contents

Executive Summary and overall performance against targets

Introduction

1. This report presents the financial position for the period ended 31 August 2019 (month 5). The report shows a £482k surplus, which is in line with plan.

2. Operational budgets are currently overspending by £2,077k. The run-rate overspend for month 5 was £486k.

3. Adult Mental Health Services budgets show the highest level of overspend (£837k) followed by Estates services (£645k), FYPC Services (£285k) and Community Health Services (£263k). The operational overspend is offset by the release of central reserves, allowing the Trust to report an on-target position against the month 5 plan. However, as in previous years, the central reserves are front-loaded in terms of the monthly profile, and this level of central support will reduce in future months. The table on page 6 shows the months in which, based on current projections, central reserves funding can no longer support the operational overspend, at which point the Trust would start to report non-delivery of plan.

4. Closing cash for August stood at £13.0m. This equates to 17.6 days' operating costs, and is above the planned cash level of £8.4m for August.

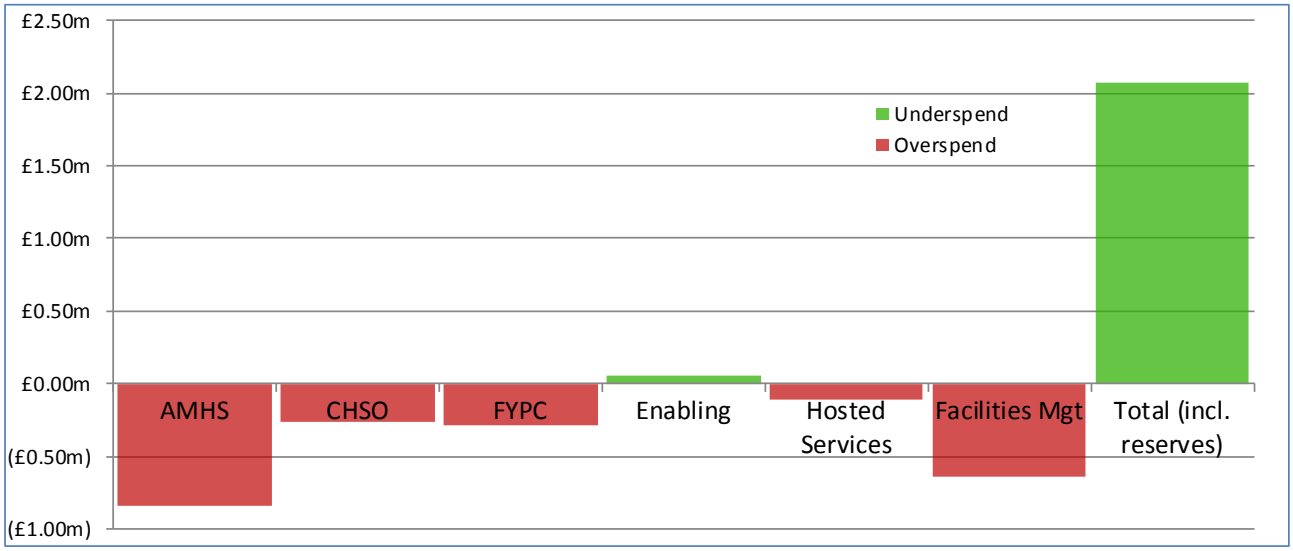
NHS Trust Statutory Duties	Year to date	Year end f'cast	Comments
1. Income and Expenditure break-even.	G	A	The Trust is reporting a surplus of £482k at the end of August 2019. This is in line with the Trust plan. The worsening run-rate increases the risk to delivery of a year end break-even **[see 'Service I&E position' and *Appendix A*]**.
2. Remain within Capital Resource Limit (CRL).	G	G	The capital spend for August is £2,647k, which is within limits.
3. Achieve the Capital Cost Absorption Duty (Return on Capital).	G	G	The dividend payable is based on the actual average relevant net assets; therefore the capital cost absorption rate will automatically be 3.5%.
4. Remain within External Financing Limit (EFL).		G	Cash levels of £13.0m are currently above target. The forecast year end cash balance will deliver the EFL requirement.

Secondary targets	Year to date	Year end f'cast	Comments
5. Comply with Better Payment Practice Code (BPPC).	G	G	The target is to pay 95% of invoices within 30 days. Cumulatively the Trust achieved all of the 4 BPPC targets in August.
6. Achieve Cost Improvement Programme (CIP) targets.	G	R	CIP schemes are currently under delivering, showing £1,089k achieved compared to a £1,307k year to date target (equating to 83.4% delivery) at the end of month. **[See 'Efficiency Savings Programme' + *Appendix B*].** The year end forecast (for operational schemes) currently shows 67% achievement by the end of the year.
7. Deliver financial plan surplus	G	R	(Also see target 1 above). A surplus of £482k has been reported in month 5, in line with plan. The Trust plan for the year assumes a £0.5m LPT generated surplus, plus £2.1m PSF funding dependant on delivery of the NHSI breakeven control total. Delivery of the stretch target surplus by the year endis dependent on delivery of the Financial Turnarond Plan.
Internal targets	**Year to date**	**Year end f'cast**	**Comments**
8. Achieve a Financial & Use of Resources metric score of 2 (or better)	G	G	The Trust is currently scoring 2 for year-to-date performance. Despite the potential risks to the year end I&E surplus stretch target, the strong cash position means that a score of 2 overall for the year is still likely.
9. Achieve retained cash balances in line with plan	G	G	A cash balance of £13.0m was achieved at the end of August 2019. Delivery of the year end cash forecast is expected to exceed target due to notification (after plan submission) of the 2018/19 incentive PSF. **[See 'cash and working capital']**
10. Deliver capital investment in line with plan (within +/- 15% YTD planned spend levels)	G	G	Capital expenditure totals £2,647k at the end of month 5; £155k below plan. **[See 'Capital Programme 2019/20']**

Income and Expenditure position

The month 5 position includes a significant operational overspend that is currently offset by the release of all central reserves.

The chart below shows the year-to-date I&E variance against budget/plan and the individual service surplus/deficits contributing towards this overall position.



Income and expenditure forecast

The month 5 operational overspend of £2,077k represents a negative movement of £486k compared to month 4 (£1,591k). The month 5 position is worse than expected based on the forecast projections made last month. This is primarily due to AMH pressures – in particular the high levels of out of area placements – causing the AMH overspend to increase by almost £300k across the month.

Appendix F (risks, pressures and mitigations) provides details of the risk-adjusted year end forecast. This forecast has worsened by c. £400k since last month , reflectingthe worsening AMH position. After factoring in reserves underspends and other mitigations already identified, the financial recovery plan will need to deliver additional savings of £1.9m in order to achieve the planned £2.6m surplus by the end of the year.

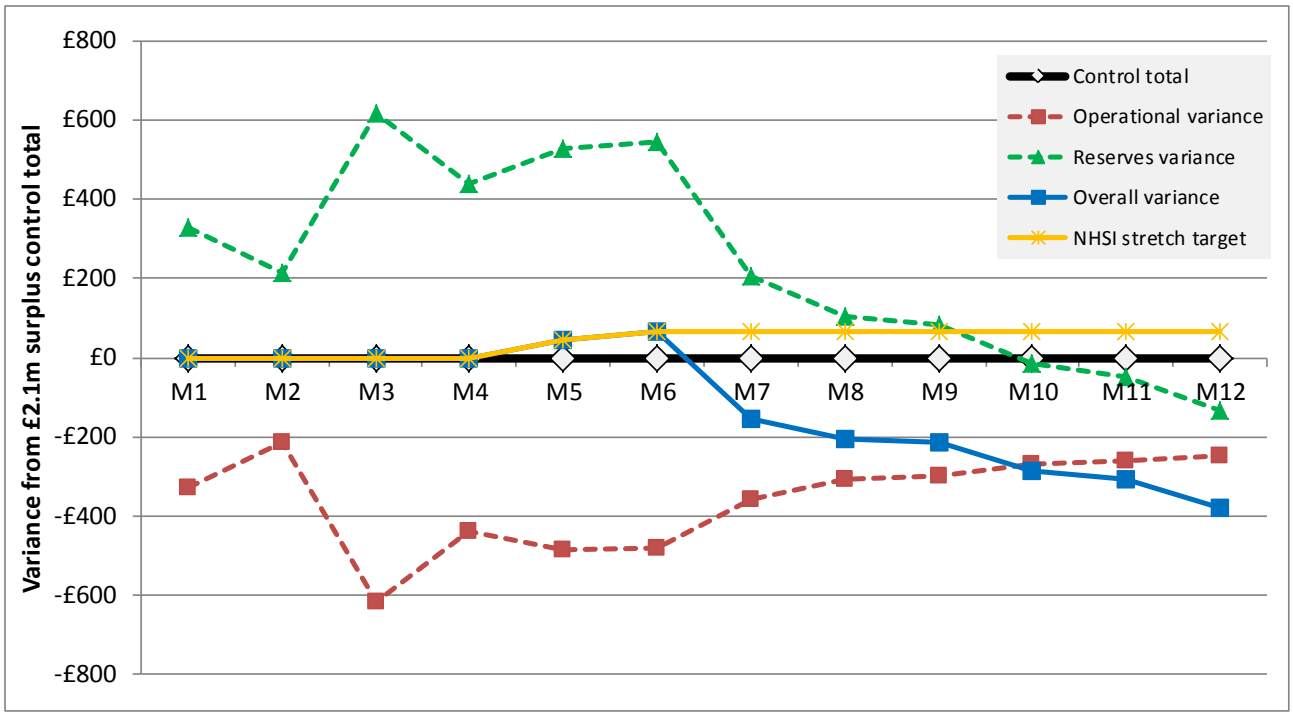
Run-rate variances – position excluding financial recovery savings

The graph below shows the monthly run-rate variance position, based on current forecasts (and excluding any financial recovery actions).

The Trust's control total surplus is the 'baseline' (i.e the black line '£0' position on the graph). The NHSI plan including the £500k stretch target is therefore shown as a variance to the control total (the yellow line), phased into the position from month 5. The operational variance is reflected as the red dotted line, with the reserves variance represented by the green dotted line. The blue line is the combined overall operational / reserves variance.

The reserves variance (underspend) fully offsets the operational variance up to month 6. However, from month 7, the availability of additional reserves benefit reduces rapidly to the extent that reserve underspends can no longer offset the expected operational overspends. At this point the blue overall variance line diverges from the yellow plan line – showing that the Trust will then go off plan. The cumulative under-performance from month 7 (before financial recovery actions are reflected) is a £1.4m shortfall against the £2.1m control total and a £1.9m shortfall against the £2.6m planned surplus

Run-rate variances

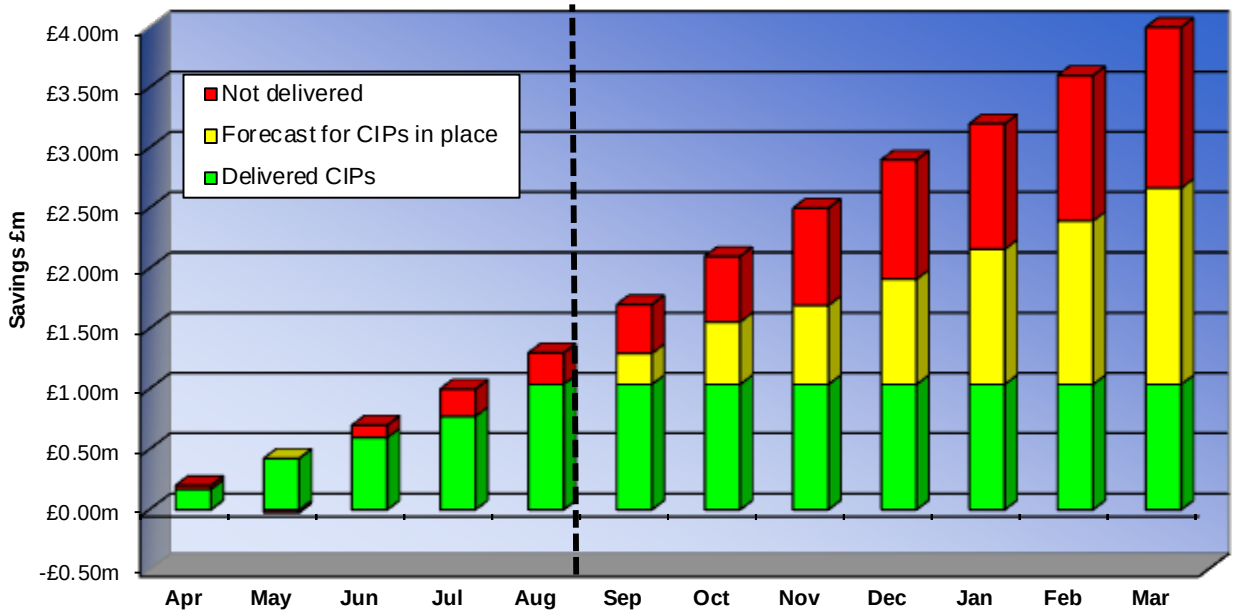


The risk adjusted forecast (shown at ***Appendix F***) assumes that £1.9m recovery actions can be delivered, thus achieving the planned surplus including the £0.5m stretch target (£2.6m). The phasing of recovery actions is yet to be confirmed, but the aim would be to ensure that these can be delivered in such a way that the Trust can still, as a minimum, achieve the control total each month, thus securing the PSF funding.

Delivery of this level of financial recovery plan must be recognised as a significant challenge, and the revised forecast reflects a move towards a 'best case' scenario.

Directorate Efficiency Savings Programme

CIP performance (directorate schemes) as at month 5



	Apr £000	May £000	Jun £000	Jul £000	Aug £000	Sep £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	Mar £000
Monthly plan total:	**212**	**427**	**672**	**967**	**1,307**	**1,666**	**2,061**	**2,456**	**2,852**	**3,249**	**3,648**	**4,047**
Actual performance to date												
Achieved	169	474	648	824	1,089	1,089	1,089	1,089	1,089	1,089	1,089	1,089
Forecast achieved	*0*	*0*	*0*	*0*	*0*	*257*	*518*	*654*	*872*	*1,121*	*1,355*	*1,628*
Total savings:	**169**	**474**	**648**	**824**	**1,089**	**1,346**	**1,607**	**1,743**	**1,962**	**2,210**	**2,445**	**2,717**
Variance:	**(43)**	**47**	**(24)**	**(143)**	**(217)**	**(320)**	**(453)**	**(713)**	**(890)**	**(1,039)**	**(1,203)**	**(1,330)**

At the end of August, CIP delivery amounted to £1,089k, against an overall year to date target of £1,307k. This equates to 83.4% delivery.

However, the year end forecast predicts performance significantly lower than plan by the end of March 2020 (67% delivery). The expected worsening performance is due to unidentified CIPs, the savings for which are phased in later in the year. This unidentified element includes the additional £500k CIP required to deliver the higher surplus target set for the Trust by NHS Improvement.

Statement of Financial Position (SoFP)

PERIOD: August 2019	2018/19 31/03/19 Audited £'000's	2019/20 31/08/19 August £'000's
NON CURRENT ASSETS		
Property, Plant and Equipment	200,260	199,846
Intangible assets	1,909	1,788
Trade and other receivables	653	652
Total Non Current Assets	**202,822**	**202,286**
CURRENT ASSETS		
Inventories	319	381
Trade and other receivables	13,802	16,881
Cash and Cash Equivalents	8,357	13,012
Total Current Assets	**22,478**	**30,274**
Non current assets held for sale	**0**	**0**
TOTAL ASSETS	**225,300**	**232,560**
CURRENT LIABILITIES		
Trade and other payables	(14,856)	(21,761)
Borrowings	(220)	(220)
Capital Investment Loan - Current	(190)	(190)
Provisions	(1,202)	(1,158)
Total Current Liabilities	**(16,468)**	**(23,329)**
NET CURRENT ASSETS (LIABILITIES)	**6,010**	**6,945**
NON CURRENT LIABILITIES		
Borrowings	(8,025)	(8,024)
Capital Investment Loan - Non Current	(3,510)	(3,429)
Provisions	(1,129)	(1,129)
Total Non Current Liabilities	**(12,664)**	**(12,582)**
TOTAL ASSETS EMPLOYED	**196,168**	**196,650**
TAXPAYERS' EQUITY		
Public Dividend Capital	83,675	83,674
Retained Earnings	48,288	48,770
Revaluation reserve	64,205	64,205
TOTAL TAXPAYERS EQUITY	**196,168**	**196,650**

Non-current assets

- Property, plant and equipment (PPE) amounts to £199.8m. For the first six months of the year depreciation charges are likely to exceed capital spend, resulting in a reduced PPE balance.

Current assets

- Current assets of £30.3m include cash of £13.0m and receivables of £16.9m.

Current Liabilities

- Current liabilities amount to £23.3m and mainly relate to payables of £21.8m
- Net current assets / (liabilities) show net assets of £7m.

Working capital

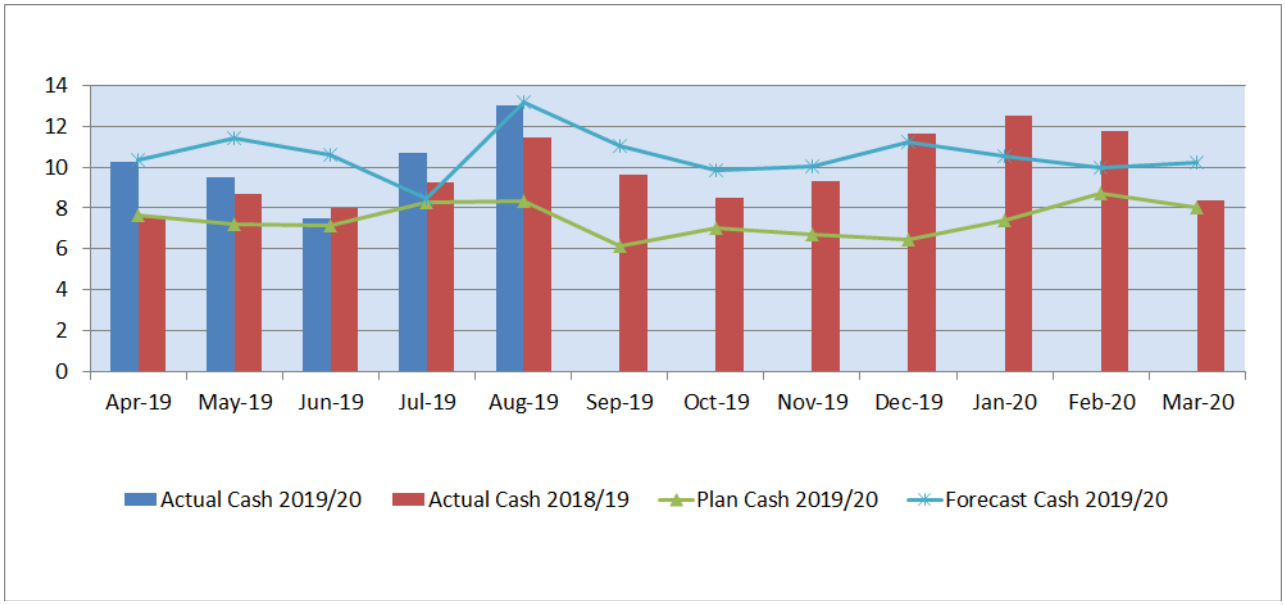
- Cash and changes in working capital are reviewed on the following pages.

Taxpayers' Equity

- August's year to date surplus of £482k is reflected within retained earnings.

Cash and Working Capital

12 Months Cash Analysis Apr 18 to Mar 19



Cash – Key Points

August's closing cash balance is £13.0m and equates to 17.6 days' operating expenses - this is £4.6m above the planned cash balance of £8.4m.

Internal cash forecasts are updated each month. The receipt of £3m relating to last year's PSF funding was received earlier than forecast and is responsible for the cash over-achievement against plan in recent months.

The cash position is forecast to reduce next month following the planned dividend payment of £2.8m to the Department of Health. The year end cash forecast of £10.24m as at 31st March 2020 is £2.2m above the planned year end cash balance of £8m. This is due to NHSI notification in April of the incentive PSF funding awarded to the Trust for achieving its 2018/19 financial duties (£2.2m). The revised forecast of £10.244m is reliant on the delivery of the planned I&E outturn and the receipt of 2019/20 PSF funding.

A detailed cashflow forecast is included at ***Appendix E.***

Receivables

Current receivables (debtors) total £16.9m. It should be noted that financial instruments such as accruals are also included in this calculation.

Receivables	Current Month (August 2019)					
	NHS	Non NHS	Emp's	Total	% Total	% Sales Ledger
	£'000	£'000	£'000	£'000		
Sales Ledger						
30 days or less	1,577	1,137	2	**2,716**	**15.8%**	**33.9%**
31 - 60 days	1,380	301	10	**1,691**	**9.8%**	**21.1%**
61 - 90 days	355	102	4	**461**	**2.7%**	**5.8%**
Over 90 days	2,435	545	168	**3,148**	**18.3%**	**39.3%**
	5,747	2,085	184	**8,016**	**46.5%**	**100.0%**
Non sales ledger	5,667	3,198	0	**8,865**	**51.4%**	
Total receivables current	**11,414**	**5,283**	**184**	**16,881**	**97.9%**	
Total receivables non current		360		360	**2.1%**	
Total	**11,414**	**5,643**	**184**	**17,241**	**100.0%**	**0.0%**

Debt greater than 90 days amounts to £3.1m, a decrease of £10k since last month. Receivables over 90 days should not account for more than 5% of the overall total receivables balance. The proportion at Month 5 is 18.3% (last month: 17%).

Aged debts > 90 days

Based on the RAG ratings below (see key), 45 invoices totalling £565k are deemed to be red, a reduction of £6k (1 invoice) since last month. The Accounts Receivable team focus on the green and amber debts, whilst the red debts are passed to Service areas once all general debt recovery processes have been exhausted. The majority of 'red' invoices relate to disputed AMH out-of-area recharges. Work continues to resolve these debts.

RAG	M3		M4		M5		Diff	
	£000	No	£000	No	£000	No	£000	No
Green	1,732	403	1,521	364	1,489	341	(32)	(23)
Amber	1,056	98	1,066	97	1,095	100	29	3
Red	543	45	571	46	565	45	(6)	(1)
Total	**3,331**	**546**	**3,158**	**507**	**3,149**	**486**	**(9)**	**(21)**

Key:

Green – invoice is in early stages of being chased / no queries or issues
Amber – invoice query raised / has been passed to requester to help resolve any disputes
Red * – invoice query raised which AR team cannot resolve / chased twice with requester

* If debts are red rated, this does not imply that they need to be written-off, just that more work is required to get disputes or queries resolved. There has not been any movement in the general bad debt provision of £374k since the start of the financial year.

Payables

The current payables position in Month 5 is £21.8m, an increase of £1.0m during the month. The over 90 days NHS supplier debt of £1,253k continues to relate to two suppliers: UHL (£483k) and NHS Property Services (£755k). Work is ongoing to resolve these invoice disputes.

Payables	Current Month August 2019				
	NHS £'000	Non NHS £'000	Total £'000	% Total	% Purchase Ledger
Purchase Ledger					
30 days or less	1,319	2,603	**3,922**	**18.0%**	**53.0%**
31 - 60 days	1,234	217	**1,451**	**6.7%**	**19.6%**
61 - 90 days	755	19	**774**	**3.6%**	**10.5%**
Over 90 days	1,239	14	**1,253**	**5.8%**	**16.9%**
	4,547	2,853	**7,400**	**34.0%**	**100.0%**
Non purchase ledger	1,913	12,448	**14,361**	**66.0%**	
Total Payables Current	**6,460**	**15,301**	**21,761**	**100.0%**	
Total Payables Non Current	0	0	**0**		
Total	6,460	15,301	21,761	**100.0%**	

Better Payment Practice Code (BPPC)

The specific target is to pay 95% of invoices within 30 days. Cumulatively the Trust achieved all of the 4 BPPC targets in August, however during the month the Trust did not pay all NHS invoices within the required period (94%).

