The theme of today's board is Learning Disability Services (LD)

Leicestershire Partnership NHS Trust

Public Meeting of the Trust Board
9.30 am Thursday 23 May 2019
Venue: NSPCC Training Centre, Beaumont Leys

public meeting

Item No.	Timings	Item	Purpose	Paper Ref	Discussion to be led by
1	**9.30**	Apologies for absence: and welcome: Mark Farmer (Healthwatch)			Cathy Ellis
2	10 mins	Patient voice film – learning disability service	Quality Improvement		Anne Scott
3	9.40	Declarations of interest in respect of items on the agenda			
4		Minutes of the previous meeting, 25 April 2019	Assurance	A	Cathy Ellis
5		Matters arising actions Action 860i – update to the board following suicide prevention conference in May	Assurance	B	Cathy Ellis Sue Elcock
6		Chairman's Report	Information	C	Cathy Ellis
7		Chief Executive's environmental scan	Information	D	Pete Miller
		Risk			
8	9.50 10 mins	Board Assurance Framework	Assurance	Oral	Pete Miller
Total for section = 30 minutes					
		Strategy			
9	10.00 5 mins	Better Care Together (BCT), Sustainability and Transformation Partnership (STP) status, and System Leadership Team (SLT) update • Better Care Together Partnership Board briefing	Information	Oral E	Pete Miller
10	10.05 20 mins	STP workstream – Leicester, Leicestershire and Rutland LD Transforming Care Programme (TCP) & Marmot report Sarah Warmington in attendance:	Information	Presentation	Helen Thompson

		Jules Galbraith			
Total for section = 25 minutes					
Performance and Assurance Reports					
Highlight reports (taken as read) from board committees: (those highlighted have been reviewed at one or more of the board committees)					
11	10.25 5 mins	Quality Assurance Committee highlight report, 21 May 2019	Assurance	Oral	Liz Rowbotham
12	10.30 5 mins	• Patient and Carer Experience and Involvement (including Complaints) quarter 4 report	Assurance	F	Anne Scott
13	10.35 5 mins	• Patient Safety Report – quarter 4	Assurance	G	Anne Scott
14	10.40 5 mins	• Mortality data quarterly report	Assurance	H	Sue Elcock
	10.45 10 mins	**Break**			
15	10.55 5 mins	Finance and Performance Committee highlight report, 21 May 2019	Assurance	Oral	Faisal Hussain
16	11.00 5 mins	• Finance monthly report – month 1	Performance	Ii Iii	Dani Cecchini
17	11.05 10 mins	Integrated Quality and Performance monthly report	Performance	J1 J2 J3	Dani Cecchini
18	11.15 5 mins	Audit and Assurance Committee highlight report, 3 May 2019	Assurance	K	Darren Hickman
19	11.20 5 mins	Strategic Workforce Group highlight report, 15 May 2019	Assurance	L	Pete Miller
Total for section = 60 minutes					
Quality Improvement and Compliance Reports					
20	11.25 5 mins	Safer staffing – monthly report	Assurance	M	Anne Scott
21	11.30 10 mins	Care Quality Commission progress update	Quality Improvement Links to all STEP up to GREAT priorities	N	Anne Scott
22	11.40 10 mins	Suicide prevention plan (inpatients) report to NHS England	Quality Improvement	O	Sue Elcock
23	11.50 5 mins	Guardian of Safe Working Hours (Junior Doctors contract) quarterly report	Assurance and compliance	P	Sue Elcock
Total for section = 30 minutes					
Governance and Risk					
24	11.55 5 mins	For approval: • NHS provider licence - self-certification	Compliance	Qi Qii Qiii	Anne Scott
25		Any additional risks highlighted as a result of Board discussion			Cathy Ellis

		today?			
26		Information Pack (circulated to Board members only) containing: • Draft Revised Board Assurance Framework • Step Up To Great Presentation	Information		Cathy Ellis
27		Any other urgent business			Cathy Ellis
28		Public questions on agenda items			Cathy Ellis
29	12.10	**Date of next meeting:** The next public Trust Board meeting will be held on Thursday 25 July 2019 at 9.30 am – County Hall			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 Extraordinary Trust Board Meeting
12.45 on Thursday 23 May 2019

The venue will be
NSPCC

AGENDA

Item No.	Timings	Item	Purpose	Paper Ref	Discussion to be led by
Extraordinary confidential meeting part 1					
1	12.45	Apologies for absence: And welcome			Cathy Ellis
2		Declarations of interest in respect of items on the agenda			Cathy Ellis
3	12.50	Receive Auditor's Annual Governance Statement (ISA 260)	Assurance	AA	Laura Bedford/ Andy Bostock
4	1.00	Overview Paper	Assurance	BB	Dani Cecchini
5	1.05	2018/19 review of Trust's Going Concern status	Assurance	CC	Dani Cecchini
6	1.10	Accounting Policies	Approval	DD	Dani Cecchini
7	1.15	Receive Head of Internal Audit Opinion	Assurance	EE	Tim Thomas/ Jenny Robinson
8	1.20	Approve Letter of Representation – Finance Approve Letter of Representation - Quality	Approval Approval	FFi FFii	Dani Cecchini Anne Scott
9	1.25	Receive Trust's Annual Governance Statement 2018/19	Approval	GGi GGii	Pete Miller
10	1.30	Approve 2018/2019 Audited Financial Accounts	Approval	HH	Dani Cecchini
11	1.40	Approve 2018/19 Annual Report	Approval	II	Pete Miller

12	1.45	Approve 2018/19 Annual Quality Account	Approval	JJ	Anne Scott
13	1.55	Any other urgent business			Cathy Ellis

Extraordinary confidential meeting part 2/board development					
Item No.	Timings	Item	Purpose	Paper Ref	Discussion to be led by
1	2.00 30 mins	Staff voice – Learning Disability Service (including reference to QI)	Quality Improvement		Sarah Willis
2		Apologies for absence: and welcome			Cathy Ellis
3	2.30	Declarations of interest in respect of items on the agenda			Cathy Ellis
4		Minutes of the previous confidential meeting, 25 April 2019	Assurance	AAA	Cathy Ellis
5		Matters arising	Assurance	BBB	Cathy Ellis
Total for section = 35 minutes					
Strategy					
6	2.35 10 mins	Chief Executive's report *(including update on CAMHS reprovision, NHFT buddy arrangements, NHSI Undertaking letter previously circulated 9 May)*	Assurance	Oral	Pete Miller
7	2.45 5 mins	Sustainability Transformation Plan, Better Care Together and System Leadership Team briefing	Information	Oral	Pete Miller
8	2.50 30 mins	Updates on 2019/20 priorities: status report and key risks • Electronic Patient Record (10 mins) • Mental Health Inpatient Strategic Outline Case (20 Mins)	Progress on delivery of STEP up to GREAT priorities	Oral CCC	Sue Elcock Dani Cecchini
9	3.20 10 mins	Break			
Total for section = 55 minutes					
Finance and performance					
10	3.30 5 mins	Confidential Finance Report – month 1	Performance	DDDi DDDii	Dani Cecchini
Total for section = 5 minutes					
Quality					
11	3.35 20 mins	External review of Serious Incidents Presentation In attendance: Hilary McCallion	Quality Improvement	Oral	Anne Scott
12	3.55	Reportable issues log	Quality	EEE	Anne Scott

	5 mins		Improvement		
Total for section = 25 minutes					
Board development					
13	4.00 30 mins	Service presentation – LD service update *(short breaks/Agnes Unit/CQC follow up)*	Quality Improvement Links to High Standards priority	Oral	Helen Thompson
14	4.30 5 mins	Board development action tracker on priorities	Assurance	FFF	Cathy Ellis
15	4.35 20 mins	CQC Quality Summit Presentation – (Board review in advance of meeting on 5th June)	Assurance	Oral	Peter Miller
16	4.55 5 mins	Any Other Business – check if any further update is required to the Board Assurance Framework?	Assurance	Oral	Cathy Ellis
17	5.00	Close			

UNCONFIRMED

Leicestershire Partnership NHS Trust

Trust Board

Minutes of the Meeting held in public on Thursday 25 April 2019, 9.30 am

Framland Conference Room, County Hall

A

Present:
Ms C Ellis, Chair
Mr G Rowbotham, Non-Executive Director/Deputy Chair
Ms R Marchington, Non-Executive Director
Mr D Hickman, Non-Executive Director
Mr F Hussain, Non-Executive Director
Mrs E Rowbotham, Non-Executive Director
Professor K Harris, Non-Executive Director
Dr P Miller, Chief Executive
Ms D Cecchini, Director of Finance
Dr S Elcock, Medical Director
Dr Anne Scott, Interim Chief Nurse

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
Mrs M Morton, Minute Secretary
Mr M Farmer, Leicester and Leicestershire Healthwatch (participating observer)
Ms Cathy Geddes, NHSI Improvement Director

For item TB/19/075: Mr Dan Collard, Temporary Staffing Manager
For item TB/19/066: Ms Tamsin Hooton (Lead for Community Service Redesign)

		ACTION
TB/19/058	Apologies and welcome The Chair welcomed Chris Brooks (Clinical Governance Manager FYPC – participating in the Trust's 'We Nurture' programme), Dan Collard (Temporary Staffing Manager and Lead for the BAME network), Chris Moyo (Bank Workforce Supervision Lead), Nikki Beacher (Head of Service, CHS), Jude Smith (Interim Deputy Chief Nurse and Head of Nursing / Deputy Clinical Director for CHS – shadowing Dr Anne Scott) Jacynth Ivey (West Midlands Ambulance Service part of the Aspiring Chair programme – shadowing Cathy Ellis), Saskya Falope (Ashby Ward Sister, Bradgate Unit), Michele Morton (minute taker), Karen Mayo (Capita) and Kamy Basra(Head of Communications).	

		ACTION
	Tamsin Hooton (Lead for Community Service Redesign) would be attending to present the update on the Community Service Redesign. The Chair also welcomed those around the board table, including; Mark Farmer (representing Healthwatch as a participating observer), Cathy Geddes (NHS Improvement), Anne-Maria Newham (Interim Chief Executive, Lincolnshire Partnership NHS Foundation Trust) who would be joining the Trust in July as Director of Nursing, Kate Dyer (Head of Assurance).	
TB/19/059	Patient Voice	
	The Board watched a film introduced by Helen Biggs, Acting Ward Sister on East Ward at Hinckley & Bosworth Hospital, where patients with rehabilitation needs, medical step down from the acute Trust, and those that were not coping well at home were cared for. A patient, Betty Shingler (aged 91), talked about the care she had received and what dignity and respect meant to her. In particular: • She had been kept up to date on her care and treatment. • On entering hospital she was unable to walk, but could walk slightly better since treatment and gaining strength. • The food was good and everywhere was clean. • She felt she could trust every one of the nurses and was comfortable receiving personal care from male nurses.	
	Ms Bilsborough referred to a slight identified issue with the length of time answering patient call bells and explained this was due to the length of the hospital corridors and the large amount of space in hospitals generally. Mrs Beacher added that patients would often ring the bell to feel reassured and to be able to see a member of staff. As a result volunteers had been engaged and organised into teams, supporting teams of nurses and responding to call bells. Nurse stations had also been relocated closer to patient beds. Patients were also being encouraged to make better use of the day spaces to avoid feeling isolated.	
	Ms Marchington asked about the transition arrangements for patients stepping down from hospital care into residential homes. She also added that there was evidence that patients often lost mobility whilst in a hospital setting which was one of the drivers for keeping patients at home, however it was pleasing to see that Mrs Shingler's mobility had improved. Ms Bilsborough acknowledged a slightly increased risk when patients were moved, however when moving patients into a residential care setting each patient would have a therapy plan with outcomes, and an intensive community support team would visit the care setting. She added that local authorities were working closer with residential care homes, together with other services to support reablement.	

		ACTION
TB/19/060	Declarations of interest Board members confirmed that they had no conflicts of interest in relation to the agenda items. The Chair encouraged all Board members to record any declarations, or a nil return, on the new self-service LPT Declare.	
TB/19/061	Minutes of the previous public meeting, 28 February 2019 **Resolved: The minutes of the meeting held on Thursday 28 February 2019 were confirmed.**	
TB/19/062	Matters arising actions	
	Trust Board members reviewed the list of matters arising actions at Paper B. All actions were green and complete.	
TB/19/063	Chair's report	
	The Chair presented Paper C, which provided a report on her activities between 28 February and 25 April 2019 with patients, staff and stakeholders, and the events/committees she had attended. Also included were the activities of the Non-Executive Directors (NEDs). The following key highlights were noted:	
	Hearing the patient and staff voice • NEDS had been visible in their board walks, which were included in paper C. • The Chair had given the opening speech at the Infant Feeding conference held at the University of Leicester which had approximately 200 attendees, including LPT staff and volunteer breast-feeding peer supporters.	
	Staff engagement and quality improvement • Opening of the Bradgate Unit gym, financed through the Charitable Funds committee, a legacy from a previous patient. Board members had visited the gym, as well as newly refurbished ward and garden areas.	
	Stakeholder liaison • A number of key stakeholder meetings had been held during the previous month.	
	Good governance • A meeting had been held with Angela Hillary (CEO of outstanding Northamptonshire Healthcare NHSFT) and the executive team to benchmark and agree areas of support for LPT. Angela would continue to work with LPT to confirm and challenge on CQC progress. • A meeting had been held with Anna Pridmore who was conducting	

		ACTION
	an external governance review. • The date of the trust's Annual General Meeting had been established as Saturday 6th July 2019 and would be held at the University of Leicester in the Ken Edwards lecture theatre starting at 12.00 noon. This was part of a Health Fair event including other local organisations.	
TB/19/064	Chief Executive's Environmental Scan	
	Dr Miller highlighted the following from Paper D:	
	National; • The 10 year plan for the NHS had been published, with 3 priorities; best start in life, world class care for major health problems and ageing well. The workforce component was still awaited and that posed the biggest risk within the trust. A further key area was the development of primary care and primary care networks (PCNs) that were being developed locally, with an expected 23 across LLR, each with its own clinical director. A different focus would be placed on how the networks would be working together and it would be important for LPT to work with the networks to further develop enhanced integrated locality based services (place based and local). IT systems would be compatible with PCNs and one of the key priorities would be the development of Systemone.	
	Regional; • NHS Improvement and NHS England were working more closely together, with a single Director, Mr Dale Bywater. A local link person, Frances Shattock, would be provided for LPT and one of the priorities would be to hold both providers and commissioners to account.	
	Local stakeholders; • Dr Miller reported that he had been chairing the Senior Leadership Team (SLT) of the STP for the previous six months and would be shortly relinquishing the rotational position. Work continued towards progress of an integrated care system and also a single accountable officer appointment for the three CCGs. An announcement was awaited on a successful candidate. • Contract negotiations had successfully concluded in line with national expectations. • A productive meeting had been held with Leicester University on the development of an academic partnership. The Research Centre would be increased with an objective of further research development.	
	Board of Directors; • A welcome was extended to Anne Maria Newham who would be starting with the trust on the 1st June 2019 as Director of Nursing. • Preparations were in hand for a quality review meeting on 5th June with stakeholders which would have a focus on the CQC responses	

		ACTION
	and progress with the actions.	
	Organisational development; • The national WRES team held a listening event with a focus group of BAME staff. An action plan had subsequently been developed and a new Equality and Diversity Lead, Haseeb Ahmad had been appointed. A zero tolerance campaign would be launched shortly. • A cultural transformation programme had been launched during March where 92 change agents had been recruited from our staff and they would subsequently undertake training. Board interviews on cultural transformation would be held during May and work continued with the communications team to identify the current culture of the organisation and what needed to be done differently. • A STEP up to GREAT initiative on the definition of the trust's priorities had been launched to staff that provided clarity on the trust's key priorities and deliverables for 2019/20.	
	Service areas; • CAMHS waiting list reduction work continued and almost 300 access appointments had been offered within a week, which was expected to have a significant impact on access waiting lists. • The community services review continued at a pace with detailed clinical, finance, activity and operational modelling. • A visit had been received from the national perinatal services team. Feedback on progress had been positive • Refurbishment was almost complete on two of the wards at the Bradgate Unit.	
	Mr Farmer informed Board members that Healthwatch England had been one of the lead bodies on the consultation of the 10 year plan for the NHS.	
	Mr Farmer referred to the mental health transformation project and the review of the community health services, and he asked if there was any evidence of social services co-liaison between the two reviews, and how priorities might be integrated to improve service provision. Dr Miller replied that liaison took place at a senior level, via the SLT (that included City and County) where shared objectives would enable the development of integrated locality services and locally based integration. Ms Bilsborough added that active engagement took place with local authority partners who were supportive of co-design. Furthermore Ms Thompson reported collaboration also took place within mental health services. The mental health partnership board was piloting a number of social care collaborations, one of which was looking at different ways of working.	
	Resolved: The Trust Board considered the Chief Executive's report and environmental scan.	

		ACTION
	Strategy	
TB/19/065	LPT 2019/20 Priorities Launch	
	Dr Miller presented paper E that set out the vision, priorities, objectives and values of the trust, developed in conjunction with the executive team and the communications team. Board members noted the following:	
•	Narrative had been developed following reviews by NHS Improvement and the CQC that included clarification of trust priorities, actions and work areas.	
•	Information formed part of a 'STEP up to GREAT', achievement of high standards and getting it right first time.	
•	There was a need to ensure strategic outline business cases were appropriately developed and produced (notably for the Bradgate Unit) and that patients were involved in the co-design of services to ensure they were well governed.	
•	A single electronic patient record migration from Rio to System one was underway.	
•	There would be an overarching approach to quality improvement and a focus on the nine priorities, to be performance managed by the executive team.	
	Mr Rowbotham reported that he had received positive feedback on the STEP up to GREAT following a service visit. He emphasised the importance of getting things right the first time, every time and from a branding perspective he stressed that it would be important not to have any variations on the wording. He added that the challenge was a difficult one, however consistent language and the same order was an important factor for the brand.	
	Mr Hussain said considerable work had contributed towards the final vision and priorities and it would be important to ensure robust future monitoring and implementation. As part of the organisational development and strategic performance management, each member of staff must recognise how they were able to make an appropriate contribution and how they were improving the health and wellbeing of patients.	
	Mr Farmer said it was useful to know how outcomes impacted on service user experiences and care and when Board members held a further review then Healthwatch and patients should be more closely involved. Dr Miller replied that the issue had been debated and the importance acknowledged of involvement of other organisations.	

		ACTION
	Mr Farmer asked if the document would translate into performance indicators, and the Chair replied that each priority would be provided with resources and KPIs where there would be an excellent opportunity for further patient involvement. Dr Scott added that STEP up to GREAT had been discussed at a café conversation and that the clinical priorities that under-pinned the work was currently being consulted on; she said she would welcome the support of Mr Farmer in respect of involvement and collaboration.	
	Resolved: The Trust Board considered the LPT 2019/20 Priorities Launch	
TB/19/066	Better Care Together (BCT) and Sustainability and Transformation Partnership (STP) status and System Leadership Team (SLT) updates	
066.1	Dr Miller explained that BCT, STP and SLT had a combined aim of improving system working and from the perspective of good governance one of the objectives was to develop a memorandum of understanding. As part of that the importance was acknowledged of ensuring greater involvement of NEDs, CCG boards, councils and other partners.	
066.2	STP Partnership Group Terms of Reference	
	Dr Miller presented paper F and explained that a few minor changes had been made to the STP terms of reference since the previous SLT meeting. The STP would hold the SLT to account on how organisations worked together and that they were signed up to a collective endeavour rather than individual boards.	
	Ms Marchington felt the terms of reference were not sufficiently clear around being held to account for outcomes for service users. Dr Miller felt the issue was partially covered under point 7 of the terms of reference which explained that organisations would be expected to behave in a way that delivered collectively rather than individually. Ms Marchington felt that a gap still existed and the Chair agreed that PM should feed back her comments.	**PM**
	Ms Bilsborough said she had expected to see a more explicit statement around the purpose and accountability relating to the SLT. She felt it was also important for the STP Partnership to identify and oversee timescales on delivery. Ms Thompson added that reference should be more explicit around the group's purpose for the population regarding health and wellbeing.	
	Ms Thompson sought clarification on the arrangements with the three CCGs and one accountable officer. Dr Miller replied CCGs had not merged but would have a single accountable officer. A further management of change process where a merger was anticipated, would take approximately a year to complete.	

		ACTION
	The Chair agreed that PM would feedback the above comments. Dr Miller agreed to circulate any further iterations of the terms of reference outside the meeting.	**PM** **PM**
	Resolved: The Trust Board received the update on the work related to Better Care Together (BCT), Sustainability and Transformation Partnership (STP) status, System Leadership Team (SLT), and approved the STP Partnership Group terms of reference.	
TB/19/067	STP Workstream update – Community Service Redesign update	
	Ms Hooton gave a presentation on the LLR Community Services Redesign programme that included:	
	• Summary of the new model	
	• An established community services transformation group	
	• Engagement events and a summary of feedback from those events	
	• Specification developed and the progress towards sign-off	
	• Identification of operational and financial implications	
	• Time frame for implementation in 2019/20 and transition to new team structures	
	• Key risks and next steps	
	Professor Harris said he agreed with the proposed new model but felt the risks were significant, notably around affordability and also workforce. Ms Hooton replied that it was important to recognise that there was insufficient capacity in community health services at present to provide the required quality of care, and consideration must be given on how to move towards increased capacity that would include ensuring staff were part of appropriate team structures and that staff were working in the best possible way. That would include working with primary care and crisis response. Considerable duplication currently existed though it was important not to downplay the scale of the challenge which must be faced collectively.	
	Ms Hooton reported that the community services review programme was trying to establish a way of working that allowed the development of a workforce that built on career progression, therapy delivery in people's homes and progress had been made in other parts of the country with a similar integrated care model. A large amount of work was carried out in hospitals that could be delivered within the home environment.	
	Professor Harris agreed with Ms Hooton's comments but expressed concern that if the calculations were unworkable then patients would come to harm. He felt the workforce gap was too large. Ms Hooton replied the potential existed to keep people at home and also that it	

		ACTION
	was important not to make too many assumptions. She added it was possible to maintain management of the same number of people in a better way than presently. Capacity would be increased prior to the reduction of hospital admissions.	
	Mrs Rowbotham referred to some recent disquiet regarding levels of concern with carer services and she asked how that was being addressed. Ms Hooton replied that further work needed to be carried out, particularly on the community equipment model which was due to go out for retender. Mrs Rowbotham said it was important to know what would inspire the confidence of carers to keep an elderly person at home. Carers needed to be high profile as ultimately it would be their decision on which services to access.	
	Ms Marchington referred to the current work around productivity gains and she asked if data was available that sat behind the figure of £1.9 million. Ms Hooton replied that broadly gains were from community nursing, staff in therapy teams and ICS. Ms Bilsborough added as part of the transformation scope there was an awareness of productivity opportunities, along with skill mix and remodelling. She felt confident about the productivity gains and confirmed to Ms Marchington the importance of having data to substantiate the position and to avoid double counting.	
	Mr Hussain said he would appreciate further clarification on the aims of the changes and how improvements in health and wellbeing would be made to patient outcomes. He referred to the whole system change and asked if any pilot projects had been carried out to identify potential problems or risks. Ms Hooton replied the purpose of the changes was as a result of population management, integration and feedback from patients, carers and staff. She added elements of the programme were being piloted, specifically within the integrated locality teams. Some fundamental barriers had been faced but also feedback had been positive from a number of early implementers, including an appreciation of how a real integrated multi-disciplinary team should work. A home first model of integrated triage had been piloted and those pilots had made great strides.	
	Following a recent service visit Mr Rowbotham said he felt the staff did support the community service changes but were less clear about the timescales for delivery and that was causing some unnecessary distress. Ms Bilsborough explained that the next round of engagement events would be held in May and Ms Hooton would be invited to participate in those.	
	Mr Rowbotham felt the disinvestment element posed a risk and Ms Hooton said it was difficult to confirm certain arrangements when decisions had not been fully made. Ms Cecchini added that it would also be important for the trust Board to sign off a final model, specifically within the context of risk awareness. The trust would be working with primary care networks and it would be important to know	

		ACTION
	what was being recorded and who was monitoring and confirming that arrangements were safe.	
	Dr Scott said she assumed a quality impact assessment had been carried out and that it was dynamic. She said she would welcome sight of that. Ms Hooton replied that a quality impact assessment had been carried out on the final model, but that did not include the risks.	
	Ms Cecchini said it would be important to know who was accountable for the delivery of the model and any possible impact on finances. She also sought reassurance that the trust would have the ability to influence any inter-dependencies. The Chair asked that the executive team considered the above comments and to then feedback to board members once the risks and quality impact assessment had been reviewed.	**DC**
	Resolved: The Trust Board received the presentation on the Community Service Redesign.	
TB/19/068	Board Assurance Framework (BAF) 2019/20 arrangements	
	Ms Dyer presented paper G, an updated BAF that was being developed for 2019/20. Risks to the achievement of the 2019/20 strategic objectives and priorities had been identified and had been included in the report. Work was on-going to further scope the risk descriptors, and to identify the controls, assurances, gaps, actions and risk scoring prior to submission for approval to the May Board.	
	Ms Dyer reported that work continued on the reformatting of the document and the strengthening of some of the content.	
	Board members noted that the sub-committee terms of reference would be updated to align with risk areas.	
	The Chair thanked Ms Dyer for her work on updating the BAF.	
	Recommendation: The Trust Board received an update on progress with the 2019/20 Board Assurance Framework and approved the BAF risks identified for 2019/20.	
	Performance and assurance reports	
TB/19/069	Quality Assurance Committee (QAC) highlight reports	
	Mrs Rowbotham presented the highlight reports at Paper Hi and Hii from the meetings on 19 March and 16 April 2019. She drew the attention of the Board to the following items:	
•	The single red area from the 19th March meeting was adult mental health and learning disabilities 18 week waiting time target for ADHD	**GR**