The Finance team will continue to meet with any non-complying departments to help maintain this position and support achievement of all four targets at the end of the financial year.

Further details are shown in ***Appendix C***.

Capital Programme 2019/20

Capital expenditure totals £2.65m at the end of month 5, £155k below plan. Spend has increased this month, mainly due to payment of Interserve invoices for the construction of the CAMHS unit, Bradgate ward refurbishments and preparations for the Riverside office relocation.

Confirmation has now been received from NHSI to spend to plan. The annual expenditure plan of £13.96m was reliant on NHSI approval of the Trust's capital resource limit (CRL). £1.6m of the plan is supported by internally generated cash and it is the approval to spend this cash that has now been granted.

The commencement of several schemes had been delayed until funding confirmation from NHSI. This has resulted in natural slippage on some projects. The Capital Management Team is reviewing the progress of all schemes in September and revising forecasts to ensure achievement of the Trust's CRL by the end of the financial year.

	Annual Plan	Aug YTD Plan	Aug YTD Actual	Aug YTD Variance	Year End Forecast	Revision to Plan
Sources of Funds	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Depreciation	7,179	2,802	2,647	(155)	7,179	0
PDC capital for CAMHS	5,102	0	0	0	5,102	0
PFI Agnes Unit capital lifecycle replacement	100	0	0	0	100	0
I&E Surplus	1,576	0	0	0	1,576	0
Asset Sales	0	0	0	0	0	0
Total Capital funds	**13,957**	**2,802**	**2,647**	**(155)**	**13,957**	**0**
Application of Funds	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Estates & Innovation						
Service Improvements	(7,138)	(1,401)	(1,424)	(23)	(7,133)	5
Estates & Equipment	(2,911)	(660)	(215)	445	(2,775)	136
Sub-total:	**(10,049)**	**(2,061)**	**(1,639)**	**422**	**(9,908)**	**141**
IT Programme	**(3,908)**	**(741)**	**(1,008)**	**(267)**	**(4,049)**	**(141)**
Total Capital Expenditure	**(13,957)**	**(2,802)**	**(2,647)**	**155**	**(13,957)**	**0**
(Over)/underspend against resource available	**0**	**0**	**0**	**0**	**0**	**0**

APPENDIX A - Statement of Comprehensive Income (SoCI)

Statement of Comprehensive Income for the period ended 31st August 2019	YTD Actual M5 £000	YTD Plan M5 £000	YTD Var. M5 £000	Year end forecast £000
Revenue				
Total income	118,368	116,243	2,125	278,567
Operating expenses	(114,923)	(112,798)	(2,125)	(268,805)
Operating surplus (deficit)	**3,445**	**3,445**	**(0)**	**9,762**
Investment revenue	15	15	(0)	36
Other gains and (losses)	0	0	0	0
Finance costs	(415)	(415)	0	(996)
Surplus/(deficit) for the period	**3,045**	**3,045**	**(0)**	**8,802**
Public dividend capital dividends payable	(2,563)	(2,563)	0	(6,154)
I&E surplus/(deficit) for the period (before tech. adjs)	**482**	**482**	**(0)**	**2,648**
IFRIC 12 adjustments	0	0	0	0
Donated/government grant asset reserve adj	0	0	0	0
Technical adjustment for impairments	0	0	0	0
NHSI I&E control total surplus	**482**	**482**	**(0)**	**2,648**
Other comprehensive income (Exc. Technical Adjs)				
Impairments and reversals	0	0	0	0
Gains on revaluations	0	0	0	0
Total comprehensive income for the period:	**482**	**482**	**(0)**	**2,648**
Trust EBITDA £000	**6,600**	**6,600**	**(0)**	**17,336**
Trust EBITDA margin %	**5.6%**	**5.7%**	**-0.1%**	**6.2%**

APPENDIX B – Monthly Operational CIP performance by Service

CIP performance by Directorate		2019/20 Financial Year													
		1 Apr £'000	2 May £'000	3 June £'000	4 July £'000	5 Aug £'000	6 Sept £'000	7 Oct £'000	8 Nov £'000	9 Dec £'000	10 Jan £'000	11 Feb £'000	12 March £'000	19/20 YTD £'000	19/20 yr/end plan £'000
AMH & LD	Plan	25	25	56	61	61	61	63	63	63	64	65	65	229	674
	Actual / *Forecast*	0	141	10	12	48	19	51	-69	15	45	31	65	210	368
	Variance	-25	116	-47	-49	-13	-42	-12	-132	-49	-19	-34	0	-18	-306
	Cumulative Variance	-25	91	44	-5	-18	-60	-72	-204	-253	-272	-306	-306		
	Cuml. % delivered	0%	280%	141%	97%	92%	79%	80%	51%	47%	50%	50%	55%	92%	55%
FYPC	Plan	49	49	49	49	49	49	49	49	49	49	49	49	244	586
	Actual / *Forecast*	49	49	49	49	49	49	49	49	49	49	49	49	244	586
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Cumulative Variance	0	0	0	0	0	0	0	0	0	0	0	0		
	Cuml. % delivered	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Community H/S	Plan	73	73	73	73	73	73	73	73	73	73	73	73	363	870
	Actual / *Forecast*	73	73	73	73	73	73	73	73	73	73	73	73	363	870
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Cumulative Variance	0	0	0	0	0	0	0	0	0	0	0	0		
	Cuml. % delivered	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Enabling	Plan	46	46	46	46	46	46	46	46	46	46	46	46	231	555
	Actual / *Forecast*	45	38	38	38	46	46	46	45	45	44	44	46	205	521
	Variance	-1	-8	-8	-8	0	0	0	-1	-1	-2	-2	0	-26	-34
	Cumulative Variance	-1	-9	-17	-26	-26	-26	-26	-28	-29	-31	-33	-34		
	Cuml. % delivered	98%	90%	87%	86%	89%	91%	92%	93%	93%	93%	93%	94%	89%	94%
Estates Services	Plan	19	22	22	66	66	66	99	100	100	100	101	102	195	862
	Actual / *Forecast*	2	5	5	5	5	5	38	38	38	38	38	40	22	257
	Variance	-17	-17	-17	-61	-61	-61	-61	-62	-62	-62	-63	-62	-173	-605
	Cumulative Variance	-17	-34	-51	-112	-173	-234	-294	-356	-418	-480	-543	-605		
	Cuml. % delivered	0%	0%	0%	13%	11%	10%	18%	22%	25%	27%	29%	30%	11%	30%
Trust-wide savings	Plan	0	0	0	0	45	65	65	65	65	65	65	65	45	500
	Actual / *Forecast*	0	0	0	0	45	65	5	0	0	0	0	0	45	115
	Variance	0	0	0	0	0	0	-60	-65	-65	-65	-65	-65	0	-385
	Cumulative Variance	0	0	0	0	0	0	-60	-125	-190	-255	-320	-385		
	Cuml. % delivered	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	100%	23%
Total	Plan	212	215	246	295	340	360	394	396	396	397	399	400	1,307	4,047
	Actual / *Forecast*	169	305	174	176	265	257	262	135	219	248	234	273	1,089	2,717
	Variance	-43	91	-72	-118	-74	-103	-133	-260	-177	-149	-164	-127	-217	-1,330
	Cumulative Variance	-43	47	-24	-143	-217	-320	-453	-713	-890	-1,039	-1,203	-1,330		
														83%	67%
Cumulative Delivered		80%	111%	96%	85%	83%	81%	78%	71%	69%	68%	67%	67%		

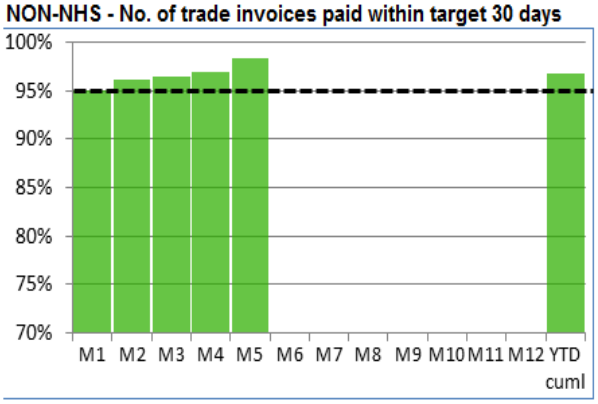
APPENDIX C – BPPC performance

Trust performance – current month (cumulative) v previous

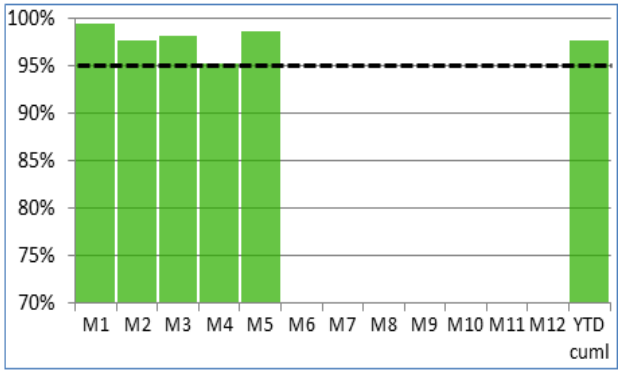
Better Payment Practice Code	August (Cumulative)		July (Cumulative)	
	Number	£000's	Number	£000's
Total Non-NHS trade invoices paid in the year	11,275	40,755	8,916	32,751
Total Non-NHS trade invoices paid within target	10,911	39,846	8,590	31,943
% of Non-NHS trade invoices paid within target	**96.8%**	**97.8%**	**96.3%**	**97.5%**
Total NHS trade invoices paid in the year	309	20,452	244	16,324
Total NHS trade invoices paid within target	297	20,436	236	16,312
% of NHS trade invoices paid within target	**96.1%**	**99.9%**	**96.7%**	**99.9%**
Grand total trade invoices paid in the year	11,584	61,207	9,160	49,075
Grand total trade invoices paid within target	11,208	60,282	8,826	48,255
% of total trade invoices paid within target	**96.8%**	**98.5%**	**96.4%**	**98.3%**

Trust performance – run-rate by all months and cumulative year-to-date

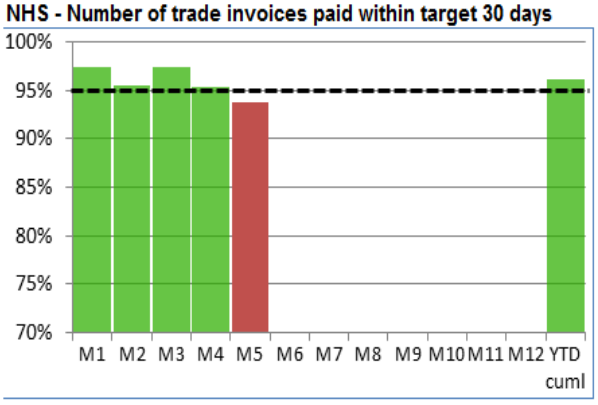
NON-NHS - No. of trade invoices paid within target 30 days



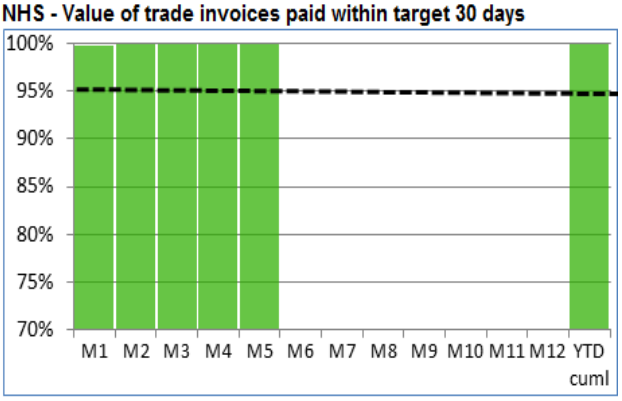
NON-NHS - Value of trade invoices paid within target 30 days



NHS - Number of trade invoices paid within target 30 days



NHS - Value of trade invoices paid within target 30 days



APPENDIX D – Agency staff expenditure

2019/20 Agency Expenditure (includes prior yr comparators)	2018/19 Outturn £000s Actual	2018/19 Avg. £000s Actual	2019/20 M1 £000s Actual	2019/20 M2 £000s Actual	2019/20 M3 £000s Actual	2019/20 M4 £000s Actual	2019/20 M5 £000s Actual	2019/20 M6 £000s F'Cast	2019/20 M7 £000s F'Cast	2019/20 M8 £000s F'Cast	2019/20 M9 £000s F'Cast	2019/20 M10 £000s F'Cast	2019/20 M11 £000s F'Cast	2019/20 M12 £000s F'Cast	19/20 YTD £000s Actual	19/20 Year End £000s F'cast
AMH/LD																
Agency Consultant Costs	-609	-51	-60	-64	-94	-59	-75	-80	-62	-45	-45	-45	-45	-45	-352	-719
Agency Nursing	-1,528	-127	-122	-142	-158	-173	-157	-140	-135	-135	-155	-150	-120	-110	-752	-1,697
Agency Scient, Therap. & Tech	-232	-19	-33	-18	-21	-26	-23	-25	-25	-25	-25	-25	-25	-25	-122	-297
Agency Non clinical staff costs	-409	-34	-48	-43	-31	-14	-25	-15	-15	-10	-10	-10	-10	-10	-161	-241
Sub-total	**-2,778**	**-231**	**-264**	**-267**	**-303**	**-273**	**-280**	**-260**	**-237**	**-215**	**-235**	**-230**	**-200**	**-190**	-1,387	**-2,954**
CHS																
Agency Consultant Costs	-182	-15	-15	-15	-12	-13	-11	-15	-15	-15	-15	-7	-7	-7	-66	-145
Agency Nursing	-3,579	-298	-306	-243	-305	-332	-302	-290	-290	-290	-320	-290	-270	-270	-1,489	-3,509
Agency Scient, Therap. & Tech	-644	-54	-54	-41	-47	-53	-49	-50	-50	-50	-50	-50	-50	-50	-244	-594
Agency Non clinical staff costs	-43	-4	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sub-total	**-4,447**	**-371**	**-375**	**-299**	**-365**	**-398**	**-362**	**-355**	**-355**	**-355**	**-385**	**-347**	**-327**	**-327**	-1,799	**-4,249**
FYPC																
Agency Consultant Costs	-429	-36	-42	-12	-29	-30	-41	-30	-30	-30	-30	-30	-30	-30	-154	-364
Agency Nursing	-521	-43	-118	-160	-163	-94	-96	-90	-90	-70	-70	-50	-50	-50	-631	-1,101
Agency Scient, Therap. & Tech	-26	-2	-4	-7	-11	-16	-5	-5	-5	-5	-5	-5	0	0	-44	-69
Agency Non clinical staff costs	-32	-3	-8	-15	-15	-28	-3	-5	0	0	0	0	0	0	-69	-74
Sub-total	**-1,007**	**-84**	**-172**	**-194**	**-218**	**-168**	**-145**	**-130**	**-125**	**-105**	**-105**	**-85**	**-80**	**-80**	-898	**-1,608**
Enabling, Hosted & reserves																
Agency Consultant Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Agency Nursing	-49	-4	0	29	0	0	0	0	0	0	0	0	0	0	29	29
Agency Scient, Therap. & Tech	-42	-4	-7	-4	-8	-10	-8	-9	-9	-9	-9	-9	-9	-9	-36	-99
Agency Non clinical staff costs	-623	-52	-22	-31	-24	-27	-19	-23	-23	-23	-23	-23	-23	-23	-123	-284
Sub-total	**-714**	**-60**	**-28**	**-6**	**-32**	**-38**	**-27**	**-32**	**-32**	**-32**	**-32**	**-32**	**-32**	**-32**	-130	**-354**
TOTAL TRUST																
Agency Consultant Costs	-1,220	-102	-117	-90	-136	-103	-126	-125	-107	-90	-90	-82	-82	-82	-572	-1,228
Agency Nursing	-5,676	-473	-546	-516	-626	-599	-556	-520	-515	-495	-545	-490	-440	-430	-2,842	-6,277
Agency Scient, Therap. & Tech	-944	-79	-99	-71	-87	-105	-85	-89	-89	-89	-89	-89	-84	-84	-446	-1,059
Agency Non clinical staff costs	-1,107	-92	-78	-89	-70	-70	-47	-43	-38	-33	-33	-33	-33	-33	-354	-600
Total	**-8,946**	**-746**	**-839**	**-766**	**-918**	**-877**	**-814**	**-777**	**-749**	**-707**	**-757**	**-694**	**-639**	**-629**	-4,214	**-9,164**
Agency ceiling (£8,122k)			-675	-677	-677	-677	-677	-677	-677	-677	-677	-677	-677	-677	-3,383	-8,122
Variance (+better/-worse)			**-164**	**-89**	**-241**	**-200**	**-137**	**-100**	**-72**	**-30**	**-80**	**-17**	**38**	**48**	-831	**-1,042**
Trust financial plan			-710	-681	-680	-678	-677	-675	-674	-670	-673	-675	-673	-656	-3,426	-8,122
Variance (+better/-worse)			**-129**	**-85**	**-238**	**-199**	**-137**	**-102**	**-75**	**-37**	**-84**	**-19**	**34**	**27**	-788	**-1,042**

At month 5, total Trust agency costs were £4,214k. This is higher than year-to-date planned spend of £3,426k, and also higher than the year-to-date agency spend ceiling of £3,383k set by NHS Improvement.

The year end plan was initially set to deliver the NHSI agency spend ceiling of £8,122k. However, since the plan was set, agency projections have increased significantly, mainly as a result of much higher spend within FYPC, due to the work to reduce CAMHS waiting lists.

After month 5, the revised forecast for the year is £9.2m against the plan / NHSI ceiling of £8.1m

APPENDIX E – Cash flow forecast

APPENDIX E: 2019/20 CASH-FLOW FORECAST	AUG	AUG	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	YTD	19/20
	FORECAST	ACTUAL	VARIANCE	FORECAST	FORECAST	FORECAST	FORECAST	FORECAST	FORECAST	FORECAST	ACTUAL	FORECAST
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
OPENING BALANCE	**10,696**	**10,696**	**0**	**13,163**	**11,033**	**9,885**	**10,073**	**11,211**	**10,522**	**9,994**	**8,356**	**8,356**
INCOME												
CCG Block Contracts	17,951	17,951	**0**	17,951	17,951	17,951	17,951	17,951	17,951	17,951	89,755	215,412
NHS England Specialist Commissioning Contracts	680	623	**(57)**	623	623	623	623	623	623	623	3,343	7,704
Health Education England Medical Training Contracts	689	689	**0**	697	683	679	685	678	677	683	3,743	8,525
Local Authorities	2,207	2,219	**12**	1,437	1,437	1,437	1,437	1,437	1,437	2,157	5,860	16,639
UHL Contracts	800	413	**(387)**	587	200	200	200	200	200	400	413	2,400
Non Contract Activity (NCA) re service provision for Non- Leicester patients	225	489	**264**	325	325	325	311	325	325	575	1,064	3,575
Health Informatics Service (HIS)	682	362	**(320)**	943	827	600	850	740	850	1,049	541	6,400
360 Assurance Audit Services	449	310	**(139)**	381	442	242	242	242	242	323	555	2,669
Property income for rents and service charges	630	0	**(630)**	756	126	126	126	126	126	126	0	1,512
STP Funding 18/19	0	0	**0**	352	322	0	430	0	0	644	0	1,748
STP Funding 17/18 - Q4 plus incentive and bonus allocation	0	0	**0**	0	0	0	0	0	0	0	3,180	3,180
HMRC Mill Lodge VAT refund for construction works	0	0	**0**	0	0	0	0	0	0	800	0	800
HMRC VAT reclaims	545	545	**0**	344	259	259	259	259	259	259	1,344	3,242
Property disposals	0	0	**0**	0	0	0	0	0	0	0	0	0
Capital Loan	0	0	**0**	0	0	0	0	0	0	0	0	0
Other income receipts and recharges (including PDC)	1,494	930	**(564)**	1,345	620	1,335	620	620	1,334	1,166	2,700	9,737
PDC capital funding support	564	0	**(564)**	1,589	0	0	1,476	0	0	2,037	0	5,102
Income receipts relating to previous year	666	69	**(597)**	400	150	412	200	200	197	0	5,233	6,792
Total Receipts	**27,582**	**24,600**	**(2,982)**	**27,730**	**23,965**	**24,189**	**25,410**	**23,401**	**24,221**	**28,793**	**117,731**	**295,437**
PAYMENTS												
Payroll	16,940	16,812	**(128)**	16,940	16,940	16,940	16,940	16,940	16,940	16,940	85,485	204,065
Capital	1,178	757	**(421)**	1,745	1,681	808	1,200	1,017	1,077	907	2,022	10,457
Non pay general expenditure	4,360	3,123	**(1,237)**	4,578	4,560	4,200	4,200	4,200	4,700	5,405	18,682	50,525
Recovery actions (CIP schemes)	0	0	**0**	0	0	0	0	0	0	0	0	0
UHL - Estates & FM Services	827	827	**0**	827	827	827	827	827	827	827	3,308	9,097
UHL - Other contracts	352	0	**(352)**	528	176	176	176	176	176	176	532	2,116
Rents and Service Charges (NHS Properties & Community Health Partnership)	658	95	**(563)**	1,594	329	329	329	329	329	330	380	3,949
HCL Agency Nursing Costs	400	519	**119**	400	400	400	400	400	500	531	1,724	4,755
Out of Area (OOA) costs for patients placed in private hospitals	400	151	**(249)**	449	200	200	200	200	200	200	823	2,472
Public dividend capital payment (PDC)	0	0	**0**	2,798	0	0	0	0	0	3,077	0	5,875
Other finance costs (inc loan interest and principal repayments)	0	0	**0**	0	0	120	0	0	0	0	119	239
Total Payments	**25,115**	**22,284**	**(2,831)**	**29,859**	**25,113**	**24,000**	**24,272**	**24,089**	**24,749**	**28,393**	**113,075**	**293,550**
CLOSING CASH BOOK BALANCE	**13,163**	**13,012**	**(151)**	**11,033**	**9,885**	**10,073**	**11,211**	**10,522**	**9,994**	**10,394**	**13,012**	**10,243**
Plan	**8,369**	**8,369**	**0**	**6,158**	**7,014**	**6,681**	**6,436**	**7,383**	**8,711**	**8,000**	**7,216**	**8,000**
Variance to plan	**4,794**	**4,643**	**(151)**	**4,875**	**2,871**	**3,392**	**4,775**	**3,139**	**1,283**	**2,394**	**5,796**	**2,243**

APPENDIX F – Risks, Pressures and Mitigations

Risk adjusted estimated year end position as at month 5

Likely Scenario					Scenario Analysis		
Description	Risk £000	Pressure £000	Mitigation £000	Net Total £000	Best £000	Likely £000	Worst £000
Opening 2018/19 budgets - break-even assumption	**-**	**-**	**-**	**0**	**0**	**0**	**0**
Operational positions							
Adult Mental Health & LD	(446)	(1,640)	446	**(1,640)**	(1,034)	(1,640)	(2,094)
Community Health Services	(1,050)	0	600	**(450)**	100	(450)	(950)
Families, Young People and Childrens Services	0	(1,790)	1,200	**(590)**	(440)	(590)	(990)
Enabling Services	0	(222)	447	**225**	350	225	100
Estates	0	(1,948)	334	**(1,614)**	(1,450)	(1,614)	(1,816)
Hosted Services	0	(1,000)	775	**(225)**	(150)	(225)	(450)
Service Delivery - total	**(1,496)**	**(6,600)**	**3,802**	**(4,294)**	**(2,624)**	**(4,294)**	**(6,200)**
Trustwide/Corporate							
Reserves contingency release (includes release of unused 18/19 provisions)	**0**	0	1,480	**1,480**	1,250	1,480	1,000
Risk of loss of income due to 'fixed' 19/20 cost based contract with Commissioners. Mitigation is early identification of issues and witholding of budget where funding is not forthcoming	(250)	0	250	**0**	0	0	(125)
Opening contract value risk. £0.9m is within LPT position and is covered by additional CIP (albeit CIPs are unidentified). Remaining £2.0m rests with CCGs - the mitigation for this is that it will only be reflected in the contract if definite QIPP/cost reduction can be agreed by both parties.	(2,000)		2,000	**0**	0	0	(892)
Additional £500k CIP linked to the increased NHSI surplus expectation (stretch target). Potential mitigation will be allocation/identification of additional CIP target (tbc)		(500)	0	**(500)**	0	(500)	(500)
0-19 contract pay award funding risk - uncertainty about how funding will be applied locally. Mitigation is that principle of NHS funding has been confirmed nationally.	(500)		500	**0**	0	0	(500)
Risk that previous IT software VAT reclaims will be rescinded due to a change in HMRC approach. Mitigation is further unrelated VAT reclaims not yet reported.	(240)		240	**0**	400	0	(240)
Potential Recovery Actions							
Mill Lodge VAT reclaim - income not recognised in prior year as currently under appeal. External advisers suggest a high liklihood of the Trust winning at appeal stage			730	**730**	730	730	0
Freeze Invest to Save reserve in 2019/20			550	**550**	550	550	0
Cap 2019/20 redundancy costs at £200k			100	**100**	100	100	0
Additional financial recovery options - tbc			1,934	**1,934**	1,934	1,934	0
Trustwide/Corporate total:	**(2,990)**	**(500)**	**7,784**	**4,294**	**4,964**	**4,294**	**(1,257)**
Budget variance after net risks, pressures and mitigations	**(4,486)**	**(7,100)**	**11,586**	**0**	**2,340**	**0**	**(7,457)**
Trust plan surplus (includes additional £500k NHSI target)				**2,648**	**2,648**	**2,648**	**2,648**
Net I&E performance				**2,648**	**4,988**	**2,648**	**(4,809)**

Summary, including PSF forecast	Trust plan	PSF	Total
Trust control total	0	2,148	**2,148**
NHSI plan (includes £500k 'stretch' target)	500	2,148	**2,648**
Current forecast surplus/(deficit)	500	2,148	**2,648**
Forecast variance against £2.6m planned surplus	**0**	**0**	**0**

Leicestershire Partnership NHS Trust

Meeting	Trust Board
Date of meeting	1st October 2019
Paper number	Vi

Name of Report	Integrated Quality and Performance Report

For approval		For assurance	X	For information	

Presented by the Accountable Director	Dani Cecchini – Director of Finance, Business and Estates	Author (s)	Laura Hughes – Head of Information

Alignment to CQC domains:		Alignment to the LPT strategic objectives:		Alignment to LPT priorities for 2019/20 (STEP up to GREAT):	
Safe		Safe		S – High Standards	
Effective		Staff		T - Transformation	
Caring		Partnerships		E – Environments	
Responsive		Sustainability	X	P – Patient Involvement	
Well-Led	X			G – Well-Governed	X
				R – Single Patient Record	
				E – Equality, Leadership, Culture	
				A – Access to Services	
				T – Trust wide Quality improvement	

Report previously reviewed by		
Committee / Group	Date	Assurance obtained (Significant/Limited/None)
not reviewed	not reviewed	not assessed

Assurance: What level of assurance does this report provide in respect of the Board Assurance Framework Risks? (Significant / Limited / No Assurance)	Links to BAF risk numbers
TBC	TBC

Recommendations of the report
The Board is recommended to: • Receive assurance with regard to areas of quality and performance where performance improvement action is being undertaken; • Receive the NHSI compliance segment rating of three.

1 Introduction/ Background

1.1 The Integrated Quality and Performance Report (IQPR) summarises the Trust's performance against key NHS Improvement (NHSI), Commissioner and other targets; and provides analysis and commentary on those areas which require additional actions to ensure that we achieve our targets and objectives.

1.2 The strategic objective measures aligned to the Trust's 'STEP up to GREAT' priorities will be reviewed during 2019/20 and included in a future iteration of this report.

1.3 The report format is continually evolving to ensure it is aligned to the:
a) key performance indicators (KPIs)
b) Trust governance groups
c) corporate risk register (CRR) and board assurance framework (BAF)
d) Trust priorities

1.4 It should be noted that from May 2019, the following NHSI compliance is demonstrated in the report:

Segment Rating	3 - Providers receiving mandated support for significant concerns

2 Aim

2.1 The aim of this report is to provide the Trust Board with an integrated quality and performance report showing levels of compliance with the NHS Improvement's (NHSI) Single Oversight Framework and Care Quality Commission (CQC) registration, together with detailed analysis for those areas requiring additional action to ensure achievement of targets.

3 Discussion

3.1 The next three chapters highlight the key quality and performance indicators for each of the committees:
i. Quality Assurance Committee (QAC)
ii. Finance and Performance Committee (FPC)
iii. Strategic Workforce Assurance Group (SWAG)

3.2 Each chapter is separated into two themes:
i. NHS Improvement (NHSI) Single Oversight Framework (SOF)
ii. Trust identified quality of care/ performance/ organisational health indicators

3.3 The full integrated quality and performance review (IQPR) dashboard is available in Annex A and is referred to throughout the paper. Annex A provides monthly trends and supporting exception reports to support discussions.

4 Quality Assurance Committee (QAC)

NHS Improvement (NHSI) quality of care indicators

4.1 There is one identified NHSI trigger(s) in 2019/20 quarter four relating to the care programme approach seven day (CPA seven day) indicator.

4.2 Trust performance against the CPA seven day follow up standard is reported as two separate measures to account for:

i. only those patients discharged from a general psychiatric unit on a CPA;
ii. all patients discharged from a general psychiatric unit on CPA and on non-CPA.

4.3 Performance for patients discharged on CPA during July 2019 is 97.3% against a national lower limit target of 95% (reported one month in arrears).

4.4 The performance for all patients discharged on CPA and on non-CPA during July 2019 is 91.3% against a national lower limit target of 95% (reported one month in arrears). Based on the SPC chart, there is special cause improvement of CPA 7 Day rates since July 2018; however the Trust will inconsistently meet the target of >=95% unless further improvements are made.

4.5 In July 2019, there were eleven patients recorded who breached the CPA seven day standard – of which, six were not contacted with attempts made; four not contacted with no attempt made; one data quality issues identified classifying it as a breach in the month. The data quality patient was not seen within the timescale by the service. A record of year to date data quality errors affecting this indicator are retained to support the audit for this Quality Account indicator.

4.6 The 2019/20 trajectory for clostridium difficile (C. Diff) has been set by the Leicester, Leicestershire and Rutland (LLR) clinical commissioning groups (CCGs) as an upper limit of twelve cases per annum. There has been one (1) cases of C. Diff in the month of August 2019. The year to date total occurrences of C.Diff is two (2). If this level of quality is sustained, the Trust can receive assurance of meeting this year end target. Based on the SPC chart, there is no significant change to the number of reported cases since April 2018; and the Trust will consistently meet the trajectory. (See Annex A - detailed exception report – clostridium difficile (C Diff) cases).

Trust quality of care indicators

4.7 The CPA 12 month standard performance as at August 2019 is 90.8% against a lower limit threshold of 95%. The performance continues to improve following the implementation of patient level reporting and reminders to care co-ordinator. As per the new process, the circumstances leading to patients not receiving their 12 month review in a timely manner will be investigated following escalation to the appropriate manager(s). Based on the SPC chart, there is special cause improvement of CPA 12 month rates since December 2018; however the Trust will consistently fail the target of >=95% unless further improvements are made. (See Annex A - detailed exception report – CPA 12 month review).

5 Finance and Performance Committee (FPC)

NHS Improvement (NHSI) use of resources indicators

5.1 The NHSI single oversight framework (SOF) uses financial metrics to assess financial performance. Providers are scored from one to four against each metric and an aggregate overall score is derived (see Appendix One for details).

5.2 As at 2019/20 month 05, the year to date financial assessment is scored at two (2). The 2019/20 forecast outturn score is also two (2).

NHS Improvement (NHSI) operational performance indicators

5.3 There are no identified NHSI trigger(s) in August 2019.

5.4 The Trust continues to meet its national access targets for 18 week referral to treatment (RTT) services (incomplete pathways >=92% target), six week diagnostic services and two week early intervention in psychosis services. The Trust has no patients waiting more than 52 weeks for treatment on RTT pathways (see Annex A – detailed exception report – national access standards).

5.5 Inappropriate adult mental health out of area (OOA) bed days have shown an overall reduction since April 2018 as the Trust works to reduce mental health OOA bed days to zero by 2020/21. Over the last 12 months, the Trust has seen a sustained decline in OOA bed days from 1673 in 2018/19 quarter one to 1364 in 2019/20 quarter one. Quarter two bed days are showing as 1975 with one month in the quarter remaining. An Out of Area exception report will be provided for the August-19 IQPR.

5.6 It should be noted that OAP bed days are slightly inflated due to the source data held on RiO being incorrect. Actions are being taken to reduce the occurrence of data quality errors made at source and to ensure errors are rectified at source in a timely manner. This issue is technical in nature and is specific to data held on RiO. It is expected the ongoing issues will be mitigated as part of the planned migration from RiO to SystmOne in 2020/21. NHS Digital have been informed of this data quality issue which has inflated the 2018/19 bed days by approximately 300 days and the 2019/20 bed days by approximately 60 days.

5.7 In May 2019, the Trust, in partnership with Leicester, Leicestershire and Rutland (LLR) commissioners, provided access to ‘progress beds’ for patients nearing the end of their acute mental health inpatient spell. This ‘progress bed’ initiative aims to increase availability of AMH acute beds for patients presenting with acute needs so enabling prompt admission to a local bed.

5.8 This arrangement is anticipated to be an interim arrangement pending the commissioning of enhanced crisis and early discharge provision later in 2019/20. The qualitative and quantitative impact of progress beds will be formally reviewed every two months with findings reported via contract monitoring and internal governance routes. As progress beds are provided by Cygnet Healthcare in a range of units located outside of LLR, it is anticipated that there will be an increase in the total number of out of area placements in the first instance; however as acute OOA placements are repatriated the expectation is that overall OOA numbers will either remain static or potentially reduce.

5.9 The Trust's data quality maturity index (DQMI) score is now published nationally one month in arrears by NHS Digital. NHSI have specifically identified the mental health services data set (MHSDS) as an area for provider scrutiny. Nationally, NHS Digital are supporting NHS regulatory bodies to access and use this submitted data to develop tools such as the model hospital and more recently the STP mental health dashboards.

5.10 The DQMI MHSDS criteria expanded during 2019/20 and the Trust anticipated a drop in compliance to approximately 80% when the new criteria were implemented. . The Trust has agreed to a data quality improvement plan (DQIP) as part of the 2019/20 contract with the CCG commissioners to focus on improving performance against the new DQMI standards.

5.11 To support these improvements, three specific work streams have been implemented:

i. recording of patient demographics - in May 2019, a pilot data collection form was introduced in mental health outpatient services. A review of success is arranged for August 2019;
i. clinical coding - a review is underway to understand processes relating to the recording of primary diagnosis codes;
ii. technical submission process – a review is underway to understand processes relating to the development and validation of submission files.

5.12 The May 2019 DQMI MHSDS compliance rate has decreased slightly to 84.6% from 84.8% the previous month. Targeted actions are in place to identify the cause of the decline with a view to see improvements during 2019/20 quarter two (See Annex A – detailed exception report – data quality maturity index (DQMI)).

5.13 The percentage of patients admitted to inpatient services who are given access to Crisis Resolution/ Home Treatment teams ('gate keeping') in line with best practice standards returned to national submissions for 2019/20 quarter one. Following recommendation from the Executive Team, the Trust Board agreed to remove 'gate keeping' from national reporting for 2018/19 quarter three and four.

5.14 2019/20 quarter one gate keeping performance is achieving 84.5% against a lower limit threshold of 95%. It should be noted; the monthly performance breakdown for this quarter is 69.5%, 82.8% and 100% for April, May and June 2019 respectively, which suggests the improvements made over the period following the implementation and embedding of the new gatekeeping protocol from April 2019 had the desired impact. August 2019 performance is achieving 100%. This indicator will continue to be closely monitored in the directorate to maintain the level of improvements.

5.15 The Trust has submitted the gatekeeping rate as 84.5% for the period April 2019 to June 2019 to NHS Digital, with no identified data quality issues.

Trust operational performance indicators

5.16 The management of patients experiencing a delayed transfer of care (DToC) remains high on the Trust agenda. As at August 2019, the Trust is above the 3.5% upper limit threshold at 4.6%. It should be noted the Leicester, Leicestershire and Rutland (LLR) DToC rate, which incorporates delays in the acute trust and LLR patients delayed in non-LLR hospitals is within the target threshold.

6 Strategic Workforce Assurance Group (SWAG)

NHS Improvement (NHSI) organisational health indicators

6.1 There are zero (0) identified NHSI trigger in August 2019.

6.2 Staff sickness absence remains above target at 4.7% in July 2019 (reported one month in arrears) – of which, 2.9% is long term sickness and 1.8% is short term sickness. Support to manage staff sickness absence is pro-actively offered to managers by the human resources department.

6.3 Based on the SPC chart, there is no significant change in the rate of staff sickness since February 2018; and the Trust will inconsistently meet the Trust target of <=4.5%. (see Annex A – detailed exception report - % staff sickness).

6.4 Staff turnover (normalised) was 8.5% for August 2019, which meets the Trust threshold of performing at less than 10% for a rolling twelve month period.

Trust human resources – workforce performance indicators

6.5 The Trust vacancy rate in August 2019 remains at 8.9%, which is above the upper limit threshold of 7%.

6.6 Cumulative year-to-date Trust agency costs were £4,214K as at 31 August 2019 (month 5). This is above the planned spend of £3,426k for the same period. The August year-to-date NHSI agency ceiling target is £3,383k. This Trust is exceeding this limit by £831k.

7 Conclusion

7.1 This report demonstrates that whilst there are a significant number of targets being achieved, along with some notable areas of improvement, there remain a number of targets which are not currently being achieved and where attention is now being directed to ensure continued improvement in the coming months.

8 Recommendations

1 The Board is recommended to:

i. Receive assurance with regard to areas of quality and performance where performance improvement action is being undertaken;
ii. Receive the NHSI compliance segment rating of three.

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i. Appendix One – description of NHSI segmentation
ii. Annex A – Integrated Quality and Performance Report

9 Appendices

Appendix one – description of NHSI segmentation

Segmentation helps NHSI determine the level of support required. It does not give a performance assessment in its own right, nor is it intended to predict the ratings given by CQC. It also does not determine the specifics of the support package needed − this is tailored by teams working with the provider in question. NHSI are segmenting the sector into four, depending on the extent of support needs identified through the oversight process.

1 - Providers with maximum autonomy − no potential support needs identified across our five themes – lowest level of oversight and expectation that provider will support providers in other segments.

2 - Providers offered targeted support − potential support needed in one or more of the five themes, but not in breach of licence (or equivalent for NHS trusts) and/ or formal action is not needed.

3 - Providers receiving mandated support for significant concerns – the provider is in actual/ suspected breach of the licence (or equivalent for NHS trusts).

4 - Special measures − the provider is in actual/ suspected breach of its licence (or equivalent for NHS trusts) with very serious/ complex issues that mean that they are in special measures.

Paper Vii

Leicestershire Partnership NHS Trust

Integrated Quality and Performance Report

Advancing health and well-being

End of August 2019 Position

Data to 31 August 2019 unless otherwise stated

Previous month's data refreshed where available

Leicestershire Partnership NHS Trust

Contents

NHS Improvement Themes of the Single Oversight Framework

Themes		Measures	Q1 Self Assessed Concerns	Q2 Forecasted Concerns
Quality of Care	Care Quality Commission (CQC) judgements on the Quality of Care provided by the Trust; safe, effective, caring and responsive	CQC 'inadequate' or 'requires improvement' assessment in one or more of:- 'safe', 'effective', 'caring', 'responsive' -CQC warning notices -Any other material concerns identified through, or relevant to, CQC's monitoring process, e.g. civil or criminal cases raised, whistleblower information, etc. -Concerns arising from trends in our quality indicators (Appendix 2) -Delivering against an agreed trajectory for the four priority standards for 7-day hospital	Yes current CQC rating of 'requires improvement'	Yes
Finance & Use of Resources	Strengthening financial performance and accountability by overseeing financial efficiency and financial control total	-Poor levels of overall financial performance (average score of 3 or 4) -Very poor performance (score of 4) in any individual metric -Potential value for money concerns	No	No
Operational Performance	Improve and sustain performance against NHS Constitution standards	For providers with Sustainability and Transformation Fund (STF) trajectories in any metric: failure to meet the trajectory for this metric in more than two consecutive months (quarterly for quarterly metrics) For providers without STF trajectories: failure to meet any standard in more than two consecutive months	No	No
Strategic Change	Delivering strategic changes set out in the Five Year Forward View focussing on sustainability and transformation plans (STP)	Material concerns with a provider's delivery against the transformation agenda, including new care models and devolution	Governance arrangements of STP under review. Consultation and implementation yet to be confirmed	Governance arrangements of STP under review. Consultation and implementation yet to be confirmed
Leadership & Improvement Capability	Good governance and leadership	-Material concerns -CQC 'inadequate' or 'requires improvement' assessment against 'well-led'.	Yes current CQC rating of 'inadequate'	Yes

Segment Rating: 3

The five themes above are used by NHS Improvement to support providers to improve to attain and/or maintain a CQC 'good' or 'outstanding' rating.

Segmentation:
NHS Improvement (NHSI) use information from data monitoring processes and insights gathered though work with providers, to identify where providers have a potential support need under one or more of the five themes. NHSI will also use judgement, based on consistent principles, to determine whether or not providers are in breach of licence – or the equivalent for NHS trusts – and to determine, as part of that judgement, if providers should go into special measures (segment 4).

Rated **GREEN** No issues identified or Universal or Targeted support is agreed with NHSI **RED** where mandated support is issued by NHSI. Where the trust identifies a concern, a written description stating the issue and any associated actions to address those concerns will be accompanied and is locally rated as **Amber**.

Leicestershire Partnership NHS Trust

NHS Improvement Quality of Care Metrics

	NHSI Sector	Indicator	NHSI Monitoring Frequency	Monthly Performance: Reporting Period (rolling three months) Jun-19	Jul-19	Aug-19	Sparkline YTD	Quarterly Performance: 2018/19 Q4	2019/20 Q1	Q2	Q3	Q4	Annual Performance: 2018/19 Year End Total	2019/20 Year to Date Total	Trigger (two consecutive monthly breaches)	Current month directorate performance: Adult Mental Health/ Learning Disabilities	Community Health	Families, Young People & Children	Enabling Services	Comments
SAFE	All	**Occurrence of any Never Event**	Monthly *(six month rolling)*	**0**	**0**	**0**		**0**	**0**				**1**	**0**	0	**0**	**0**	**0**	**0**	Methodology: count of 'never events' in rolling six- month period
	All	**NHS England/NHS Improvement Patient Safety Alerts not completed by deadline**	Monthly	**0**	**0**	**0**		**0**	**0**				**0**	**0**	0	**0**	**0**	**0**	**0**	Methodology: number of NHS England or NHS Improvement patient safety alerts outstanding in most recent monthly snapshot
	Acute	**VTE Risk Assessment**	Monthly	**246**	**246**	**238**		**793**	**737**				**3249**	**1221**	0		**238**			
	Acute	**Clostridium Difficile Occurrence (against contractual year to date target of 12)**	Monthly	**1**	**0**	**1**		**2**	**1**				**5**	**2**	0	**0**	**1**	**0**		
	Acute	**Clostridium Difficile - infection rate (per 100,000 bed days)**	Monthly	**38.1**	**0**	**39.93**		**26.74**	**13.06**				**13.06**	**15.81**	0	**0**	**38.07**	**0**		Source of methodology is DoH website Cdiff annual data report
	Mental Health	**Admissions to adult facilities of patients who are under 16 years**	Monthly	**0**	**0**	**0**		**0**	**0**				**1**	**0**	0	**0**	**0**	**0**		Methodology: number of children and young persons under 16 who are admitted to adult wards
EFFECTIVE	Mental Health	**Care Programme Approach (CPA) follow up - proportion of discharges from hospital followed up within 7 days**	Monthly	**93.7%**	**91.3%**			**94.6%**	**93.1%**						1					Methodology: proportion of discharges from general psych wards followed up within 7 days (including MHSOP)
	Mental Health	**% clients in employment (two months in arrears)**	Monthly	*results due to be published Sept 2019*	*Not due*	*Not due*		**0.0%**	*Not due*						0	**2.0%**				Methodology: percentage of people aged 18 to 69 period in contact with mental health services in employment Latest data is for May 2019 Low performance is linked to a technical submission issue and is not reflective of practice. Work continues with NHS Digital to resolve the reported performance
	Mental Health	**% clients in settled accommodation (two months in arrears)**	Monthly	*results due to be published Sept 2019*	*Not due*	*Not due*		**37.0%**	*Not due*						0	**36.0%**				Methodology: percentage of people aged 18 to 69 in contact with mental health services in settled accommodation Latest data is for May 2019
CARING	All	**Written complaints - rate**	Quarterly	**66.7%**	**76.2%**	**56.0%**		**68.2%**	**70.2%**				**70.2%**	**68.5%**	0	**77.8%**	**50.0%**	**37.5%**		Methodology: count of written complaints/ count of total complaints
	Acute	**Mixed sex accommodation breaches (sleep breaches only)** *National methodology aligned to NHS England guidance*	Monthly	**0**	**0**	**0**		**0**	**0**				**0**	**0**	0	**0**	**0**	**0**		Methodology: The number of breaches of mixed-sex accommodation (MSA) sleeping accommodation
	All	**Staff Friends and Family Test % recommended - care**	Quarterly												0					
	Acute	**Inpatient scores from Friends & Family Test - % positive**	Monthly	**95.8%**	**96.1%**	**95.9%**									0	**88.1%**	**96.3%**	**100.0%**		Methodology: count of those categorised as extremely likely or likely to recommend/ count of all responders
	Community	**Community scores from Friends & Family Test - % positive**	Monthly	**98.3%**	**97.4%**	**96.5%**									0	-	**96.3%**	**97.0%**		Methodology: count of those categorised as extremely likely or likely to recommend/ count of all responders
	Mental Health	**Mental Health scores from Friends & Family Test - % positive**	Monthly	**97.1%**	**96.9%**	**94.0%**									0	**93.1%**	**100.0%**	**92.6%**		Methodology: count of those categorised as extremely likely or likely to recommend/ count of all responders

Identified Triggers	1

NB: The NHSI Single Oversight Framework has no specified target for the Quality of Care Monitoring Metrics

NHS Improvement Financial and Use of Resources Metrics (2019/20 M5)

Area	Weighting	Metric	Definition	Scoring				YTD Score/ weighted score		F/OT Score/ weighted score	
				1	2	3	4				
				Year to Date (YTD)		Forecast/ Outturn (F/OT)					
Financial sustainability	0.2	Capital servicing capacity	Degree to which provider's generated income covers its financial obligations	>=2.5x	1.75 - 2.5x	1.25 - 1.75x	<1.25x	2	0.4	2	0.4
				2.2		2.3					
	0.2	Liquidity (days)	Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown	>=0	(7) - 0	(14) - (7)	<(14)	1	0.2	1	0.2
				9.0		4.8					
Financial efficiency	0.2	Income and expenditure (I&E) margin	I&E surplus or deficit / total revenue	>=1%	0-1%	(1) - 0%	<=(1%)	2	0.4	2	0.4
				0.41%		0.77%					
Financial controls	0.2	Distance from financial plan	Year-to-date actual I&E margin (surplus/deficit) in comparison to year-to-date plan I&E margin (surplus/deficit) on a control basis	>=0%	(1)-0%	(2) - (1%)	<=(2)%	1	0.2	2	0.4
				0.00%		-0.20%					
	0.2	Agency spend	Distance from provider's cap	<=0%	0% - 25%	25 - 50%	>50%	2	0.4	2	0.4
				24.6%		15.0%					

	YTD		F/OT
FINANCE SCORE:	**2**		**2**

Comments:
Under the Single Oversight Framework (SOF), NHS Improvement use these financial metrics to assess financial performance by:
• scoring providers 1 (best) to 4 against each metric
• averaging individual providers' scores across all the metrics to derive a use of resources score for the provider.