		ACTION
	referrals. Mr Rowbotham agreed to raise the issue in the FPC report to the Board.	
•	Two children had been admitted to an adult ward. Dr Elcock confirmed to Mr Farmer that the children were not of a young age and were almost adult. Due to the level of risk they posed it was deemed safer to admit them to an adult ward rather than keep them at home. The stay was also for the shortest possible time.	
•	Paper Hii had a new format where the main changes had derived from a request to be clearer around why a specific assurance level had been awarded, rather than just commented on. Also when actions were being taken on risks a request had been made for timelines to be added.	
•	A series of deep dives had taken place on quality risk areas, for example, record keeping, care plans, care planning and patient and carer involvement.	
•	The focus on adult mental health care planning was noted, that included the need to be mindful that the community health services risk should be included within that.	
•	The QAC received and approved LPT's annual declaration of compliance for 2018/19 with regard to eliminating mixed sex accommodation. Dr Scott reported a slight change had been made to some of the wording to ensure the declaration was more transparent and clearer (removing the words in paragraph 2 'in an emergency' and adding in paragraph 3 'in adult mental health, in an emergency patients may be admitted to an ensuite bedroom').	
	Resolved: The Trust Board received assurance on the issues raised in the Quality Assurance Committees of 19 March and 16 April 2019.	
TB/19/070	Finance and Performance Committee (FPC) highlight reports	
	Mr Rowbotham presented Paper Ii and Iii from the meetings held on 19 March and 16 April 2019. There were a number of points within the reports on the board agenda. He noted the following from the two meetings:	
•	Good assurance was received on financial outcome and contracts, and the achievements in both of those areas were acknowledged with thanks given to all concerned for their hard work.	
•	A monthly dashboard had been developed for estates and facilities. Within that the CAMHS new unit NHS capital investment position was confirmed and contracts should be in place by the end of April 2019.	
•	A strategic outline case was on track for the Bradgate Unit and should	

		ACTION
	be presented to the Trust Board in September 2019.	
•	In respect of the waiting times summary report and improved action plan, updates were received on: • 52 week waits where overall the numbers had reduced significantly. • 2 national targets were not met in AMH services (adult ADHD and ASD). Recovery proposals would be developed by the executive team to provide FPC appropriate assurance. • Current capacity in CAMHS was broadly sufficient to meet demand and the team were working on reducing backlogs with clear trajectories given • Some improvement in performance was noted for 8 services identified as a priority for action. The Chair added that the Trust was expecting to see trajectories against each of the waiting times targets and Dr Miller confirmed that the executive team would be considering that prior to the next Board meeting.	
	FPC received limited assurance concerning the overall Trust's waiting time position.	
	Resolved: The Trust Board received assurance on the issues raised in the Finance and Performance Committee of 19 March and 16 April 2019.	
TB/19/071	Finance monthly report	
	Ms Cecchini reported that the final accounts had been submitted on the 24th April 2019 in line with the timetable specified by the Department of Health. She added that LPT had met all of the statutory duties, which included a break even position, capital resource limit, cash limit and 99% CIP achievement.	
	Ms Cecchini said a key plan had been to deliver £3.2 million surplus as part of the provider sustainability surplus to support the national position. £2.2 million had also been redistributed from central funds to LPT that provided an overall surplus of approximately £5.5 million, of which £900,000 was generated by LPT and helped the cash position. The bonus £2.2million has restrictions how it could be used by LPT.	
	The Chair thanked all who contributed toward the final position and Dr Miller added that the message surrounding the financial position required careful handling, notably at the Annual General Meeting, as some services were still finding it difficult financially.	
	Resolved: The Trust Board noted the oral update.	
TB/19/072	Strategic Programme progress report, quarter 4	
	Ms Cecchini presented Paper J, the aim of which was to provide	

		ACTION
	assurance on the mechanism for delivery of the strategic objectives, with an update on delivery and exception reports for any projects with a red RAG rating.	
	Mr Rowbotham congratulated Ms Cecchini for the introduction of actions to help with the difficulties some people were experiencing with the new system and he hoped that would improve the risk position and mitigation around the key milestones.	
	Mr Rowbotham felt the priorities list in the report should be aligned with the priorities for the year 2019/20. Ms Cecchini replied that discussion had taken place on how best to use the system and she confirmed the list would be used to check progress against the 9 strategic priorities. She added that it was important the list remained live and that a multitude of reporting mechanisms should be avoided.	
	A brief discussion was held on the usefulness of the project management system and Ms Cecchini said information was currently being transferred from an old to a new version of the software for the system. Once that was complete it would be possible to take stock and determine whether the new system was adding value.	
	Mr Hussain said it was important that project managers fully understood the methodology behind the various projects and that they were confident in the use of the system. Dr Elcock replied that some areas were better resourced than others in terms of support for staff and a review should be held to identify how that might be improved.	**DC**
	Resolved: The Trust Board noted the position with regard to the strategic priority projects and received the exception reports as shown.	
TB/19/073	Integrated Quality and Performance (IQPR) monthly report	
	Paper K provided an integrated quality and performance dashboard that showed levels of compliance against key targets set by NHS Improvement, including the Single Oversight Framework, commissioners and others. Commentary was included on those areas requiring additional actions to ensure that targets and objectives were met. The report also provided analyses on specific areas of quality and performance, that included financial and workforce information which had been discussed at QAC, FPC and the Strategic Workforce Group, and identified in their highlight reports. Appended to the IQPR were schedules on waiting times compliance in the services.	
	Mr Rowbotham highlighted Clostridium difficile cases as an area where LPT had met the target with headroom space.	
	A brief discussion was held on identification of KPIs for the year. Ms Marchington asked for reassurance that the executive team were considering KPIs and linking them to the priorities of the BAF. The	

		ACTION
	format of the IQPR report could then be reviewed. Ms Cecchini replied that work still needed to be carried out with an objective of increasing visibility and further clarification on which KPIs would be targeted together with their trajectories. Information would be ready in May or June and results would be aligned with the final evaluation of the performance management framework for Board.	
	Resolved: The Trust Board; • **Received assurance with regard to areas of quality and performance where performance improvement action was being undertaken;** • **Received assurance of the NHSI compliance score of two;** • **Received the waiting times compliance tables.**	
TB/19/074	Audit and Assurance Committee (AAC) highlight report	
	Mr Hickman presented Paper L, the highlight report from the meeting held on 1 March 2019. He reported that in respect of the internal audit follow-up of actions, further work was being carried out by the Executive Team to ensure that the appropriate organisational culture existed. A deep dive had been planned for the May AAC meeting, however that had since been deferred. The governance review would now be taken as the deep dive.	
	The Chair said that the follow-up actions had been discussed by the executive team and she questioned whether a deep dive on this area was still necessary. Dr Elcock felt it would be helpful to have a better understanding that the issues and processes were working and that the procedure was closely linked to the BAF.	
	Board members acknowledged the AAC needed to assure itself that new processes had been established for closing down management risk actions. Mr Hickman said discussion could help with the forthcoming development day and he was interested in exploring a piece of work with Ms Cecchini on the format of the AAC.	
	Resolved: The Trust Board received assurance on the issues raised in the Audit and Assurance Committee of 1 March 2019.	
TB/19/075	Strategic Workforce Committee (SWG) highlight report	
	Dr Miller presented Paper M, the highlight report from the meeting held on 13 March 2019. Key points were:	
•	Significant work was being carried out around the staff survey results where work had commenced on the organisational culture and an action plan for the Workforce Race Equality Standard (WRES). He added that one area where more assurance was required was that processes and actions were in place to deliver required outcomes for recruitment and retention and risks around vacancies.	

		ACTION
•	Overall turnover had reduced but remained a significant risk and the approach to that was under review.	
•	The number of temporary staff had recently increased however spend on agency had reduced from £12 million to £8 million over the previous 3 years.	
	Mrs Willis reported that the bank staff survey results had been discussed at the SWG where it was reaffirmed that bank staff had equal status as substantive staff. She added that all actions from the bank staff survey were being integrated, particularly those that related to the BAME workforce. Mr Rowbotham thanked Mrs Willis for her work and welcomed the development of the above approach and that groups of staff were all seen as the same. Dr Miller said work on the bank staff survey was excellent and Mr Dan Collard was thanked for his contribution to that work. We need to ensure further work with bank staff continues to ensure that we deliver the actions and improve their engagement.	
	The Chair noted the much improved position on mandatory training but that further progress was needed for bank staff.	
	Resolved: The Trust Board received assurance on the issues raised in the Strategic Workforce Group of 13 March 2019.	
TB/19/076	Listening to and Engaging our Staff	
	Mrs Willis presented Paper N. Key points were:	
•	92 members of staff had put themselves forward for change champions. They would be organised into 4 teams in order to provide a spread across the organisation. Some analysis had been carried out on the 92 champions that provided significant diversity across professions, bands and ethnicity.	
•	LPT has been cited nationally for its work which had been done on the bank survey as it was not known that other trusts did this. The Trust had been approached by the national WRES team to present work in relation to the bank staff survey at a national conference.	
•	With regard to the staff survey a discussion had been held at the HR Directors Workforce Group on regional comparisons. The Trust was the most improved regionally on the theme of harassment and bullying.	
	Ms Marchington said she welcomed the review held to ensure a strategic approach to priorities and the new dashboard had picked out some of the indicators. She emphasised the importance of having conversations to ensure a strategic approach linked to Trust priorities.	

		ACTION
	The Chair referred to the listening into action section of the report and she circulated information on an initiative from a staff member which was the wearing of a green lanyard to indicate that she was a newly qualified member of staff and would as a consequence require extra support.	
	The Chair highlighted the key actions that had been identified following the big bank survey 2018, with attached timescales and she was pleased to see the positive direction on the WRES work.	
	Resolved: The Trust Board; • **Supported the current mechanisms and activities in place for engaging staff and the actions being taken.** • **Reviewed progress made in terms of engaging staff and responding to staff feedback.** • **Agreed to receive a revised strategic approach to staff engagement at a future Trust Board meeting.**	
TB/19/077	Charitable Funds Committee (CFC) highlight report	
	The Chair presented paper O and highlighted the following key points from the report of the meeting held on 5 March 2019:	
•	Raising Health launched its new website on 5th March that profiled the fundraising projects and also allows members of the public to make on-line donations. Charitable funds did make a real difference to patient care and the charity would be further promoted in the community hospital sites.	
•	The staff lottery participant numbers had increased by 10% since quarter 2. Proceeds contributed towards health and wellbeing initiatives. There had been increasing participation from staff in the lottery.	
	Resolved: The Trust Board received assurance on the issues raised in the Charitable Funds Committee of 5 March 2019.	
TB/19/078	Mental Health Act Assurance Committee (MHAAC) highlight report	
	Mr Hussain presented Paper P, the highlight report from the meeting held on 9 April 2019. He noted the following:	
•	A report was received on the policy database which was a key monitoring tool ensuring MHA policy and code of practice were implemented and up to date. The senior MHA administrator would be carrying out a review to identify any gaps.	
•	Some service specific policies and procedural documents were difficult for staff to access, with no evidence that they were appropriately updated. Further discussion was held on a wider issue of a lack of a	

		ACTION
	single Trust wide repository that all staff were able to access easily on the staff intranet	
•	An update was received on the deep dive into the community treatment order and quality improvement collaborative focused session.	
•	An update was received on the proposal to scope out the idea for the creation of a legal office. Further analysis would be required once the outcome of the governance review was known.	
•	The MHAAC received highlight reports from service areas which did provide assurance. However the recent CQC MHA visits had highlighted a number of recurring themes around CPA, privacy and dignity, medicine management, ligature risks and general environment issues. The issue made the committee consider whether false assurances were being received. As a result all services leads would be reviewing the CQC action plans following visits in order to identify and address any fundamental issues.	
•	Concern was noted from the most recent CQC MHA visit that had highlighted key issues with the use of seclusion and its appropriate recording. MHAAC would subsequently carry out regular scrutiny on all MHA actions assigned to it and ensure they were completed on time, with lessons learned and shared.	
•	A verbal update was received on the change of provider for Independent Mental Health Advocates (IMHA) services from LAMP to POhWER. Dr Miller informed Board members that service was commissioned by the local authority.	
	A brief discussion was held on accessibility of key policy documents on the staff intranet. Mrs Basra said a new staff intranet was being tested out shortly prior to a full launch. Dr Miller acknowledged there were currently some difficulties around accessibility which would also be picked up by the governance review.	
	Resolved: The Trust Board received assurance on the issues raised in the Mental Health Act Assurance Committee of 9 April 2019.	
	Quality improvement and compliance reports	
TB/19/079	Safer staffing – monthly report	
	Dr Scott presented paper Q, the monthly report that provided assurance to the Board on the Trust's response to the National Quality Board (NQB) safer staffing guidance. The report provided an analysis of safer staffing in two parts; part one referred to Trust inpatient areas and part two related to community teams.	

		ACTION
	Mr Rowbotham commended the report which he felt had considerably more granularity than previously. He asked if it was possible to start to take a more forward looking view. Dr Scott agreed to hold further discussion Mr Rowbotham outside the meeting.	**AS/GR**
	Mr Hickman referred to the gradual increase of temporary workers, with one ward in particular operating at 66%. He asked whether that situation was workable, whether the trend was expected to continue and if any problems were envisaged. Dr Scott explained that the temporary staffing situation was related mainly to covering sickness and maternity leave. Mrs Willis added the issue had been discussed at the SWG and a plan was being developed to increase the level of bank staff so there were no concerns at the present time. Agency staff numbers were declining and bank staff numbers were increasing as part of the Trust's workforce. As part of the development of workforce safer standards a further establishment review would be carried out in July.	
	Ms Marchington felt the strategic initiatives carried out around the different areas were beginning to have a positive impact and that was beginning to be reflected in the safer staffing report. One example was the positive outcomes of the nurse associate appointments.	
	A brief discussion was held on the importance of linking the strategic approach to staffing with what actually took place on ward areas. For example the 66.5% of temporary workers on Griffin Ward would be based on levels of acuity and observations which Dr Scott said was assessed on a daily basis.	
	The Chair asked what action was being taken to address current concerns with the district nursing teams based in Leicester City. Ms Bilsborough replied that in the first instance block contracts for well trained temporary staff were being secured. She added a broader issue existed around recruitment challenges within the city but using well trained temporary staff to support the teams had the biggest impact.	
	Resolved: The Trust Board received assurance that processes were in place to monitor and ensure that inpatient and community nurse safer staffing levels were maintained.	
TB/19/080	Care Quality Commission (CQC) progress update	
	Ms Dyer presented paper R and outlined the 3 phase approach in responding to the actions identified by the CQC in the 2018/19 warning notice and inspection report. In particular she referred to phase 2 that required a systematic wholesale approach to making improvements. A phase 3 approach was currently being worked on to ensure that all the checks and processes would be built on, followed up and also that spot checks for phase 3 would be launched on the 3 May 2019. Mrs	

		ACTION
	Rowbotham said a lengthy discussion had taken place at the QAC and they were supportive of the approach being adopted.	
	Mr Farmer reported he had met with Ms Dyer recently and had suggested that Healthwatch might be more involved in phase 2. He also looked forward to working with the new Head of Patient Involvement. Ms Dyer added work continued on the most appropriate way of sharing the phase 2 work.	
	With regard to the 27 May CQC warning notice deadline, Dr Miller reported that the Trust currently had a fortnightly review of the actions and the Trust Board would be updated on progress. A report would be submitted to the CQC tomorrow and other relevant stakeholders to show the significant and consistent progress made. The executive team would also be reviewing the actions on a weekly basis and evidence was being gathered for a return visit of the CQC in June and July 2019. Ms Thompson said the 2019 process was significantly more robust than previously and was also linked into ongoing quality improvement. Further assurance would be gained once the outcomes into key areas were more apparent.	
	Resolved: The Trust Board received the proposed approach for responding to the CQC findings.	
TB/19/081	Suicide Prevention Plan (inpatients)	
	Dr Elcock reported that a paper had been due for submission to the Board, however following submission of a report to NHS England, they had subsequently introduced a further phase of feedback for all trusts. The final report would be available at the May Trust Board meeting. Dr Elcock made the following comments:	
•	A regional peer group had been formed that recognised the challenges to be faced. An initial meeting had been held the previous week which was helpful and representatives from Coventry had shared their very supportive work on Suicide Prevention.	
•	Work continued with patient experience and involvement and closer working was occurring with the patient safety teams. At the meeting it had been agreed that plans would be both similar and aligned.	
•	Dr Elcock reported that a Suicide Prevention Plan would be submitted to NHS England at the end of April and content was based very much on national guidance on suicide prevention. Much of the content also linked to issues with the CQC.	
	Resolved: The Trust Board noted the update on the Suicide Prevention Plan.	

		ACTION
	Governance and risk	
TB/19/082	Review of Risk	
	Dr Miller advised that Paper S provided the summary Corporate Risk Register (CRR)/Board Assurance Framework (BAF) and the top five service risks. A significant review of the Trust's approach to the BAF and risk registers had been undertaken.	
	A brief discussion was held on the process for future receipt of risks escalated from service risk registers and how they translated on to the BAF. Ms Dyer added it had not been decided whether the top 5 risks from each Directorate would still be listed. Board members noted the BAF would be much more detailed in the future and risks would be linked into the sections of the Board highlight reports.	
	Resolved: The Trust Board reviewed the summary Corporate Risk Register/Board Assurance Framework and top 5 risks.	
TB/19/083	Codes of Conduct and Accountability (including Fit and Proper Persons self-declarations)	
	Mr Lusk presented Paper T and explained that annually the Trust Board members were asked to affirm their commitment to the Department of Health 'Codes of Conduct and Accountability for NHS Boards'. Mr Lusk reported that the Code included the requirement for conflicts of interest to be declared by all staff, including Board Directors. All committee agendas included an item for members to declare any conflicts of interest that related to the business of the meeting. In addition, during 2018/19 a new on line system, LPT Declare, had been introduced to staff to enable them to self-declare. Mr Lusk advised, following a question from Ms Marchington on the guidance included in the pack of papers, that it was acceptable for the Chair of Audit committee to hold also the role of Senior Independent Director.	
	Resolved: The Trust Board; • **Reaffirmed its commitment to the principles contained in the Codes of Conduct and Accountability for NHS Boards.** • **Reaffirmed its commitment to the Standards for members of NHS boards and Clinical Commissioning Groups governing bodies in England.**	
TB/19/084	Standing Orders (SOs) and Standing Financial Instructions (SFIs) and Scheme of Reservation and Delegation (SoRD)	
	Mr Lusk presented paper U, the Trust's SFIs that included the SORD	

		ACTION
	which was last approved and updated in March 2018. The Trust's SOs had been reviewed and no changes had been required. A full copy of updated SOs, SFIs and the SORD was available on request.	
	Resolved: The Trust Board approved the proposed SOs, SFIs and SORD amendments.	
TB/19/085	Receipt of documents for information	
	Resolved: The Trust Board confirmed receipt of; • **System Leadership Team, November 2018 and February 2019** • **Health and Wellbeing Board Annual Report 2018 (from QAC)** • **Sexual Safety Annual Report 2018-19 (from QAC)** • **Quality Impact Assessment for Nursing Associate (paper Q refers)** • **Better Care Together bulletin March 2019** • **Eliminating Mixed Sex Accommodation annual declaration (from QAC)**	
TB/19/086	Any other Business	
	There was no other business.	
TB/19/087	Public questions on agenda items	
	There were no public questions.	
TB/19/088	Date of next meeting	
	The next public meeting would be held at 9.30 am on Thursday 23 May 2019, at the NSPCC.	

Leicestershire Partnership NHS Trust

B

TRUST BOARD 23 May 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)
880	April TB/19/066.2	STP Partnership Group Terms of Reference Board feedback - Gap in clarity about being held to account for outcome for service users - More explicit statement on purpose and accountability, and timescales on delivery - Purpose for the population regarding health and wellbeing.	Peter Miller	May	
881	April TB/19/066.2	Circulate further iterations of the STP Partnership Group terms of reference when available.	Peter Miller	May	

Action No	Meeting month and minute ref	Action/issue	Lead Officer	Due date	Outcome/evidence (actions are not considered complete without evidence)
882	April TB/19/067	STP Workstream Community Service Re-design Executive team to consider comments made on who was accountable for delivery of CSR and any possible impact on finances.	Dani Cecchini	May	
883	April TB/19/069	Raise issue at FPC on single red area from 19.3. meeting around adult mental health and learning disabilities 18 week waiting time target for ADHD	Geoff Rowbotham	May	
884	April TB/19/072	Review project management system to see how support for projects can be improved.	Dani Cecchini	May	
885	April TB/19/079	Hold further discussions on having a more forward looking view on safer staffing monthly reports.	Anne Scott/Geoff Rowbotham	May	Meeting being arranged.

C

LPT Chair's report summarising activities and key events:

Trust Board 23rd May 2019

The period covered by this report is from 25th April 2019 to 23rd May 2019

Hearing the patient and staff voice	• Boardwalks to Children's Speech & Language Therapy and Stewart House (Adult Mental Health rehab services) • Non-Executive Directors (NEDs) 4 boardwalks to: CAMHS access, Diana team, Frail Older Persons Advice & Liaison service, Health Visiting Melton/Rutland • Meeting with two carers to explore how we can better involve them in developing LPT services • Visit to the LPT Recovery College – launch of promotional film
Quality improvement (QI)	• Gave the opening speech at the "Learning from when Young People take their own lives" - multi-agency conference focused on Quality Improvement • Attended LPT Nurses conference – strong focus on Accountability, Leadership and Quality Improvement
Equality Leadership & Culture	• Attended two STEP up to GREAT staff briefings which focus on our 9 priorities for 2019/20 • Interviewed by Change Champion as part of the LPT Culture programme "Our Future, Our Way" • Mentoring meeting with BAME Aspirant Chair from another trust
Stakeholder liaison meetings	• Attended CEO and Chairs meeting with Simon Stevens (NHS Chief Executive) and Baroness Dido Harding (NHSI Chair) • Attended NHSI Regional Chairs meeting hosted by Dale Bywater NHSI Regional Director • Meeting with Frances Shattock – Regional NHSI Director of Strategic Transformation • Attended STP senior leaders development session for the LLR system • Meeting with LLR Chairs to discuss CCG collaboration and STP developments • Meeting with Dee Sissons, CEO of Rainbows • University of Leicester : Council meeting
Good Governance / Board development	• Attended Audit committee to observe as part of the governance review and NED appraisal process • Attended Quality Committee and Finance & Performance Committee • Interviews for Consultant appointment to Old Age Psychiatry • Planning for Board development session in June to focus on our 2019/20 priorities, Quality Improvement and preparation for our next CQC visit

Abbreviations:

LLR = Leicester, Leicestershire & Rutland; **STP** = Sustainability and Transformation Partnership;

NHSI = NHS Improvement – regulation & oversight of NHS provider trusts; **CQC** = Care Quality Commission

UHL – University Hospitals of Leicester ; **CCG** –Clinical Commissioning Group;

CAMHS – Childrens and Adolescents Mental Health Services; **BAME** = Black Asian Minority Ethnic

May 2019 ENVIRONMENTAL SCAN

D

National

- 10 year plan for the NHS published -3 priorities, best start in life, world class care for major health problems and ageing well. Delivered through 5 areas – doing things differently, prevention, backing our workforce, digital technology, and efficiency. Workforce plans during summer
- Publication of NHS people plan due soon – key priorities – culture, making the NHS a great place to work, leadership, nursing supply, flexible careers.
- Simon Stevens and Dido Harding visit to midlands region – 15/5/19 – focus on 10 year plan, GP networks, a new focus for community health services 'synching' response times. Obsolete outpatient appointments. Supported by IM&T, workforce and estate.

Board – Board of Directors

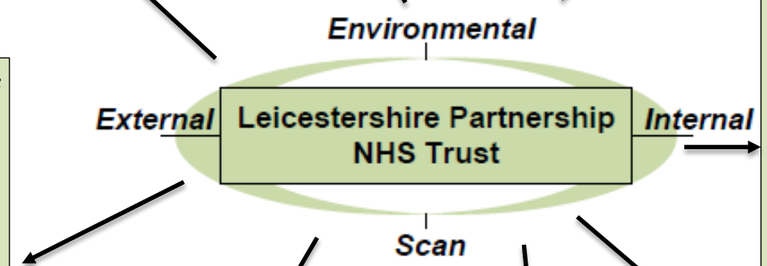
- CEO announces his retirement – recruitment process underway
- Board development – focus on key Priorities – CQC response, culture, priorities, improvement and governance.
- Appointment of Director of Nursing - Anne Maria Newham – start date 1st June. Anne Scott, interim chief nurse.
- Cathy Geddes, working with board as improvement director

Regional

- NHSi performance rating – SoF level 3 (CQC report impact)
- Undertakings letter received – outlining expectations of CQC response, reducing waiting times and the development of a quality improvement plan
- Local workforce action board (LWAB) meeting in May – focus on strategy development in light of new NHS plan. Priorities of

Organisational Development

- Buddying Relationship developed with Northants Healthcare
- National WRES team held listening event with focus group of BAME staff, actions developed. Appointment of new Equality and diversity lead – Haseeb Ahmad
- CQC inspection report, expectation of completion of initial action plan by 27 May. Quality review meeting on 5 June
- Cultural transformation approach launched in March – 92 change agents recruited – training in May. Board interview started
- International Nurses week celebrated across Trust – Mrs Mason, coroner, gave keynote address to nursing conference



Directorate Focus: FYPC

- Good response to the 'Learning from when Young People Take Their Own Lives Conference 8th May.
- 5 'stocktake' engagement events have been held to discuss and plan service changes with the Healthy Together team in response to the planned reduction of the Public Health Grant and contract. Hundreds of staff in the team have been involved so far.
- CAMHS Access average waiting time for assessment has reduced from 22 weeks in March to 8 weeks and continues to fall, and the number waiting has reduced by 350.
- 100 plus responses to the Random Acts of Kindness initiative in April.

Local Stakeholders

- SLT, publication of 'next steps' document. Focused on STP planning and delivery. Developing approach to integrated care system. SLT in May– working towards an ICS – approving Governance and partnership board. Understanding the impact of Primary care networks. Expectation of provider alliances
- Monthly performance review meeting with NHSi – risks on CQC rating, CAMHS waiting list trajectory, well led framework
- Local CCGs working appointing single accountable officer
- Contract agreed for 2019/20
- Local Primary care networks starting to form

Directorate Focus: CHS

- Visit by CQC to city district nursing teams
- Directorate arranged and hosted first ever TPP Autoplanner conference attended by 38 Trusts and 98 delegates
- Detailed clinical, finance, activity and operational modelling continues for Community Service Redesign work
- Community Service Redesign public engagement events taken place across city and county – useful feedback

EM Research/Innovation

- CRN partnership group – CEO chairs – focus on recruiting to time and target – national performance review – high performing CRN
- UoL/LPT/UHL strategic meeting – agreed in principle the development of an Academic health partnership.
- Vice-Chancellor changes at both Leicester universities.

Directorate Focus: AMH/LD

- A Safety Huddle briefing has been established each morning on the BMHU for unit leaders to share information on acuity, staffing and pipeline issues
- Refurbishment of Ashby ward is now complete and Bosworth ward is nearing completion
- All acute wards are now smoke-free and staff are offering alternatives to smoking on admission including vapes and other NRT products

Dr Peter Miller
Chief Executive

Paper E

Better Care Together Partnership update

A business update for partner boards, governing bodies and members

April 2019

Welcome to the second of a regular 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.