Note: Where providers have a score of 4 or 3 in the 'financial and use of resources' theme, it will identify a potential support need, as will providers scoring a 4 (i.e. significant under performance) against any of the individual metrics. Providers in financial special measures will score a 4 on this theme.

TRUST BOARD | QUALITY AND ASSURANCE | FINANCE AND PERFORMANCE | STRATEGIC WORKFORCE ASSURANCE | EXCEPTION REPORTS

NHS Improvement Operational Performance

	NHSI Sector	Indicator	Target	NHSI Monitoring Frequency	Monthly Performance: Reporting Period (rolling three months) Jun-19	Jul-19	Aug-19	Sparkline YTD	Quarterly Performance: 2018/19 Q4	2019/20 Q1	Q2	Q3	Q4	Annual Performance: 2018/19 Year End Total	2019/20 Year to Date Total	Trigger (two consecutive monthly breaches)	Current month directorate performance: Adult Mental Health/ Learning Disabilities	Community Health	Families, Young People & Children	Comments
OPERATIONAL PERFORMANCE METRICS	Acute & Specialist	**Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway**	>=92%	Monthly	**94.9%**	**94.3%**	**92.4%**		**96.5%**	**96.8%**				**96.8%**	**95.5%**	0	**92.4%**			Methodology: count of the number of patients whose clock period is less than 18 weeks during the calendar months of the return/ count of number of patients whose clock has not stopped during the calendar months of the return
	Acute & Specialist	**Maximum 6-week wait for diagnostic procedures - patients on an incomplete pathway**	>=99%	Monthly	**100.0%**	**100.0%**	**100.0%**		**100.0%**	**100.0%**				**100.0%**	**100.0%**	0			**100.0%**	Methodology: proportion of patients referred for diagnostic tests who have been waiting for less than six weeks
	Mental Health	**People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral (SDCS and MHSDS) - patients on a completed pathway**	>=53%	Quarterly *(three month rolling)*	**66.7%**	**81.8%**	**81.3%**		**76.5%**	**83.3%**				**83.3%**	**82.6%**	0			**81.3%**	Methodology: percentage of people with a first episode of psychosis beginning treatment with a NICE-recommended care package within two weeks of referral
	Mental Health	**Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas:**																		
		a) Inpatient Wards	>=90%	Annually												0				Methodology: the number of patients in the defined audit sample who have both: - a completed assessment for each of the cardio-metabolic parameters with results documented in the patient's electronic care record held by the secondary care provider. - a record of interventions offered where indicated, for patients who are identified as at risk as per the red zone of the Lester Tool. a) Internal mental health provider sample submitted to national audit provider for the CQUIN b) Early intervention: Internal mental health provider sample submitted to the Royal College of Psychiatrists CCQI EIP Network c) Mental health: Internal mental health provider sample submitted to national audit provider for the CQUIN
		b) Early Intervention in Psychosis Services	>=90%	Annually												0				
		c) Community Mental Health Services (people on CPA)	>=65%	Annually												0				
	Mental Health	**Inappropriate adult mental health out of area placements (OAPs)**	0 by March 2020	Monthly	**482**	**727**	**1248**		**538**	**1364**				**3462**	**3339**	0				Methodology: Total number of bed days patients have spent out of area in period This measure should show a demonstrable reduction in total number of bed days patients have spent inappropriately out of area against rolling annual baseline, working towards elimination of inappropriate out of area placements by 2020/21
	Mental Health	**Data quality maturity index (DQMI) score (mental Health services only)**	>=95%	Quarterly	See DQMI exception report for details				*not yet available*							0				Methodology: MHSDS quarterly score in DQMI (ethnic category, general medical practice code (patient registration), NHS number, organisation code (code of commissioner), person stated gender code, postcode of usual address)

Identified Triggers	0

Leicestershire Partnership NHS Trust

NHS Improvement Organisational Health

	NHSI Sector	Indicator	NHSI Monitoring Frequency	Monthly Performance: Reporting Period (rolling three months) Jun-19	Jul-19	Aug-19	Current Year to Date Total	Quarterly Performance: 2018/19 Q4	2019/20 Q1	Q2	Q3	Q4	Annual Performance: 2018/19 Year End Total	2019/20 Year to Date Total	Trigger (two consecutive monthly breaches)	Current month directorate performance: Adult Mental Health/ Learning Disabilities	Community Health	Families, Young People & Children	Enabling Services	Comments
ORGANISATIONAL HEALTH	All	**Staff Sickness (month in arrears)**	Monthly	**4.7%**	**4.7%**			**4.3%**	**4.5%**				**4.9%**	**not due**	0	**5.3%**	**5.2%**	**4.7%**	**2.9%**	Methodology: number of days sickness reporting within the month/ number of days available within the month
	All	**Staff Turnover**	Monthly	**9.0%**	**8.7%**	**8.5%**			*not applicable to quarterly reporting*				**9.6%**		0	**8.9%**	**9.2%**	**8.0%**	**6.9%**	Methodology: number of leavers reported within the period / average of number of total employees at end of the month and total employees at end of the month for previous 12 month period
	All	**NHS Staff Survey** Key Finding 2. Staff satisfaction with the quality of work and care they are able to deliver	Annual	**3.69**					*not applicable to quarterly reporting*						0					2018 staff survey results Methodology: staff recommendation of the organisation as a place to work or receive treatment
	All	**Proportion of Temporary Staff**	Monthly	**12.7%**	**12.3%**	**12.2%**		**12.2%**	**12.7%**						0					Methodology: agency staff costs (as defined in measuring performance against the provider's cap) as a proportion of total staff costs. Calculated by dividing total agency spend over total pay bill.
	Acute	**CQC Inpatient/MH and Community Survey: Community**	Annual	**6.1**					*not applicable to quarterly reporting*						0					Survey results for 2018. Rating of Overall Experience out of 10.0, where 10.0 is the highest rating.
	Mental Health	**CQC Inpatient/MH and Community Survey: Mental Health**	Annual	**6.6**					*not applicable to quarterly reporting*						0					Survey results for 2018. Rating of Overall views of care and services out of 10.0, where 10.0 is the highest rating.

Identified Triggers	0

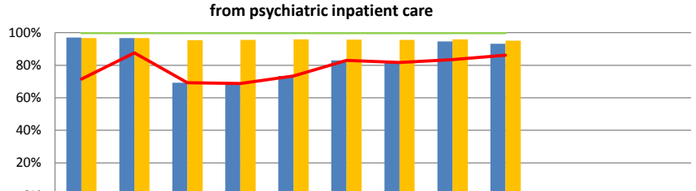
NB: The NHSI Single Oversight Framework has no specified target for the Quality of Care Monitoring Metrics.

Leicestershire Partnership NHS Trust

LPT Benchmarking Information

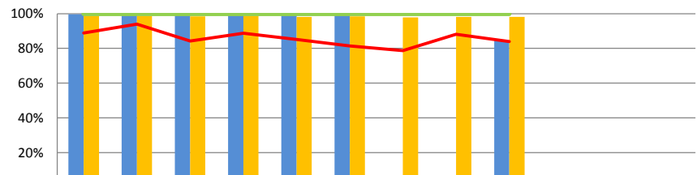
Description	Benchmarking comparisons are taken from NHS England's official statistics publications. Each graph show the Leicestershire Partnership NHS Trust performance against the highest and lowest performing trusts in that period **IMPORTANT**: National data conforms to strict data quality requirements and is a reflection of performance at specific points in time. For this reason, the nationally reported performance may differ slightly from the Trust's locally reported performance. The aim is to reduce these differences by improving timely and accurate data entry onto the Trust's clinical systems.

Proportion of patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care



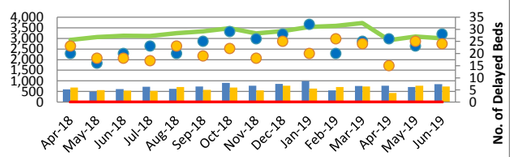
	2017/18 Q1	Q2	Q3	Q4	2018/19 Q1	Q2	Q3	Q4	2019/20 Q1	Q2	Q3	Q4
LPT	96.9%	96.7%	69.2%	68.8%	73.4%	83.0%	81.6%	94.6%	93.1%			
England	96.7%	96.7%	95.4%	95.5%	95.8%	95.7%	95.5%	95.8%	95.1%			
Highest	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			
Lowest	71.4%	87.5%	69.2%	68.8%	73.4%	83.0%	81.6%	83.5%	86.1%			

Proportion of admissions to acute wards that were gate kept by the CRHT teams



	2017/18 Q1	Q2	Q3	Q4	2018/19 Q1	Q2	Q3	Q4	2019/20 Q1	Q2	Q3	Q4
LPT	99.6%	99.2%	100.0%	99.5%	99.6%	100.0%	0.0%	0.0%	84.5%			
England	98.7%	98.6%	98.5%	98.7%	98.1%	98.4%	97.8%	98.1%	98.2%			
Highest	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			
Lowest	88.9%	94.0%	84.3%	88.7%	85.1%	81.4%	78.8%	88.2%	84.0%			

Delayed Transfer of Care (DToC)



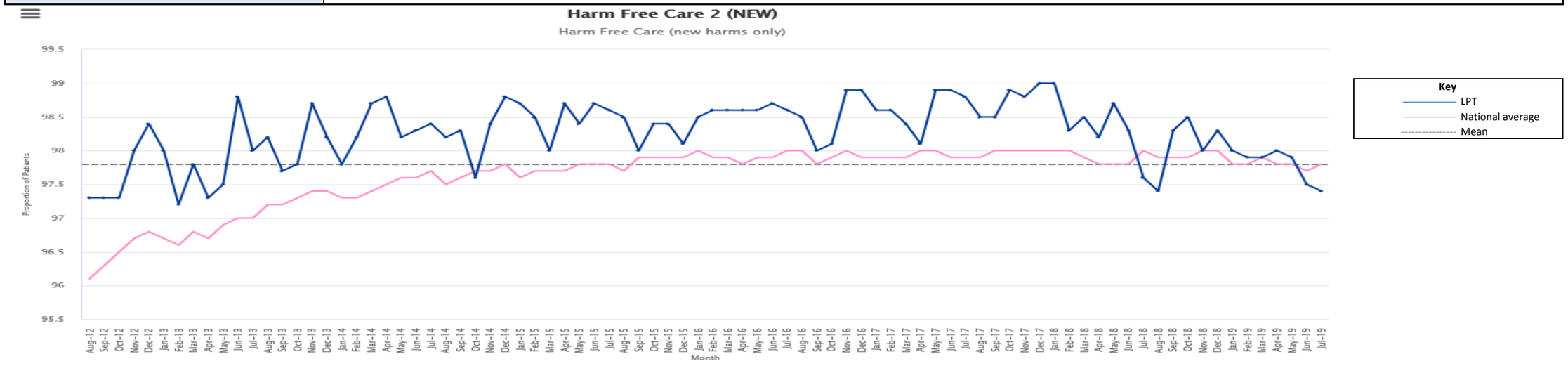
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
LPT Days Delayed	600	490	613	719	631	737	912	767	862	994	548	762	775	709	840
UHL Days Delayed	682	563	544	527	711	574	689	554	768	632	717	739	435	768	730
Highest Days Delayed	2927	3059	3130	3106	3244	3326	3480	3231	3345	3542	3588	3718	2915	3087	2996
Lowest Days Delayed	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
LPT DToC Beds	20	16	20	23	20	25	29	26	28	32	20	25	26	23	28
UHL DToC Beds	23	18	18	17	23	19	22	18	25	20	26	24	15	25	24

Comments:
Gatekeeping: The LPT national gatekeeping figures for 2017/18 Q2 reflects the inclusion of one elective patient; and 2017/18 Q2 reflects one excluded A&E patient. NHS Digital have advised they are not accepting amendments to national data for this financial year. The Trust is not reporting national gatekeeping data for 2018/19 Q3 and Q4

CPA 7 Day: As a result of data quality work undertaken in 2018/19 quarter one and quarter three, we are awaiting confirmation from NHS Digital to allow us to resubmit the national CPA seven day 2018/19 information, which will reflect in increased performance for the period

LPT Safety Thermometer

Description	The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing 'harm free' care. The data shown relates to prevelance of harm (VTEs, falls, pressure ulcers, UTIs), collected on a specific day; and is not directly comparable to the NRLS harm free rates, which is representative of all harms. Safety Thermometer data is not intended for benchmarking against other organisations.



Comments:

Trust Quality of Care

		Trust Performance														Current month directorate performance					
		Source	Reporting Frequency	Quality Indicator	Reporting Period (rolling three months) Jun-19	Jul-19	Aug-19	Sparkline YTD	2018/19 Q4	2019/20 Q1	Q2	Q3	Q4	Year to Date Position	Year End Target	Adult Mental Health/ Learning Disabilities	Community Health	Families, Young People & Children	Enabling Services	3rd party/ External	Comments
SAFE	Total incidents reported (including near misses) taken from Safeguard	TRUST	Monthly		1528	1758	1534		4316	4578				7870		566	698	143	12	115	
	- of which Total Serious Incidents (SIs)	COM	Monthly		14	17	1		14	30				48		1	0	0	0	0	
	STEIS - SI action plans implemented within timescales	COM	Monthly	=100%	100.0%	100.0%	90.9%		96.3%	100.0%				94.2%	=100%	100.0%	40.0%	100.0%			
	Total patient safety incidents reported (including near misses) (NRLS)	TRUST	Monthly		963	1150	955		2753	2768				4873		418	434	94	9		
	MRSA Bacteraemia cases - Community	COM	Monthly		0	0	0		0	0				0	0	0	0	0			
	Clostridium Difficile (C Diff) Occurrence	COM	Monthly	<=12 (per annum)	1	0	1		2	1				2	12	0	1	0			
	NHSE/ NHSI Patient Safety Alerts Outstanding	NHSI	Monthly	=0	0	0	0		0	0				0	0	0	0	0			
CARING	Total compliments received	TRUST	Monthly		105	123	99		243	298				520		34	57	7	1		
	Total complaints received	TRUST	Monthly		21	21	25		107	84				130		9	8	8	0		
	Complaints acknowledged within 3 working days	TRUST	Monthly	=100%	100.0%	100.0%	100.0%		100.0%	98.8%				99.2%	=100%	100.0%	100.0%	100.0%			
EFFECTIVE	Meeting commitment to serve new psychosis cases by early intervention teams: % newly diagnosed cases against commissioner contract	COM	Monthly	>=95%	109.1%	190.9%	136.4%		145.5%	136.4%				147.3%	>=95%			136.4%			
	Care Programme Approach (CPA) patients: % receiving follow-up contact within seven days of discharge (in arrears)																				
	- Only patients identified as being discharged on CPA	TRUST	Monthly	>=95%	94.7%	97.6%			96.8%	95.6%				96.0%	>=95%	97.0%	100.0%	-			
	- All patients discharged from a psychiatric inpatient unit *(national methodology aligned to Quality Account)*	TRUST	Monthly	>=95%	93.7%	91.3%			94.6%	93.1%				92.6%	>=95%	89.3%	100.0%	-			
	Care programme approach (CPA) patients: % having formal review within 12 months	TRUST	Monthly	>=95%	90.4%	91.9%	90.8%							90.8%	>=95%	91.7%	98.0%	71.4%			
	Access to Healthcare for All		Monthly	=4	4	4	4		4	4				4	4						

Comments and Actions:
The pressure ulcer indicator has been removed from the IQPR due to a change in National guidance from NHSE around ceasing to describe as Avoidable and Unavoidable. The Trusts intends to reinstate a pressure ulcer measure following recommendation at the Trust Patient Safety Improvement Group of a new indicator definition.

Incident Reporting: The approach taken by LPT in monitoring incident related KPIs is to encourage a reporting culture in line with the National Patient Safety Agency (NPSA) and the National Reporting and Learning System (NRLS) reports into incident reporting rates.

Total Serious Incidents (SIs): Previous months' figures have been updated and amended after a review to reflect accurate position.

STEIS - SI action plans implemented within timescales: Previous months' figures have been updated and amended after a review to reflect accurate position.

Total patient safety incidents reported (including near misses): Previous month's figures have been updated to reflect accurate position.

MRSA Bacteraemia - Community: Cases are not validated until 15th of each month following lock down on the national system MESS. This process could result in current month figures changing. Year end target of zero (0) is based on the Commissioner target.

Clostridium Difficile (C Diff) Occurrence: The trajectory for 2019-20 for Clostridium difficile is twelve (12). There has been one reported case for Clodtridium difficile at Ward 3, St Lukes Hospital during the month of August 2019.

Compliments: All figures received are subject to continual validation and any changes will be reported in the next IQPR.

Complaints: All figures received are subject to continual validation and any changes following data validation will be reported in the next IQPR.

Complaints Acknowledged within 3 working days: 1 acknowledgement letter did not meet the 3 working day target for April 2019. The complaint was for Community Services and was very complex with issues from 2013. Due to this the acknowledgement was also used to advise some of the issues were out of time to be investigated and the letter therefore took longer to compose due to needing to tailor the information.

Meeting commitment to serve new psychosis cases by early intervention teams - % newly diagnosed cases against commissioner contract: The small numbers involved in the denominator for the calculation of this indicator can equate to significant swings in performance month on month. The figures are refreshed each month to ensure an accurate position is monitored and accounts for data entry after IQPR production cut off. The service enters data by the 15th of the month therefore performance maybe underinflated due to the early deadline set for the IQPR. 136.4% for the month of August 2019 is the result of 15 newly diagnosed cases against the provisional monthly commissioner target of 11. The service is dependent on the number of referrals received and the appropriateness of the referral.

Care Programme Approach (CPA) patients: % receiving follow-up contact within seven days of discharge (All patients discharged from a psychiatric inpatient unit): The Trust has undertaken a deep dive data quality review on CPA 7 day data. The outcome is an improvement in 2018/19 Q1 performance in line with the Q2 performance of approximately 80%. We are awaiting confirmation from NHS Digital to resubmit this information nationally.

Care programme approach (CPA) patients: % having formal review within 12 months: Please refer to CPA 12 Month exception report for further details.

National CQUINS 2018-19

CQUIN No	Description	Services	Funding Available	Q1 Target	Current month	Q1	Q2	Q3	Q4	Comment on Red & Amber Ratings
1a	Introduction of health & wellbeing of NHS staff		£182,801						0.0%	
1b	Healthy food for NHS staff, visitors and patients		£182,801						100.0%	
1c	Improving the uptake of flu vaccinations for frontline clinical staff		£182,801						25.0%	
3a	Improving Physical healthcare - SMI		£438,722			100.0%			100.0%	
3b	Improving Physical healthcare collaboration with GPs		£109,680			100.0%	100.0%	100.0%	100.0%	
4	Improving services for people with MH at A&E		£346,359			100.0%	100.0%	100.0%	100.0%	
5	Transitions out of Children and Young People's MHS		£346,359			100.0%	27.5%		32.5%	Partial payments achieved for discharge readiness (12.5%) and post transition goal (15%). 0% achived for planning for transition
9 a-e	Preventing ill health by risky behaviours - Smoking & Alcohol		£548,402			30.0%	67.0%	75.0%	90.0%	Q1 - 30% partiel payment achieved Q2 - 67% achieved Q3 - Achieved 100% for 9a,b,c,d, and no payment for 9e
10	Improving the assessment of wounds		£346,359				100.0%		100.0%	
11	Personalised care and support planning		£346,359						100.0%	

Key: Blue = Forecast/unconfirmed; **Green** = Fully achieved; **Amber** = Partially achieved; **Red** = Not achieved

Commentary:
All payments for quarter 1 have been confirmed except for CQUINs 9a-e. Quarter 2 payments have been confirmed except for CQUINs 5 and 9a-e. Quarter 3 payments were confirmed except for CQUIN 9e.

Quarter 4 - Full payment was achieved for 6/10 CQUINs and partial payment for 3/10 CQUINS. The health and wellbeing of staff CQUIN (1a) was not achieved although there had been year on year improvement on all 3 indicators the comparison with 2016 did not meet the improvement thresholds.

National CCG CQUINS 2019-20

CQUIN No	Description	Min Threshold	Max Threshold		Q1	Q2	Q3	Q4	Commentary
CCG 2	Staff Flu Vaccinations	60%	80%				**50.0%**	**80.0%**	Forecast minimum threshold of 60%. By achieving the minimum threshold the payment will be £0
CCG 3a	Alcohol & Tobacco- Screening	40%	80%			**50.0%**	**80.0%**	**80.0%**	2019/20 Q1 requirements are to provide a position statement. New systems are in place to capture data and training is being provided.
CCG 3b	Tobacco Brief Advice	50%	90%			**50.0%**	**75.0%**	**90.0%**	
CCG 3c	Alcohol Brief Advice	50%	90%			**50.0%**	**75.0%**	**90.0%**	
CCG 4	72 Hour follow up post discharge	50%	80%				**71.0%**	**80.0%**	Not due to report until 2019/20 Q3. Early indications show LPT are meeting the minimum threshold.
CCG 7	Three high impact actions to prevent hospital falls	25%	80%			**30.0%**	**50.0%**	**80.0%**	2019/20 Q1 position statement required. Only applicable to community hospitals. Templates are being introduced to enable data capture.
CCG 9	Stroke 6 Months reviews	35%	55%		**55.0%**	**55.0%**	**55.0%**	**55.0%**	SSNAP is a new way of reporting in LPT. Service is embracing the new system and CQUIN; and are forecasting to achieve maximum thresholds.

NHSE CQUINS 2019-20

CQUIN No	Description	Min Threshold	Max Threshold		Q1	Q2	Q3	Q4	Commentary
PSS4	Health weight in adult secure MH services	N/A	N/A		**100.0%**	**100.0%**	**100.0%**	**100.0%**	The Phoenix Ward staff are establishing new programmes including physical activity and healthy eating to help inpatients to maintain a healthy weight. The level of staff involvement and engagement with the Clinical Reference Groups work streams support the likelihood of achieving the milestones for this NHSE CQUIN.
PSS5	Addressing CAMHS T4 staff training Needs	N/A	N/A		**100.0%**	**100.0%**	**100.0%**	**100.0%**	

Key: Blue = Forecast/unconfirmed; **Green** = Fully achieved; **Amber** = Partially achieved; **Red** = Not achieved

Commentary:
These forecasts are based on quality performance of the CQUINS, rather than achievement forecasts and payment calculations.