Digital strategy

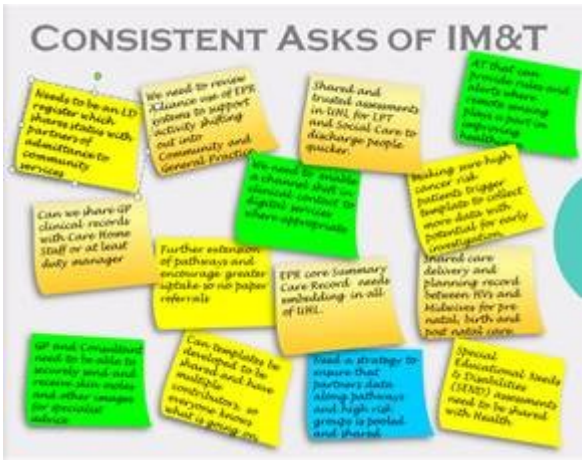
System Leadership Team (SLT) members discussed how the Digital Strategy for Leicester, Leicestershire and Rutland (LLR) should be best progressed over the next few years.

There are a number of information management and technology (IM&T) projects already being progressed across the system, a number of new demands arising from partner organisations and calls for further adoption of IM&T schemes set out in the NHS Long Term Plan.

The Digital Strategy sets out a number of strategic actions focused on system-wide transformation and improving digital capability. The strategy has considered the common asks of IM&T and reviewed them in relation to the priorities of Better Care Together (BCT). It has set out to prioritise and fund the schemes based on strategic fit, levels of complexity, and patient and broader benefits.

Four strategic priorities have emerged:

- Record sharing - real-time access to LLR clinical records for all professionals
- Digital self-care - enabling patients to self-manage and navigate the health and care system for themselves using digital means
- Supporting pathways - ensuring the patient journey is captured electronically and information is transferred with professionals and patients involved in the next step in care
- Business intelligence and research - integrated health and social care data analysis and business intelligence to support both direct care, research studies and population health management.



In one case study, the Rutland Integrated Discharge project has utilised the health and social care module of TPP SystmOne, with a joint electronic shared assessment form, enabling health and social care colleagues in the Rutland Hospital Discharge Team to work together on a single assessment of hospital patients as part of supporting their transfer of care. Staff are able to co-ordinate care more effectively around the patient. They have reported the system to be faster to complete assessments with joint involvement. Patients answer fewer duplicated questions, are more assured that staff are co-ordinating effectively, and are more likely to have a timely discharge with appropriate support in the community.

Clinician views:

Dr Steve Jackson, University Hospitals Leicester: *"I have seen two patients recently who have been presenting to hospital with various pains and being treated with opiates and cyclizine intravenously. They have been in various hospital departments and sent home without diagnoses. One of the patients has been to several different acute trusts in the area in the recent past. One of the patients was even, according to the S1 record, causing the GP some concerns about the stockpiling of such medication. In both records, there was a clear plan from the primary care team that the patients needed support to present less frequently to secondary care and to work on the weaning off of medication. Being aware of this when I saw the patients I was able to support this plan rather than treat as 'abdo pain requiring opiates'."*

Measuring outcomes

The SLT has reviewed the Better Care Together (BCT) Outcomes Framework which has 16 of 33 measures rated as 'green', four as 'amber' and nine as 'red'. The remaining four measures do not have agreed targets. An estimated 80 per cent of the measures in the framework have been updated since they were previously reported to the SLT. The table below shows the RAG (red, amber, green) ratings for key themes.

Better Care Together (BCT) Goals	Red	Amber	Green	not-RAG rated
A. Keep more people well and out of hospital	1	1	5	0
B. More care closer to home	1	2	3	0
C. Responsive care in a crisis	2	0	2	2
D. High quality specialised care	3	0	5	2
E. Health & social care system fit for the future	2	1	1	0
All Outcome Measures	**9**	**4**	**16**	**4**

The measures currently rated red as not achieving their target are:

- Patient waiting 18 weeks or less from referral to hospital treatment
- Patient experience of GP services
- Percentage of patients admitted, transferred or discharged from A&E within four hours
- Type one A&E attendances
- Improving access to psychological therapies – recovery
- Access to children and adolescent mental health services
- Reduce inappropriate out-of-area placements for mental health
- Primary care workforce – number of GPs
- Effectiveness of working relationships in the local system.

The Outcomes Framework is continually reviewed to ensure the measures included are relevant and useful. The latest update presented to SLT included several changes with some measures being dropped and some being replaced.

The next update of the Outcomes Framework will incorporate the latest planning round for 2019-20 across the STP footprint. It is planned that future revisions of the Outcomes Framework will integrate metrics for Integrated Community Health Services and early implementers of Integrated Locality Teams.

Terms of reference for new Partnership Group

Terms of reference have been discussed for a new Partnership Group to support the scrutiny of proposals being advanced by BCT.

It is proposed, the Partnership Group, comprised of non-executive and lay members, will provide oversight and challenge to our plans. It will help ensure early engagement and involvement of senior health, care and political leaders in the development of LLR plans and will provide advice and challenge on specific development proposals in advance of formal consultation.

The Partnership Group will not replace the role that Health Overview and Scrutiny Committees have in terms of providing oversight and challenge but it will ensure that the Joint Health Overview and Scrutiny Committee is regularly updated and consulted as appropriate. The Partnership Group will ensure that non-executive directors and elected members have input into discussions that affect the strategic direction of BCT.

It will be led by an independent chair who will be appointed for an initial two-year period with the option of a further year's extension. Membership of the group will be drawn from organisations within the LLR area. In addition there will be representation on the group by the BCT lead and SLT chair. The group will meet at least four times per year with meetings in public, ensuring openness and transparency.

In March, the SLT agreed to replace the existing Patient and Public Involvement Group (PPIG) with a new Patient and Public Involvement Assurance Group (PPIAG), consisting of 10 to 12 people with significant experience of patient engagement. The PPIAG will work within an agreed assurance framework to review, comment on and recommend actions in respect of patient involvement and engagement across BCT projects.

Revised dates for workstream updates

The SLT meetings are due to receive regular reports from the workstreams. This timetable has now been reviewed and revised accordingly:

- Prevention and inequalities - June 2019
- Planned care - June 2019
- Cancer - June 2019
- Integrated community services - July 2019
- Primary care - July 2019
- Mental health and learning disabilities - August 2019
- Urgent care - August 2019
- Workforce - October 2019
- Information management and technology (IM&T) - October 2019

This business update will include monthly features based on the work stream reports.

Communications and engagement

BCT partners are committed to greater involvement of patients, the public and stakeholders in the proposed improvements to services – particularly those that are likely to result in significant changes to the way in which services are delivered.

Communications and engagement activities for BCT that have taken place in 2019 include a series of briefings with MPs. These briefings have been updating MPs on all BCT work, with a particular focus on the acute and maternity reconfiguration and the community services re-design. These briefings are supported by all NHS BCT partners.

We have continued our programme of outreach, working with different communities including 'seldom heard' groups and those people who are vulnerable and often extensively impacted on changes to NHS services. We are particularly working through voluntary and community sector agencies and local support networks to involve these communities. We have continued with 'drop-in' public events with sessions in libraries proving the most successful.

We completed the schedule of public workshops in March to discuss the community services re-design with public, patients, carers, staff and stakeholders. The additional business intelligence gained from these workshops is being analysed and will be reported on in due course.

Public activities have reduced in recent weeks due to the local elections set to take place on 2 May 2019. The pre-election period is a 'period of sensitivity', which requires NHS and other public bodies to adhere to guidance requiring them to avoid actions which distract from or could influence the election outcome.

This period has allowed for a review of the outcomes of activities undertaken and to plan the next schedule of activities. This is set to include ensuring that workstreams have a greater level of understanding of the importance of public, patient and staff engagement, co-design and co-production and are provided guidance of what 'good' communication looks like.

We will continue building on-going and long-lasting relationships with communities across Leicester, Leicestershire and Rutland including the voluntary and community sector. We are preparing 'all-member briefings' for new councillors (post-election) to establish informal and formal two-way communication channels. We are also sourcing new sources of support to help us develop the online citizens' panel and the Public and Patient Assurance Group, complete the evaluation of insights gathered from the community services review, complete the acute and reconfiguration video and brochure, ensure more timely distribution of the BCT newsletter and enhance our web content.

Healthwatch campaign to inform BCT re-fresh of plans

Healthwatch Leicester and Leicestershire and Healthwatch Rutland recently launched a 'What would you do?' campaign to encourage people across LLR to share their views about what local NHS services should look like.

Their campaign aims to encourage people to say how extra money from the Government should be spent on local NHS services as part of the NHS Long Term Plan.

The findings will be combined with insights gathered from the public through on-going BCT partner engagement activities and will be presented to BCT partners to inform the local re-fresh of the BCT plan.

There are two public surveys to capture views and people can fill in one or both:

Survey 1. What would you do to give people more control over their care?
Survey 2. What would you do to give people better support?

Visit the Healthwatch website for more details on What Would You Do?

F

REPORT TO Quality Assurance Committee – 21st May 2019	
Title	Patient and Carer Experience and Involvement Quarter 4, 2018/19

Executive summary

This quarter four year-end report presents the Quality Assurance Committee (QAC) with assurance that Leicestershire Partnership NHS Trust (LPT) services are making consistent efforts to involve and consult with patients and their carers to gather feedback on their experience of our services.

This report also details the areas where services are taking action to make improvements, share learning and evidence positive change for patients and their families as a result of listening to patients and their carers, and through the robust systems in place to manage and learn from complaints.

Recommendation

The QAC is recommended to:

I. Receive assurance that work is being undertaken to improve how the Trust hears the voices and improves the experience of those who use our services, and their carers.

II. Receive assurance that robust systems and processes are in place to ensure that complaints are being managed effectively in accordance with both the Trust and regulatory requirements.

Related Trust goals	Strategic Objective 1: Deliver safe, effective, patient-centred care in the top 20% of our peers.
Risk and assurance	Relates to Board Assurance Framework Risk 1029: Risk of not being able to evidence the delivery of quality patient experience
Legal implications/ regulatory requirements	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17: Good Governance
Presenting Director	Anne Scott, Interim Chief Nurse
Author(s)	Helen Wallace, Patient Experience & Improvement Lead (interim) & Haley Cocker, Acting Patient Experience & Involvement Manager
*Disclaimer: This report is submitted to the QAC for amendment or approval as appropriate.	

Quality Assurance Committee – 21st May 2019

Patient and Carer Experience and Involvement (PCEI) Quarterly Report (including Complaints) Quarter 4, year-end 2018/2019

1. Introduction

This quarter four year-end report provides an update on Trust- wide patient experience and involvement activities including: Complaints, Patient Advice & Liaison Service (PALS), patient stories and the Friends and Family Test (FFT). This is in line with expectations in the NHS Constitution and the NHS Complaints Regulations 2009 (No.309).

2. Aim

To highlight work taking place Trust-wide to involve and consult with patients and carers and gather feedback on their experiences of our services to ensure robust systems are in place to manage and learn from complaints.

3. Recommendations

The Quality Assurance Committee (QAC) is recommended to:-

- Receive assurance that work is being undertaken to improve how the Trust hears the voices and improves the experience of those who use our services, and their carers.

- Receive assurance that robust systems and processes are in place to ensure that complaints are being managed effectively in accordance with both the Trust and regulatory requirements.

4. Summary key points

- Four priorities have been agreed for delivery in 2019-20 following discussion with service users, carers and staff including the successful delivery of a Café Conversation held on 5 March 2019. These priorities will inform a revised Patient Involvement and Experience Strategy. Agreed priorities are shown as a 'Plan on a page', Appendix 1.
- The PCEG agenda and work plan has been restructured; equal time will be spent discussing; how we are involving patients and carers in the improvement and development of our services; 'knowing how we are doing' supported by the introduction of a PEI Dashboard; identifying opportunities for improvement and enable learning. Whilst the Dashboard is in its infancy this approach supports the triangulation of a number of different data sources whilst reducing the number of separate data reports into PCEG and this will identify areas for improvement. The draft Dashboard is shown as Appendix 2.
- An 'Expert by experience' (*a person with lived experiences of accessing services in LPT, or a carer of someone who accesses LPT services* (LPT 2019)) has attended PCEG to inform a view on what 'regular' attendance could look like.
- In Q4, zero complaints were formally referred to the PHSO for investigation; one case has been requested with the decision awaited whether the PHSO

will investigate; one case was returned by the PHSO in Q3 which upheld a concern regarding a delay to provide physiotherapy.

- 70 complaint action plans are currently in progress and 54 of these are overdue. The Complaints Team have revised the performance monitoring of complaints progress in their updates to Directorates highlighting complaints and actions outstanding and also discuss these during their weekly complaint meetings with Directorates.
- 2,700 contacts were managed by the PEI team during 2018-19

5. Patient and Carer Experience and Involvement Strategy (PCEIS)

Progress against the PCEI 2018-19 annual objectives is presented year-end and shown in Table 1 below.

Table 1: Progress against 2018/19 priorities		Rag Rating
PCEI Strategy	The patient experience team introduced a 'Plan on a Page' approach to communicate its agreed priorities and this was well received.	Achieved
Patient Involvement	The Patient Experience Team (PEI) Administrator continues to capture patient involvement activity across the Trust and is inputting activity into a PPI module. A communications campaign was introduced in December 2019 to enable identification of local initiatives for wider sharing and learning.	Achieved
Customer Care Training	All customer care modules continued to be promoted for staff and monitored for uptake rates through to PCEG.	Achieved
Patient Feedback	Each Directorate provides quarterly assurance of how patient feedback is being used to make improvements to services via FFT, PALS, complaints and involvement activities.	Achieved
Always Events®	An Always ambition '6-in-6' was introduced in December 2019 to motivate staff and enable six teams to receive support with this national improvement methodology and complete their change cycle within six months.	Achieved
Friends and Family Test	Ongoing support for the provision of FFT data analysis from Health Informatics Service (HiS) has been secured until the new FFT national question has been confirmed. Draft costings have been identified by HiS to expand the current service provided in line with anticipated national changes and this is being further explored.	Achieved/ongoing

5.1 Patient Involvement work streams

Reward and recognition for service users/carers

The Patient Experience Team are developing a Trust wide Reward and Recognition policy which identifies how service users/carers are acknowledged, supported, and reimbursed for their involvement, engagement and improvement work. The team are scoping and bench marking national and local policies and best practice from other Trusts and NHS England and have created a benchmarking document which is being used to consult with patients, carers and a range of staff to inform and co-create the Trust approach.

Experts By Experience (EBE) Forum

This group was established during Q4, 2018/19 for the purposes of service user and carer involvement. Our definition of an EBE is someone with '*lived experiences of accessing services in LPT, or a carer of someone who accesses LPT services'*. The group are: creating a framework for involvement; developing the forum to ensure

support; developing registration for EBE's; this is all being co-designed with EBE members and the Patient Experience Team. This approach has considered the creation of a 'support and wellbeing plan' for EBE's, including how we safeguard and risk assess individuals. This forum has grown from four to eleven members; regular updates of EBE activities will be reported into PCEG and Patient Experience and Involvement reports.

Supporting Our Carers

A working group including staff and carers has been set up to develop a Trust wide approach to identify and support carers. This is a priority for delivery on 2019-20 and will consider: involvement and collaboration; information and advice; support and signposting to carers' services. We are working with the guiding principles identified within the Leicester, Leicestershire and Rutland Carers Strategy and with the 'All Age Transformation Programme' which helped to identify a need to address the Trust's Carers offer. The working group is currently consulting with carers and various carer groups in the community to co-design and co-create elements of this offer.

Examples of Directorates Involvement Activity

Table 2; Involvement Activity		
Directorate/Team	**Involvement Activity**	**Outcome/Learning**
AMH/LD **Stewart House**	Stewart House and The Willows hold monthly community meetings for patients and carers to discuss and issues and suggestions for improvements.	Feedback from a carers meeting stated that carers found it difficult to attend carers meetings in the evenings and an April meeting has been arranged for carers during ward rounds.
AMH/LD **Learning Disability Occupational Therapy Team**	'Come and share' sessions has seen a decrease in engagement and participation of patients. Can also be difficult to include people that may not have mental capacity.	The Agnes Unit is piloting a new way to capture patients experiences and involvement activities through developing a patient portfolio for all patients which will include two forms to be reviewed weekly 'how things are going' and 'patient portfolio' of activities involved with and achievements.
FYPC **CAMHS**	Service user engagement with the Eating Disorder team for co-designing.	Co-design lead is working with service users to co-design a 'Moving on' booklet for transitioning or discharge from the service.
FYPC **Immunisation Team**	Quality improvement project of the Immunisations team including feedback from schools, parents and young people (13-14 years) around immunisation consent.	Feedback enabled changes to the consent process, and paperwork. Consent 'opt out' method has been piloted in schools and seen an increase in uptake. Young people also feeling empowered by getting information regarding vaccines based in there feedback. Roll out plan developed.
CHS **Community Services Pulmonary**	Pulmonary Rehabilitation maintenance class gathered feedback about the locations of the classes offered. Feedback sought during a 'Spotlight event' attended by patients, carers,	Feedback has helped to shape a business case to offer a maintenance group in the East and is being discussed with commissioners.

Rehabilitation	and external stakeholders, hosted by the PEI team.	

Always Events®

Always Events® is a national quality improvement tool which uses co-design and PDSA cycles to evaluate and improve patients and carers experiences. The first step is to create an aim and vision statement around experiences that matter most to the service user/carer; the service will then aim to perform this consistently for every individual, every time. Following the introduction of a new '6-in-6' ambition in December 2018 the uptake has increased. Always Events are currently taking place in two CHS CMHT teams and six teams more teams are listed to commence the programme. (Table 3).

Table 3- Teams waiting to progress their Always Event		
Directorate	**Team**	**Details**
AMH	BMHU Reception Area	To progress once LIA complete
AMH	BMHU Family Rooms	To progress once LIA complete
CHS	St Luke's Stroke Team	On hold due to staffing
AMH	CMHT Teams	Meetings planned to recruit team
CHS	Memory Services	Meeting planned to introduce Always concept

5.2 Board Walk Activity

During Q4, 20 boardwalk visits were completed as shown in Table 4 below. 17 visits were to clinical teams and three to corporate services: Information Governance; Pharmacy; Research and Development.

Table 4: Directorate Boardwalk Activity, Q4, 2018/19		
Adult Mental Health and Learning Disabilities (AMH/LD)	**Community Health Services (CHS)**	**Families, Young Peoples and Children's Services (FYPC)**
8	**5**	**4**

Boardwalk feedback - themes and local improvement opportunities:

AMH/LD
Positive feedback and actions taken
Clinics attended were welcoming, empathetic and responsive. Occupational therapists are meeting and greeting patients and this approach was positive. Environmental changes to waiting areas have taken place with improved privacy and dignity.

CHS
Positive feedback and actions taken
A wound care Cquin has been very positive for patient care. Patients and their needs are central to how services are delivered. As a result of less restrictive practice with zonal observations patients are able to move more freely and safely.

FYPC
Positive feedback and actions taken
Teams received excellent patient/carer feedback. Patient involvement in 0-19 teams is evident in practice. Care Navigator role essential in tracking assessments and their completion. Introduction of opt out process for vaccinations has seen an increase in uptake.

5.3 Patient Stories

During Q4 two patient stories were presented to the Trust Board - key learning from patient stories is shown below:

AMH - Story Theme
Patient spoke of her experience when using the Olanzapine Depot clinic.

Improvements and Actions Taken
Patient suggested that privacy and dignity could be improved with adding a curtain to screen off the area where injections are given. Privacy curtain is now in place.

FYPC - Story Theme
Young person gave his views on CAMHS including room improvements, care planning, ideas to help people waiting for treatment and transition to adult services.
Improvements and Actions Taken
Some work has been completed recently in association with Soft Work Arts; however the Board acknowledged that Westcotes House requires environmental improvement.

5.4 National Community Mental Health Survey

AMH/LD and CHS identified actions following the 2017 National Community Mental Health Service User Survey.

Table 5: Community MH Survey Improvement plan summary			
Priority	**Objective**	**Position**	
		AMH	**CHS**
Priority 1	Focus on communication and involvement	Effectiveness of new leaflet measured. Service user feedback agreed improvement for CMHTs - further feedback considered. Action closed.	Remuneration of service users/carers as 'experts by experience' remains variable. Further work is ongoing and reported above.
Priority 2	Improving contact out of hours	Plan to promote the out of hours (OOH) helpline number has been successful in increasing the volume of calls. Action closed.	Additional question added to the MHSOP FFT survey relating to OOH/Crisis care.
Priority 3	Support for physical health and wellbeing	Outcome of work resulted in Listening Into Action (LiA) physical wellbeing clinic at the Mett Centre. Action closed.	LiA event on social prescribing took place. Social prescribing now part of the All age transformation - a signposting improvement arrangement is being explored.

AMH/LD progressed their improvement plan in response to the 2017 National Adult Mental Health Inpatient Survey and all actions have been closed.

Table 6: Inpatient Survey Improvement plan summary		
Priority	**Objective**	**Position**
Priority 1	Delivering Same Sex Accommodation Standards.	Action taken to ensure information in welcome packs explains how we are meeting this guidance. Staff guidance distributed and a patient information leaflet developed. Action closed.
Priority 2	To reduce the disturbance of patients due to noise at night.	Sleep hygiene roadshow devised and available to all wards on Bradgate Mental Health Unit (BMHU), reception area and involvement centre. Action closed.
Priority 3	Improving cleanliness of bathrooms.	Q3 feedback from community ward forums shows a continued satisfaction in relation to environment and cleanliness from the survey results. Action closed.
Priority 4	Improving contact within one week of discharge.	A standard operating procedure for a 7 day follow up has been developed and implemented at the BMHU with audits in place to monitor progress. Action closed.

The results relating to 2018 Community Mental Health Survey have been reported in a separate report.

5.5 Patient Experience Activity

During Q4 a total of 621 contacts were recorded compared to 677 contacts in Q3, 2018/19; Table 7 below shows the number and type of categories, and Table 8

identifies the method of contact. 398 contacts were handled directly through the Patient Advice and Liaison Service (PALS) via telephone or email.

Table 7: Total contacts and categories					
	Q4, 2017/18	**Q1, 2018/19**	**Q2, 2018/19**	**Q3, 2018/19**	**Q4, 2018/19**
Compliments	274	305	345	339	246
Concerns	180	189	208	180	176
Enquiries	172	173	168	158	193
Comments	11	10	4	0	6
Total	**637**	**677**	**725**	**677**	**621**

Table 8: Method of contact					
Contacts via;	**Q4, 2017/18**	**Q1, 2018/19**	**Q2, 2018/19**	**Q3, 2018/19**	**Q4, 2018/19**
Customer Services Web	319	334	389	347	271
PALS	318	343	336	330	350

For Q4 there was a decrease in contacts via the customer service web of 76 when compared to Q3, 2018/19. The decrease related to compliments being recorded by teams across the Trust.

The top three themes for concerns, compliments and enquiries are shown in tables 9, and 10 below.

Table 9: Top 3 themes of concerns					
Q2, 2018/19		**Q3, 2018/19**		**Q4, 2018/19**	
Patient Expectations & service delivered	27	Patient Expectations & service delivered	28	Patient Expectations & service delivered	25
Appointment delay (outpatient)	24	Appointment delay (outpatient)	21	Nursing Care	14
Nursing care	21	Nursing Care	14	Communication to patients	14

The top themes of ‘Patient Expectations & service delivered’ and ‘Nursing Care’ remain unchanged in the top three categories from Q3, 2018/19 to Q4, 2018/19. ‘Communication to patients’ moved into the top three, replacing ‘appointment delay (outpatient)’, although there was a slight reduction of four concerns in Q4, 2018/19 when compared to Q3, 2018/19.

Table 10: Top 3 Themes of Compliments					
Q2, 2018/19		**Q3, 2018/19**		**Q4, 2018/19**	
Attitude of staff (nursing)	100	Nursing Care	117	Nursing Care	100
Nursing care	93	Clinical Advice and Treatment	88	Clinical Advice and Treatment	52
Clinical Advice and Treatment	84	Attitude of staff (nursing)	64	Attitude of staff (nursing)	44

Nursing care was the highest compliment theme in Q4 with compliments made such as: receiving wonderful care; understanding; support given. FYPC compliments indicated a decrease of 67% from Q3, 2018/19 to Q4, 2018/19 with CHS also showing a decrease of 26%. AMH/LD has remained the same in both quarters.

Table 11: Top 3 Themes of Enquiries

Q2, 2018/19		Q3, 2018/19		Q4, 2018/19	
Signposting	85	Signposting	84	Signposting	104
Information	23	Information	20	Information	30
Communication/ information to patients	7	Communication to patients Patient Expectations & Services delivered	9 9	Communication to patients	8

The top two enquiry themes remained the same in all quarters during 2018/19 with an increase in signposting by 20 from Q3, to Q4, 2018/19. Of the 104 signposting enquiries 61 were signposted to other organisations. Examples of actions taken in response to concerns are shown in table 12;

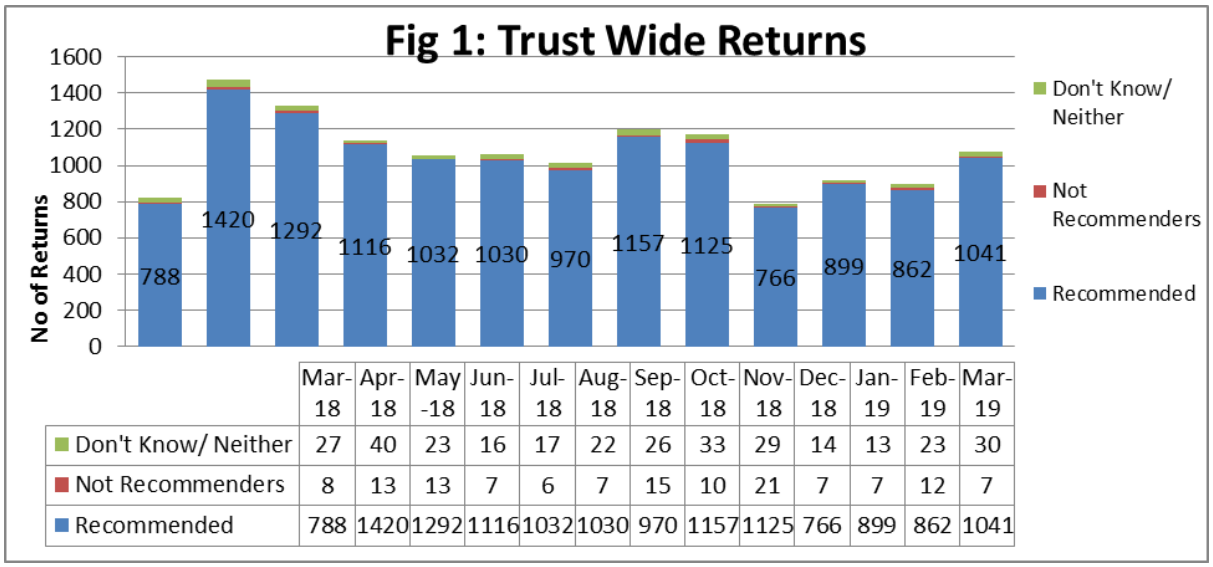
Table 12: Examples of actions taken as a concerns raised Q4, 2018/2019

Service	Concern	Action taken
AMH/LD **Category:** **Communication to patient**	Patient unhappy as service did not notify next appointment date with psychiatrist as needed to inform his solicitor.	Psychiatrist's secretary phoned to confirm appointment. Psychiatrist liaised with solicitors directly to discuss forensic report for court date.
FYPC **Category:** **Patient Expectations & Service delivered**	Consultant did not consider if patient has Autism Spectrum Disorder and has only just been put on a waiting list. Mum requested assessment is completed asap as patient has no support.	Autism Diagnostic Observation Schedule assessment not requested as previously agreed. Service apologised and Dr arranged an early appointment talk through the care that has been offered and to discuss mums concerns.
CHS **Category:** **Nursing Care**	Son unhappy with care and treatment during District Nursing visits as mother's legs not improving and would like visits to be increased.	Family contacted and daily visits have been planned. A Tissue Viability Nurse review has also been planned.

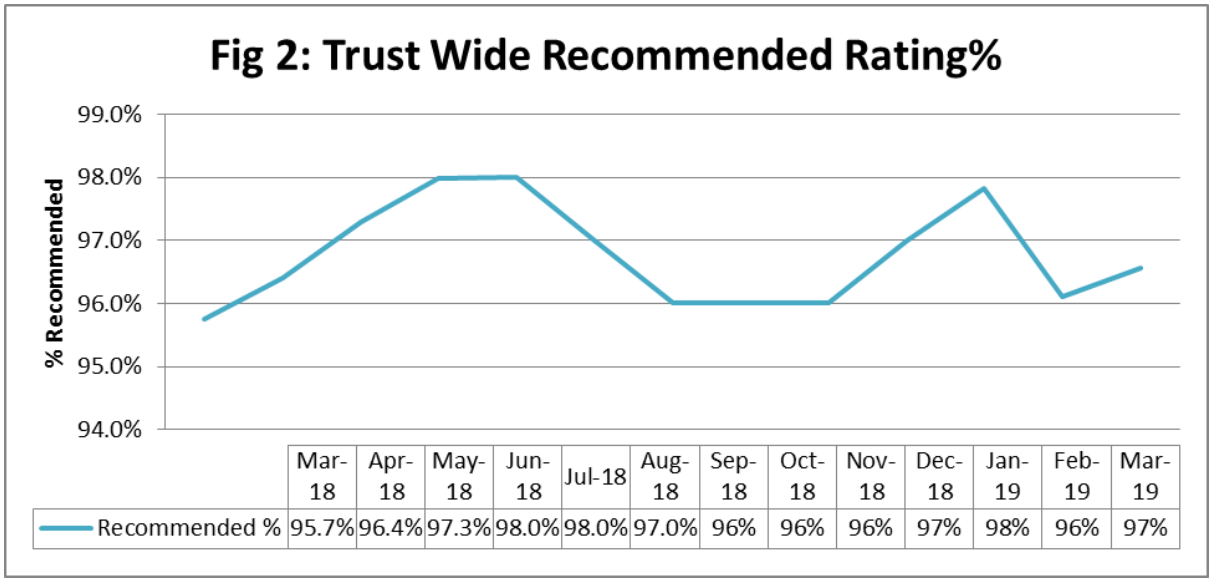
5.6 Friends and Family Test (FFT)

Trust wide returns from March 2018/19 to March 2019/20 are shown in Figures 1 and 2 below. The results show that, on average in Q4, 96% of our patients are extremely likely or likely to recommend our service and 1% of respondents would not recommend our services.

Figures 1 and 2 shows the Trust wide figure.



	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Don't Know/ Neither	27	40	23	16	17	22	26	33	29	14	13	23	30
Not Recommenders	8	13	13	7	6	7	15	10	21	7	7	12	7
Recommended	788	1420	1292	1116	1032	1030	970	1157	1125	766	899	862	1041



	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Recommended %	95.7%	96.4%	97.3%	98.0%	98.0%	97.0%	96%	96%	96%	97%	98%	96%	97%

During this quarter the Trust received 2894 comments from patients who completed the FFT survey. The Trust wide FFT comments received are mainly examples of positive feedback and as a result it remains a challenge for all three directorates to evidence improvements specifically from FFT feedback. Examples of action taken as a result of comments are shown in Table 13 below.

Table 13: Examples of actions taken as a result of FFT feedback Q4, 2018/19

Service	Comment or Theme	Action taken
AMH/LD Stewart House	More social activities wanted in the house.	Proposal of a social evening one evening per month. Activities to include a quiz night, karaoke and bingo.
FYPC Paediatric Psychology CAMHS Eating Disorders	Families' feedback on waiting area and suggestion for drinks. Feedback on waiting area ambiance, and the amount of people observing at	Bottled water cooler has been installed in waiting area for patients and carers use. More magazines and a change of radio station in waiting area. There has also been a reduction on

	assessments.	number of observers at assessments.
CHS Musculoskeletal (MSK) Telephone Ashby	Patients commented on the information shared from service could be sourced from the internet, as pictures do not show if you are performing exercises correctly.	Service offer to send exercises via email with a video attached to watch in order to support and confirm if patient is using the right techniques with the exercises.

There were 26 comments from people who would not recommend services with 11 relating to CHS MSK services regarding difficultly in making contact by telephone and telephone assessments versus being seen in person. In response the service advised that this is a new way of delivering the service and telephone consultations and provision of exercises are designed to provide an initial response to patients in a timelier manner. The service aims to speak to patients on the phone within two days and the service is also working hard to try to reduce and minimise patient waiting times for face to face appointments. Learning is ongoing for both therapy and admin staff as to how best to describe the new process to patients and further GP engagement is improving their understanding following a period of misinformation being provided to patients by GPs. 398 positive pieces of feedback were received during Q4. The remaining 15 comments relate to different services; out of the 15 an overall theme emerged in that patient and carers felt they were not being heard.

6 Complaints

During Q4 the Trust received 108 complaints which was a reduction of 11 when compared to Q3. Table 14 below identifies the number of complaints by directorate for this quarter. Figure 3 below shows the number of complaints by directorate.

Table 14: Complaints by Directorate

	Q4, 2017/18	Q1, 2018/19	Q2, 2018/19	Q3, 2018/19	Q4, 2018/19
AMH/LD	52	51	51	50	46
CHS	41	50	51	42	31
FYPC	47	38	26	26	29
Corporate	1	0	3	1	2
Trust Total	**141**	**139**	**131**	**119**	**108**

Figure 3 – Complaints by Directorate from Q1-Q4, 2018/19

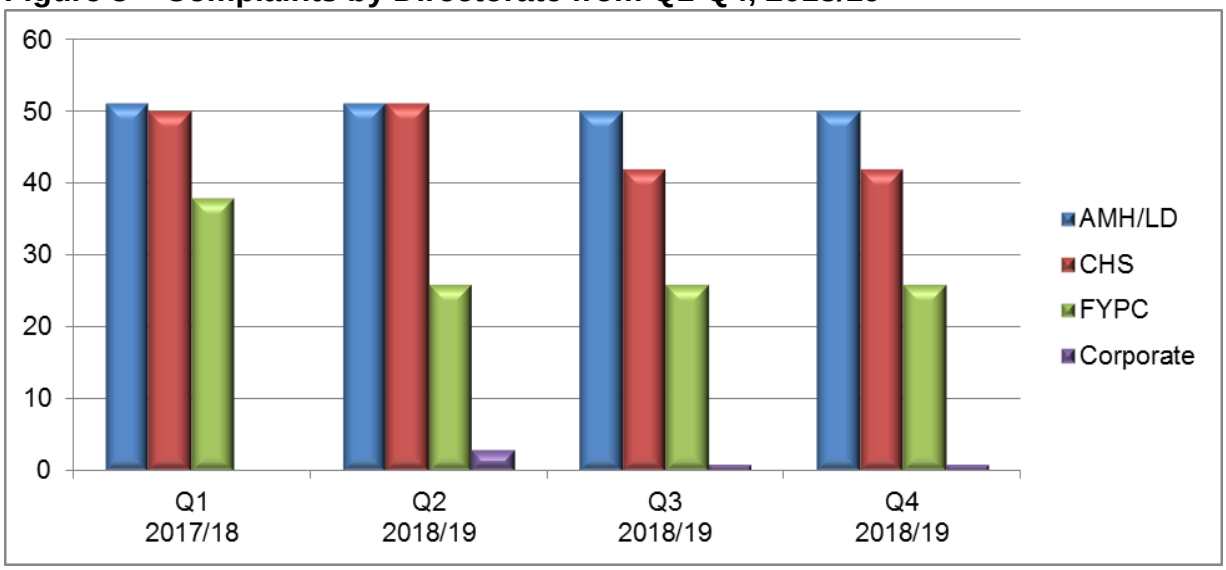


Table 15 shows the overall complaint response performance from Q4, 2017/18 to Q3, 2018/19. Performance rates have steadily improved and have remained consistent during Q and Q3. (The performance for Q4, 2018/19 will not be verified until June 2019 and therefore will be reported in the next quarterly report).

Table 15: Response timescale performance			
	Number of Complaints Received	**Response Performance**	**Number of ongoing complaints**
Q4, 2017/18	141	65.20%	0
Q1, 2018/19	139	74.50%	0
Q2, 2018/19	131	79.00%	1
Q3, 2018/19	119	79.00%	1

There was an increase in the number of complaints reopened in Q4, 2018/19 (9) compared to Q3, 2018/19 (6). However when comparing Q4, 2018/19 to Q4, 2017/18 the number of complaints reopened is significantly lower (n=16). Of the 9 reopened complaints in Q4: 6 related to AMHLD services; 2 to FYPC services and 1 for CHS. The reasons for reopened complaints were:

- New questions being raised following complainants receipt of response - 2
- Dispute about the information in the response – 2
- Response had not addressed/unresolved issues – 5

There were no themes identified regarding specific issues within the reopened complaints.

Top Complaint Themes, Q4, 2018/19

The Trust top three themes of complaints received in Q4 are shown in Table 16. The top two themes remain unchanged although appointment delay (outpatient) has moved into the top three themes of complaints with no noticeable trend or theme.

The top three department groups for complaints remained the same although in a different order when compared to Q3. Community Mental Health Team (CMHT) received the highest number of complaints in Q4 with 23 (an increase of 1 compared with Q3).

Table 16: Top 3 Themes of Complaints							
Q1, 2018/19		**Q2, 2018/19**		**Q3, 2018/19**		**Q4, 2018/19**	
Patient expectations & service delivered	**31**	Patient expectations & service delivered	**31**	Patient expectations & service delivered	**36**	Patient expectations & service delivered	**31**
Nursing care	**23**	Nursing care	**23**	Attitude of staff	**14**	Attitude of staff	**17**
Attitude of staff	**14**	Attitude of staff	**14**	Clinical advice/ treatment	**14**	Appointment – Delay (Outpatients)	**8**

Table 17: Top 3 department groups of Complaints							
Q1, 2018/19		**Q2, 2018/19**		**Q3, 2018/19**		**Q4, 2018/19**	
CMHT (AMH/LD)	**28**	CMHT (AMH/LD)	**28**	District Nursing	**24**	CMHT (AMH/LD)	**23**
District nursing	**24**	District nursing	**24**	CMHT (AMH/LD)	**22**	CAMHS	14
CAMHS	**14**	CAMHS	**14**	CAMHS	**12**	District Nursing	11

A full breakdown of complaint, by category and directorate is listed as Appendix 3.

Complaints and improvements by Directorate in Q4

AMH/LD Directorate
AMH/LD received 46 complaints; this is a reduction of four when compared to the Q3. CMHT's received 23 complaints and had the highest amount of complaints compared to other departments. Of these 23 complaints: 10 complaints were attributed to AMH City Central with appointments and difficulty/delay being accepted by the service accounting for most complaints.

The top themes from complaints for AMHLD related to Patient Expectations and Service Delivered (12), Attitude of Staff (11) and Appointments either their cancellation or delay (8).

Example of improvement made as a result of complaints received in Q4.

Complaint	Outcome/Improvement
Patient unhappy with appointment booking process and approach of staff member.	Explained appointment process with apology given for attitude of staff. Identified information provided to patients around appointment process was insufficient. Team leaflet reviewed to ensure more user friendly format and production of a clearly defined process map for the service.

CHS Directorate
CHS received 31 complaints which are comparatively lower than the number received in previous quarters (42 received in Q3). District Nursing remains the service receiving the highest number of complaints within CHS which has been the case for the previous three quarters. However, the District Nursing service received 11 complaints in Q4 which is a decrease of 13, when compared to Q3.

The top themes emerging from complaints relating to CHS in Q4 were: Patient Expectations and Service Delivered (13); Patient Safety Issues (5); Attitude of Nursing staff (3).

Example of Improvement made as a result of complaints received in Q4.

Complaint	Outcome/Improvement
Patient raised concerns regarding length of time since last catheter change and communication from staff regarding ongoing care.	Apology given for approach from staff when discussing ongoing care. Meeting held with patient to discuss concerns and agree care plan for catheter going forward.

FYPC Directorate
FYPC received 29 complaints in Q4 which is a marginal increase on the previous two quarters where they received 26. CAMHS had the highest proportion of complaints in Q4 (14) with The County Team (VC) receiving 6/14; City Team had 5/14 although there was no specific emerging trend with the complaints received.

Top themes for FYPC complaints related to: appointments either cancellation or delay (7); Patient Expectations and Service Delivered (6); Incorrect Information Contained in Documentation (4).

Example of Improvement made as a result of complaints received in Q4

Complaint	Outcome/Improvement
Child with known medical condition measured as part of National Child Measurement Programme with parent subsequently sent letter incorrectly with advisory notice about results.	Acknowledged medical condition would affect results and that letter was sent in error. Process revised with school nurse for local team now contacting parents to convey results so service is more personalised.

Monitoring of actions from complaints for Q4

Services develop and implement action plans to demonstrate improvement as a result of complaints. These actions include training for staff, reflective sessions, or changes to processes. 70 complaint action plans are currently in progress; 54 of which are overdue. Action plans are overseen with the directorates with advice and support provided by The Complaints Service. The Complaints Team have updated the monitoring of action plans and provide monthly update reports to each directorate highlighting the current actions outstanding and further discussing these at weekly complaint update meetings with each directorate.

6.1 Parliamentary and Health Service Ombudsman (PHSO)

In Q4 zero complaints were formally investigated by the PHSO although correspondence relating to one case was requested with the decision whether the PHSO deciding to investigate currently awaited.

One case was returned by the PHSO in Q3 and upheld a concern regarding the delay to provide physiotherapy input resulting in family seeking private physiotherapy care. The Trust were recommended to write to apologise and acknowledge the delay, provide a £1740 payment to cover the costs of private physiotherapy and also provide an action plan which provide assurance around changes implemented as a result of the complaint. The letter of apology and payment were sent to the complainant within one month of the PHSO decision with the action plan due to be sent to the PHSO, CQC and NHSI by the end of April 2019.

6.2 Complaint Peer Review Panel

During Q3 a successful pilot of complaints training took place and the newly appointed Complaints Manager will develop and progress this for 2019/20.

7 Conclusion

This paper presents the Q4 year-end summary on the feedback received in the Trust through Complaints, PALS and other established Patient Experience routes along with examples of improvements and learning outcomes.

Appendix 1 2019-20 Plan on a Page

NHS
Leicestershire Partnership
NHS Trust

Becoming an Involving Organisation - Plan-on-a-page 2019-20

We want to…

Deliver care that is safe and effective and is planned around the needs of our service users; deliver care at the right time in the right place by working with people and organisations that connect with our service users.	Engage with service users/carers to plan, develop and improve the quality of our services; value and respect the contributions service users/carers make enabling an inclusive approach to meet the needs of our local communities.

So we developed these promises with service users and carers….

We will listen and learn from our service users, their carers and families about their experiences of our services and ask for their suggestions about how services can be improved.	We will do this by using lots of different ways to get feedback from service users and carers. We will find out what we need to improve, how to improve it and then check to see if it has improved.	We will involve people that use and are affected by our services, especially those who find it hard to be heard and aren't often listened to. We will show how we have listened to and involved people and what we have done.

How we will do this…

Review the ways that we listen to service users/carers and the frequency that we gather feedback to remain responsive to real-time and face to face feedback.	Work with staff so they can demonstrate how involvement improves patient's experience. Enable staff to demonstrate what is working well and improvements made.	Review and improve how we analyse feedback about what is working well and what we need to consider enabling us to learn and implement organisational-wide learning.	Develop an involvement model to expand our community of practice where service users/carers agree, they feel involved in the development and improvement of services.	Review and improve our approach to how we learn so that everybody knows what has worked well and how they can learn from it.

Our Key Objectives for delivery during 2019/20 are…

1	2	3	4
To develop an involvement strategy and model in our ambition to be an 'involving organisation'	To develop a Trust-wide approach in supporting carers to include: involvement & collaboration; information & advice; support information and signposting to carer's services	To work with all services to improve how we gather and analyse patient feedback	To develop effective mechanisms which demonstrate how we have learnt and improved patient's experience

Appendix 2 PEI Dashboard framework

PATIENT EXPERIENCE DASHBOARD - APRIL 2019 V1

			DATA OVER TIME			YEAR ON YEAR VARIATION		
Indicator Ref. No.	CATEGORY	KEY MEASURE	Jan-19	Feb-19	Mar-19	Apr-19	Apr-18	Year on Year Variance
Trust-wide								
Ref 1	Always Events	Trust-wide Total number of teams engaged in an Always Event						
Ref 2	Board walks	Total number of Boardwalks completed						
Ref 3	Board walks	Total number of Boardwalks cancelled						
Ref 4	Complaints	Trust-wide Total number of registered complaints						
Ref 5	Complaints	Trust-wide Percentage of complaints acknowledged within three working days						
Ref 6	Complaints	Total number of registered complaints - Enabling						
Ref 7	Complaints	Trust-wide Percentage of complaints acknowledged within three working days						
Ref 8	Complaints	Trust-wide Total number of complaints reopened						
Ref 9	Complaints	Trust-wide Total number of complaints referred to the PHSO						
Ref 10	Complaints	Trust-wide Total number of complaints referred to PHSO resulting in full investigation						
Ref 11	Complaints	Trust-wide Total number of complaints upheld/not upheld						
Ref 12	Complaints	Trust-wide Total number of complaints not closed after 6 months						
Ref 13	Complaints	Trust-wide Percentage of Complaints Satisfaction surveys returned (as a percentage of those sent)						
Ref 14	Compliments	Trust-wide Total number of compliments recorded						
Ref 15	Complaints Training	Trust-wide Total number of staff to date completing 'Collecting and Learning' from patient feedback Ulearn module						
Ref 16	Complaints Training	Trust-wide Total number of staff to date completing 'Investigating and responding' to complaints on Ulearn						
Ref 17	Complaints training	Trust-wide Total number of staff to date completing 'Customer Care' for everyone on Ulearn						
Ref 18	Eliminating mixed sex accommodation	Total number of admissions breaching national guidance on Eliminating mixed sex accommodation (eir reports as SLEEP breaches)						
Ref 19	Eliminating mixed sex accommodation	Total number of admissions breaching national guidance on Eliminating mixed sex accommodation (eir reports as all OTHER breaches)						
Ref 20	Friends and Family Test	Total number of staff accessing ENVOY to review their Friends and Family Test feedback data						
Ref 21	Patient Care Opinion	Total number of responses uploaded on Care Opinion by the PALS team						
Ref 22	Patient Care Opinion	Total number of responses uploaded on NHS Choices by the PALS team						
Ref 23	PALS	Total number of ALL service user/carer/public contacts made to the PALS service						
Ref 24	PALS	Total number of Concerns registered by PALS						

Ref 35	Interpreting & Translation Services	Total number of bookings received						
Ref 36	Interpreting & Translation Services	Total number of bookings met (interpreter available and provided)						
Ref 37	Interpreting & Translation Services	Total number of bookings aborted						
Community Health Services Directorate								
Ref 28	Always Events	Total number of teams engaged in an Always Event - Community Health Services						
Ref 29	Complaints	Total number of registered complaints - Community Health Services						
Ref 30	Complaints	Complaint rate - Community Health Service (attended and seen)						
Ref 31	Complaints	Percentage of complaints responded to within agreed timescale - Community Health Service (>80% GREEN 70-80% AMBER <69% RED)						
Ref 32	Complaints	Total number of complaints agreed actions overdue - Community Health Services						
Ref 33	Compliments	Total number of recorded compliments - Community Health Services						
Adult Mental Health/Learning Disabilities Directorate								
Ref 34	Always Events	Total number of teams engaged in an Always Event - Adult Mental Health/Learning Disabilities						
Ref 35	Complaints	Total number of registered complaints -Adult Mental Health/Learning disabilities service						
Ref 36	Complaints	Complaint Rate - Adult Mental Health Services (attended and seen)						
Ref 37	Complaints	Percentage of complaints responded to within agreed timescale - Adult Mental Health/Learning Disabilities services (>90% GREEN 70-89% AMBER <69% RED)						
Ref 38	Complaints	Total number of complaints actions overdue - Adult Mental Health/Learning disabilities services						
Ref 39	Compliments	Total number of recorded compliments -Adult Mental Health/Learning disabilities service						
Families, Young People and Children Directorate								
Ref 40	Always Events	Total number of teams engaged in an Always Event - Families, Young People and Children						
Ref 41	Complaints	Total number of registered complaints - Families, Young People and Children						
Ref 42	Complaints	Complaint Rate - Families, Young People and Children (attended and seen)						
Ref 43	Complaints	Trust-wide Percentage of complaints responded to within agreed timescale -Families, Young People and Children (>90% GREEN 70-89% AMBER <69% RED)						
Ref 44	Complaints	Total number of complaints actions overdue - Families, Young People and Children						
Ref 45	Compliments	Total number of recorded compliments - Families, Young People and Children						

Appendix 3 Complaint numbers by category and service Q4, 2018/19

Category	AMH/LD	CHS	FYPC	Corp	Total
Aids & Appliances		1			**1**
Appointment cancellation (Outpatients)	2		5		**7**
Appointment delay (Outpatients)	6		2		**8**
Attitude of staff	11	3	4	1	**19**
Car Parking Issues				1	**1**
Clinical advice/treatment	3	2			**5**
Communication/information to carers	1	1	2		**4**
Communication/information to patients		1			**1**
Confidentiality	2		2		**4**
Diagnosis problems	1	1			**2**
Difficulty/delay in being accepted by a	2		2		**4**
Equality/Human Rights	1				**1**
Inadequate/Incomplete Assessment	1				**1**
Inadequate/Incomplete CHC Assessment		1			**1**
Incorrect information contained in documentation	1		4		**5**
Loss of Personal Property		1			**1**
Mental Health Act/Detention			1		**1**
Nursing Care		1			**1**
Other Environmental Issues			1		**1**
Patient expectations and service	12	13	6		**31**
Patient Safety	1	5			**6**
Patient's Privacy & Dignity		1			**1**
Policy & Commercial Decisions	1				**1**
SI Process	1				**1**
Total	**46**	**31**	**29**	**2**	**108**

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Leicestershire Partnership NHS Trust

PATIENT SAFETY REPORT

Q4 2018/19

CONTENTS

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. Commissioners have asked for this wider report as of Q1 19/20. The patient safety team have begun to look at how this can be achieved and how this data can best be presented.

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 is the first time this style of report has been produced and it is expected that this report will develop over time as the PSIG develop and in response to feedback of it's usefulness. It may be that it needs to separate into two.

The highest number of reported Serious Incidents relate to patient's under the care of LPT who have taken their own lives. The majority of these patients are under the care of community services however both locally and nationally we have seen an increase in deaths of patients under the care of the crisis team.

There are a number of high profile examples of organisations moving towards taking a zero tolerance approach to suicide. This provides a very powerful message to staff and communities that any death is too many. Using a just approach to investigations allows us to consider have we learnt something from this death that we can implement to support other patients rather than did anyone do anything wrong.

We are currently working with the Medical Director to develop an action plan to support a zero tolerance approach to in patient suicide (which includes patients on authorised leave and absent without leave) we have agreed to extend this plan to include the high risk areas of the first ten days following discharge and patients under the care of crisis. Further detail will be available for Q1 report.

Looking at overall trust wide incident data and comparing reporting with other similar organisations via the National Reporting and Learning System (NRLS) data identifies that LPT are high reporters of incidents in terms of numbers.

Looking at these overall numbers however does not provide any further useful intelligence, it is well reported that organisations can become very good at reporting certain types of incidents while not recognising others. This said safer organisations are described as those with high numbers of reported incidents with low/reducing degrees of harm. Safer organisations recognise and report near miss and low harm incidents in order to learn.

In relation to patient safety it is important to read incidents and understand them rather than simply counting numbers.

From a general incidents point of view looking at directorate governance/safety reports the incidents causing the most concern and increasing are violence and assault and patient self harm.