Leicestershire Partnership NHS Trust

Trust Operational Performance

	Trust Performance													Current month directorate performance		
	Source	Reporting Frequency	Monthly target	Reporting Period (rolling three months) Jun-19	Jul-19	Aug-19	Sparkline Feb 19 - Apr 19	2018/19 Q4	2019/20 Q1	Q2	Q3	Q4	Year to Date Position	Year End Target	Adult Mental Health/ Learning Disabilities	Community Health	Families, Young People & Children
Occupancy Rate - Mental Health Beds	TRUST	Monthly	<=85%	87.5%	89.5%	90.4%		83.4%	87.7%				88.6%	<=85%	92.8%	88.4%	71.7%
Occupancy Rate - Community	TRUST	Monthly	>=93%	88.0%	84.9%	84.7%		89.4%	87.8%				86.6%	>=93%		84.7%	
% Delayed Transfer of Care (DTOC)	DOH	Monthly	<=3.5%	5.3%	3.7%	4.6%		4.7%	4.8%				4.8%	<=3.5%	4.6%	7.2%	Reported only by exception
Patients admitted to inpatient services who are given access to Crisis Resolution/ Home Treatment teams in line with best practice standards - % patients gatekept *(national methodology aligned to Quality Account)*	TRUST	Monthly	>=95%	100.0%	100.0%	100.0%		*not available*	84.5%				91.3%	>=95%	100.0%		
Total number of Home Treatment episodes carried out by Crisis Resolution team year to date	COM	Monthly	>=145	233	288	233		743	737				1261	1740	233		

Comments and Actions:

Mental Health Bed Occupancy Rate: The Trust figure does not consider that certain services have different targets, e.g., MHSOP has a 90% target; Specialist Services represents Eating Disorders with a 80% target and EXCLUDES patients on leave; CAMHS INCLUDES patients on leave; Adult represents Adult Acute only and LD represents the Agnes Unit with a target of 95% for the four new Intensive Support beds but 85% otherwise. There are no service targets set therefore they are based on the Trust target of 85%. The RAG ratings are:
Green: Actual > Target AND Actual < Target + 5%; Amber: Actual >= Target + 5% AND Actual <= Target + 10% OR Actual <= Target AND Actual >= Target - 5%; Red: Actual > Target + 10% OR Actual < Target - 5%

% Delayed Patients (DToC) - Please see 'DETAILED EXCEPTION REPORT - % Delayed Transfer of Care (DToC)' for detailed commentary.

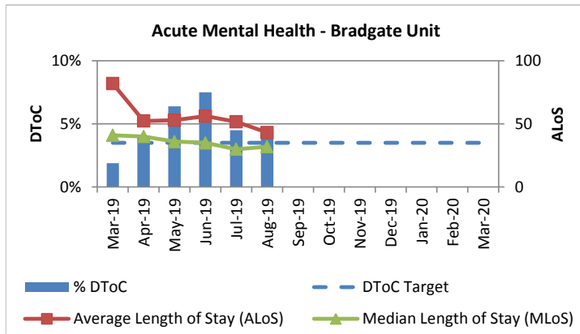
Patients admitted to inpatient services who are given access to Crisis Resolution/ Home Treatment teams in line with best practice standards: This item is no longer subject to significant data quality concerns and national report has recommenced from 1st April 2019.

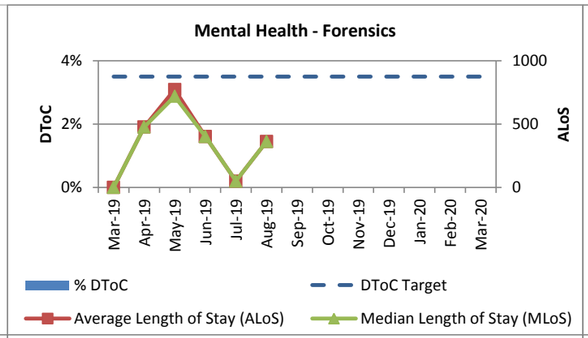
Total number of Home Treatment episodes carried out by Crisis Resolution team year to date: Year to date performance is currently 173.9% which equates to 1261 episodes against a pro-rata target of 725.

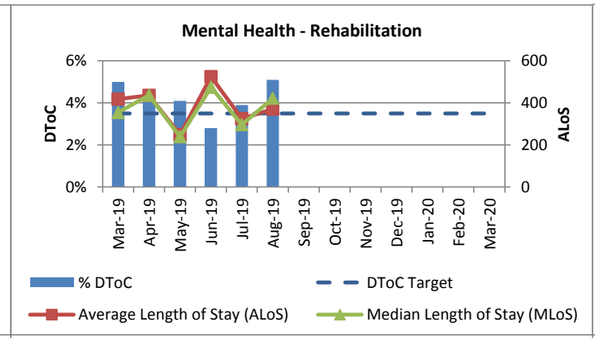
Leicestershire Partnership NHS
NHS Trust

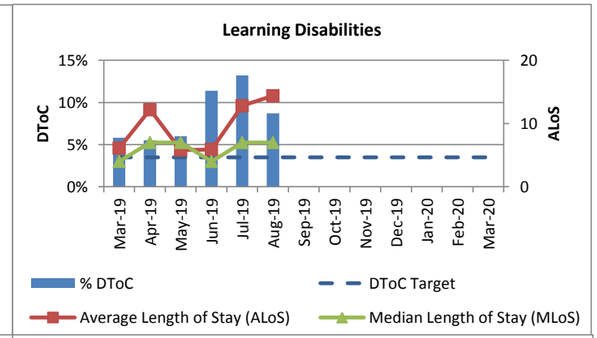
Trust Inpatient Performance

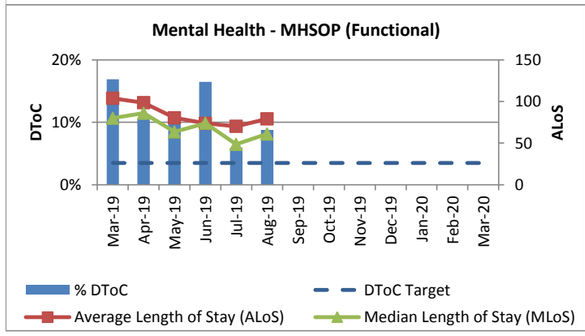
The Better Care Fund (BCF) planning guidance requires cross system organisations to work together to achieve the local, agreed ambition for delayed transfer of care (DToC) to not equate to more than 3.5% of hospital beds. DToC rates are aligned to national Unify submissions.

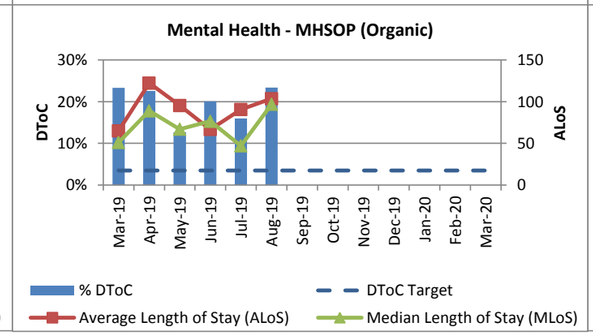


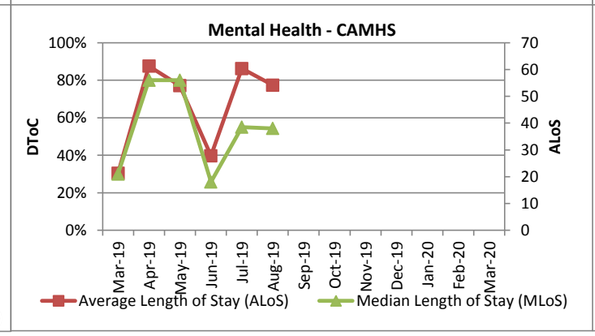


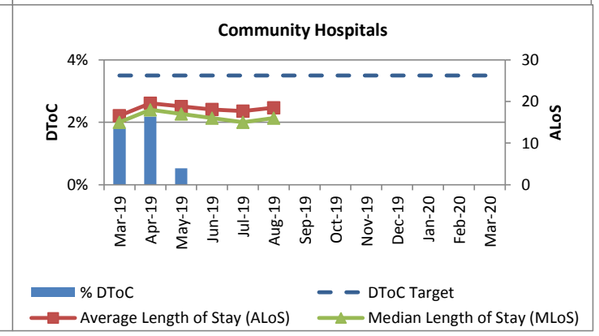












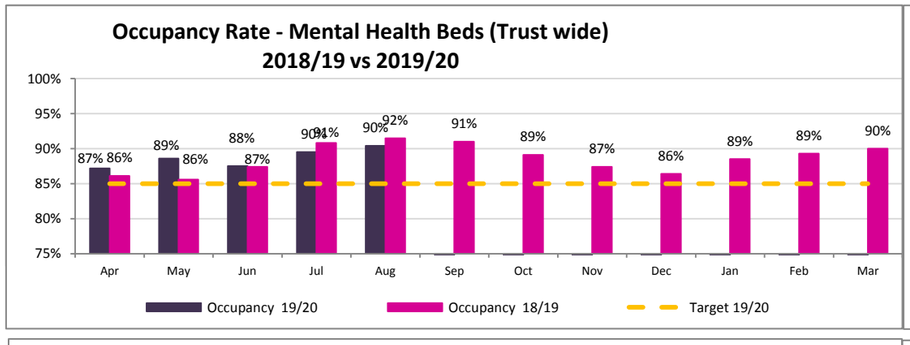
Comments and Actions

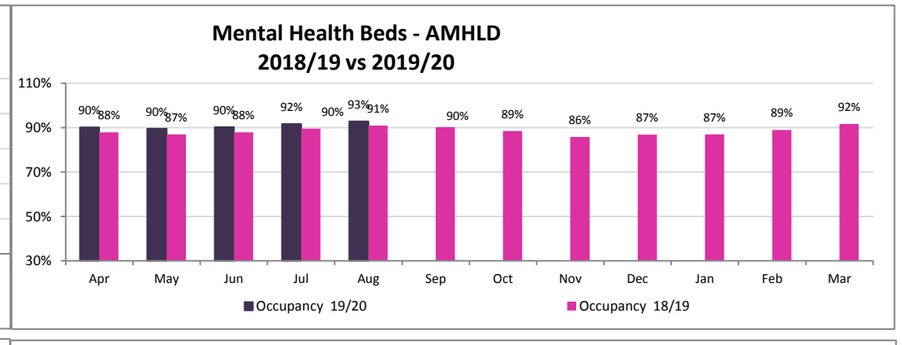
Delayed Transfer of Care (DToC)
The calculation methodology for DToC is*:
Numerator: the number of non-acute patients (aged 18 and over on admission) per day under consultant and non-consultant-led care whose transfer of care was delayed. For example, one patient delayed for five days counts as five.
Denominator: the total number of occupied bed days (consultant-led and non-consultant-led).
Delayed transfers of care attributable to social are included.

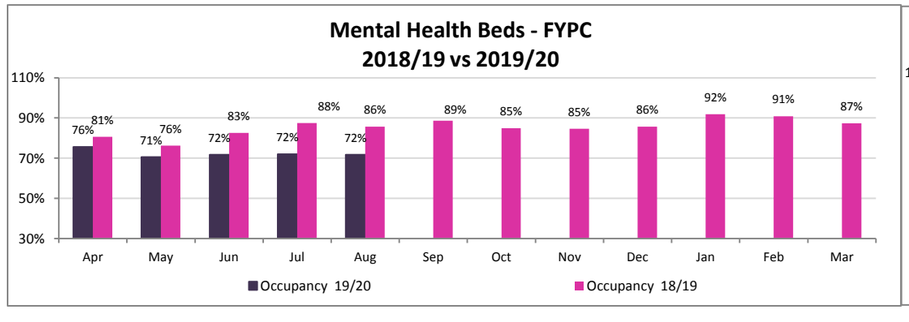
Actions to improve DToC across the Leicester, Leicestershire and Rutland system include:
- implementing an integrated discharge team and trusted assessor model which will be extended to community hospitals and mental health wards during 2017/18 following a pilot at the acute trust;
- improvements in pathways into community hospitals - for which an audit of step down beds will be used for clinical engagement;
- improvements to patient/ family choice policies and information across hospital sites, this includes clear policies around 'choice' with an agreed training and communications plan.

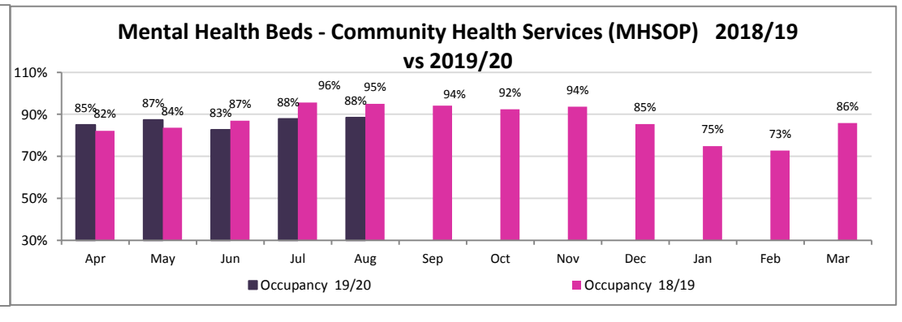
Length of Stay (LoS)
The length of stay displayed is the national operating framework definition, which takes data from Hospital Episode Statistics (HES) and includes ALL services and lengths. LoS is measured from admission to discharge, therefore a ward with no discharges in the period will not have a LoS calculated. All previous month's figures are updated each month to allow for late entry of data.
IMPORTANT: There are no patients excluded from this calculation and this KPI is not comparable with the LoS CQUIN or national benchmarking which is calculated using different exclusion parameters.

Mental Health Bed Occupancy Rate (%)









Responsible Lead: Directors of Services
Indicator Source: COM/DOH Operating Framework

Comments and Actions:

CAMHS (FYPC) - On leave beds counted as admitted

LD - On leave beds counted as admitted
This may result in occupancy rates above 100%

Trust Human Resources - Workforce Performance

		Trust Performance													Current month directorate performance				
					Reporting Period (rolling three months)				2019/20										
		Source	Reporting Frequency	Monthly target	Jun-19	Jul-19	Aug-19	Sparkline Feb 19-Apr 19	Q1	Q2	Q3	Q4	Year to Date Position	Year End Target	Adult Mental Health/ Learning Disabilities	Community Health	Enabling Services	Families, Young People & Children	Hosted Services
Workforce Profile	Number of WTE Employed	TRUST	Monthly		4638.03	4652.71	4642.35		4638.03						1156.6	1726.5	472.1	1063.9	223.2
	Substantive Staff Headcount	TRUST	Monthly		5331	5352	5338		5331						1290	2003	522	1289	234
	Bank Only Headcount	TRUST	Monthly		1047	1007	1009		1047										
	% Vacancy Rate	TRUST	Monthly	G: <=7% R: >10%	8.1%	8.6%	8.9%		8.1%					G: <=7% R: >10%	13.5%	8.9%	7.7%	5.4%	0%
	% Staff From a BME Background	TRUST	Quarterly	>=20%	22.1%	22.1%	22.3%		22.1%					>=20%					
	% of Males Employed	TRUST	Quarterly		17.0%	17.0%	17.1%		17.0%										
	% Staff Aged 16-29 Years	TRUST	Quarterly	>=12%	12.5%	12.5%	12.5%		12.5%					>=12%					
Sickness Absence (one month in arrears)	% of Sickness Absence (1 month in arrears)	TRUST	Monthly	G: <=4.5% R: >=4.75%	4.7%	4.7%			4.5%					G: <=4.5% R: >=4.75%	5.3%	5.2%	2.9%	4.7%	1.2%
	WTE Days Lost to Sickness (1 month in arrears)	TRUST	Monthly		6589	6720			19072				25791		1883	2787	421	1547	81
	% Short Term Sickness (1 month in arrears)	TRUST	Monthly		1.9%	1.8%			1.9%						1.7%	2.2%	1.1%	1.8%	0.7%
	% Long Term Sickness (1 month in arrears)	TRUST	Monthly		2.8%	2.9%			2.8%						3.6%	3.0%	1.8%	2.9%	0.5%
	Cost of Sickness (£) (1 month in arrears)	TRUST	Monthly		£ 582,080	£ 587,536			£ 1,689,689				£ 2,277,225		£162,165	£233,065	£37,573	£141,144	£13,589
Turnover	% Normalised Workforce Turnover (Rolling previous 12 months)	TRUST	Monthly	G: <=10% R: >12%	9.0%	8.7%	8.5%		9.0%					G: <=10% R: >12%	8.9%	9.2%	6.9%	8.0%	6.6%
	% Total Workforce Turnover (Rolling previous 12 months)	TRUST	Monthly	G: <=10% R: >12%	9.3%	9.2%	9.0%		9.3%					G: <=10% R: >12%	8.9%	10.3%	7.2%	8.0%	7.9%
	Executive Team Turnover	TRUST	Monthly		13.2%	26.4%	26.4%		13.2%										
	Starters minus Leavers (headcount)	TRUST	Monthly		-8	26	20		14				89		-2	1	22	-2	1
	Stability Index No. of employees with one or more years' service now/ No. of employees employed one year ago x 100	TRUST	Monthly	G: >90% R: <85%	91.3%	90.7%	91.3%		90.7%					G: >90% R: <85%	94.0%	89.1%	94.8%	90.5%	96.1%
Temporary Staffing	Bank Costs	TRUST	Monthly		£ 1,319,753	£ 1,319,959	£ 1,322,613		£ 3,813,641				£ 6,456,213						
	Agency Costs (NHSI National 2017/18 Target)	TRUST	Monthly	<=£7.7m (p/a)	£ 918,204	£ 876,966	£ 813,941		£ 2,523,307				£ 4,214,214	<=£7.7m					
	Agency Costs (LPT Internal Target)	TRUST	Monthly	<=£9.5m	£ 918,204	£ 876,966	£ 813,941		£ 2,523,307				£ 4,214,214	<=£9m					
	Temporary Staffing Spend as a % of Total Paybill (Inc. bank, agency and additional hours worked)	TRUST	Monthly		12.7%	12.3%	12.2%		12.7%										
	No of Off Framework Agency Usages	TRUST	Monthly		179	236	305		414				955						
	No of Breaches to Agency Price Cap	TRUST	Monthly		546	553	683		1531				2767						
	Agency volume (number of shifts filled by agency)	TRUST	Monthly		2746	2761	2963		7707				13431						
	Roster approval period (weeks)	TRUST	Monthly	G: >6	5.26	5.80	5.50		5.20										
	% Split of Substantive to Bank to Agency Staff (Nurses band 2-6, inpatient areas only, taken from Safer Staffing portal)	TRUST	Monthly		66.8%, 29.6%, 3.6%	66.1%, 28.7%, 5.2%	65.9%, 29.4%, 4.8%												
	% Split of Qualified to Unqualified Staff (Nurses band 2-6, inpatient areas only, taken from Safer Staffing portal)	TRUST	Monthly		36.9%, 63.1%	36.7%, 63.3%	36.4%, 63.6%												
Organisational Change	Number of Staff Made Redundant	TRUST	Monthly		0	1	0		0				0		0	0	0	0	0
	Number of Staff on Pay Protection	TRUST	Monthly		30	28	29		28				29		9	12	4	4	0
Employee Relations	Number of open formal grievances	TRUST	Monthly		1	2	1		1						1	0	0	0	0
	Number of open bullying and harassment cases	TRUST	Monthly		2	2	3		1						0	2	0	1	0
	Number of open formal disciplinary cases	TRUST	Monthly		6	9	8		7						4	4	0	0	0
	Number of open employment tribunals	TRUST	Monthly		1	2	2		1						0	1	0	1	0
	Concerns raised to an external organisation	TRUST	Monthly		1	0	0		2				2		n/a	n/a	n/a	n/a	n/a
	Concerns raised in house	TRUST	Monthly		5	13	0		16				29		n/a	n/a	n/a	n/a	n/a
Employee Engagement	% Staff recommend LPT as a place to work	TRUST	Quarterly	G: >=57%	N/A	N/A	N/A		N/A					G: >=57%					
	% Staff happy with standard of care provided	TRUST	Quarterly	G: >=67%	N/A	N/A	N/A		N/A					G: >=67%					
	Pulse and Staff Survey Response Rate	TRUST	Quarterly	G: >=50%	N/A	N/A	N/A		N/A					G: >=50%					
Learning and Development Overview	% of Consultants with a completed annual appraisal	TRUST	Monthly	G: >=90% R: <75%	96.0%	97.0%	96.0%		96.3%					G: >=90% R: <75%	97%	100%		94%	
	% of Staff with a Completed Annual Appraisal	TRUST	Monthly	>=80% R: <75%	91.7%	92.9%	93.4%		92.0%					>=80% R: <75%	93.2%	93.9%	92.8%	93.1%	92.7%
	% All Mandatory Training Compliance for substantive staff	TRUST	Monthly	G: >=85% R: <75%	92.8%	92.8%	92.1%		92.8%					G: >=85% R: <75%	89.8%	92.5%	91.7%	94.1%	91.6%
	% All Mandatory Training Compliance for bank-only nursing staff	TRUST	Monthly	G: >=75% R: <65%	81.8%	83.0%	86.6%		81.0%					G: >=75% R: <65%					
	% of new starters who attended Trust Induction on their first day (excluding bank staff)	TRUST	Monthly	G: >=85% R: <75%	100.0%	100.0%	100.0%		100.0%					G: >=85% R: <75%					
	% of staff who have undertaken clinical supervision within the last 3 months	TRUST	Monthly		81.3%	81.5%	80.0%		80.7%						77.7%	81.6%	63.2%	80.1%	100.0%
Learning and Development (Detail for Substantive Staff)	% Core Mandatory Training Compliance	TRUST	Monthly	G: >=85% R: <75%	95.4%	95.1%	95.1%		95.4%					G: >=85% R: <75%	93.7%	96.2%	93.9%	96.2%	91.5%
	% Fire Safety training compliance	TRUST	Monthly	G: >=85% R: <75%	88.1%	88.8%	88.8%		88.9%					G: >=85% R: <75%	85.5%	89.8%	88.7%	91.4%	84.6%
	% of Information Governance training compliance	TRUST	Monthly	G: >=95% R: <75%	90.6%	90.8%	91.2%		90.9%					G: >=95% R: <75%	87.6%	92.5%	88.7%	93.0%	94.9%
	% Clinical Mandatory training compliance	TRUST	Monthly	G: >=85% R: <75%	92.9%	92.6%	92.1%		92.8%					G: >=85% R: <75%	89.1%	94.1%	74.8%	92.8%	100.0%
	% Mental Health Act training compliance	TRUST	Monthly	G: >=85% R: <75%	82.4%	82.0%	82.3%		80.9%					G: >=85% R: <75%	81.7%	86.8%	36.4%	83.2%	-
Declaration of Protected Characteristics	Declared Disability	TRUST	Monthly	G: >=85% R: <75%	78.6%	78.2%	76.9%		78.4%					G: >=85% R: <75%					
	Declared Sexual Orientation	TRUST	Monthly	G: >=85% R: <75%	80.4%	80.6%	80.8%		80.4%					G: >=85% R: <75%					
	Declared Religious Belief	TRUST	Monthly	G: >=85% R: <75%	79.3%	79.3%	79.4%		79.2%					G: >=85% R: <75%					

Comments and Actions:

*** Year to Date position: Indicators in arrears show year to date for 2018/19**

% Sickness Absence - see exception report

Agency Usage - see exception report

Leicestershire Partnership NHS Trust

DETAILED EXCEPTION REPORT - Clostridium Difficile (C Diff) Cases

Responsible Director	Anne Scott
Responsible Committee	QAC

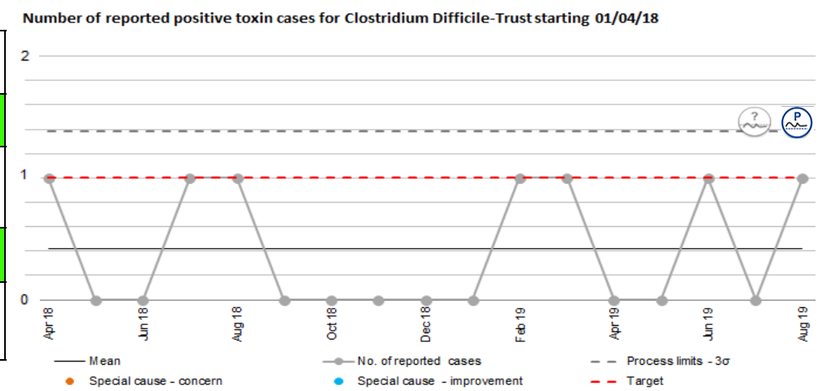
Responsible Services	All
KPI Reference ID	MSP.02

Risk Reference	
Risk Owner	

Risk Description:

Calculation Method	Count of the number of reported positive toxin cases for Clostridium Difficile each month

Clostridium Difficile (C Diff) Cases	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
2018/19	1	0	0	1	1	0	0	0	0	0	1	1	**5**
Wards	EC - Beechwood Ward	-	-	EC - Clarendon Ward	CV - Snibston Ward	-	-	-	-	-	BC - Langley Ward	H&B - North Ward	
2019/20	0	0	1	0	1								**2**
Wards	-	-	EC - Beechwood Ward	-	SL - Ward 3								



Key: CV - Coalville Hospital
FP - Feilding Palmer Hospital
H&B - Hinckley and Bosworth Hospital
SL - St Luke's Community Hospital
EC - Evington Centre
LGH - Loughborough General Hospital
MMH - Melton Mowbray Hospital
BC - Bennion Centre

Comments and Actions:

The trajectory for 2019-20 for Clostridium Difficile is twelve (12).