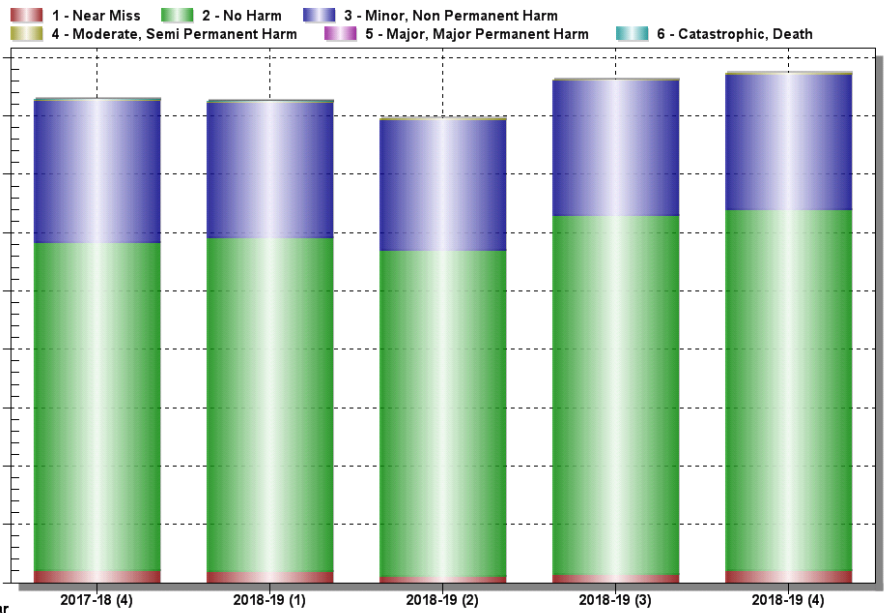
The patient safety team have requested that some of these more serious incidents have full internal incident investigations; to understand the factors that may be contributing to this increase in violence and aggression. In addition the patient safety team are meeting with the positive and safe group to discuss actions required to keep patients and staff safe.

With regard to self harm the Patient Safety Improvement group have discussed the need to have a trust wide approach to safe self harm and are sharing their plan with the Quality Committee

In relation to both of these early audit results against compliance with the search policy have identified poor compliance. The audit design did not however identify why, the audit team are now re reviewing using a QI approach.

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)
1 - Near Miss	94	86	49	64	96
2 - No Harm	2813	2859	2790	3074	3097
3 - Minor, Non Permanent Harm	1221	1163	1121	1163	1161
4 - Moderate, Semi Permanent Harm	6	10	13	6	14
5 - Major, Major Permanent Harm	0	1	0	0	0
6 - Catastrophic, Death	6	3	0	0	0

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 4,301 in quarter 3 2018/19 to 4,368 in quarter 4 2018/19.

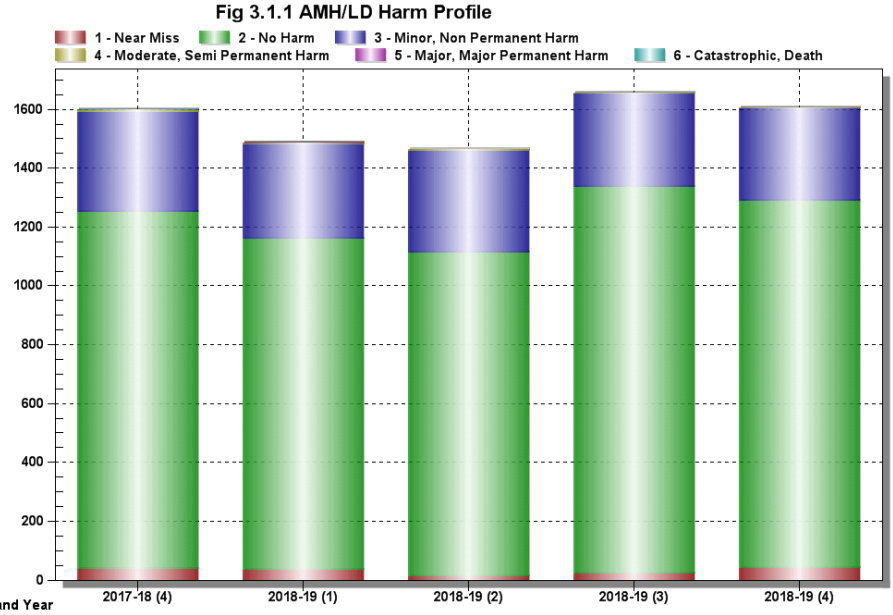
Safe organisations are identified as those that are high reporters of incidents with low harm

See section 4 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)
1 - Near Miss	35	32	12	21	40
2 - No Harm	1216	1127	1098	1313	1247
3 - Minor, Non Permanent Harm	340	320	348	319	314
4 - Moderate, Semi Permanent Harm	4	5	6	3	5
5 - Major, Major Permanent Harm	0	1	0	0	0
6 - Catastrophic, Death	4	2	0	0	0

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 1,656 in quarter 3 2018/19 to 1,606 in quarter 4 2018/19.

3.1.2 Learning

AMH have analysed their incident data during Q3 and are reporting self harm as their highest reported incident followed by Violence and Assault.

Griffin Ward being the highest reporter of self harm and the second highest to Belvoir in relation to violence and assault. This increase is likely to be due to the very challenging patients and this situation is currently being monitored weekly to ensure that we can be assured we are keeping patients and staff safe. There is a Serious Incident investigation in progress relating to an incident on Griffin which will look at the wider context, around support training of staff, models of care and patient presentation.

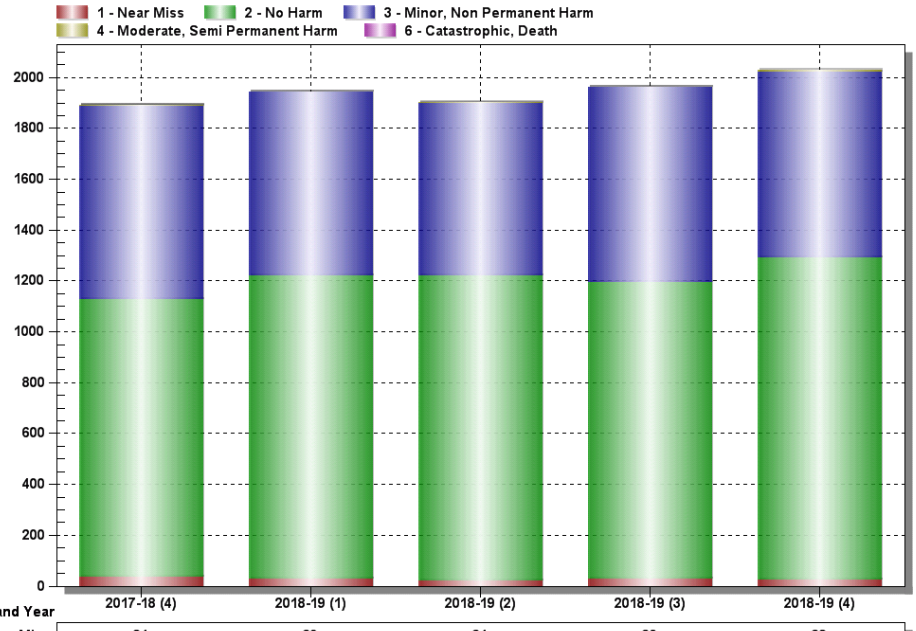
The patient safety team have requested that some of these more serious incidents have full internal incident investigations; to understand the factors that may be contributing to this increase in violence and aggression. In addition the patient safety team are meeting with the positive and safe group to discuss actions required to keep patients and staff safe.

With regard to self harm the Patient Safety Improvement group have discussed the need to have a trust wide approach to safe self harm and are sharing their plan with the Quality Committee

Analysis is also included around incidents relating to patients with contraband, these were mostly drugs prescription and non prescription and alcohol. One patient was however found in possession of a knife which was retrieved during the checking and searching process. In light of this and the fact that early audit results revealed poor compliance with the search policy reported in April this will be re audited in May using a QI approach to understand the reasons so that meaningful actions can be put in place

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)
1 - Near Miss	34	29	21	28	23
2 - No Harm	1095	1192	1198	1166	1269
3 - Minor, Non Permanent Harm	760	721	679	767	730
4 - Moderate, Semi Permanent Harm	2	3	4	1	8
6 - Catastrophic, Death	1	0	0	0	0

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 1,962 in quarter 3 2018/19 to 2,030 in quarter 4 2018/19. There has also been an increase in 'moderate harm' incidents from 1 in quarter 3 2018/19 to 8 in quarter 4 2018/19 and due to this increase CHS will be conducting a deep dive review with lead nurses, the results of which will be available at the end of June 2019. CHS have completed an initial review which has identified no real themes or obvious pattern to this increase.

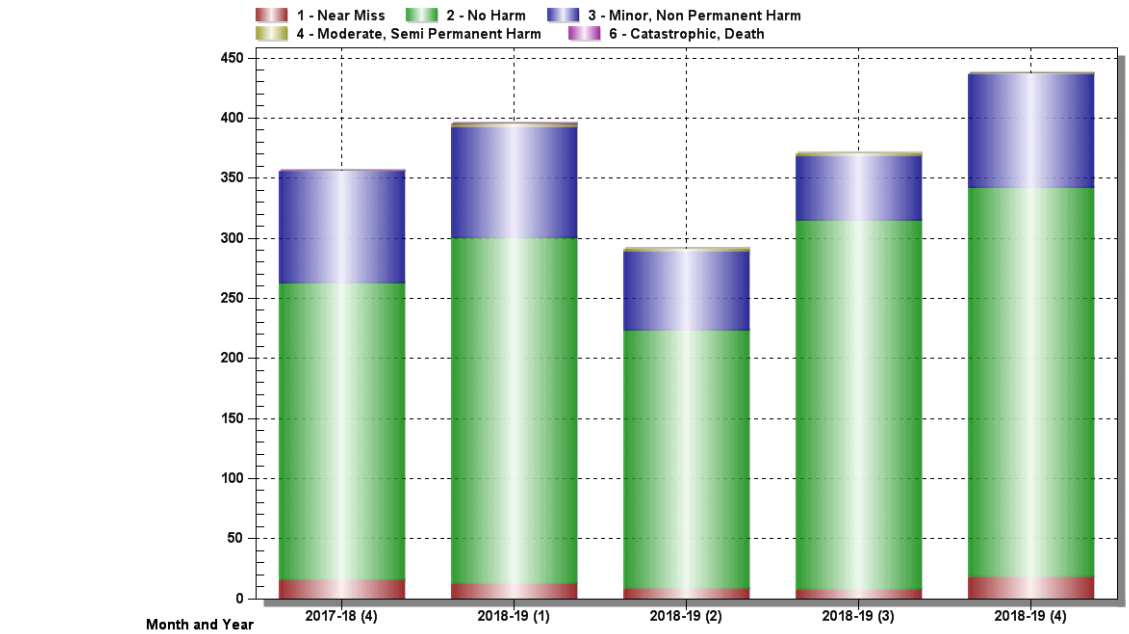
3.2.2 Learning

CHS are currently focussing on Pressure Ulcers, Self harm and suicide, learning/action is addressed in other areas of this report.

In relation Slips trips and falls a QI project has been undertaken on two wards looking at post fall huddles. The aim was to improve communication and the identification of interventions that are personalised and meaningful to the change in patient presentation at the time of a fall. Following a number of PDSA cycles the huddles have started to reap benefits in patient care delivered to patients as where a first fall had occurred and a huddle completed, 100% (7 out of 7) of patients did not go onto repeat fall

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)
1 - Near Miss	15	12	8	7	17
2 - No Harm	247	288	215	307	324
3 - Minor, Non Permanent Harm	93	92	65	54	95
4 - Moderate, Semi Permanent Harm	0	2	3	2	1
6 - Catastrophic, Death	1	1	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 370 in quarter 3 2018/19 to 437 in quarter 4 2018/19.

3.3.2 Learning

Triangulating their incidents with Serious incidents FYPC highest reported categories are Safeguarding children (increased numbers due to change in reporting) and Communication and consent.

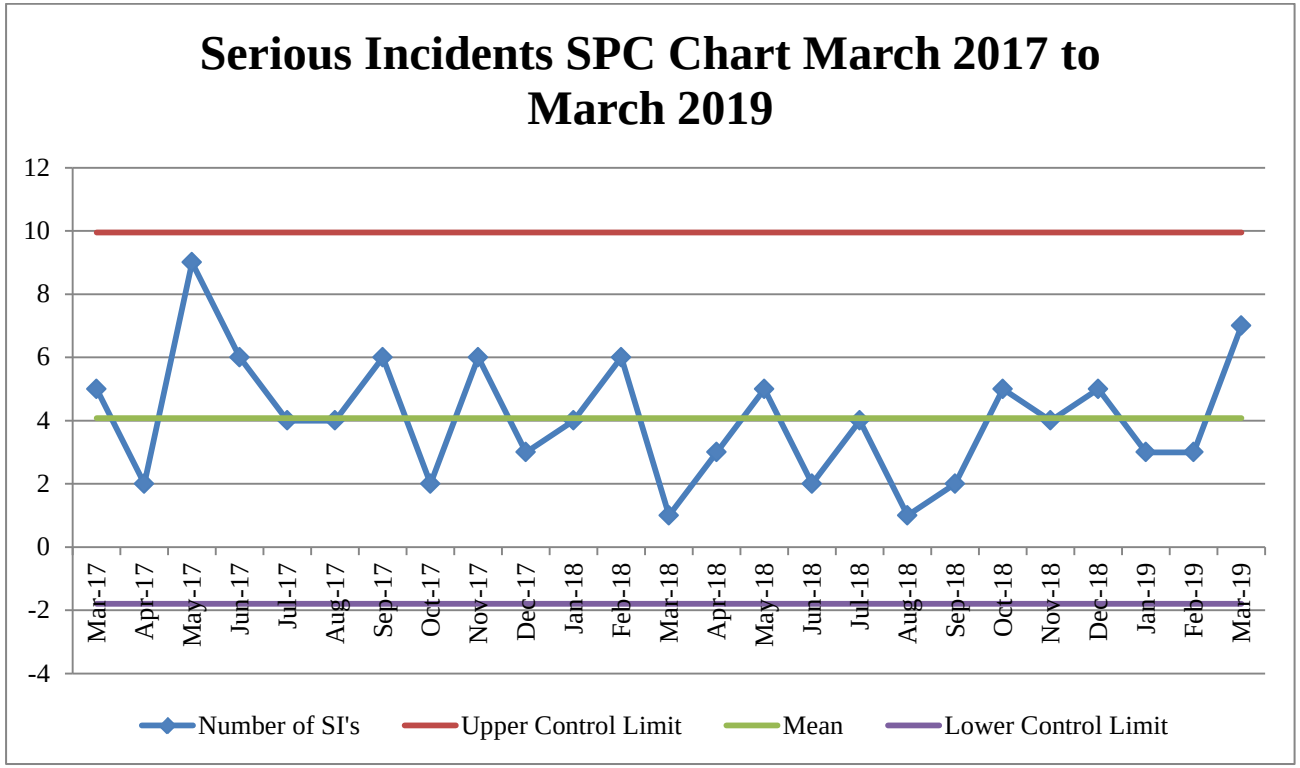
In relation to incident data only self harm incidents are also high.

In relation to the above the below learning/actions have been identified.

- Consideration to be given to expanding the range of professionals accessing specific training in respect of the care of Looked After Children
- Taking information from the parents at face value and over reliance that the parent/ grandparents could make a self-referral to services.
- Safeguarding Supervision in school nursing service needs to be robust and recorded in the record.
- Clarification of who is leading on particular actions when working between teams. To ensure care navigator is involved in complex cases.
- Staff reminded of their responsibilities for sharing information with social care as soon as concerns have been identified.
- Children and young people should be seen on their own where appropriate to allow them to give their views independently.

4. SERIOUS INCIDENT DATA TRUST WIDE

In quarter 4 2018/19 there were 14 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 March 2017.

The highest type of Serious Incident during quarter 4 2018/19 is suspected suicide (43%).

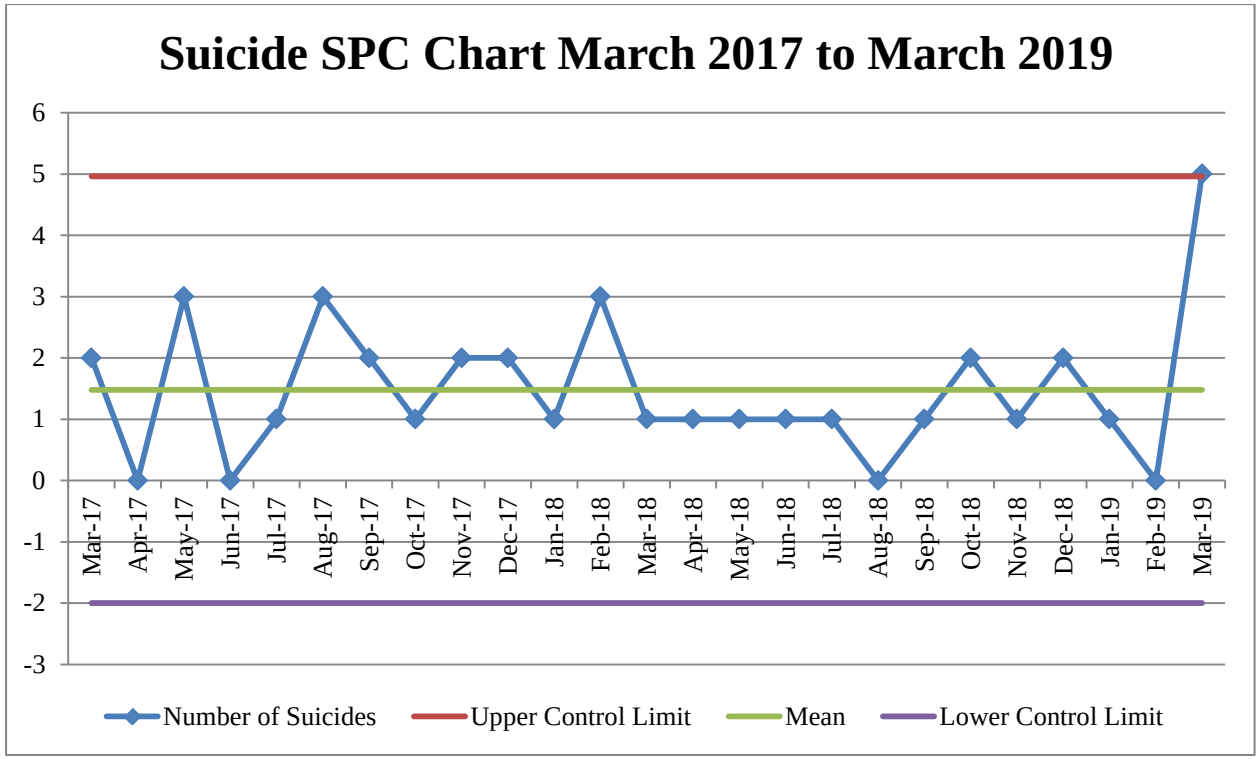
4.1 New SIs reported and actions taken to reduce immediate risk

STEIS No	Department	Incident	Incident Description	Action taken to reduce immediate risk
2019/547	Griffin Ward (PICU)	Attempted suicide (inpatient)	Patient found soon after her admission in her bedroom semi responsive having tied a ligature with a piece of elastic fabric. Patient transferred to ICU and placed on a ventilator. Patient transferred back to Griffin PICU following treatment.	Review of observation levels for new admissions
2019/1481	CRHT	Apparent suicide	Patient open to CRT since 02/01/19 was killed by a lorry at a nearby motorway on 21/01/19. Patient was last seen at his home on 20/01/19.	No immediate actions required.
2019/1522	Merlyn Vaz DNT	Pressure ulcer Cat 4	Avoidable pressure ulcer category 4 to the patient's sacrum confirmed at CHS SI sign off group.	No immediate actions required.
2019/3931	Ellistown Ward	Found with injury – cause unknown	Patient identified to have multiple blisters/developing blisters and generalised redness to buttocks, sacrum and right side of back – cause unknown.	LPT safeguarding team informed and are undertaking their own investigation.
2019/4660	The Willows	Unexpected death	Patient with a known Cardiac condition was found on the floor in the ward toilet unresponsive with no pulse. Patient taken to CCU at Glenfield hospital where he was pronounced deceased.	Police informed. Review of resuscitation process completed by Trust Lead. Debrief sessions held with staff. Investigation to consider assessment of capacity to refuse treatment.
2019/4669	Watermead Ward	Sexual abuse – pt on pt	Female patient disclosed to staff that she had been raped by a male patient in the ward toilet. Incident subject to police investigation.	Female patient transferred to all female ward. Male patient transferred to an all male ward. Safeguarding informed. Incident

				reported to police.
2019/5409	Rutland Ward	Unexpected death	Staff member administered 15,000 units of Dalteparin (treatment dose) to a male patient instead of the prescribed 5,000 units (prophylactic dose) The patient had been previously identified as approaching end of life and had been fast tracked. The patient deteriorated suddenly and died unexpectedly on the ward the following morning.	BESS score completed with member of staff. The cause of death is awaited. Clinical opinion is currently that it is unlikely to be related to the medication error. Safeguarding informed.
2019/5726	City Central CMHT	Apparent suicide	Patient open to CMHT was found deceased by hanging at their home address on 11/03/19. Patient was last seen by their CPN on 5/03/19.	No immediate actions required.
2019/6016	CAMHS County Team	Severe harm caused by patient & Admission of child into an adult bed	On 11/3/19 mother and patient report that patient and patient's brother were "play-fighting" when brother received a serious knife wound. The patient was placed in the care of his uncle until a secure bed was sought. On 14/3/19 patient's level of risk escalated and he was admitted to Belvoir PICU after failure to find a Medium Secure CAMHS bed.	Immediate actions were taken to ensure the safety of the child while on an adult ward.
2019/6228	Bradgate - Outpatients	Apparent suicide	Patient was found deceased at their home address by apparent ligature on 15/03/19. Patient was referred to CRT by GP on 09/03/19 and offered an appointment for assessment. Patient DNA'd appointment and was subsequently discharged. Patient contacted CRT on 11/3/19 but was told that he was closed to the team and to call 111, attend A&E or see GP.	No immediate action
2019/6559	Perinatal MH Service/Early Start County & Rutland	?Non accidental injury	Patient's 11 month old son admitted to QMC with head injuries. Patient was arrested and bailed with conditions that contact with her son is supervised.	Information shared on strategy call. SARS request actioned by LPT safeguarding team.

	Team			Records reviewed by named Early Start PHN and Early Start CTL and liaison with perinatal team re updates about incident and SARS request.
2019/6704	CRHT	Apparent suicide	On 21/03/19 patient was found deceased at property in supported accommodation of what appears to have been a potential drug overdose. Actual cause of death to be determined by Coroner. Patient was last seen on 19/03/19 at their home.	No immediate actions required.
2019/6775	Bosworth Ward	Apparent suicide (inpatient)	Patient on unescorted day leave was found deceased at home having ligatured.	Early review of decisions for leave undertaken. Previous successful leave and no change in patients presentation reported
2019/7146	NW Leics CMHT	Apparent suicide	On 22/12/18 patient was found deceased at home address – cause of death unknown. On 28/03/19 the Coroner confirmed the cause of death as 1a morphine and tramadol toxicity. The patient was last seen by their CPN on 11/12/18.	No immediate actions required.

5. SUICIDE DATA TRUST-WIDE



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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 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 March 2017.

5.1 Suspected Suicide SIs reported in Q4 18/19

STEIS No	Incident Date	Gender	Age	Service	Locality	Method	Diagnosis	Time in service	Ethnic Origin	Marital status	*Inquest verdict*
2019/7146	22/12/18	Female	35	NW Leics CMHT	County	Overdose	Bipolar Affective Disorder, Physical Health Diagnosis, EUPD	2 years	Not stated	Single	*Inquest date not yet set*
2019/6775	24/03/19	Male	52	Bosworth ward	County	Hanging	Severe Depressive Disorder	2 months	White British	Single	24/09/19
2019/6704	21/03/19	Male	40	CRHT	County	Suspected overdose – awaiting toxicology	Emotional unstable personality disorder	4 ½ years	White British	Single	*Inquest date not yet set*
2019/6228	15/03/19	Male	36	Bradgate Outpatients	City	Hanging	F10.2 Mental and behaviour disorder due to alcohol dependence syndrome	3 years	White British	Single	11/09/19
2019/5726	11/03/19	Female	55	City Central CMHT	City	Hanging	Anxiety and depression	5 months	White German	Single	27/04/19
2019/1481	21/01/19	Male	60	CRHT	County	Walked in	Anxiety and	3 weeks	Asian or	Married	*Inquest*

						front of traffic	depressive symptom with frequent morbid thoughts		Asian British Indian		*date not yet set*

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

There has been an increase noted in deaths of patients under the care of Crisis Team with three having been reported in the four 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	Within 10 days of discharge	Under the care of crisis team
2015	0	1	0	0	3
2016	1	1	0	2	2
2017	0	3	0	0	0
2018	0	0	0	2	3
2019	0	1	0	0	3

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 will take place on Wednesday 8th May 2019

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 Q1 report for 2019/2020.

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

There were no incidents of failure to provide an appropriate bed for patients under the age of 16 in quarter 4 2018/19.

There was however a 17year old admitted to Belvior ward due to the unavailability of a suitable CAMHS 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 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%)
Qtr 1 – 18/19	16	7 (44%)	1 (11%)

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

Submission	Total No. of SIs reported	Q4 – 18/19	Q3 – 18/19	Q2 – 18/19	Q1 – 18/19
Green (within timeline)	*45	100%	93%	100%	100%
Amber (breached ≤ 7 days)	-	-	0	-	-
Red (breached ≥ 8 days)	1	-	1	-	-

* The number of SIs reported onto STEIS during Q1, Q2 Q3 & 4 18/19.

During quarter 4 2018/19 fourteen external SIs were reported and all fourteen (100%) were reported within 2 working days of the Trust becoming aware.

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 seven incident investigations were concluded and four (57%) were submitted to the commissioners by the target date.

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

*The reason for late submissions was due to the capacity of senior staff to write up reports and new internal sign off process that is not signing off reports for submission.

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.

8. DUTY OF CANDOUR

There were zero duty of candour breaches in quarter 4 2018/19.

9. SI ACTION PLAN TRACKER - Q4 18/19

There were nine SI action plans due for completion in quarter 4 2018/19, eight met timescale and evidence received, however three actions on an AMH&LD action plan has breached timescale (please see below), all other actions on this action plan were completed within timescale.

Exception Statement (Actions 4, 5 & 6) (2018/1356)

The service has been awaiting completion of the review of the Trust's *Escorting Patients Policy,* in order to evidence completion of the actions from recommendations 4, 5 and 6. Due to the changes in the role of the CHS staff member who is leading it, there's unfortunately been a significant delay to the completion of this policy review and the service have not been able to meet the deadline for providing evidence of these actions.