There has been one reported case for Clostridium difficile at St Lukes Hospital - Ward 3 during the month of August 2019.

The total Clostridium Difficile cases for this year is two (2).

Based on the SPC chart, we can see there is no significant change to the number of reported cases since April 2018; and we will consistently meet our trajectory.

Leicestershire Partnership NHS Trust

DETAILED EXCEPTION REPORT - CPA 7 Day Follow-up

Responsible Director	Helen Thompson, Rachel Bilsborough
Responsible Committee	QAC

Responsible Services	AMH, CHS
KPI Reference ID	

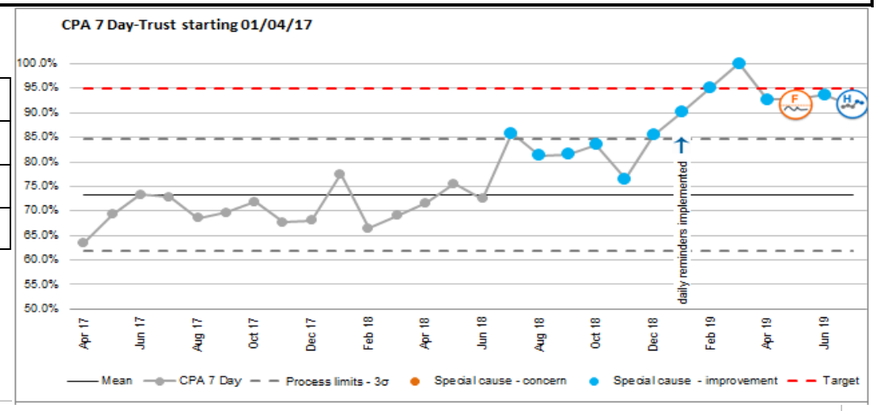
Risk Reference	
Risk Owner	

Risk Description:

Calculation Method	**Numerator:** The number of people under adult mental illness specialties who were followed up (either by face to face contact or by phone discussion) within 7 days of discharge from psychiatric in-patient care during the period **Denominator:** The total number of people under adult mental illness specialties discharged from psychiatric in-patient care during the period

Performance (%)	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20
Adult Mental Health Services	100.0%	91.0%	91.8%	91.5%	89.3%							
Community Health Services	100.0%	100.0%	100.0%	100.0%	100.0%							
Trust Total	100.0%	92.7%	92.8%	93.7%	91.3%							

CPA 7 Day is reported one month in arrears



Comments and Actions:

To improve performance against the CPA seven day standard, the Adult Mental Health and Learning Disabilities directorate (AMH .LD) have redesigned the monitoring process for CPA seven day with an aim to undertake the CPA seven day follow -ups within 48 hours. Daily individualised proactive reports and reminders will be provided to wards to undertake reviews; and missed reviews will be escalated to the service manager. We ekly performance reports will be reviewed by the business team with escalations made to the business manager for relevant actio n.

Based on the SPC chart, we can see there is special cause improvement of CPA 7 Day rates since July 2018; however we will consistently fail our target of >=95% unless further improvements are made.

Leicestershire Partnership NHS Trust

DETAILED EXCEPTION REPORT - CPA 12 Month Review

Responsible Director	Helen Thompson, Rachel Bilsborough
Responsible Committee	QAC

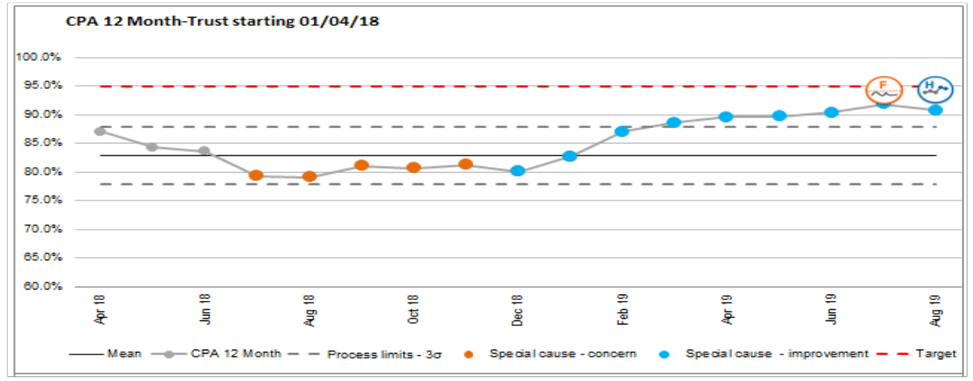
Responsible Services	AMH, CHS
KPI Reference ID	

Risk Reference	
Risk Owner	

Risk Description:

Calculation Method	**Numerator:** The number of patients on CPA (who have been on CPA for 12 months) **and** who have had a CPA review within the last 12 months **and** whose record has been authorised by a responsible clinical officer **Denominator:** The number of patients on CPA (who have been on CPA for 12 months)

Performance (%)	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Adult Mental Health Services	88.1%	89.5%	89.6%	90.8%	91.9%	91.7%							
Community Health Services	96.4%	93.7%	96.3%	95.2%	100.0%	98.0%							
Trust Total	88.7%	89.6%	89.7%	90.4%	91.9%	90.8%							



Comments and Actions:

All care plans entered against a patient record must be authorised by a responsible clinical officer in order to count as a positive contact.

To improve performance against the CPA 12 month standard, the AMH.LD directorate have produced an action plan with an aim to increase operational team focus on out of date CPA 12 month reviews, with targeted support by the directorate business team. Individualised performance information is directed to care co-ordinators, detailing their out of date reviews and those that are upcoming within the next three months. Self-service performance reports are also available to support the management of CPA 12 month performance.
As anticipated, performance has improved in February 2019 where these actions have been implemented.

Based on the SPC chart, we can see there is special cause improvement of CPA 12 month rates since December 2018; however we will consistently fail our target of >=95% unless further improvements are made.

Leicestershire Partnership NHS Trust

DETAILED EXCEPTION REPORT - % Delayed Transfer of Care (DToC)

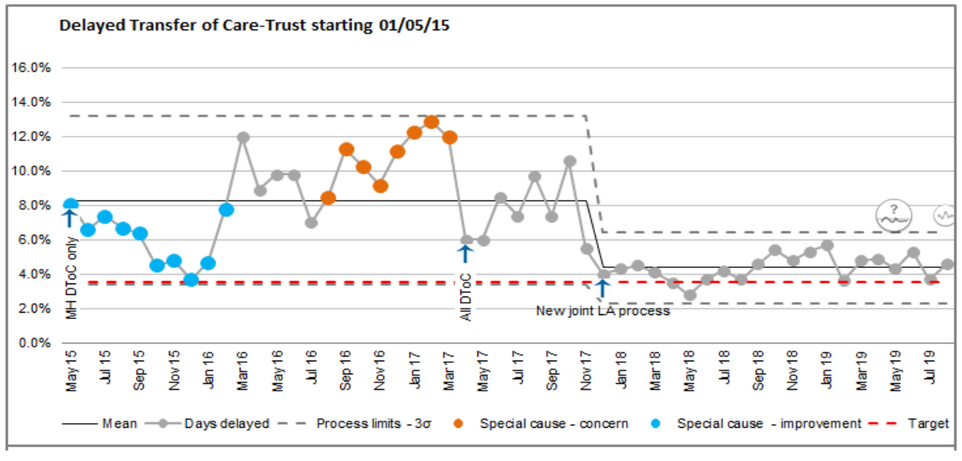
Responsible Director	Rachel Bilsborough, Helen Thompson
Responsible Committee	FPC

Responsible Services	AMH
KPI Reference ID	QEFS.06

Risk Reference	2403	**Risk Description:** Delayed Transfer of Care (DToC) is high in most of the inpatient areas in LPT reducing the bed flow within LPT and in the LLR system
Risk Owner	Sue Elcock	

Calculation Method	**Numerator:** the number of non-acute patients (aged 18 and over on admission) per day under consultant and non-consultant-led care whose transfer of care was delayed. For example, one patient delayed for five days counts as five. **Denominator:** the total number of occupied bed days (consultant-led and non-consultant-led). *Delayed transfers of care attributable to social are included.* *Delays are aligned to National Unify reporting.*

DTOC (%)	Target	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Acute Mental Health - Bradgate Unit	<=3.5%	1.9%	4.1%	6.4%	7.5%	4.5%	4.5%							
Mental Health - Forensics	<=3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%							
Mental Health - Rehabilitation	<=3.5%	5.0%	4.1%	4.1%	2.8%	3.9%	5.1%							
Learning Disabilities	<=3.5%	5.8%	5.5%	6.0%	11.4%	13.2%	8.7%							
Mental Health - MHSOP (Functional)	<=3.5%	16.9%	10.5%	10.3%	16.5%	5.9%	8.8%							
Mental Health - MHSOP (Organic)	<=3.5%	23.3%	22.6%	12.7%	20.1%	16.0%	23.4%							
Community Hospitals	<=3.5%	1.8%	2.2%	0.5%	0.0%	0.0%	0.0%							
TRUST TOTAL	<=3.5%	4.8%	4.9%	4.3%	5.3%	3.7%	4.6%							



LLR System DTOC figures are reported nationally in arrears, they are shown below for illustrative purposes														
		Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
LLR SYSTEM TOTAL *(inc UHL, out of area patients etc.)*	<=3.5%	3.1%	2.1%	2.6%	2.9%									

Comments and Actions:

% DToC - Mental Health: Patients delayed during discharge for the month of August 2019 are the result of the following top four categories: Housing (19.3%), Joint (14.5%), Other (11.2%), Social Services (11.2%) and all other reasons (43.5%).

% DToC - Community: Delays for community hospital patients during the month of August 2019: There were 0 days delayed.

A clinical discharge meeting is chaired by the Clinical Director and covers all wards in mental health and forensic inpatient areas. The meeting is attended by all relevant multi agency partners to focus on manging DToCs as well as potential / emerging DToCs in the system. Similar arrangements are also in place in MHSOP, rehabilitation and learning disability services. DToCs in learning disability services are escalated to the Transforming Care Board; and complex clinical decisions are escalated to a clinical cabinet for resolution. Multi-agency issues that cannot be addressed by the group are escalated to the multi-agency DToC meeting chaired by the Medical Director and attended by the director/ senior management representation from all partner organisations.

A multi agency action plan is in progress to improve the DToC position (an update on actions since January 2018):
- The redesign of discharge pathway 2 (home with new support) and pathway 3 (complex transfers – unable to go straight home) led by Home First is due to take place. This will include agreeing and implementing an LLR-wide model for Discharge to Assess and reablement.
- The development of a trusted assessment between multi agency staff.
- Bring the Housing Enablement Team into the integrated discharge team (IDT) and increase in resources to support IDT presence at the front door.
- Review the discharge hub environment usage to ensure multi agencies can work together to pursue complex discharges.
- Explore opportunities for all adult social care staff facilitating discharges to have access to NHS systems to share information about patient needs.
- Combining the IDT with Red2Green to allow a wider resource to be focused on similar issues and responses.
- A review of the effectiveness of the continuing healthcare end to end process implemented within Community and Community Hospitals
- A phased implementation of the continuing healthcare end to end process for UHL with an assessor for MLCSU commencing in March 2018 to support the Complex Discharge Team

Based on the SPC chart, we can see there is no significant change in the rate of DToCs since December 2017; and we will inconsistently meet our Trust target of <=3.5%.

Risk Associated Actions:

- Implementation of Red Green approach in mental health to improve the inpatient pathway leading to timely identification of patients needs and addressing the needs
- Consistent approach to managing patient choice through development and implementation of a guidance appropriate to community hospitals and mental health
- Improve the engagement of nursing homes with trusted assessment to reduce the delays
- Operationalise move on housing for DToC from Bradgate unit and ensure robust process in place for maintaining the flow
- Improve the process for speedy resolution of AHP placements working with CCG
- Improving the process of CHC funding working with CCG and social care for Community Hospital patients
- Ensuring the sustainability of Red to Green approach across all areas within the community hospitals in a sustainable manner

Leicestershire Partnership NHS Trust

DETAILED EXCEPTION REPORT - National Access Standards

Responsible Director	Helen Thompson
Responsible Committee	FPC

Responsible Services	AMHLD/ FYPC
KPI Reference ID	18wkRTT; DM01

Risk Reference	n/a	**Risk Description:**
Risk Owner	n/a	

Description	NHS Improvement (NHSI) monitors the Trust against three access standards: % of service users on incomplete referral to treatment (RTT) pathways (yet to start treatment) waiting no more than 18 weeks from referral (92%) % of service users on incomplete referral to diagnostic pathways (yet to start treatment) waiting no more than six weeks from referral (99%) zero tolerance RTT waits over 52 weeks for incomplete pathways (0%) *Targets are taken from the NHSI Single Oversight Framework (SOF) 2017* *Referrals waiting and compliance are taken from the national monthly returns (18wkRTT and DM01) and may be reported in arrears due to the timings of national reports* *Reason for breaches are taken form service patient tracking list (PTL) meetings*

18 Week Referral to Treatment (Asperger's and ADHD Services)

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
STF RTT Trajectory - max no. of referrals breaching in month	6	6	6	9	9	6	6	6	9	9	6	6	6	6	6	9	9	6	6	6	9	9	6	6
Referrals waiting over 18 weeks	0	11	8	9	1	2	1	7	30	31	16	8	0	11	26	0	36	0	0	0	0	0	0	0
- of which patient choice	*4*	*11*	*8*	*9*	*1*	*2*	*1*	*7*	*30*	*31*	*16*	*8*	*11*	*11*	*26*	*0*	*14*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
- of which Trust delays	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*22*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Incomplete waiting time compliance (%)	98.3%	96.7%	97.6%	97.4%	99.7%	99.4%	99.7%	98.5%	94.1%	94.0%	97.0%	98.5%	98.0%	97.7%	94.9%	94.3%	92.4%							

Key: Forecast figures (may change)

6 Week Referral to Diagnostic Test (Children's Audiology Service)

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
STF RTT Trajectory - no. of referrals breaching in month	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
Referrals waiting over 6 weeks	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
- of which patient choice	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
- of which Trust delays	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Incomplete waiting time compliance (%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							

Zero tolerance RTT waits over 52 weeks for incomplete pathways (0%)

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
No. of RTT referrals over 52 weeks	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0							

Comments and Actions:
The RTT services participate in regular patient tracking list (PTL) meetings to manage patient access. This process allows the service to predict potential and known breaches as shown in the pink trajectory section of the table. Patient choice allows patients the right to defer their treatment to a date to suit them, which may breach the 18/ 6 week target and these instances are recorded in the trajectory table.

In some cases, a patient who has requested an appointment 18/ 6+ weeks in the future may show as a breach in the trajectory table; however if they do not attend (DNA) or cancel multiple appointments, the clinician may use professional clinical judgement to cancel the referral and refer the patient back to their GP. In this case, the patient will be removed from the waiting list and will not be identified as an 18/ 6 week breach in line with national guidelines. However, if the decision to remove the referral from the waiting list is after the breach date, the referral breach may still be reported nationally. These scenarios are managed by the service PTL on a case by case basis.

Leicestershire Partnership NHS Trust

DETAILED EXCEPTION REPORT - Data Quality Maturity Index (DQMI)

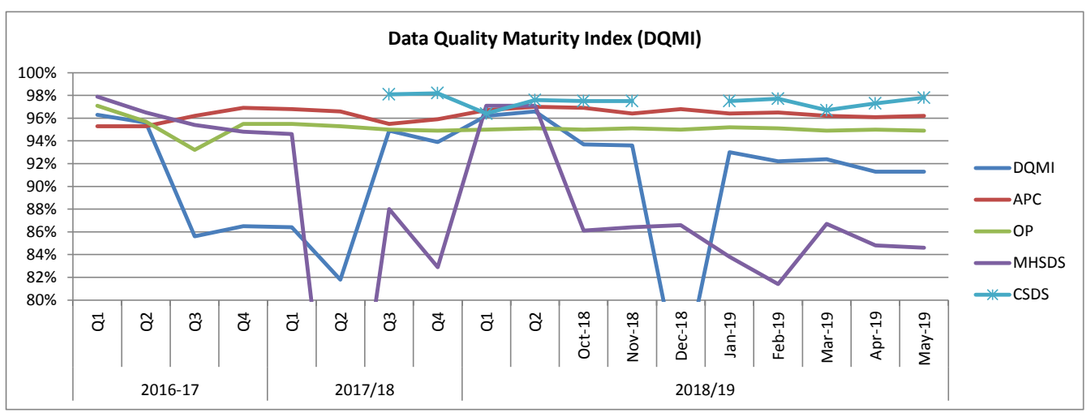
Responsible Director	Dani Cecchini
Responsible Committee	FPC

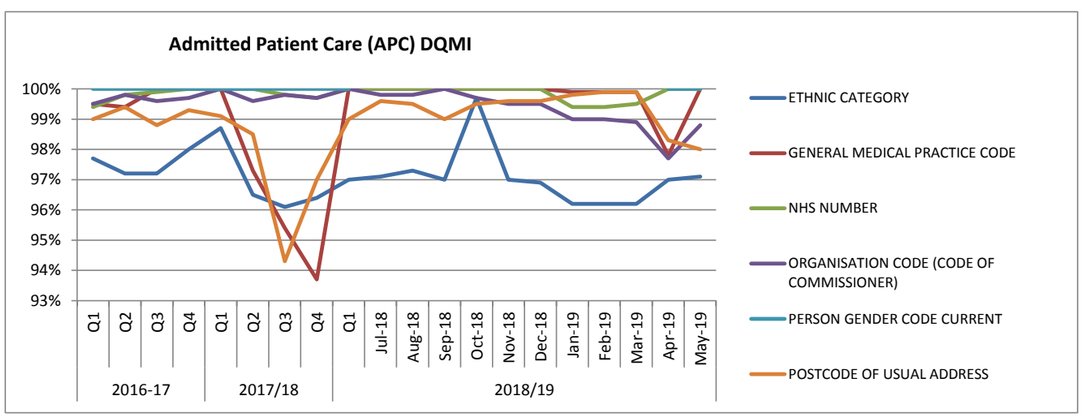
Responsible Services	AMH, CHS, FYPC
KPI Reference ID	

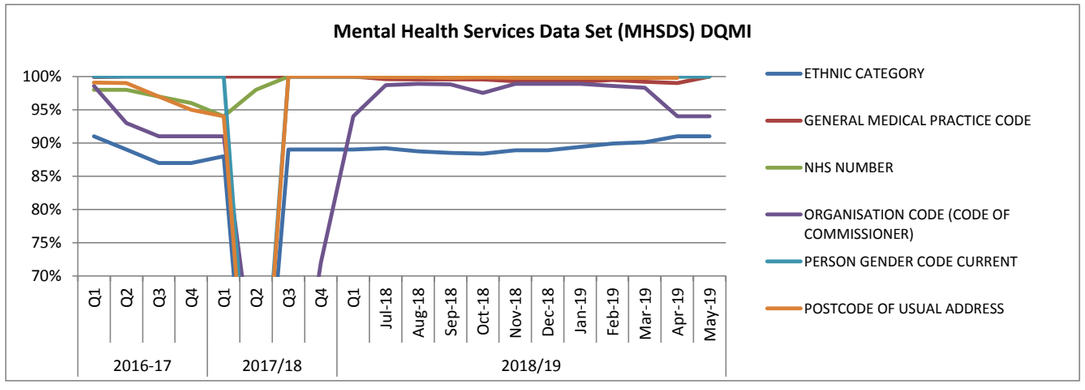
Risk Reference	1119
Risk Owner	Dani Cecchini

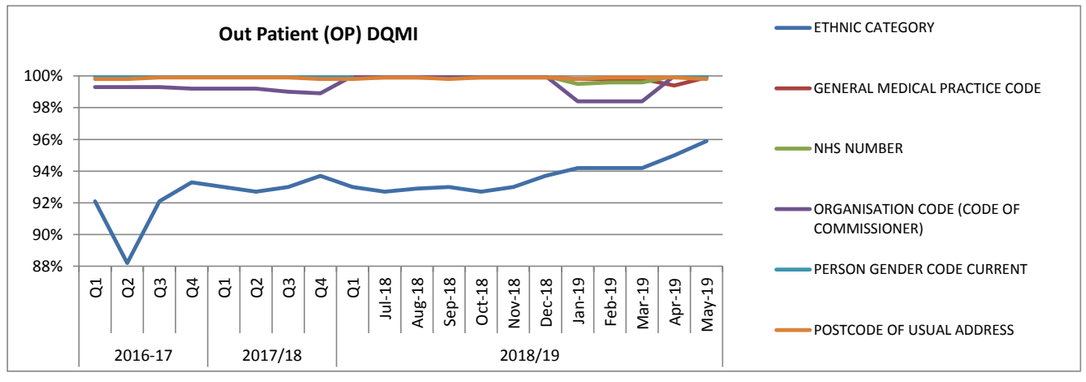
Risk Description: There is a risk we cannot assure ourselves of the accuracy and validity of all information we provide from our patient information systems; which could adversely affect patient outcomes where information is required to make decisions.

Calculation Method	Proportion valid and complete data items **Numerator:** ((Coverage)*(mean proportion valid and complete for each data item)*100))









Comments and Actions:

National dataset compliance is published six months in arrears. Local performance is shown monthly where available in lieu of nationally published performance.

Data Quality Maturity Index (DQMI)

The sudden decrease in compliance during 2017/18 Q2 is attributed to a technical error which is not linked to data quality.

Work to improve completeness and validity of DQMI in submissions was completed in May 2018. We expect to see a change in DQMI compliance for 2018/19 Q1 in line with the improved submission process.

The recording of ethnicity data is being managed through the clinical effectiveness group (CEG) from June 2018. We expect to see improvements to ethnicity recording from July 2018.

The spine matching processes across the Trust and primary care services is being reviewed for improvements. We expect to see incremental improvements to all indicators from July 2018 as actions are completed.

Leicestershire Partnership NHS
NHS Trust

DETAILED EXCEPTION REPORT - % Staff Sickness

Responsible Director	Sarah Willis
Responsible Committee	SWG

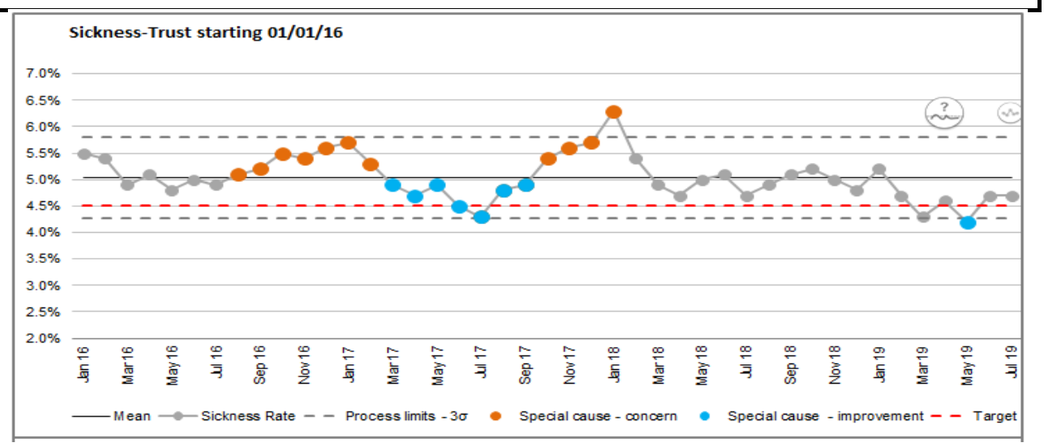
Responsible Services	AMH, CHS, FYPC, Enabling
KPI Reference ID	

Risk Reference	1833
Risk Owner	Kathryn Burt

Risk Description: Quality of service provided to our patients and service users will be affected by the high level of sickness absence within the Trust. There will also be an impact on the health and wellbeing linked to the increased reliance on use of temporary staffing.

Calculation Method	**Numerator:** the number of available calendar days lost to staff sickness in the period **Denominator:** the total number available calendar days in the month

Performance (%)	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Adult Mental Health Services	<=5.6%	5.4%	5.0%	5.9%	5.3%								
Community Health Services	<=4.8%	5.0%	4.5%	5.0%	5.2%								
Families, Children and Young People's Services	<=4.3%	4.7%	4.4%	4.5%	4.7%								
Enabling Services	<=2.3%	2.6%	2.0%	2.5%	2.9%								
Hosted Services	<=2.3%	2.0%	1.4%	1.9%	1.2%								



Comments and Actions:

% Sickness Absence:

AMH.LD sickness is showing significant improvement from last year. The cumulative rate for 2018/19 was 5.4 % (below target of 5.6%). This is a 0.8% reduction from 2017/18 and builds on improvements made in 2016/17. This indicates that the initiatives being used in AMH.LD to reduce sickness absence are having a sustained impact. Although advice from Amica and Occupational Health is that the complexity of the client group supported in AMH.LD means that higher levels of sickness absence should be anticipated.
Actions in place:
- HR support to focus on supporting, training and coaching Managers.
- Target setting for staff who reach the Trust triggers and if breached formal action taken.
- Monthly teleconference for managers, HR and the Director to discuss actions being taken to tackle sickness absence.
- HR Team focusing on supporting staff with underlying health conditions using guidance from the Reasonable Adjustment Policy and Tailored Adjustment Agreements.

CHS Sickness absence remains high on the workforce agenda with community services receiving a daily situation report on all staffing and sickness concerns. They have also undertaken a review of sickness trends and patterns and HR have provided a number of bespoke training sessions. Across CHS a commitment has been made to identify and support all current line managers to undertake the four training courses designed to support with staff management. A focus on health and wellbeing has been initiated to support staff with expanding the health and wellbeing agenda within their own areas.

FYPC There has been a slight increase in sickness absence and is now showing as red, this is still a slight improvement on same time last year. This is discussed in length at Workforce Meetings, FYPC SMT have also agreed to discuss this in more detail in the FYPC Operational Meetings on a monthly basis. Work will continue with Teams and Managers, including training, advice on target setting and continued monthly monitoring of staff sickness within teams. Information has been provided to SMT on staff who are line managers and have not attended Management of Ill Health Training and also to encourage Managers to attend half day refresher training. Stress Tools are discussed at Workforce Group and communicated to Managers through Comms and individual Team Meetings. The HR team will undertake further 1 x 1 work with Managers who have a 6% and over the target rate. Hot spots will be identified and fed back to SMT for discussion.

Enabling - services sickness has seen a slight increase in sickness absence and is now showing as red. All absence is being appropriately managed within the services with support from HR.

Based on the SPC chart, we can see there is no significant change in the rate of staff sickness since February 2018; and we will inconsistently meet our Trust target of <=4.5%.

Risk Associated Actions:

1. Managers to be reminded on an ongoing basis of the need to input sickness absence in a timely way.
2. HR staff to ensure that all sickness absence cases are recorded on case management system to aid reporting.
3. Management of Ill-Health Policy to be revised and agreed by staff side.
4. Programme of health and wellbeing interventions to be available for staff.

Leicestershire Partnership NHS Trust

DETAILED EXCEPTION REPORT - Agency Costs

Responsible Director	Anne Scott
Responsible Committee	FPC/ SWG

Responsible Services	All
KPI Reference ID	PW.35

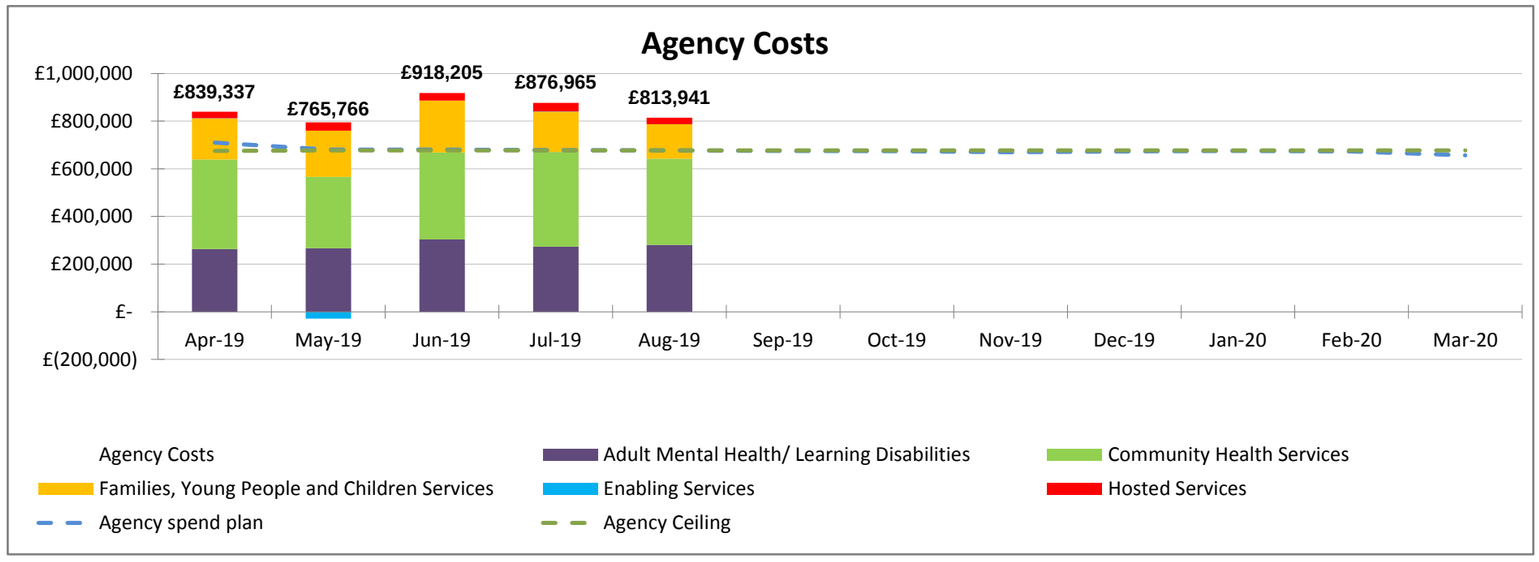
Risk Reference	1932	**Risk Description:** Inability to achieve sufficient workforce supply to deliver the workforce requirements set out within the Trust business plan and people strategy. . Links to risks 1037, 1038, 2515 and the safer staffing risk.
Risk Owner	Sarah Willis	

Risk Reference	1260	**Risk Description:** Substantive staffing on inpatient units is below the funded establishment and this could have an impact on patient care and the ability to deliver effective care on a consistent basis. Links to risk 1932.
Risk Owner	Anne Scott	

Calculation Method	Total cost of Trust agency pay bill

Split by Services

	Current Month	Previous Month
Adult Mental Health/ Learning Disabilities	£ 280,616	£ 272,828
Community Health Services	£ 362,092	£ 398,240
Families, Young People and Children Services	£ 144,544	£ 168,377
Enabling Services	£ 283	£ 1,362
Hosted Services	£ 26,406	£ 36,158



Comments and Actions:

Cumulative year-to-date Trust agency costs were £4,214K as at 31 August 2019 (month 5). This is above the planned spend of £3,426k for the same period.

The August 2019 year-to-date NHSI agency ceiling target is £3,383k. This Trust is exceeding this limit by £831k

Risk Associated Actions:

Appendix 1: IQPR Change Log

Date	Indicator Code	Indicator Description	Requested by	Change
Apr-17		Quality Pages	QAC	All Quality indicators reviewed
Jul-17		Operational Performance	FPC	re-formatted layout in line with Quality pages
Oct-17		DToC for Community Health	ET	Community moved to national methodology
Sep-19		SPC graphs	Board	SPC graphs introduced into exception reporting where possible
Sep-19		Radar charts	FPC	Removed radar chart page as duplicated information

Paper Viii

WeAre C.B.I.T
Corporate Business Information Team

Waiting Times Compliance - Adult Mental Health Services and Learning Disabilities

Leicestershire Partnership NHS
NHS Trust

Service Details				Patient Flow (referrals and discharges in month)								Incomplete Pathways (at end of month)										Complete Pathways (in month)										Information Assurance Framework				
				No. of New Referrals Received				No. of Discharges				No. of Referrals Waiting			Length of Wait		Waiting Time Compliance					No. of Referrals Seen			Length of wait		Waiting Time Compliance									
Service Spec	Service Name	Target Waiting Time *(all targets are locally agreed unless otherwise stated)*	Wait Time Measure	Jun-19	Jul-19	Aug-19	Referrals Trendline (Rolling 12 Months)	Jun-19	Jul-19	Aug-19	Discharge Trendline (Rolling 12 Months)	No of Patients Within Target	Patients > target < 52 weeks	Patients > target >= 52 weeks	Longest Waiter Over target < 52 Weeks	Longest Waiter >= 52 Weeks	Target	Jun-19	Jul-19	Aug-19	Incomplete Compliance Trendline	No of Patients Within Target	Patients > target < 52 weeks	Patients > target >= 52 weeks	Longest Waiter Over target < 52 Weeks	Longest Waiter >= 52 Weeks	Target	Jun-19	Jul-19	Aug-19	Complete Compliance Trendline	Service Line Mapping Agreed	Targets Agreed	SOP in place	PTL in place	KPI authorised as correct by executive
LD02	LD - Community Teams	8 Weeks	Referral to Assessment	104	116	92		110	110	86		111	15	0	15	0	95%	91.4%	95.1%	88.1%		81	7	0	11	0	95%	92.8%	83.9%	92.0%						
MH02	Assertive Outreach	6 Weeks	Referral to Assessment	1	2	2		1	1	2		4	0	0	0	0	95%	N/A	100.0%	100.0%		0	0	0	0	0	95%	100.0%	N/A	N/A						
MH06	Personality Disorders	13 Weeks	Referral to Assessment	96	117	73		42	26	56		284	371	1	39	53	95%	49.3%	48.1%	43.3%		14	42	0	41	0	95%	9.5%	11.1%	25.0%						
MH07	Dynamic Psychotherapy	13 Weeks	Referral to Assessment	23	21	23		3	25	8		39	0	0	0	0	95%	100.0%	100.0%	100.0%		14	0	0	0	0	95%	100.0%	100.0%	100.0%						
MH08	Perinatal Mental Health Service	4 Weeks	Referral to Assessment	84	95	100		96	96	79		48	22	0	10	0	95%	63.8%	68.3%	68.6%		77	13	0	19	0	95%	79.2%	75.0%	85.6%						
		2 Working Days		14	9	12		16	8	11		0	0	0	0	0	95%	100.0%	N/A	N/A		12	0	0	0	0	95%	92.3%	100.0%	100.0%						
		4 Hours		0	0	0		0	0	0		0	0	0	0	0	95%	N/A	N/A	N/A		0	0	0	0	0	95%	N/A	N/A	N/A						
MH09	Psycho-oncology (Routine and Urgent)	4 Weeks	Referral to Assessment	26	18	16		16	26	24		14	66	0	24	0	95%	36.0%	26.3%	17.5%		4	13	0	18	0	95%	17.6%	22.2%	23.5%						
		48 Hours		5	9	10		2	4	5		9	2	0	26	0	95%	60.0%	85.7%	81.8%		0	5	0	4	0	95%	33.3%	20.0%	0.0%						
MH10	Liaison - Psychiatry	1 Working Day	Referral to Assessment	34	38	34		46	38	26		7	6	0	1	0	95%	50.0%	100.0%	53.8%		26	4	0	0	0	95%	72.7%	94.3%	86.7%						
		13 Weeks		18	16	8		23	24	56		28	4	0	44	0	95%	87.5%	93.2%	87.5%		18	1	0	38	0	95%	90.0%	95.7%	94.7%						
MH11	Cognitive Behavioural Therapy	13 Weeks	Referral to Assessment	36	64	53		57	26	26		116	3	0	18	0	95%	96.9%	98.2%	97.5%		32	0	0	0	0	95%	94.1%	97.4%	100.0%						
MH13	Forensic - Community and Out Patients	8 Weeks	Referral to Assessment	30	19	18		7	12	14		27	24	0	26	0	95%	72.7%	75.0%	52.9%		14	7	0	14	0	95%	41.7%	50.0%	66.7%						
MH18	Adult General Psychiatry - Community Mental Health Teams and Outpatients - Treatment	6 Weeks	Referral to Assessment	412	428	378		422	419	413		524	747	5	49	92	95%	45.0%	47.3%	41.1%		159	136	2	48	86	95%	57.5%	56.5%	53.5%						
		5 Days		21	18	14		9	15	12		2	9	0	8	0	95%	46.2%	25.0%	18.2%		8	3	0	5	0	95%	78.6%	53.8%	72.7%						
MH20	Mett Day Centre and Linnaeus Nursery	4 Weeks	Referral to Assessment	1	1	1		5	5	7		1	0	0	0	0	95%	100.0%	N/A	100.0%		0	0	0	0	0	95%	100.0%	100.0%	N/A						
MH21	Huntington's Disease	4 Weeks	Referral to Assessment	2	2	2		2	1	0		2	1	0	8	0	95%	50.0%	0.0%	66.7%		0	0	0	0	0	95%	50.0%	66.7%	N/A						
MH23	Adult ADHD Service Consultant-Led Service	National incomplete target 92%: 18 Weeks	Referral to Treatment	96	117	82		51	47	27		355	20	0	29	0	92%	97.3%	95.8%	94.7%		33	35	0	28	0	95%	88.7%	90.5%	48.5%						
MH24	Homeless Service	1 Week	Referral to Assessment	25	42	42		36	32	40		1	24	0	6	0	95%	15.8%	29.4%	4.0%		25	10	0	6	0	95%	53.3%	67.4%	71.4%						
MH25	Aspergers Assessment Consultant-Led Service	National incomplete target 92%: 18 Weeks	Referral to Treatment	51	61	35		39	23	40		76	16	0	29	0	92%	87.7%	90.5%	82.6%		59	4	0	31	0	95%	57.7%	67.4%	93.7%						
MH48	Crisis Intervention (Crisis Level 1 and 2)	4 Hours	Referral to Assessment	2	7	7		3	7	7		0	0	0	0	0	95%	100.0%	100.0%	N/A		4	4	0	0	0	95%	100.0%	66.7%	50.0%						
		24 Hours		281	337	290		292	308	346		3	0	0	0	0	95%	100.0%	100.0%	100.0%		252	42	0	2	0	95%	92.3%	80.1%	85.7%						
MH49	Mental Health Triage Team	1 Hour	Referral to Assessment	421	406	368		355	385	324		0	0	0	0	0	95%	N/A	N/A	N/A		186	173	0	0	0	95%	46.0%	46.3%	51.8%						
		Emergency 2 Hours	Referral to Assessment	421	406	368		355	385	324		9	19	0	14	0	95%	66.7%	36.4%	32.1%		274	85	0	0	0	95%	76.0%	70.4%	76.3%						
		Crisis 4 Hours	Referral to Assessment	27	28	43		20	27	38		1	3	0	14	0	95%	60.0%	0.0%	25.0%		40	2	0	0	0	95%	96.0%	92.9%	95.2%						
MH16	Adult General Psychiatry-Acute Recovery Team	3 Working Days																																	
		48 hours																																	
		7 days																																	

Comments and Actions:

MH49 - Mental Health Triage Team 1 hour
Emergency referral via the Leicester Royal Infirmary Emergency Department – As LPT are working towards the NHS England Liaison target 20/21 which states that no acute hospital is without an all age mental health service in an emergency department. Compliance against the 1 hour target will be measured as part of the service development planned in order for the mental health triage to deliver the Core24 standards. Achievement of the target is subject to ongoing review of capacity, performance and resource.

Methodologies

RTT Methodology:
The RTT methodology is correct as per the way that RiO electronic patient record functions. There are system level action dates that are needed to sequence the information for the calculation. This means that the front end processing of RTT needs to happen as it occurs and entered in to RiO. Therefore, any information entered into RiO that is back dated will take the

Incomplete:
Incomplete waiting list performance is based on the number of patient referrals on an active waiting list at month end; and the percentage of those within the target waiting times.

Complete:
Complete wait time performance is based on the number of patient referrals completed with or without treatment during the reporting period; and the percentage of those within the target waiting times.

WeAreC.B.I.T
Corporate Business Information Team

Waiting Times Compliance - Community Health Services

Leicestershire Partnership NHS
NHS Trust

Service Details				Patient Flow (referrals and discharges in month)								Incomplete Pathways (at end of month)										Complete Pathways (in month)										Information Assurance Framework				
				No. of New Referrals Received				No. of Discharges				No. of Referrals Waiting			Length of Wait		Waiting Time Compliance					No. of Referrals Seen			Length of wait		Waiting Time Compliance									
Service Spec	Service Name	Target Waiting Time *(all targets are locally agreed unless otherwise stated)*	Wait Time Measure	Jun-19	Jul-19	Aug-19	Referrals Trendline (Rolling 12 Months)	Jun-19	Jul-19	Aug-19	Discharge Trendline (Rolling 12 Months)	No of Patients Within Target	Patients > target < 52 weeks	Patients > target >= 52 weeks	Longest Waiter Over target < 52 Weeks	Longest Waiter >= 52 Weeks	Target	Jun-19	Jul-19	Aug-19	Incomplete Compliance Trendline	No of Patients Within Target	Patients > target < 52 weeks	Patients > target >= 52 weeks	Longest Waiter Over target < 52 Weeks	Longest Waiter >= 52 Weeks	Target	Jun-19	Jul-19	Aug-19	Complete Compliance Trendline	Service Line Mapping Agreed	Targets Agreed	SOP in place	PTL in place	KPI authorised as correct by executive
CHS03	Continence Nursing Service	20 Working Days	Referral to first clinically relevant contact	637	684	661		3500	2005	893		590	1318	0	45	0	95%	34.4%	30.0%	30.9%																
		Level 1 Assessment																				21	139	0	50	0	95%	17.0%	22.2%	13.1%					
CHS04	Respiratory Specialist Service	Urgent	Referral to first clinically relevant face to face contact	5	10	6		6	8	7		2	0	0	0	0	90%	100.0%	100.0%	100.0%		5	1	0	3	0	90%	100.0%	100.0%	83.3%						
		Routine		133	203	149		187	140	135		129	12	0	9	0	90%	88.6%	96.1%	91.5%		135	27	0	9	0	90%	88.3%	91.8%	83.3%						
		Rapid Response																																		
CHS07	Heart Failure Service	Urgent	Referral to first clinically relevant face to face contact	10	26	10		7	6	6		0	0	0	0	0	90%	100.0%	100.0%	N/A		11	1	0	3	0	90%	100.0%	92.0%	91.7%						
		Routine		145	178	173		161	77	122		133	12	0	14	0	90%	98.0%	94.0%	91.7%		131	11	0	10	0	90%	96.6%	95.6%	92.3%						
CHS10	Physiotherapy	Routine 4 Weeks	Referral to first clinically relevant contact	0	0	0		645	914	411		1	7	0	40	0	95%	2.4%	0.0%	12.5%		0	15	0	40	0	95%	7.3%	7.4%	0.0%						
		Urgent 5 Working Days		0	0	0		141	246	74		0	0	0	0	0	95%	N/A	N/A	N/A		0	0	0	0	0	95%	N/A	N/A	N/A						
		Non self Urgent RTT 5 Working Days	Referral to Treatment	38	24	22		31	43	28		7	4	0	2	0	92%	68.4%	62.5%	63.6%		11	7	0	20	0	95%	88.9%	66.7%	61.1%						
		Non self Routine RTT 30 Working Days		375	358	333		283	452	346		164	232	0	28	0	92%	30.1%	34.3%	41.4%		241	171	0	28	0	95%	54.2%	48.1%	58.5%						
		Self Referrals Urgent RTT 5 Working Days		390	453	427		228	197	297		87	107	0	5	0	92%	66.2%	47.8%	44.8%		151	223	0	6	0	95%	43.9%	35.3%	40.4%						
		Self Referrals Routine RTT 30 Working Days		1731	1904	1770		877	901	1196		902	254	0	26	0	92%	75.6%	74.8%	78.0%		1566	106	0	26	0	95%	91.7%	92.6%	93.7%						
CHS19	Podiatry	Routine 20 Working Days	Referral to first clinically relevant face to face contact	1356	1472	1356		1374	1401	1246		1087	39	0	13	0	95%	96.0%	97.0%	96.5%		1261	94	0	12	0	95%	93.0%	93.3%	93.1%						
		Urgent 5 Working Days		23	40	34		10	14	14		3	1	0	2	0	95%	50.0%	100.0%	75.0%		21	0	0	0	0	95%	94.4%	100.0%	100.0%						
CHS22	Speech Therapy	Routine 4 Weeks	Referral to first clinically relevant face to face contact	276	312	326		256	353	283		247	33	0	23	0	95%	87.1%	83.9%	88.2%		223	65	0	18	0	95%	81.6%	82.8%	77.4%						
		Urgent 10 Working Days		42	50	40		26	42	36		16	1	0	2	0	95%	92.9%	100.0%	94.1%		31	1	0	2	0	95%	100.0%	98.0%	96.9%						
CHS69/70/80	Community Therapy	3 Working Days (P1)*	Referral to first clinically relevant contact	135	133	118		145	153	125		15	1	0	2	0	95%	100.0%	90.9%	93.8%		102	11	0	1	0	95%	84.2%	86.4%	90.3%						
		20 Working Days (P2)*		522	655	576		497	601	583		427	529	0	24	0	95%	47.0%	47.3%	44.7%		240	313	0	22	0	95%	39.9%	43.1%	43.4%						
		60 Working Days (P3)*		85	103	99		82	95	103		211	64	0	23	0	95%	77.1%	79.8%	76.7%		35	36	0	25	0	95%	38.0%	41.5%	49.3%						
CHS87	Stroke & Neuro	3 Working Days	Referral to first clinically relevant contact	6	8	5		5	1	6		0	0	0	0	0	95%	N/A	N/A	N/A		5	0	0	0	0	95%	100.0%	100.0%	100.0%						
		20 Working Days		182	229	214		195	245	183		161	91	0	12	0	95%	69.9%	71.4%	63.9%		102	94	0	19	0	95%	59.5%	63.5%	52.0%						
MH37	MHSOP Community Teams	High Priority 4 Weeks	Referral to first clinically relevant face to face contact	13	19	26		18	14	18		16	9	0	10	0	95%	92.3%	73.7%	64.0%		16	5	0	6	0	95%	100.0%	80.0%	76.2%						
		Routine 6 Weeks		104	104	93		90	88	80		93	22	0	13	0	95%	93.3%	90.2%	80.9%		65	13	0	17	0	95%	80.0%	85.6%	83.3%						
MH40	MHSOP - Memory Clinics	RTT 18 Weeks	Referral to Treatment	210	246	225		150	130	140		733	66	0	49	0	92%	91.3%	94.4%	91.7%		156	25	0	45	0	95%	76.3%	83.5%	86.2%						
		High Priority 4 Weeks	Referral to first clinically relevant face to face contact	0	0	0		0	0	0		0	0	0	0	0	95%	N/A	N/A	N/A		0	0	0	0	0	95%	N/A	N/A	N/A						
		Routine 6 Weeks		0	0	0		8	8	7		0	0	0	0	0	95%	N/A	N/A	N/A		0	0	0	0	0	95%	N/A	N/A	N/A						
MH45	MHSOP Outpatient Service	High Priority 4 Weeks	Referral to first clinically relevant face to face contact	4	1	2		5	6	3		1	1	0	6	0	95%	N/A	100.0%	50.0%		1	0	0	0	0	95%	100.0%	100.0%	100.0%						
		Routine 6 Weeks		133	130	128		88	144	106		147	33	0	14	0	95%	78.8%	84.8%	81.7%		84	26	0	26	0	95%	80.3%	82.9%	76.4%						
CHS05a	Planned End of Life Care Service (Hospice at Home)	2 Weeks	Referral to first clinically relevant face to face contact	0	2	1		0	2	1		0	0	0	0	0	95%	N/A	N/A	N/A		1	0	0	0	0	95%	N/A	100.0%	100.0%						
		24 Hours		68	75	62		69	75	61		0	0	0	0	0	95%	N/A	N/A	N/A		56	5	0	0	0	95%	94.0%	95.9%	91.8%						
		2 Hours		65	67	62		65	66	62		0	0	0	0	0	95%	N/A	N/A	N/A		45	15	0	0	0	95%	93.8%	92.4%	75.0%						
MH55	Integrated Care – Mental Health	15 Working Days	Referral to first clinically relevant face to face contact	26	36	26		26	28	24		17	10	0	7	0	95%	95.0%	76.7%	63.0%		7	22	0	7	0	95%	72.7%	50.0%	24.1%						
CHS17	City Reablement Service	5 Working Days																																		
CHS05b	Specialist Palliative Care Nursing Service (Macmillan)	2 Working Days																																		
		5 Working Days																																		
MH38	Care Homes In Reach Team	72 Hours																																		