STEIS NO	INCIDENT TYPE	DEPT	DUE DATE FOR COMPLETION OF ALL ACTIONS	RAG RATING	CURRENT ACTION PLAN POSITION
2018/11597	Contraband Found / Used	Phoenix Ward	31/01/2019		Action plan closed and evidence received.
2018/12763	Apparent Suicide	PIER Team	31/01/2019		Action plan closed and evidence received.
2018/16685	Self harm - medication	West Leics CMHT	31/01/2019		Action plan closed and evidence received.
2018/18042	Unexpected death	Thornton Ward	31/01/2019		Action plan closed and evidence received.
2018/19167	Loss of consciousness / cardiac arrest	Ashby Ward	31/01/2019		Action plan closed and evidence received.
2018/16881	Attempted suicide	School Nursing – Hinckley & Bosworth	28/02/2019		Action plan closed and evidence received.
2018/1356	Absconded from escorted leave	Beaumont Ward	31/03/2019		Actions 4, 5 & 6 under implementation. All other actions closed and evidence received.
2018/14885	Never Event	Heather Ward	31/03/2019		Action plan closed and evidence received.
2019/1522	Pressure Ulcer Category 4	Merlyn Vaz DNT	31/03/2019		Action plan closed and evidence received.

9.1 SI action plans monitoring of embeddedness

CHS have undertaken a spot check around fall incidents on MHSOP wards during the quarter.

- Action plans from four previous Serious Incidents reported in 2017 and 2018 were reviewed and the resulting actions identified formed the basis of the spot check tool. The Governance team visited two MHSOP wards, spoke to ten staff members and ten patient notes were checked. All ten staff questioned were in date with the three yearly Falls mandatory training and had read the falls policy. They were able to advise on the documentation that needs to be completed within 24 hours of a patient being admitted onto the ward ie; MUST, FRAT, Risk Assessment, Management of Falls Checklist and Care Plan. All ten staff

questioned understood their role in supporting individual patient centred care for patients at high risk of falling. They were able to confirm what equipment they would need to put in place for a patient that falls frequently i.e. sensor mats, high/low bed and one to one care where appropriate. All ten staff were able to confirm that after a fall what documentation needed to be reviewed and updated i.e. Falls care plan, review and update previous Falls assessments, FIR charts and Incident reporting. A review of ten patient records showed that all relevant clinical records including admission/transfer information, risk assessments and care plans were in place and follow up assessments had been completed in a timely way. A theme was identified regarding patients being admitted with inappropriate footwear which could contribute to a fall. There is now a slipper store for patients who require foot wear and non-slip socks for all MHSOP wards to use on Wakerley Ward at the Evington Centre. This has been sourced by Therapy Services.

FYPC have undertaken a spot check around the application of the weekly ward round SOP for all inpatients.

- FYPC reviewed an action from an SI investigation into the apparent suicide of a CAMHS inpatient in 2017. The action from the SI which was reviewed was as follows;
    - The function of the multi-disciplinary team, inclusive of the processes and systems used, needs to be reviewed and amended to ensure that the oversight of patients care is established whilst enabling decisions to be clinically challenged. In doing so, the culture of the ward will be transformed allowing for professional curiosity and growth, as well as patient driven care.

  The original actions were to formulate a Standard Operating Procedure (SOP) for the weekly ward round meetings and then audit the application of the SOP for all inpatients. Both actions were carried out and there was good compliance to the SOP found within the original audit.

  The FYPC Clinical Governance Manager attended the ward and observed ward round meetings for three patients. It was found that there continued to be good evidence of compliance to the SOP as follows;

    - Patients views were heard and documented
    - Carers views were heard and documented
    - There was an opportunity for professional discussion regarding the plan of care from the MDT
    - The meetings were quorate for each patient
    - Outpatient colleagues attended for two of the patients who were due for discharge and who needed specialist oversight from the learning disability team

- Minutes of the meeting were maintained within the patients S1 record in the agreed template and a copy was given to the patient and parents at the end of the meeting.

This showed good evidence that the SOP remains embedded into practice.

Adult Mental Health and Learning Disability have not undertaken any spot check audits of embedded actions from SIs for quarter 4.

10. INTERNAL ROOT CAUSE ANALYSIS INVESTIGATION DATA AND LEARNING

Incident No	Department	Incident	Incident Description	Action taken to reduce immediate risk
232293	AMH Charnwood CMHT	Self harm – medication	Patient took an overdose of paracetamol and received treatment at the LRI for raised paracetamol levels.	CPN updated risk assessment and safety plan with patient at their next appointment.
229246	AMH South Leics CMHT	Unexpected Death	Patient found deceased at her home address. Cause of death 1a multiple drug toxicity	No immediate actions required.
228972	AMH West Leics CMHT	Self harm – medication	Patient admitted to hospital for treatment following an overdose	No immediate actions required.
233396	Ashby Ward	Self harm – self poisoning	Patient drank a mixture of antifreeze and coolant he had brought on to the ward in a labelled Lucozade bottle. Patient transferred to A&E for treatment.	No immediate actions required.
233089	Bosworth Ward	Physical abuse – pt on st	Patient threatening to hit staff and encouraging other patients to smoke in lounge area on ward.	Instigator was managed and ultimately transferred to PICU.
233436	Clarendon Ward	Fall	Patient sustained a fractured right neck of femur and underwent surgery at the LRI following an unwitnessed fall on the ward.	Falls pathway updated following fall
232905	Coleman Ward	Fall	Patient sustained a C2 odontoid peg un-displaced fracture following a fall on the ward.	Falls pathway updated following fall.
232295	Crisis Resolution Team	Suspected Suicide	Patient was found hanging at her home address. Patient was not open to services, but was assessed by the Mental Health Triage Team at the LRI two days prior to the incident and not taken on for treatment.	Early review of investigation as this may need to be escalated to SI
231440	Rutland District Nursing Team	Unexpected death	Patient was found deceased at their home on 4/2/19. Patient was due a DN visit on 1/2/19; however DN could	Review of DNA policy.

			not gain entry so a note was left.	
223491	Loughborough District Nursing Team	Pressure ulcer	Category two pressure ulcer to sacrum deteriorated to category 4. Patient was cachexic and approaching end of life. Poor nutritional intake contributed to skin failure.	Training records scrutinised and pressure ulcer prevention training provided to staff. This may be upgraded to STEIS following review by the Patient Safety Team.
230721	Gwendolen Ward	Fall	Patient lost their balance and fell whilst in the lounge on the ward sustaining a left extracapsular neck of femur fracture, which required surgery.	Records demonstrated all documentations, risk assessment and care plans were in place pre and post fall. To look at training for top to toe assessment post fall and prior to hoisting
229428	Heather Ward	Self harm – medication	Patient returned from leave and reported that she had taken an overdose of 4 boxes of paracetamol. She was transferred to A&E at the LRI for treatment.	Risk assessment and care plan updated.
231278	Heather ward	Failure to return from authorised leave	Patient on a Section 3 of the MHA failed to return from unescorted leave. Police found the patient in City centre and reported to have taken an overdose. Patient transferred to A&E at the LRI for treatment.	Review of leave decisions
233437	Heather ward	Unexpected death	Patient on a Section 3 of the MHA was transferred to Surgical Assessment Unit on 13/3/19 following a CT scan that had been completed on 12/3/19. The scan showed a bowel obstruction, which was likely to be a cancerous tumour from bowel cancer that had returned, having previously been treated. The surgical team said that it was unlikely that any interventions would be given due to the progression of the cancer. On 17/3/19 LRI staff informed the ward that the patient had passed away. Cause of death 1a small bowel obstruction, 2 metastatic colon cancer.	No immediate actions required. Full review to be undertaken in relation to 'learning from deaths' to also consider the support provided in relation to treatment and capacity to make decisions

231613	LD Outreach Team	Self harm – ingestion of foreign body	Manager at residential home contacted staff informing them that the patient had swallowed a foreign body. He was taken to A&E and then transferred to Glenfield Hospital for surgery.	No immediate actions required.
229586	MHSOP South Leics CMHT	Self-harm medication	Patient admitted to LRI following an overdose of paracetamol tablets with the intention of killing herself. Patient treated with N-acetylcysteine.	Patient assessed by FOPAL team and admitted to MHSOP ward for further assessment and treatment.
229945	MHSOP South Leics CMHT	Self harm – self poisoning	Patient took an overdose of paracetamol, which required treatment at the LRI.	No immediate actions required.
229564	MHSOP Integrated Care Team	Attempted Suicide	Patient took a deliberate overdose of prescribed medication with the intention to end their life. Patient admitted to A&E for treatment and later transferred to ward 36 at the LRI.	Patient admitted to MHSOP ward for further assessment and treatment.
231286	Phoenix Ward	Physical health complications / concerns	Patient returned from leave and was reported wobbly and unsteady on their feet. Patient's observations were normal except SATS at 88%. Patient put on 15 litres of oxygen and taken to A&E. Urine drug screen tested positive.	Patient searched on return from A&E and room searched. Risk assessment and care plans updated.
232666	Phoenix Ward	Failure to return from authorised leave (sectioned)	On 01/03/19 patient utilised unescorted leave but failed to return at the agreed time. Missing person initiated as per trust policy and police contacted. The patient was returned to the ward on 04/03/19 unharmed.	Core mental health assessment and risk assessment updated.
231715	Agnes Unit	Fall	Patient stumbled and fell backwards in her bedroom and sustained a hairline fracture to her pelvis.	Falls care plan updated
225725	AMH City Central Outpatients	Unexpected death	Patient found deceased at home address. Cause of death 1a Dihydrocodeine toxicity.	Review of medical notes and care received.

228227	AMH Charnwood outpatients	Unexpected death	Patient found deceased at home address. Cause of death 1a Tramadol toxicity, 2 hypertensive heart disease	No immediate action required. Now escalated to SI as GP stated a suicide note had been left
230505	Triage Car	Suspected Suicide	Patient found deceased at home address. Cause of death 1a combined fentanyl, tramadol, codeine, morphine and lorazepam toxicity. Last contact with CRT 7 months ago.	No immediate action required. May require escalation to STEIS depending on the findings from the investigation
230922	Fielding Palmer Hospital	Fall	Patient fell whilst transferring from chair to bed and being supervised by two staff members and landed on her buttock. Patient taken to A&E for x-ray, which confirmed right ankle fracture.	A patient centred falls care plan completed.
233542	Welford Ward	Fall	Patient was found on the floor by staff, he reported that he stood up from his chair and fell backwards. Patient taken to A&E for x-ray which revealed L1 Wedge fracture.	Review of post falls review and decisions re moving with potential spinal injury

11. PREVENTING FUTURE DEATHS AND RESPONSES

In quarter 4 2018/19 the trust received one report to prevent future deaths from the Leicester City and Leicestershire South Coroner's office in response to the death of a detained patient in an acute psychiatric ward. The patient was diagnosed with Aspergers and was awaiting a specialist permanent placement to be identified for her. The jury returned a very full narrative response to an agreed set of questions and the Coroner's matters of concern are as follows;

1. *Too many LPT employees do not have any or any sufficient training in autistic spectrum disorders. This lack of knowledge makes a difficult situation considerably worse for any presenting patient, with potentially dangerous consequences. The Coroner was not reassured that training is given at the earliest possible opportunity to reduce these risks, or that all appropriate staff are receiving or accessing training to a suitable standard. In this case even when it was acknowledged that the patient would remain an in-patient for some time, front line staff including the patient's named nurse and the ward matron was ill-equipped to understand the patient's communication needs and care requirements. The Coroner asked LPT to review and reconsider the current training planning in this area.*

Response

The Head of Nursing and Director for Adult Mental Health and Learning Disability Services have reviewed the Trust training provision. The Trust introduced an e-learning Autism Awareness module in November 2017 which is accessible to all staff. A recommendation went to the Trust Learning and Development Group in February 2018 that this training becomes role essential for clinical staff in AMH/LD Services; this was agreed and will be finalised at the Trust's Strategic Workforce Group in March 2019.

In March 2018 a Recognising and Caring for People with Autistic Spectrum Disorders (ASD) practical workshop took place involving a range of professionals with experience of working with people with autism, Tom Doheney a Speech and Language Therapists (SLT) Assistant and Consultants from the Autism Diagnostic Service and Learning Disability Service. The Trust is currently looking at how to develop this training further for inpatient areas that will be working with patients with ASD in Mental Health Services. A training task and finish group has been set up with representatives from mental health wards, learning disability services, SLT and Occupational Therapy (OT) to develop a more in depth training product and this will be reporting back to the Directorate Management Team in April 2019. The group are considering how elements of the patient's video interview with SLT can be used to enhance either the existing e-learning module or further training.

The Head of Nursing and Director for Adult Mental Health and Learning Disability Services met with the patient's mum who is keen to support the training review. They shared the e-learning module with her and she felt that whilst this was a good basic awareness resource and that it was important to ensure ward staff in particular were equipped with the practical skills in how to apply the knowledge gained. She provided helpful insight and suggestions as to how the e-learning could be built on and is keen to support the development of the training.

In the interim the Directorate has identified some specialist mental health SLT resource. The individuals providing this support to the wards at the Bradgate Unit are skilled in ASD diagnosis and management. All in-patients with a diagnosis of ASD will be referred to the SLT service to ensure the care plans reflect a bespoke and differentiated approach. In addition the SLTs are looking at the best ways to support ward staff and are working with the OTs to develop a decision making flowchart. Again the feedback from the patient's mum will inform this tool

2. *The court was advised that it was "custom and practice" on bank holidays for the nursing staff to agree between themselves to have a shorter hand over and work an hour less. This removed an important part of the expected staff communication and left a significant gap in the safe transfer of information, on the days when senior staff are likely to be on leave and it was recognised that bank staff may be covering. Furthermore, patients on an acute mental health ward are likely to struggle emotionally on these important social occasions when they are apart from family and familiarity. The handover on such days should be more, or less robust and the Coroner asked that LPT conduct an urgent review and senior level scrutiny regarding this matter.*

The inquest was just before Christmas bank holiday period and immediate action was taken by the Heads of Nursing across the Trust to ensure the working arrangements and expectations of staff around the handover of patient care was clear during this period. On the wards at the Bradgate Unit there is a senior nurse on duty as the 'Clinical Duty Manager' (CDM) at all times (24 hours, 7 days a week). The CDM visited wards over the Christmas and New Year period to ensure handovers were taking place appropriately.

In January 2019 the learning from this death and the inquest was discussed again at the Chief Nurse's meeting with all Heads of Nursing and as a result the Trust's Handover Policy and documentation will be reviewed and a further programme of checking the handover on wards will be developed. In April 2019 the Mental Health and Learning Disability wards will commence introducing Nerve Centre which enables each staff member on duty to carry a hand-held device allowing them immediate access to a set of patient information including the latest handover for that patient. Staff members can directly add information about the patients care whilst with the patient, which then provides an automatic update to the central information

for that patient held on Nerve Centre so all users can see any changes to care immediately.

12. PRESSURE ULCER INFORMATION

Quarterly Pressure Ulcer Report (April 2019)

1.0 Numbers of Avoidable Pressure Ulcers

1.1 Pressure ulcers that patients' develop, or those that deteriorate in our care, are reported and investigated. The purpose of the investigation is to understand if the pressure ulcer development or deterioration is attributable to the standard of care a patient has received. If it is so, the pressure ulcer is determined as 'avoidable'; to enable numbers of pressure ulcers that may have been attributed to the standard of care to be counted.

Quarter 3:	**Cat 2's**	**Cat 3's**	**Cat 4's**	**Total**
October 2017	4	0	0	4
November 2017	4	0	0	4
December 2017	3	2	0	5
Total	11 ↑	2 —	0 —	13 ↑
Quarter 4:	**Cat 2's**	**Cat 3's**	**Cat 4's**	**Total**
January 2018	2	0	0	2
February 2018	6	0	0	6
March 2018	1	0	0	1
Total	9 ↓	0 ↓	0 —	9 ↓
Quarter 1:	**Cat 2's**	**Cat 3's**	**Cat 4's**	**Total**
April 2018	4	1	0	5
May 2018	3	2	0	5
June 2018	4	1	0	5
Total	11 ↑	4 ↑	0 —	15 ↑
Quarter 2:	**Cat 2's**	**Cat 3's**	**Cat 4's**	**Total**
July 2018	3	0	0	3
Aug 2018	1	1	0	2
Sept 2018	2	2	0	4
Total	6 ↓	3 ↓	0 —	9 ↓
Quarter 3:	**Cat 2's**	**Cat 3's**	**Cat 4's**	**Total**
Oct 2018	3	0	0	3
Nov 2018	0	1	0	1
Dec 2018	1	1	1	1

Total	4 ↓	2 ↓	1 ↑	7 ↓
Quarter 4:	**Cat 2's**	**Cat 3's**	**Cat 4's**	**Total**
January 2019	2	1	0	3
February 2019	1	0	0	1
March 2019	1	0	0	1
Total	4 —	1 ↓	0 ↓	5 ↓

2.0 Trajectory for Improvement

2.1 Community CHS / AMH / FYPC / LD:

The trajectory for the financial year 2018/19: Category 2 is for no more than 70 avoidable ulcers for the total year (6 per month). Category 3 is for no more than 8 avoidable pressure ulcers (2 per quarter). Category 4 is for 0 avoidable pressure ulcers per month.

Category 2 Avoidable Pressure Ulcers

	Jan	Feb	March
Trajectory	**6**	**6**	**6**
Actual	0	1	0

There has been 1 category 2 avoidable pressure ulcer this quarter, the quarterly trajectory of 6 category 2 avoidable pressure ulcers has been achieved.

Category 3 Avoidable Pressure Ulcers

	Jan	Feb	March
Trajectory		**2**	
Actual	1	0	0

There has been 1 category 3 avoidable pressure ulcers this quarter, so the quarterly trajectory of 2 category 3 avoidable pressure ulcers has been achieved.

Category 4 Avoidable Pressure Ulcers

	Jan	Feb	March
Trajectory	**0**	**0**	**0**
Actual	0	0	0

There have been 0 category 4 avoidable pressure ulcers this quarter. The quarterly trajectory of 0 category 4 avoidable pressure ulcers has been achieved.

2.2 Inpatient CHS (Inclusive of MHSOP / AMH / LD / FYPC):

Category 2 Avoidable Pressure Ulcers

	Jan	Feb	March
Trajectory	**0**	**0**	**0**
Actual	1	0	1

There have been two category 2 avoidable pressure ulcers this quarter. The category 2 pressure ulcer quarterly trajectory of 0 avoidable pressure ulcers for inpatient areas has not been achieved.

Category 3 Avoidable Pressure Ulcers

	Jan	Feb	March
Trajectory	**0**	**0**	**0**
Actual	0	0	0

There have been 0 category 3 avoidable pressure ulcers this quarter. The category 3 pressure ulcer quarterly trajectory of 0 avoidable pressure ulcers for inpatient areas has been achieved.

Category 4 Avoidable Pressure Ulcers

	Jan	Feb	March
Trajectory	**0**	**0**	**0**
Actual	0	0	0

There have been 0 category 4 avoidable pressure ulcers this quarter. The category 4 pressure ulcer quarterly trajectory of 0 avoidable pressure ulcers for inpatient areas has been achieved.

3.0 Quarter 4 Analysis

Overall there has been a reduction this quarter compared to the previous quarter in avoidable pressure ulcers; this has been identified in terms of category 3 and 4 pressure ulcers.

Within Community services all avoidable trajectories have been met this quarter. A review of the avoidable as well as those deemed unavoidable with care recommendations pressure ulcers has been undertaken which has identified themes around gaps in the Holistic Assessments being completed for complete SSKIN assessments / checks. It has been agreed that all category 2 or above pressure ulcer will be discussed as part of the board round patient review process to ensure learning is identified to avoid further deterioration where possible.

Within Community Hospitals there has been a reduction in Avoidable pressure ulcers with only two reported for this quarter, both for different wards. Improvement has been sustained within Ellistown Ward at Coalville Hospital, where the ward has been avoidable pressure ulcer free since January 2019. This has been attributed to the extensive work undertaken to address the previous trends and actions which have included clinical supervision sessions for all registered nursing staff and HCA's.

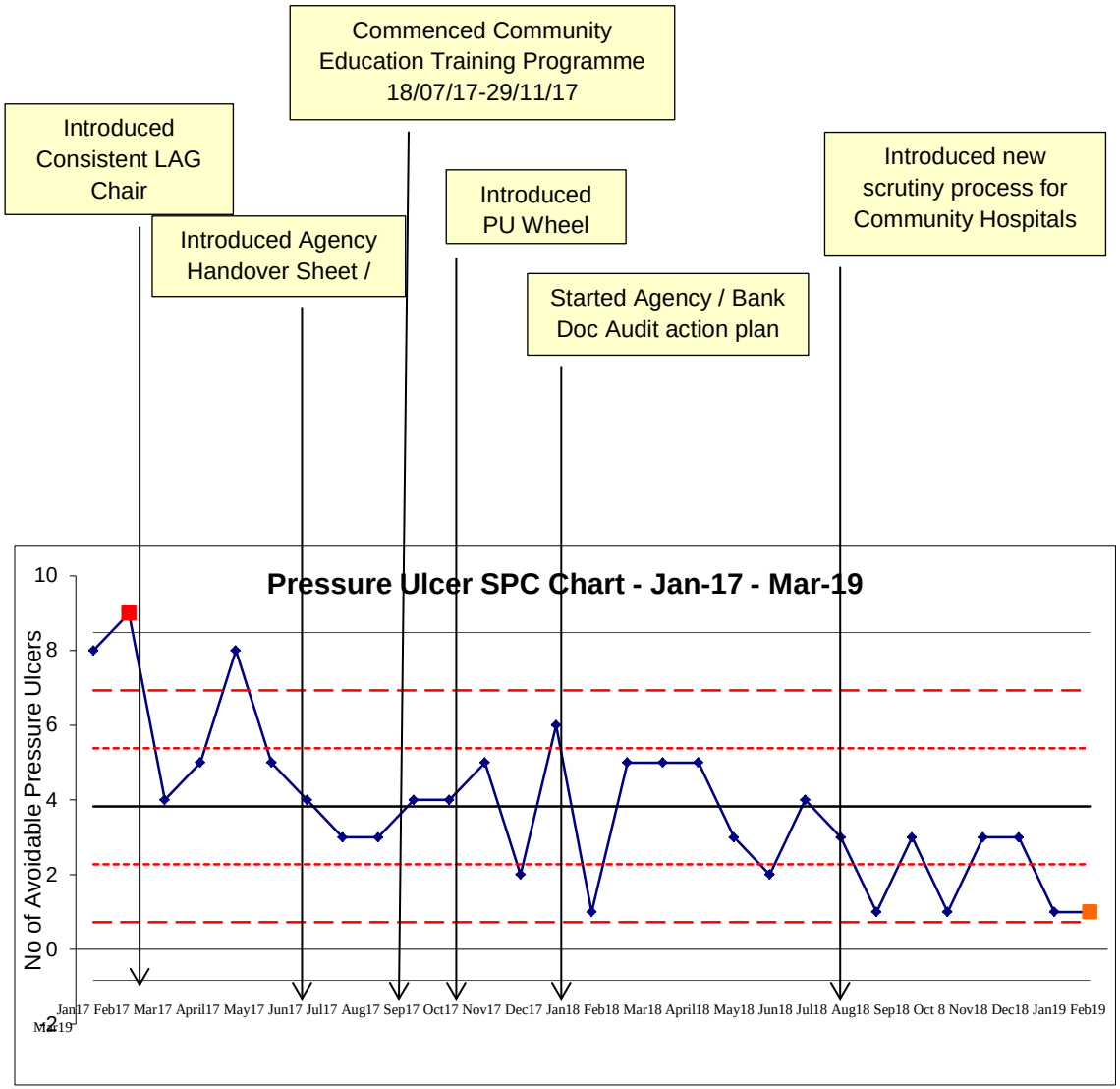
These sessions reviewed the current ward process which included organisation roles & responsibilities and delegation of care to non-registered staff.

The Lead Nurse for Community Hospitals, together with the Operational Lead for Tissue Viability are currently reviewing the use of the SSKIN Assessment process to ensure it meets the needs of the service.

The LPT Pressure Ulcer Ambition Group meet every month to review and identify themes and trends which could help us improve the treatment and experience for all patients with pressure ulcers. The group has reviewed and designed a new Pressure Ulcer Scrutiny Template to ensure we capture all learning and actions taken from Pressure Ulcer incidents, which ensures we can meet the new national Pressure Ulcer reporting guidance. This system went live on 1st April 2019 and the first review of extracted data being captured has given positive results. The group will now be focussing on the improvement journey we need to take to reduce the number of pressure ulcers developing in our care including how we monitor this.

4.0 Quality Improvement

Avoidable Pressure Ulcer SPC Chart (Jan17-Mar-19)



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
- Four of Five points outside the one sigma limit
- Eight in a row on the same side of centreline

Interpretation

This chart demonstrates we are still within control limits for avoidable pressure ulcers for this period

Planned Future Interventions

- The new scrutiny process is being piloted in the community ready for roll out on 1st April 2019

5.0 Unavoidable Pressure Ulcer Figures (Quarter 4)

Month	In Patient Unavoidable Cat 2	In Patient Unavoidable Cat 3	In Patient Unavoidable Cat 4	Total Community Unavoidable Cat 2	Total Community Unavoidable Cat 3	Total Community Unavoidable Cat 4
	Quarter 3					
Oct-17	**11**	**1**	**1**	**40**	**26**	**9**
Nov-17	**12**	**0**	**0**	**36**	**19**	**6**
Dec-17	**6**	**0**	**0**	**43**	**20**	**8**
Total	**29** ↑	**1** ↓	**1** —	**119** ↑	**65** ↓	**23** ↑
	Quarter 4					
Jan-18	14	0	0	51	16	13
Feb-18	15	0	0	37	17	5
Mar-18	13	1	0	44	13	6
Total	**42** ↑	**1** —	**0** ↓	**132** ↑	**46** ↓	**24** ↑
	Quarter 1					
April-18	10	1	0	23	59	19
May-18	9	0	0	30	19	11
June-18	14	0	0	29	32	7
Total	**33** ↓	**1** —	**0** —	**82** ↓	**110** ↑	**37** ↑
	Quarter 2					
July-18	7	0	0	37	13	5
Aug-18	8	0	0	34	13	1
Sept-18	10	0	0	17	7	4
Total	**25** ↓	**0**	**0** —	**88** ↑	**33** ↓	**10** ↓
	Quarter 3					
Oct-18	6	1	0	24	24	4
Nov-18	9	1	0	33	27	2
Dec-18	3	0	0	27	15	2
Total	**18**	**2**	**0**	**84**	**66**	**8**
	Quarter 4					
Jan-19	11	1	0	39	39	11
Feb-19	5	0	0	26	20	8
Mar-19	4	0	0	35	21	6
Total	**20**	**1**	**0**	**100**	**77**	**24**

TRUST BOARD – 23rd May 2019

Mortality Surveillance Group Quarterly Report

Introduction

1. 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. "National Guidance on Learning from Deaths – A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care" (National Quality Board March 2017) set out extensive guidance for Trusts in terms of approaches to reviewing mortality, learning from deaths and reporting information.

Aim

2. This is to provide assurance of that work.

Recommendations

3. Receive the information related to all deaths in scope for Q3 OF 2018/19 and notes the themes.

4. Note the priorities for further work as set by MSG.

Discussion

Background

5. July 2017 NHS Improvement produced a document titled **"Implementing the Learning from Deaths framework: key requirements for trust boards**" stated that Learning from Deaths framework placed a number of new requirements on trusts which are now in place:

    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. **Updated policy** now on the intranet.
    c. **Publish information on deaths**, reviews and investigations via a quarterly agenda item and paper to public board meetings.
    d. **June 2018 onwards**, **publish** an annual overview of this information in Quality Accounts.

6. NHS Improvement (NHSI) stated that it is fully aware that many organizations, particularly mental health and community care providers, have less clarity on methodologies and scope for the new requirements. NHSI is clarifying with national

partners and providers what good looks like and did not expect providers to have developed perfect processes by autumn 2017. The NHSI intend to support the system to learn over the course of the next 12 months. The Royal College of Psychiatrists is in the process of developing a tool for MH Trusts.

7. The trust joined the network established by Mazars for a large number of mental health trusts to share learning on the mortality review framework. The Final meeting focusing on progress made by the Trusts involved took place in March 2018.

Progress update since Q2 report 2017/18

8. The policy is reviewed and circulated for consultation with plan to ratify at next MSG.

9. The Trust has recently had an audit undertaken by 360 Assurance which reviewed Mortality arrangements. The findings have been presented to the MSG and an action plan that was agreed is being implemented.

10. The process for collating mortality information established by the Patient Safety Team is reviewed regularly and the integrity of the data cleansed before it is shared with the directorates.

11. A regional mortality meeting was hosted by LPT on 30th January 2019 where experience shared across trusts in the region.

12. The Patient Safety Lead attended the Royal College of Psychiatrists launch of the Learning from Deaths Mental Health Tool and feedback at the Mortality Screening Group. A productive discussion was held and it was felt that as the Trust already has an established tool this would continue to be used.

13. The learning Disabilities Mortality Review (LeDeR) programme has been reconvened and reviewers have had update training. From the 1st February 2019, with the exception of deaths that meet the SI criteria, all other Learning Disability deaths are reviewed by the LeDeR programme with learning shared with relevant organisations.

14. The Trust has continued to work with the Patient safety team at UHL. These links are active and used to communicate to the relevant service when there is a requirement for joint review.

Data Limitations

15. National guidance indicates that it would be inappropriate to draw comparisons or use any published data for benchmarking between organisations. This is because organisations have locally determined their approach to mortality reviews, including the scope of deaths to be included in mortality review and reporting processes. There are also likely to be inter-reviewer variations. The focus will be on using mortality data internally to monitor quality of services, derive learning and inform improvement to services.

16. The position in terms of the mortality data reported in quarterly reports will continually change as further information on deaths is received by the Trust and reviews are completed. The information presented is only reflective of the position at that specific point in time and may be subject to change in future reports. This report represents the position for Q3 as at 10th April 2019.

17. Until the Mortality review policy was approved in September 2017 there was no approved methodology in place to assign a grading for the extent to which deaths could be judged as due to "problems in care", however deaths in Q3 are reviewed using the agreed methodology. Assurance can be provided that all deaths in scope have had at minimum a clinical case note review and that those meeting SI criteria have been subject to a robust investigation.

Presentation and analysis of Mortality data for Q3 2018/19

18. The attach annex sets out a summary of deaths within scope for mortality review in Q3 and the level of review/investigation that these deaths have been subjected to. The content and presentation of the data will be refined as mortality review evolves both locally and nationally.

Learning from CDOP Reviews completed in Q2 18/19 (deaths occurred in 2015-2017)

19. 027 2015 – this case was also a SCR and learning has been disseminated in FYPC (the Healthy Together CTLs will be delivering a presentation to practitioners during team meetings over the next couple of months related to the recommendations within the Child A Leicestershire SCR that was published in June 2018)

20. 056 2016 – this case was also an SCR and a learning briefing has been circulated to FYPC. In addition the case formed part of the themed review that CDOP undertook into learning from when young people take their lives; the outcomes from this work are forming part of the conference that is scheduled for 2019

21. 032 2017 – learning was identified pertaining to the need to ensure CSE awareness training remains a priority within agencies

22. 053 2017 – an Si was undertaken for this case
    - A focused programme will be undertaken in the CAMHS service to improve the timelines of record keeping and quality of risk assessments. This will include staff training sessions; guidance will be added to the CAMHS Standard Operating Guidance, peer review and increased awareness of the LPT Record Keeping Policy and LPT Clinical Risk Assessment Policy.
    - Suicide awareness update training to be made essential for CAMHS practitioners.
    - A revised induction programme will be implemented for all newly appointed CAMHS practitioners, including temporary staff.

23. Case has also been involved in the themed review undertaken by CDOP ongoing work stream currently being developed

24. There was an open inquest – but practitioners were not notified of this; this posed difficulties in terms of managing support for staff

Priorities for Q4

25. Further work to support and involve Families

- The Trust is committed to open and transparent communication with families following a death. The duty of candour policy is used for all deaths reported as serious incidents and has been updated in accordance with the new Mortality Review Policy.

- Work underway to develop Bereavement leaflet for family and carers that suffered loss of patients who are not covered by SI processes.

26. **To strengthen the reporting process across directorate and patient safety team**:
    - in view of review of the reporting forms and change in personal.

27. **Strengthen the LeDeR process**:
    - through closer links with its lead and increase number of trained reviewers.

28. **Complete the review of the policy and implement the action plan from 360 Assurance audit**.

Conclusion

29. This is the quarterly report of the mortality data and lessons learnt through our learning from deaths work at the Trust wide Mortality Surveillance Group.

Presenting Director: Dr Sue Elcock, Medical Director
Author(s): Professor Mohammed Al-Uzri
Jo Nicholls,

May 2019

Annex A

Quarterly Report of Death Reviews for Mortality Surveillance Group

Directorate: AMHLD **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
3	35	25	19	10	0	Incidents of poor record-keeping on EPR have resulted in failure to identify incidents that required DtR by Directorate MSSG; and/or instigation of incident investigation process. Gaps in information & understanding regarding PST reports of patient mortality & morbidity to Directorate MSSG	Individual issues to be addressed with specific teams involved. Process for wider learning across the Directorate to be identified Instigation of closer working with Patient Safety Team required, to clarify requirements and minimise risk of gaps in coverage;

						have been identified, which have resulted in failure in some cases to instigate M&M DtR process in line with Policy requirements.	meeting to be arranged.

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
3	47	46	53 * 41 reviewed from Q2 and 12 reviewed from Oct 2018	1	0	EOL paperwork has been updated and documented within S1 notes more adequately. 2. There has been 157% increase in EOL paperwork documentation compared to Q3 2017 3. Ceilings of care and escalation plans not always adhered to byNursing staff	1. EOL champions continue their work in spreading the message on 'quality of death' 2. Matrons have been informed of issues with ceilings of care and are working with wards to distribute learnings

Directorate: **FYPC** **Year:2018/19**

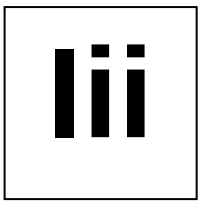
Quarter	Total number of deaths meeting threshold	Number of deaths subject to case review (desktop review of case notes using a structured method)	Number of cases reviewed within the Quarter	Number of deaths subject to an SI investigation	Number of deaths reviewed/ investigated and as a result considered 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
3	10 (all child deaths 2 expected and 8 unexpected)	0	0	0	0	No themes have been identified by CDOP	Nil

REPORT TO THE TRUST BOARD – May 2019	
Title	Finance Report for the period ended 30 April 2019 (month 1) – **Public meeting**.

Executive summary
This report is brought to the Trust Board to provide an update on the Trust's financial position as at the end of April 2019 (being month 1 of financial year 2019/20). As is normal at the beginning of the year, owing to the ongoing audit of the prior year draft accounts and the limited availability of new year data, the month 1 position includes a greater degree of estimation than usual. In addition, detailed forecasts will not yet be available. The Trust is reporting a year-to-date income and expenditure surplus of £1k which is in line with the year-to-date plan. However, operational budgets are already overspending by £325k. Whilst acknowledging that a considerable number of estimates will have been included in the position, this level of overspend is a significant cause for concern. It is clear that early action will need to be taken to manage down the overspend if year end targets are to be achieved. Cash balances are higher than plan (£10.2m v £7.7m planned). This is a carry over of the higher than expected cash balances retained at the end of 2018/19. At this early stage in the year, annual statutory financial duties are expected to be delivered by 31st March 2020. However, given the emerging pressures, it is already evident that delivery of targets will be extremely challenging.
Recommendation
The Trust Board is asked to receive the financial position update as at month 1.

Related Trust objectives	Ensure sustainability: continue to deliver a balanced financial plan
Risk and assurance	Relevant to all Corporate Finance risks
Legal implications/ regulatory requirements	NHS Statutory Financial Duties; Delivery of NHS Improvement authorised financial plan and control total.
Evidence for the Quality Governance Framework	
Presenting Director	Danielle Cecchini – Director of Finance, Business and Estates
Author(s)	Chris Poyser, Head of Corporate Finance Jackie Moore, Financial Controller
*Disclaimer: This report is submitted to the Trust Board for amendment or approval as appropriate. It should not be regarded or published as Trust Policy until it is formally agreed at the Board meeting, which the press and public are entitled to attend.	

Leicestershire Partnership NHS
NHS Trust



Finance Report for the period ended
30 April 2019

For presentation at the
Public Trust Board
23 May 2019

Contents

Executive Summary and overall performance against targets

Introduction

1. This report presents the financial position for the period ended 30 April 2019 (month 1). The report shows a £1k surplus, which is in line with plan. As is normal at the beginning of the year, owing to the ongoing audit of the prior year draft accounts and the limited availability of new year data, the month 1 position includes a greater degree of estimation than usual. In addition, detailed forecasts will not yet be available.

2. Operational budgets are currently overspending by £325k. This level of overspend – even considering the potential for some prudent over-estimation in month 1 – is a cause for considerable concern. Estates shows the highest level of overspend (£116k) followed by Adult Mental Health services (£76k) and Community health Services (£65k). The operational overspend is offset by the release of central reserves, allowing the Trust to report an 'on-target' position against the month 1 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.

3. Following the additional analysis of the month 1 position that will take place across May, and with the greater availability of data, the month 2 position will be expected to provide a more accurate view – both year-to-date, and in terms of a year end forecast.

4. Closing cash for April stood at £10.2m. This equates to 13.9 days' operating costs, and is above the planned cash level of £7.7m for April.

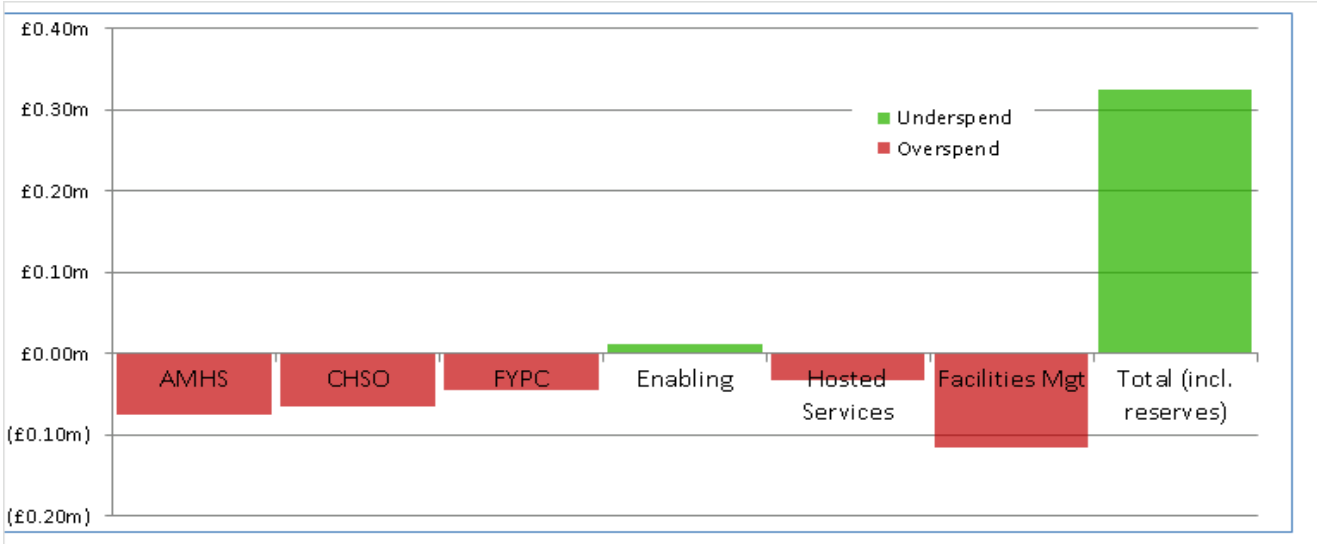
NHS Trust Statutory Duties	Year to date	Year end f'cast	Comments
1. Income and Expenditure break-even.	G	G	The Trust is reporting a surplus of £1k at the end of April 2019. This is in line with the Trust plan. **[see 'Service I&E position' and *Appendix A*]**.
2. Remain within Capital Resource Limit (CRL).	G	G	The capital spend for April is £284k, 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 £10.25m 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 April.
6. Achieve Cost Improvement Programme (CIP) targets.	R	tbc	CIP schemes have delivered £160k of the £254k year to date target (equating to 63% delivery) at the end of month. CIP year end forecasts have not yet been fully worked up – these will be available from month 2.
7. Achieve positive monthly income and expenditure run rate (a surplus).	G	A	(Also see target 1 above). A surplus of £1k has been reported in month 1. Further work will be required to develop a year end forecast, but based on the month 1 operational overspend and the limited availability of future central reserves support, significant risks to delivery are emerging.
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, the strong cash position means that a forecast 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 £10.2m was achieved at the end of April 2019. Measures are in place in the overall financial plan to maintain cash. Delivery of the year end cash forecast is now expected to exceed target due to the notification of 2018/19 incentive PSF. **[See 'cash and working capital']**
10. Deliver capital investment in line with plan (within +/- 15% YTD planned spend levels)	A	G	Capital expenditure totals £284k at the end of month 1; £0.5m below plan. **[See 'Capital Programme 2019/20']**

Income and Expenditure position

The month 1 position includes a significant operational overspend, that is currently offset by the release of 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.



Efficiency Savings Programme

At the end of April, CIP delivery amounted to £160k, against an overall year to date target of £254k. This equates to 63% delivered. The majority of the under delivery relates to the unidentified estates CIP target, and initial shortfalls against AMH schemes.

Forecast CIP delivery for the remainder of the year has not yet been fully assessed. This information will be included in the report from month 2.

Statement of Financial Position (SoFP)

PERIOD: April 2019	2018/19 31/03/19 Draft £'000's	2019/20 30/04/19 April £'000's
NON CURRENT ASSETS		
Property, Plant and Equipment	200,260	199,932
Intangible assets	1,911	1,885
Trade and other receivables	653	653
Total Non Current Assets	**202,824**	**202,470**
CURRENT ASSETS		
Inventories	320	319
Trade and other receivables	13,803	16,806
Cash and Cash Equivalents	8,356	10,246
Total Current Assets	**22,479**	**27,371**
Non current assets held for sale	**0**	**0**
TOTAL ASSETS	**225,303**	**229,841**
CURRENT LIABILITIES		
Trade and other payables	(14,859)	(19,448)
Borrowings	(220)	(220)
Capital Investment Loan - Current	(190)	(190)
Provisions	(1,202)	(1,152)
Total Current Liabilities	**(16,471)**	**(21,010)**
NET CURRENT ASSETS (LIABILITIES)	**6,008**	**6,361**
NON CURRENT LIABILITIES		
Borrowings	(8,025)	(8,024)
Capital Investment Loan - Non Current	(3,510)	(3,510)
Provisions	(1,129)	(1,129)
Total Non Current Liabilities	**(12,664)**	**(12,663)**
TOTAL ASSETS EMPLOYED	**196,168**	**196,169**
TAXPAYERS' EQUITY		
Public Dividend Capital	83,675	83,674
Retained Earnings	48,288	48,289
Revaluation reserve	64,205	64,205
TOTAL TAXPAYERS EQUITY	**196,168**	**196,169**

Non-current assets

- Property, plant and equipment (PPE) amounts to £202m. At the start of the year depreciation charges are exceeding capital spend, resulting in a reduced PPE balance .

Current assets

- Current assets of £27m include cash of £10.2m and receivables of £16.8m.

Current Liabilities

- Current liabilities amount to £21m and mainly relate to payables of £19.4m
- Net current assets /(liabilities) show net assets of £6.4m.

Working capital

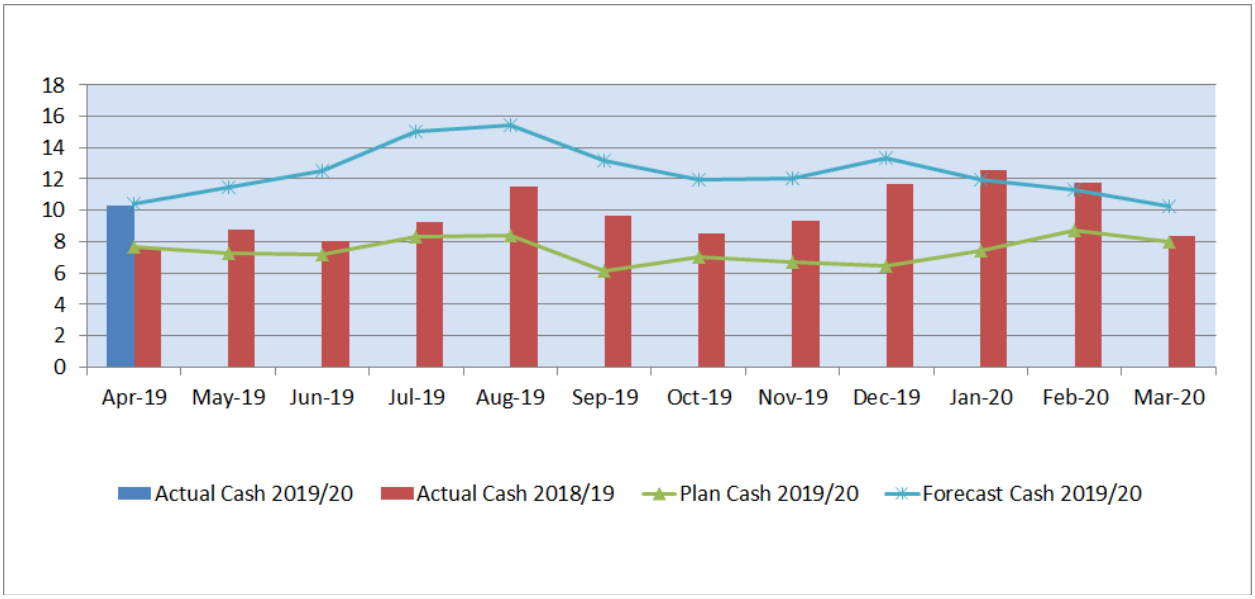
- Cash and changes in working capital are reviewed on the following pages.

Taxpayers' Equity

- April's year to date surplus of £1k is reflected within retained earnings.

Cash and Working Capital

Rolling 12 Months Cash Analysis Apr 18 to Mar 19



Cash – Key Points

April's closing cash balance is £10.2m and equates to 13.9 days' operating expenses - this is £2.6m above the planned cash balance of £7.7m.

The main reason for the Month 1 improved cash position compared to plan is the increase in creditors of £4.6m. NHS supplier invoices for April's activity were received during the month but payment for these is planned tor May (still meeting the 30-day payment terms). In addition to this, April's capital expenditure of £284k is £500k less than plan due to slippage on individual schemes' spend.

The year end cash forecast 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 therefore reliant on the receipt of incentive PSF funding and delivery of the planned I&E outturn of £2.15m.

Receivables

Current receivables (debtors) total £16.8m. It should be noted that financial instruments such as accruals are also included in this calculation.

Receivables	Current Month (April 2019)					
	NHS	Non NHS	Emp's	Total	% Total	% Sales Ledger
	£'000	£'000	£'000	£'000		
Sales Ledger						
30 days or less	790	335	3	**1,128**	**6.6%**	**16.8%**
31 - 60 days	1,079	1,326	15	**2,420**	**14.1%**	**36.1%**
61 - 90 days	101	379	3	**483**	**2.8%**	**7.2%**
Over 90 days	1,941	565	163	**2,669**	**15.5%**	**39.8%**
	3,911	2,605	184	**6,700**	**39.0%**	**100.0%**
Non sales ledger	6,028	4,078	0	**10,106**	**58.9%**	
Total receivables current	**9,939**	**6,683**	**184**	**16,806**	**97.9%**	
Total receivables non current		360		360	**2.1%**	
Total	**9,939**	**7,043**	**184**	**17,166**	**100.0%**	**0.0%**

Debt greater than 90 days amounts to £2.7m, an increase of £654k since last month. Receivables over 90 days should not account for more than 5% of the overall total receivables balance. The proportion at Month 1 is 15.5% (last month: 14.2%).

UHL, East Leicestershire CCG and both Leicester and Leicestershire County Councils have contributed towards the increase in aged debt > 90 days. These customers will be contacted in May, as part of the monthly debt recovery process.

There has not been any movement in the bad debt provision since last month. An update of any debts written off with be provided at Quarter 1.

Payables

The current payables position in Month 1 is £19.5m. The over 90 days NHS supplier debt of £886k relates to two suppliers: UHL (£125k) and NHS Property Services (£760k). Work is ongoing to resolve these invoice disputes.

Payables	Current Month April 2019				
	NHS £'000	Non NHS £'000	Total £'000	% Total	% Purchase Ledger
Purchase Ledger					
30 days or less	523	2,632	**3,155**	**16.2%**	**77.7%**
31 - 60 days	19	1	**20**	**0.1%**	**0.5%**
61 - 90 days	0	0	**0**	**0.0%**	**0.0%**
Over 90 days	886	0	**886**	**4.6%**	**21.8%**
	1,428	2,633	**4,061**	**20.9%**	**100.0%**
Non purchase ledger	957	14,430	**15,387**	**79.1%**	
Total Payables Current	**2,385**	**17,063**	**19,448**	**100.0%**	
Total Payables Non Current	0	0	**0**		
Total	2,385	17,063	19,448	**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 April.

The Finance team will continue to meet with 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 B***.

Capital Programme 2019/20

Capital expenditure totals £284k at the end of month 1, £546k below plan. It is anticipated that spend will increase from June, following the commencement of larger estates schemes, including the CAMHS unit.

The annual expenditure plan of £13.96m is reliant on NHSI approval of the Trust's capital resource limit (CRL). £1.6m of the plan is supported by internally generated cash, however due to the national constriction on capital spend in 2019/20, CRL approval to spend Trust cash has not yet been granted. The commencement of several schemes has been delayed until funding is confirmed.