Comments and Actions:
General Notes:

Respiratory and Heart Failure Services, the Urgent waiting times target is 10 working days and the Routine waiting times target is 20 working days.
Respiratory and Heart Failure Service Targets have been updated to reflect the new service specifications and back dated from April-19 to Current Reporting Month this has been updated for patients on Complete and Incomplete Pathways.

CHS04 - Respiratory Specialist Service
The Rapid Response waiting times target is 1 working day and the element of this within the Respiratory Service will officially commence from 1st November 2019 once commissioners investment is paid to the service to support the 1 working day referrals. Therefore, it will be greyed out until then.

CHS03 - Continence Nursing Service
The increase in discharges was expected in June 2019 as patients have been discharged from the Annual Review caseloads within the old LLR Specialist Services unit. as part of the discharge process, patients have been provided with the relevant information to contact the service. In addition the supplier for the prescription products has changed and patients have been informed. Patients that self-refer (including carer/relative referrals) into the service will be seen under the 'Reassessment' pathway. There has been an increase in the number of referrals from the referral sources: patient, carer and relative.

In April 2019, the service underwent a migration phase from the LLR Specialist Services unit into its own LLR Continence Service unit in SystmOne. The migration took 3 weeks during April 2019 to complete. Therefore, fewer patients were on the complete pathway.

CHS10 - Physiotherapy
Provided New MSK Physiotherapy RTT data. Still awaiting final sign off by commissioners.

The service started to accept referrals from 1st February 2019 on the referral to treatment (RTT) pathway.
The different 'Target Waiting Time' are:
• Urgent RTT 5 working days (Non-self Referrals) – these referrals exclude referrals sources: 'Self Referral' and 'Self-Referral: GP Suggested'
• Routine RTT 30 working days (Non-self Referrals) – these referrals exclude referrals sources: 'Self Referral' and 'Self-Referral: GP Suggested'
• Urgent RTT 5 working days (Self Referrals) – these referrals only include referrals sources: 'Self Referral' and 'Self-Referral: GP Suggested'
• Routine RTT 30 working days (Self Referrals) – these referrals only include referrals sources: 'Self Referral' and 'Self-Referral: GP Suggested'

Methodologies

RTT Methodology:
The RTT methodology is correct as per the way that RiO electronic patient record functions. There are system level action dates that are needed to sequence the information for the calculation. This means that the front end processing of RTT needs to happen as it occurs and entered in to RiO. Therefore, any information entered into RiO that is back dated will take the action date as the RTT status/outcome. We are educating staff to outcome appointments within a timely manner as defined by Trust policy for record keeping.

Incomplete:
Incomplete waiting list performance is based on the number of patient referrals on an active waiting list at month end; and the percentage of those within the target waiting times.

Complete:
Complete wait time performance is based on the number of patient waits completed with or without treatment during the reporting period; and the percentage of those within the target waiting times.

WeAre C.B.I.T
Corporate Business Information Team

Waiting Times Compliance - Families, Young People and Children's Services

Leicestershire Partnership NHS
NHS Trust

Service Details				Patient Flow (referrals and discharges in month)								Incomplete Pathways (at end of month)										Complete Pathways (in month)										Information Assurance Framework				
				No. of New Referrals Received				No. of Discharges				No. of Referrals Waiting			Length of Wait		Waiting Time Compliance					No. of Referrals Seen			Length of wait		Waiting Time Compliance									
Service Spec	Service Name	Target Waiting Time *(all targets are locally agreed unless otherwise stated)*	Wait Time Measure	Jun-19	Jul-19	Aug-19	Referrals Trendline (Rolling 12 Months)	Jun-19	Jul-19	Aug-19	Discharge Trendline (Rolling 12 Months)	No of Patients Within Target	Patients > target < 52 weeks	Patients > target > = 52 weeks	Longest Waiter Over target < 52 Weeks	Longest Waiter >= 52 Weeks	Target	Jun-19	Jul-19	Aug-19	Incomplete Compliance Trendline	No of Patients Within Target	Patients > target < 52 weeks	Patients > target > = 52 weeks	Longest Waiter Over target < 52 Weeks	Longest Waiter >= 52 Weeks	Target	Jun-19	Jul-19	Aug-19	Complete Compliance Trendline	Service Line Mapping Agreed	Targets Agreed	SOP in place	PTL in place	KPI authorised as correct by executive
CHS23	Childrens Audiology	National incomplete target 99%: 6 Weeks	Referral to clinically relevant contact	464	408	331		455	482	462		228	0	0	0	0	99%	100.0%	100.0%	100.0%		280	0	0	0	0	92%	99.7%	99.8%	100.0%						
CHS24	Childrens Occupational Therapy	18 Weeks	Referral to Treatment	25	38	26		33	29	32		95	1	0	20	0	92%	100.0%	100.0%	99.0%		31	1	0	19	0	92%	100.0%	100.0%	96.9%						
CHS25	Childrens Physiotherapy	18 Weeks	Referral to Treatment	9	23	10		26	35	12		59	2	0	18	0	92%	96.0%	95.1%	96.7%		5	1	0	18	0	92%	95.2%	100.0%	83.3%						
CHS27	Childrens Speech & Language Therapy	18 Weeks	Referral to Treatment	138	247	116		246	244	330		524	15	0	27	0	92%	97.5%	97.8%	97.2%		260	9	0	27	0	92%	100.0%	97.5%	96.7%						
CHS29	LNDS & HENS Domiciliary	4 Weeks	Referral to Assessment	94	129	116		127	118	118		76	62	0	15	0	95%	39.5%	33.9%	55.1%		68	59	0	14	0	92%	47.6%	41.3%	53.5%						
	LNDS & HENS Outpatients	18 Weeks	Referral to Assessment	390	478	422		313	262	275		1055	80	0	32	0	95%	92.1%	89.3%	93.0%		299	28	0	37	0	92%	93.7%	91.2%	91.4%						
CHS34	Community Paediatrics	18 Weeks	Referral to Treatment	63	148	67		37	80	59		240	10	0	28	0	92%	96.7%	96.7%	96.0%		83	7	0	21	0	92%	93.8%	90.4%	92.2%						
MH19	PIER - First Episode in Psychosis Service	National complete target 53%: 2 Weeks	Referral to Treatment	52	59	55		47	44	45		15	7	0	6	0	53%	60.0%	52.6%	68.2%		12	3	0	5	0	53%	66.7%	81.0%	80.0%						
MH30	CAMHS Young People's Team	13 weeks	Referral to Treatment	36	25	24		18	42	41		39	0	0	0	0	92%	100.0%	97.1%	100.0%		15	0	0	0	0	92%	100.0%	100.0%	100.0%						
MH31	CAMHS Learning Disabilities	18 weeks	Referral to Treatment	9	12	12		1	9	9		23	0	0	0	0	92%	100.0%	100.0%	100.0%		8	0	0	0	0	92%	88.9%	100.0%	100.0%						
MH33	CAMHS Paediatric Psychology	18 weeks	Referral to Treatment	29	30	19		24	25	37		76	3	0	27	0	60%	95.6%	92.5%	96.2%		27	11	0	29	0	60%	75.0%	61.1%	71.1%						
MH47	CAMHS - Eating Disorders	Routine 4 Weeks	Referral to face to face assessment	14	11	7		13	8	11		3	6	0	10	0	60%	87.5%	66.7%	33.3%		8	4	0	10	0	60%	66.7%	80.0%	66.7%						
		Urgent 1 Week	Referral to face to face assessment	3	5	1		0	0	1		0	0	0	0	0	60%	0.0%	N/A	N/A		0	1	0	0	0	60%	100.0%	40.0%	0.0%						
MH47	CAMHS - Eating Disorders	Commissioner: Routine 6 Weeks	Referral to NICE Concordant Treatment	14	11	7		13	8	11		5	4	0	9	0	95%	84.6%	63.6%	55.6%		2	3	0	10	0	95%	50.0%	66.7%	40.0%						
		Commissioner: Urgent 4 Weeks		3	5	1		0	0	1		0	0	0	0	0	95%	100.0%	N/A	N/A		1	0	0	2	0	95%	100.0%	100.0%	100.0%						
MH47	CAMHS - Eating Disorders	National monitoring: no target Routine 4 Weeks	Referral to NICE Concordant Treatment	14	11	7		13	8	11		3	6	0	9	0	95%	69.2%	36.4%	33.3%		2	3	0	10	0	95%	0.0%	33.3%	40.0%						
		National monitoring: no target Urgent 1 Week		3	5	1		0	0	1		0	0	0	0	0	95%	100.0%	N/A	N/A		0	1	0	2	0	95%	100.0%	60.0%	0.0%						
MH50	CAMHS Access and Outpatients	4 weeks	Referral to first clinically relevant contact	55	55	26		56	67	19		18	1	0	8	0	92%	100.0%	62.5%	94.7%		26	6	0	10	0	92%	100.0%	100.0%	81.3%						
		13 weeks		188	159	134		219	193	79		104	2	0	14	0	95%	98.6%	98.6%	98.1%		108	3	0	22	0	92%	74.7%	97.2%	97.3%						
MH51	CAMHS Crisis and Home Treatment	24 Hours	Referral to first clinically relevant contact	66	47	43		54	65	27		0	0	0	0	0	92%	0.0%	0.0%	N/A		39	4	0	3	0	95%	88.2%	80.0%	90.7%						
CHS28a	CAfSS ;- Diana Community & Family Service	28 calender days	Referral to Assessment																																	
CHS28b	DIANA CHILDRENS COMMUNITY NURSING	2 Working Days	% of acute referrals actioned within 2 working days																																	
CHS29	LNDS & HENS Community Hospital Inpatients	Urgent 48 Hours																																		
		Routine 5 days																																		
CHS67	Childrens Respiratory Physiotherapy	Urgent 48 Hours																																		
		Routine 4 Weeks																																		
MH04	Eating Disorders Outpatients and Day Care	Urgent 10 Days																																		
		Routine 13 Weeks																																		

Comments and Actions:
Services working to national wait times definitions have targets aligned to national guidance.

Services working to Referral to Treatment methodologies have a 92% target

Services working to Referral to Assessment/ First relevant clinical Contact methodologies have a 95% target.

MH50 CAMHS Access and Outpatients
The 6 Patients that Appear on the CAMHS Access and Outpatients 4 weeks Waiting Time label over Target Completes, have been rectified to 4 Patients as 2 patients where incorrectly recorded on SystmOne.

Methodologies:

RTT Methodology
The RTT methodology is correct as per the way that RiO electronic patient record functions. There are system level action dates that are needed to sequence the information for the calculation. This means that the front end processing of RTT needs to happen as it occurs and entered in to RiO. Therefore, any information entered into RiO that is back dated will take the action date as the RTT status/outcome. We are educating staff to outcome appointments within a timely manner as defined by Trust policy for record keeping.

Incomplete:
Incomplete waiting list performance is based on the number of patient referrals on an active waiting list at month end; and the percentage of those within the target waiting times.

Complete:
Complete wait time performance is based on the number of patient waits completed with or without treatment during the reporting period; and the percentage of those within the target waiting times.

Information Assurance Framework Definition	
Indicator	**Description**
Targets have been agreed in the service spec and are reflected correctly in the report	o Green – Targets agreed as correct in the report against the service line o Red – Targets not agreed as correct in the report against the service line
SOPs are in place to support the data entry and management of the KPI	Continence Nursing Service
PTLs are undertaken by the service to validate the waiting list prior to release of this report	o Green – PTL in place and compliance agreed as correct o Amber - PTL in place and cleansing waiting lists o Red – PTL not yet in place – show a date when PTLs will start
The KPI has been authorised for release using the Trust authorisation process	o Green – report signed-off by authorised executive o Red – report not signed-off by authorised executive

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TRUST BOARD – 1 OCTOBER 2019

CHARITABLE FUNDS COMMITTEE – 10 SEPTEMBER 2019

HIGHLIGHT REPORT TO BOARD

The key headlines/issues and levels of assurance are set out below, and are graded as follows:

Assurance level	Colour to use in 'Assurance level*' column below
Not assured	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans If red, commentary is needed in "Next Actions" to indicate what will move the matter to "full assurance"
Partially assured	Amber - there are gaps in assurance but we are assured appropriate action plans are in place to address these
Assured	Green – there are no gaps in assurance

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
Fundraising manager's report		The fundraising manager's report highlighted: • Colour My Memories Appeal – Dementia wards at Evington Centre - Dementia Garden. It was highlighted that progress continued to be slow due to difficulties gaining consensus on safe tile surfaces. We may need to decline a donation offered by a tile supplier. • Miles for Smiles – 'Green Courtyard' fundraising event at Mill Lodge was very successful and raised £1,250. There were some Health & Safety requirements around the event that impacted on time and cost • A new CAMHS appeal would be launched at the Topping out for the new CAMHS unit on 20th September. It was agreed that this would be a good opportunity to raise awareness of the charity and raise funds for a garden and sensory items.	Quarterly updated to be provided Chair to follow up on lack of progress. Chair to ask Health & Safety and estates leads to attend the next meeting for a discussion on how schemes and events can be supported Raising Health to launch new appeal at the topping out ceremony	December 2019 December 2019 September 2019

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
Risk Register review		A comprehensive review of the risk register had taken place and recommendations were made to close several low rated risks and reduce the score on the remaining risk. The risks had been mitigated by improved processes that were now embedded.		
GDPR update		An update was provided on the systems and processes in place to ensure that any changes or updates in relation to the Data Protection Regime are considered for the charity in line with other areas of the Trust.	A quarterly update would be requested from the Trust's IG lead for assurance of ongoing compliance	December 2019
Quarter 1 2019/20 Finance Report, including 3 year business plan		The finance report for quarter 1 was presented. Highlights include: • The overall fund value stands at £1.7m, an increase of £67k. • 2019/20 total expenditure to date £62k; commitments in the pipeline total £196k. • 2019/20 income to date of £129k, comprising donations (£12k), fundraising appeals (£7k), lottery income (£14k), dividends (£17k), "unrealised" (ie notional) investment gain (£51k), Carlton Hayes (£27k) and legacy income (£1k). • The 3-year updated plan has been set at the previous year's income and expenditure levels. The plan will be reviewed and refreshed in October. • We currently have 1,188 lottery ticket entries, a net increase of 28 tickets since the start of the financial year. The latest super-draw generated 57 new ticket sales	Next quarterly update including refresh of 3 year plan.	December 2019
Transition of Investment Advisors		There have been protracted discussions with the new investment manager about the NHS standard contract terms and as a result the Raising Health investment fund had not yet transferred to the new investment manager. Concern was expressed about the delay in transfer	Head of Procurement to conclude contract discussions by the end of September or escalate as necessary.	30 September 2019
Charitable Funds processes and Procedures Update		A discussion took place around the issues that Bosom Babies were having in accessing their funds in a simple way for small purchases.	Finance staff will be meeting representatives to see what is feasible	December 2019

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
Approval, deferral and rejection of bids		No bids received The committee agreed that the focus on patient experience and wellbeing was appropriate and gardens and gym equipment remained the priority for this year.	A review of the fundraising strategy was agreed for 2020 – first draft to come to December 2019 meeting.	
Bids approved post meeting		• None.		
Any other business		• None.		

Recommendation	The Trust Board receives and notes the issues raised in the highlight report.
Author	Cathy Ellis – Trust Chair / Committee Chair Sharon Murphy – Deputy Director of Finance & Procurement
Presented by (Chair of committee)	Cathy Ellis

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Leicestershire Partnership NHS Trust

TRUST BOARD 1 October 2019

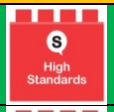
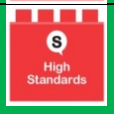
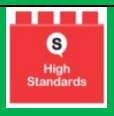
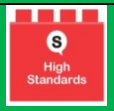
Strategic Workforce Group (SWG) 11 September 2019

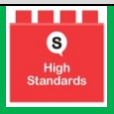
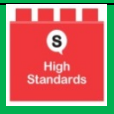
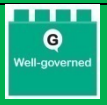
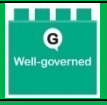
OVERVIEW REPORT TO BOARD

The key headlines/issues and levels of assurance are set out below, and are graded as follows:

Assurance level	Colour to use in 'Assurance level*' column below
Not assured	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans If red, commentary is needed in "Next Actions" to indicate what will move the matter to "full assurance"
Partially assured	Amber - there are gaps in assurance but we are assured appropriate action plans are in place to address these
Assured	Green – there are no gaps in assurance

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
Assurance on Mandatory Training Position	High Standards			
• Mandatory Training Report		Update provided and assurance noted	Continue to progress	
• Changes to Mandatory Training Core	High Standards	Presentation on changes to Core Mandatory Training modules and role essential training reducing the number of core mandated statutory training requirements.	Agreed to progress with changing the register. But noted both were still mandated training. Further discussion at ET.	Oct 2019
• Bank Mandatory Training		Received progress report noted the improvement approach is working.	Continue to progress	Oct 2019
Workforce Resourcing, Attraction and Retention	High Standards			
• Recruitment		Received progress report time to recruit improvements made	Continue with approach Services to encourage social media	Oct 2019
• Retention		Received progress report	More focused work a workforce groups on retirements	Oct 2019
Supervision Policy Changes/Changes to uLearn	High Standards	Draft proposal for new supervision policy received	Task finish group to be urgently established to finalise and review	Nov 2019

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
			systems in place to capture supervision	
Clinical Supervision Dashboard		Performance discussed	Task and finish group to review	Nov 2019
Management Supervision Data Capture Exercise Update		Progression on data capture discussed with 60 % return.	Task finish group to be urgently established to finalise and out systems in place to capture supervision. Directorates to review compliance of the returns	Nov 2019
Professional Standards Highlight Report		Report received discussing themes and learning to be shared across the trust.	Share the posters for learning and consider where sits within the new governance structure.	Oct 2019
Career Pathways		Progress on career pathways route maps received	To be send to workforce groups and on resource support area on U Learn.	Oct 2019
Culture and Leadership Programe Update		Progress against strategic priority received.	Move to phase 2 of the Programme the design phase	Oct 2019
Equality, Diversity and Inclusion Update		Progress against strategic priority received Divisional SMT have received race and cultural understanding training. Progress is being made towards having 100% diverse recruitment panels.	Continue to deliver against the actions in the plan	Oct 2019
Staff Survey 2019 and Communications Plan		Update on staff survey due 1st Oct communications plan to be development connected to our future our way	Communications to go out.	Oct 2019
Listening to Staff		Discussion on future reporting requirements Consider our future our way .	This will be considered as part of the our future our way work going forward. Mapping exercise of where activity takes place and is reported.	Oct 2019
Job Planning Update Report		Noted the report and progress policy adopted.	Progress the actins aiming for completion in Jan 2020	Jan 2020

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
Options Appraisal Agency Nursing and AHP		Discussions on proposal on future agency supply contracting options. Supported a blended approach using master vend and tiering model.	Take to ET.	Oct 2019
Payroll Update		Update on changes to the payroll contract moving to new provider and migration arrangements also communications to staff.	Agreed risk could be closed.	Oct 2019
Changes to SWG Governance Review Briefing Paper		Briefing paper on changes discussed agreed moving to quarterly from Jan TOR and work plan to be finalised at the Nov meeting.	All to feedback on the TOR and work plan.	31st Oct
Health and Wellbeing Update		Progress on health and wellbeing initiative received		
Assurance Dashboards				
• Temporary Staffing		Received further work to be progressed through the Turnaround work stream. HCA Thornbury use has ceased. Admin and clerical agency use will cease within the month	Progress through the turnaround meetings.	Oct 2109
CRR Risks		Noted close down of the payroll risk.		
Celebratory Acknowledgements		Thank you employee services and all involved in the migration to new payroll provider The work of the change champions.		

Recommendation	The Trust Board receives and notes the issues raised in the highlight report.
Author	Sarah Willis – Director of HR & OD
Presented by (Chair of committee)	Sarah Willis – Director of HR & OD