	Annual Plan	Apr YTD Plan	Apr YTD Actual	Apr YTD Variance	Year End Forecast	Revision to Plan
Sources of Funds	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Depreciation	7,179	598	598	0	7,179	0
PDC capital for CAMHS	5,102	564	0	(564)	5,102	0
PFI Agnes Unit capital lifecycle replacement	100	0	0	0	100	0
I&E Surplus (CRL adjustment not confirmed)	1,576	0	0	0	1,576	0
Asset Sales	0	0	0	0	0	0
Total Capital funds	**13,957**	**1,162**	**598**	**(564)**	**13,957**	**0**
Application of Funds	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Estates & Innovation						
Service Improvements	(7,138)	(609)	(107)	502	(7,175)	(37)
Estates & Equipment	(2,911)	(104)	(30)	74	(2,911)	0
Sub-total:	**(10,049)**	**(713)**	**(137)**	**576**	**(10,086)**	**(37)**
IT Programme	**(3,908)**	**(117)**	**(147)**	**(30)**	**(3,871)**	**37**
Total Capital Expenditure	**(13,957)**	**(830)**	**(284)**	**546**	**(13,957)**	**0**
(Over)/underspend against resource available	**0**	**332**	**314**	**(18)**	**0**	**0**

APPENDIX A - Statement of Comprehensive Income (SoCI)

Statement of Comprehensive Income for the period ended 30th April 2019	YTD Actual M1 £000	YTD Plan M1 £000	YTD Var. M1 £000	Year end forecast £000
Revenue				
Total income	23,523	23,862	(339)	278,567
Operating expenses	(22,930)	(23,269)	339	(269,305)
Operating surplus (deficit)	**594**	**593**	**1**	**9,262**
Investment revenue	3	3	(0)	36
Other gains and (losses)	0	0	0	0
Finance costs	(83)	(83)	0	(996)
Surplus/(deficit) for the period	**513**	**513**	**0**	**8,302**
Public dividend capital dividends payable	(512)	(512)	(0)	(6,154)
I&E surplus/(deficit) for the period (before tech. adjs)	**1**	**1**	**(0)**	**2,148**
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	**1**	**1**	**(0)**	**2,148**
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:	**1**	**1**	**(0)**	**2,148**
Trust EBITDA £000	**1,225**	**1,224**	**1**	**16,836**
Trust EBITDA margin %	**5.2%**	**5.1%**	**0.1%**	**6.0%**

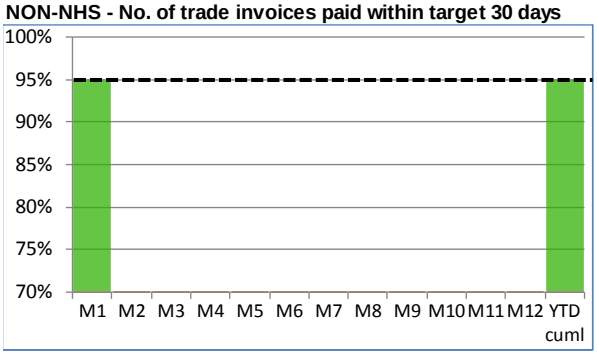
APPENDIX B – BPPC performance

Trust performance – current month (cumulative) v previous

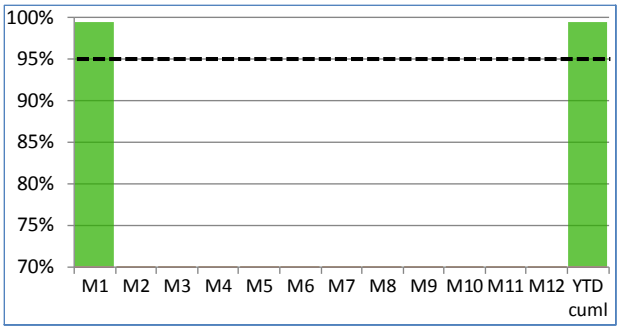
Better Payment Practice Code	April (Cumulative)	
	Number	£000's
Total Non-NHS trade invoices paid in the year	1,324	6,328
Total Non-NHS trade invoices paid within target	1,258	6,292
% of Non-NHS trade invoices paid within target	**95.0%**	**99.4%**
Total NHS trade invoices paid in the year	79	3,419
Total NHS trade invoices paid within target	77	3,411
% of NHS trade invoices paid within target	**97.5%**	**99.8%**
Grand total trade invoices paid in the year	1,403	9,747
Grand total trade invoices paid within target	1,335	9,703
% of total trade invoices paid within target	**95.2%**	**99.5%**

Trust performance – run-rate by all months and cumulative year-to-date

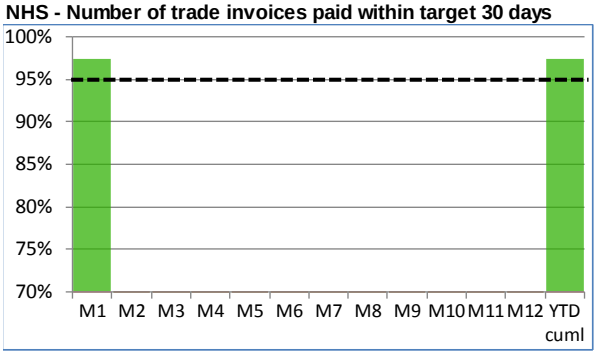
NON-NHS - No. of trade invoices paid within target 30 days



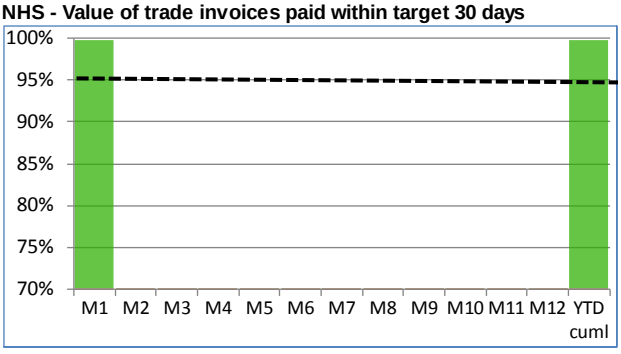
NON-NHS - Value of trade invoices paid within target 30 days



NHS - Number of trade invoices paid within target 30 days



NHS - Value of trade invoices paid within target 30 days



APPENDIX C – 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 F'Cast	2019/20 M3 £000s F'Cast	2019/20 M4 £000s F'Cast	2019/20 M5 £000s F'Cast	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	-65	-65	-65	-45	-45	-45	-45	-55	-55	-45	-65	-60	*-655*
Agency Nursing	-1,528	-127	-122	-128	-120	-120	-115	-115	-115	-110	-110	-110	-110	-110	-122	*-1,385*
Agency Scient, Therap. & Tech	-232	-19	-33	-36	-36	-36	-36	-36	-36	-36	-36	-36	-36	-36	-33	*-429*
Agency Non clinical staff costs	-409	-34	-48	-51	-45	-45	-45	-40	-40	-35	-35	-35	-35	-35	-48	*-489*
Sub-total	**-2,778**	**-231**	**-264**	**-280**	**-266**	**-266**	**-241**	**-236**	**-236**	**-226**	**-236**	**-236**	**-226**	**-246**	-264	***-2,959***
CHS																
Agency Consultant Costs	-182	-15	-15	-15	-15	-15	-15	-15	-15	-15	-15	-15	-15	-15	-15	*-175*
Agency Nursing	-3,579	-298	-306	-290	-290	-290	-290	-270	-270	-270	-290	-270	-270	-270	-306	*-3,376*
Agency Scient, Therap. & Tech	-644	-54	-54	-50	-50	-50	-50	-50	-50	-50	-50	-50	-50	-50	-54	*-604*
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**	**-355**	**-355**	**-355**	**-355**	**-335**	**-335**	**-335**	**-355**	**-335**	**-335**	**-335**	-375	***-4,156***
FYPC																
Agency Consultant Costs	-429	-36	-42	-45	-45	-45	-45	-45	-45	-45	-45	-45	-45	-45	-42	*-537*
Agency Nursing	-521	-43	-118	-125	-125	-130	-130	-130	-130	-130	-130	-130	-130	-130	-118	*-1,538*
Agency Scient, Therap. & Tech	-26	-2	-4	-5	-5	-5	0	0	0	0	0	0	0	0	-4	*-19*
Agency Non clinical staff costs	-32	-3	-8	-7	-7	-7	-7	-7	-7	-7	-7	-7	-7	-7	-8	*-85*
Sub-total	**-1,007**	**-84**	**-172**	**-182**	**-182**	**-187**	**-182**	**-182**	**-182**	**-182**	**-182**	**-182**	**-182**	**-182**	-172	***-2,179***
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	0	0	0	0	0	0	0	0	0	0	0	0	*0*
Agency Scient, Therap. & Tech	-42	-4	-7	-7	-7	-7	-10	-10	-10	-10	-10	-10	-10	-10	-7	*-108*
Agency Non clinical staff costs	-623	-52	-22	-25	-25	-25	-25	-30	-30	-30	-30	-30	-30	-30	-22	*-332*
Sub-total	**-714**	**-60**	**-28**	**-32**	**-32**	**-32**	**-35**	**-40**	**-40**	**-40**	**-40**	**-40**	**-40**	**-40**	-28	***-439***
TOTAL TRUST																
Agency Consultant Costs	-1,220	-102	-117	-125	-125	-125	-105	-105	-105	-105	-115	-115	-105	-125	-117	*-1,367*
Agency Nursing	-5,676	-473	-546	-543	-535	-540	-535	-515	-515	-510	-530	-510	-510	-510	-546	*-6,299*
Agency Scient, Therap. & Tech	-944	-79	-99	-98	-98	-98	-96	-96	-96	-96	-96	-96	-96	-96	-99	*-1,161*
Agency Non clinical staff costs	-1,107	-92	-78	-83	-77	-77	-77	-77	-77	-72	-72	-72	-72	-72	-78	*-906*
Total	**-8,946**	**-746**	**-839**	**-849**	**-835**	**-840**	**-813**	**-793**	**-793**	**-783**	**-813**	**-793**	**-783**	**-803**	-839	***-9,733***
Agency ceiling (£8,122k)			-675	-677	-677	-677	-677	-677	-677	-677	-677	-677	-677	-677	-675	*-8,122*
Variance (+better/-worse)			**-164**	**-172**	**-158**	**-163**	**-136**	**-116**	**-116**	**-106**	**-136**	**-116**	**-106**	**-126**	-164	***-1,611***
Trust financial plan			-710	-681	-680	-678	-677	-675	-674	-670	-673	-675	-673	-656	-710	*-8,122*
Variance (+better/-worse)			**-129**	**-168**	**-155**	**-162**	**-136**	**-118**	**-119**	**-113**	**-140**	**-118**	**-110**	**-147**	-129	***-1,611***

At month 1, total Trust agency costs were £839k. This is higher than year-to-date planned spend of £710k, and also higher than the year-to-date agency spend ceiling of £675k set by NHS Improvement.

This financial year – for the first time – the plan assumed that agency costs could be kept within the NHSI-set ceiling (being £8.1m for the year). However, since the plan was finalised in March, agency projections have increased significantly. The majority of the increase is within FYPC, due to a commitment to tackle CAMHS waiting lists.

After month 1, the revised forecast for the year is £9.7m against the plan / NHSI ceiling of £8.1m

J1

Leicestershire Partnership NHS Trust

TRUST BOARD – 23RD MAY 2019

INTEGRATED QUALITY AND PERFORMANCE REPORT (IQPR)

Introduction

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.

2. 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)
   d) strategic objectives from the Trust's five year plan

3. 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

Aim

4. 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.

Recommendations

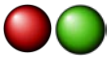
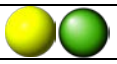
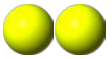
5. The Trust board is recommended to:

   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.

Quality Assurance Committee

Five year plan objective – 'deliver safe, effective, patient centred care in the top 20% of our peers'

Strategic Objective Measure(s)	2014/15	2015/16	2016/17	2017/18	2018/19	five year rolling trend
care programme approach (CPA) patients: % being followed up in 7 days	*not comparable to 2017/18*			69.0%*	82.8%	
care programme approach (CPA) patients: % having formal review within 12 months	*not comparable to 2016/17*		89.1%	84.7%	88.7%	
clostridium difficile (C Diff) cases	11	12	11	13	5	
pressure ulcers grade 3 & 4 (avoidable, developed in our care)	*not comparable to 2015/16*	12	20	11	11	
zero harm % patient safety incidents reported (NRLS)	60.8%	64.3%	63.1%	64.8%	65.1%	

**Performance reflects quarter three and four nationally submitted data post methodology change*

NHS Improvement (NHSI) quality of care

6. There is <u>one</u> identified NHSI trigger(s) in 2018/19 quarter four relating to the care programme approach seven day (CPA seven day) indicator. It is anticipated this trigger will be removed in 2019/20 quarter one following the improvements in performance since February 2019.

7. 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 <u>on a CPA</u>;
   ii. <u>all</u> patients discharged from a general psychiatric unit <u>on CPA and on non-CPA</u>.

8. Performance for patients discharged <u>on CPA</u> during March 2019 is 100% against a national lower limit target of 95% (reported one month in arrears).

9. The performance for all patients discharged <u>on CPA and on non-CPA</u> during March 2019 is 100% against a national lower limit target of 95% (reported one month in arrears).

10. The actions implemented in the clinical directorates to redesign the monitoring process for CPA seven day have resulted in the significant improvement in performance against this standard.

11. Data quality corrections for CPA seven day records were 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. When NHS Digital republish our amended submission, it will mean the performance reported in the Trust Quality Account for the period 2018/19 will be lower than the published national performance (see Annex A – LPT Benchmarking information).

12. The trajectory for 2018-19 for clostridium difficile (C. Diff) has been re-set by the Leicester, Leicestershire and Rutland (LLR) clinical commissioning groups (CCGs) as an upper limit of twelve cases per annum. There have been zero (0) cases of C. Diff in the month of April 2019. The year to date total occurrences of C.Diff is zero (0). The Trust met its 2018/19 annual target of having less than 12 cases per annum. (see Annex A - detailed exception report – clostridium difficile (C Diff) cases).

Trust quality of care

13. Trust performance against the care programme approach (CPA) 12 month review as at March 2019 is 89.6%, which remains below the lower limit target of 95%. Performance has improved since February 2019 following the implementation of sustainable new processes; and improvements will continue to be seen over the next few months as overdue reviews are completed. (see Annex A - detailed exception report – CPA 12 month review).

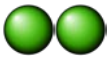
14. The pressure ulcer indicator has been removed from the IQPR due to a change in national guidance from NHS England (NHSE), which is ceasing to describe pressure ulcers as 'avoidable' and 'unavoidable'. The Trust intends to reinstate a pressure ulcer measure following recommendation at the Trust Patient Safety Improvement Group of a new indicator definition.

15. The Safety Thermometor benchmarking information has been presented to show the Trust's 'new harm free care' prevelance against a national average. The Trust is delivering harm free care above the national trend. (see Annex A – LPT Benchmarking Information).

16. The Committee have been provided with a first look at how the 'data quality flag', representing the six domains of data quality could be presented in the IQPR. In line with the approved workplan, the data quality flag has been provided against three indicators: CPA 7 day, DToC and 18 week referral to treatment (RTT) wait times.

Finance and Performance Committee

Five year plan objective - 'to ensure sustainability'

Strategic Objective Measure(s)	2014/15	2015/16	2016/17	2017/18	2018/19	five year rolling trend
NHS Improvement finance score	2	2	2	1	1 (draft accounts)	
energy consumption (kwh)	38,023,090	49,434,916	46,608,389	34,154,366	Not yet available	 --
estate related carbon emissions (CO2 tonnes)	10,731	14,238	13,738	8,570	Not yet available	 --

NHS Improvement (NHSI) and use of resources

17. 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).

18. As at 2019/20 month 01, 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

19. There are no identified NHSI trigger(s) in April 2019.

20. 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. These three national waits met their annual targets for 2018/19. (see Annex A – detailed exception report – national access standards).

21. Inappropriate adult mental health out of area placements (OAP) are showing a continued overall reduction since April 2018 as the Trust works to reduce mental health OAPs to zero by 2020/21. In 2018/19 quarter one, the Trust utilised 1673 mental health OAP bed days, reducing to a stable reduced trend of 574 mental health OAP bed days in 2018/19 quarter two; 677 in 2018/19 quarter three and 538 in 2018/19 quarter four. The April 2019 OAP bed days is 147.

22. 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.

23. This arrangement is anticipated to be an interim arrangement pending the commissioning of enhanced crisis and early discharge provision later in 2019/20. The qualititative 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 anticpated 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.

24. 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. As at 2018/19 quarter one, the Trust achieved a DQMI rate of 97.1% and maintained this level of performance in 2018/19 quarter two. Areas for improvement have been identified as recording of patient ethnicity. Specific workstreams have been implemented through the clinical effectiveness group (CEG) and information management and technology delivery group (IM&TDG) to drive improvements. In May 2019, a pilot data collection form was introduced in mental health outpatient services. The impact on the completeness of data will be assessed at the end of June 2019.

25. The DQMI MHSDS criteria expanded during 2019/20 and the Trust anticipated a drop in compliance to approximately 80% when the new criteria was implemented. The January 2019 DQMI MHSDS compliance rate is 83.8% in line with expectation. 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. (see Annex A – detailed exception report – data quality maturity index (DQMI)).

26. 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 was identified as a data quality concern during 2018/19 quarter three and four; and reported performance was not reflective of actual clinical practice.

27. Following recommendation from the Executive Team, the Trust Board agreed to remove 'gate keeping' from national reporting for 2018/19 quarter three and four. Following the completion of remedial actions, national reporting from 2019/20 quarter one has recommenced. Performance against this standard as at April 2019 is 66.2%. This performance is expected to rise to approximately 80% by the end of 2019/20 quarter one as the actions are embedded into business as usual practice.

Trust operational performance

28. The management of patients experiencing a delayed transfer of care (DToC) remains high on the Trust agenda. As at April 2019, the Trust is above the 3.5% upper limit threshold at 4.9%. The overall DToC rate for 2018/19 quarter four is 4.7%. 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.

29. The Committee have been provided with a first look at how the 'data quality flag', representing the six domains of data quality could be presented in the IQPR. In line with the approved workplan, the data quality flag has been provided against three indicators: CPA 7 day, DToC and 18 week referral to treatment (RTT) wait times.

Strategic Workforce Assurance Group

Five year plan objective – 'ensure staff will be proud to work here and will attract and retain the best people'

Strategic Objective Measure(s)	2014/15	2015/16	2016/17	2017/18	2018/19	five year rolling trend
% vacancy rate	7.2%	7.8%	10.1%	11.8%	10.1%	
% normalised workforce turnover (rolling previous 12 months)	10.1%	8.4%	10.8%	9.1%	9.6%	
% sickness absence*	4.7%	5.1%	5.2%	4.8%	4.3%	
% staff with a completed annual appraisal*	74.5%	78.8%	87.2%	89.6%	96.0%	
% core mandatory training compliance*	92.7%	95.1%	93.9%	93.5%	95.0%	
% of staff who have undertaken clinical supervision within the last 3 months	33.2%	49.4%	64.0%	76.6%	78.6%	
staff engagement score	3.63	3.72	3.74	3.71	3.69	
registered nurse day safer staffing fill rate (inpatient)*	103%	100%	99.7%	98.8%	101.4%	

* As at 31st March each financial year

Five year plan objective – 'partner with others to deliver the right care in the right place at the right time

Strategic Objective Measure(s)	2014/15	2015/16	2016/17	2017/18	2018/19	five year rolling trend
proportion of workforce in clinical academic roles	-	0.05%	0.07%	0.10%	0.19%	

NHS Improvement (NHSI) organisational health

30. There is one (1) identified NHSI trigger in March 2019 for staff sickness absence.

31. Staff sickness absence remains above target at 4.3% in March 2019 (reported one month in arrears) – of which, 2.3% is long term sickness and 2.0% is short term sickness. Support to manage staff sickness absence is pro-actively offered to managers by the human resources department (see Annex A – detailed exception report - % staff sickness).

32. Staff turnover (normalised) was 9.3% for April 2019, which meets the Trust threshold of between 10% and 12%.

Trust human resources – workforce performance

33. The Trust vacancy rate in April 2019 is 8.1%, which is above the upper limit threshold of 7%.

34. Cumulative year-to-date Trust agency costs were £839K as at 30 April 2019 (month 1). This is above the planned spend of £710k for the same period. The April 2019 year-to-date NHSI agency ceiling target is £675k. This Trust is exceeding this limit by £164k.

35. Trust had planned to achieve the full year NHSI ceiling target; however, based on initial data for April 2019, forecast spend is now likely to be significantly higher and achievement of the NHSI ceiling target may not be possible. This is mainly due increasing agency costs within the FYPC directorate. A revised forecast will be made available next reporting period. (See Annex A – detailed exception report – agency costs).

Conclusion

36. 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.

Appendix One – description of NHSI segmentation
Annex A – Integrated Quality and Performance Report

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.

Leicestershire Partnership NHS Trust

Integrated Quality and Performance Report

Paper J2

Advancing health and well-being

End of April 2019 Position

Data to 30 April 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**.

NHS Improvement Quality of Care Metrics

	NHSI Sector	Indicator	NHSI Monitoring Frequency	Reporting Period (rolling three months)			Sparkline Feb 19 - Apr 19	2018/19	2019/20				Year to Date Total	Trigger (two consecutive monthly breaches)	Current month directorate performance				Comments
				Feb-19	Mar-19	Apr-19		Q4	Q1	Q2	Q3	Q4			Adult Mental Health/ Learning Disabilities	Community Health	Families, Young People & Children	Enabling Services	
SAFE	All	**Occurrence of any Never Event**	Monthly *(six month rolling)*	**0**	**0**	**0**		**0**					**0**	**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**	Methodology: number of NHS England or NHS Improvement patient safety alerts outstanding in most recent monthly snapshot
	Acute	**VTE Risk Assessment**	Monthly	**268**	**262**	**219**		**793**					**219**	**0.0**		**219**			
	Acute	**Clostridium Difficile Occurrence (against contractual year to date target of 12)**	Monthly	**1**	**1**	**0**		**2**					**0**	**0.0**	**0**	**0**	**0**		
	Acute	**Clostridium Difficile - infection rate (per 100,000 bed days)**	Monthly	**42.84**	**39.21**	**0**		**26.74**					**0**	**0.0**	**0**	**0.00**	**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**	**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	*National data published in quarterly periods*				**94.6%**						**1.0**					Methodology: proportion of discharges from general psych wards followed up within 7 days (including MHSOP) Awaiting publication of quarterly national data
	Mental Health	**% clients in employment (two months in arrears)**	Monthly					*not yet available*						**0.0**	**0.0%**				Methodology: percentage of people aged 18 to 69 period in contact with mental health services in employment Latest data is for February 2019
	Mental Health	**% clients in settled accommodation (two months in arrears)**	Monthly					*not yet available*						**0.0**	**38.0%**				Methodology: percentage of people aged 18 to 69 in contact with mental health services in settled accommodation Latest data is for February 2019
CARING	All	**Written complaints - rate**	Quarterly	**66.7%**	**64.7%**	**67.4%**		**68.2%**					**67.4%**	**0.0**	**64.3%**	**68.8%**	**69.2%**		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**		Methodology: The number of breaches of mixed-sex accommodation (MSA) sleeping accommodation
	All	**Staff Friends and Family Test % recommended - care**	Quarterly											**0.0**					
	Acute	**Inpatient scores from Friends & Family Test - % positive**	Monthly	**96.2%**	**96.6%**	**96.7%**								**0.0**	**90.7%**	**97.2%**	**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	**96.3%**	**97.8%**	**98.2%**								**0.0**	**-**	**97.5%**	**99.0%**		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	**93.4%**	**91.4%**	**92.3%**								**0.0**	**96.4%**	**100.0%**	**88.2%**		Methodology: count of those categorised as extremely likely or likely to recommend/ count of all responders

Identified Triggers	0.0

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 M1)

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
				2.0		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
				9.7		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
				0.00%		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	1	0.2
				0.0		0.0					
	0.2	Agency spend	Distance from provider's cap	<=0%	0% - 25%	25 - 50%	>50%	2	0.4	2	0.4
				24%		20%					

	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.

NHS Improvement Operational Performance

	NHSI Sector	Indicator	Target	NHSI Monitoring Frequency	Reporting Period (rolling three months)			Sparkline Feb 19 - Apr 19	2018/19	2019/20				Year to Date Total*	Trigger (two consecutive monthly breaches)	Current month directorate performance			Comments
					Feb-19	Mar-19	Apr-19		Q4	Q1	Q2	Q3	Q4			Adult Mental Health/ Learning Disabilites	Community Health	Families, Young People & Children	
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	**97.0%**	**98.5%**	**98.0%**		**96.5%**					**98.0%**	**0.0**	**98.0%**			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%**	**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 (Unify2 and MHSDS) - patients on a completed pathway**	>=53%	Quarterly *(three month rolling)*	**70.6%**	**85.7%**	**81.0%**		**76.5%**					**81.0%**	**0.0**			**81.0%**	Methodology: percentage of people with a first episode of psychosis beginning treatment with a NICE-recommended care package within two weeks of referral
		Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas:																	
	Mental Health	**a) Inpatient Wards**	>=90%	Annually											**0.0**				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
	Mental Health	**b) Early Intervention in Psychosis Services**	>=90%	Annually											**0.0**				
	Mental Health	**c) Community Mental Health Services (people on CPA)**	>=65%	Annually											**0.0**				
	Mental Health	**Inappropriate adult mental health out of area placements (OAPs)**	0 by March 2020	Monthly	**195**	**166**	**147**		**538**					**147**	**0.0**				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 'Exception Report - Data Quality Maturity Index' for details				*not yet available*						**0.0**				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	**0.0**

NHS Improvement Organisational Health

	NHSI Sector	Indicator	NHSI Monitoring Frequency	Reporting Period (rolling three months)			Sparkline YTD	2018/19	2019/20				Year to Date Total	Trigger (two consecutive monthly breaches)	Current month directorate performance				Comments
				Feb-19	Mar-19	Apr-19		Q4	Q1	Q2	Q3	Q4			Adult Mental Health/ Learning Disabilities	Community Health	Families, Young People & Children	Enabling Services	
ORGANISATIONAL HEALTH	All	**Staff Sickness (month in arrears)**	Monthly	**4.7%**	**4.3%**			**4.3%**						**1.0**	**4.5%**	**4.7%**	**4.7%**	**2.8%**	Methodology: number of days sickness reporting within the month/ number of days available within the month
	All	**Staff Turnover**	Monthly	**10.0%**	**9.6%**	**9.3%**			*not applicable to quarterly reporting*					**0.0**	**10.1%**	**10.2%**	**8.3%**	**7.9%**	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*					**0.0**					2018 staff survey results Methodology: staff recommendation of the organisation as a place to work or receive treatment
	All	**Proportion of Temporary Staff**	Monthly	**12.1%**	**12.2%**	**11.7%**		**12.2%**						**0.0**					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*					**0.0**					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*					**0.0**					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	1.0

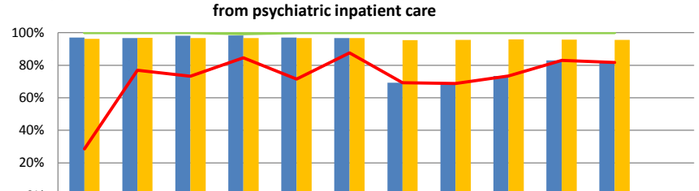
NB: The NHSI Single Oversight Framework has no specified target for the Quality of Care Monitoring Metrics.

Leicestershire Partnership NHS Trust

LPT Benchmarking Information

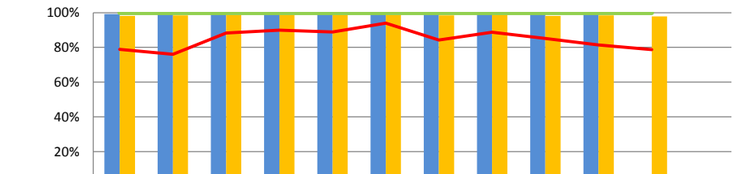
Description	Benchmarking comparisons are taken from NHS England's official statistics publications. Each graph show the Leicestershire Partnership NHS Trust performance against the highest and lowest performing trusts in that period **IMPORTANT**: National data conforms to strict data quality requirements 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



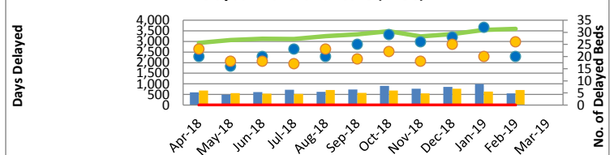
	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19
LPT	96.9%	96.6%	98.1%	98.3%	96.9%	96.7%	69.2%	68.8%	73.4%	83.0%	81.6%	
England	96.2%	96.8%	96.7%	96.7%	96.7%	96.7%	95.4%	95.5%	95.8%	95.7%	95.5%	
Highest	100.0%	100.0%	100.0%	99.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Lowest	28.6%	76.9%	73.3%	84.6%	71.4%	87.5%	69.2%	68.8%	73.4%	83.0%	81.6%	

Proportion of admissions to acute wards that were gate kept by the CRHT teams



	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19
LPT	99.2%	100.0%	99.6%	100.0%	99.6%	99.2%	100.0%	99.5%	99.6%	100.0%	0.0%	
England	98.1%	98.4%	98.7%	98.8%	98.7%	98.6%	98.5%	98.7%	98.1%	98.4%	97.8%	
Highest	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Lowest	78.9%	76.0%	88.3%	90.0%	88.9%	94.0%	84.3%	88.7%	85.1%	81.4%	78.8%	

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
LPT Days Delayed	600	490	613	719	631	737	912	767	862	994	548	
UHL Days Delayed	682	563	544	527	711	574	689	554	768	632	717	
Highest Days Delayed	2927	3059	3130	3106	3244	3326	3480	3231	3345	3542	3588	
Lowest Days Delayed	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	
UHL DToC Beds	23	18	18	17	23	19	22	18	25	20	26	

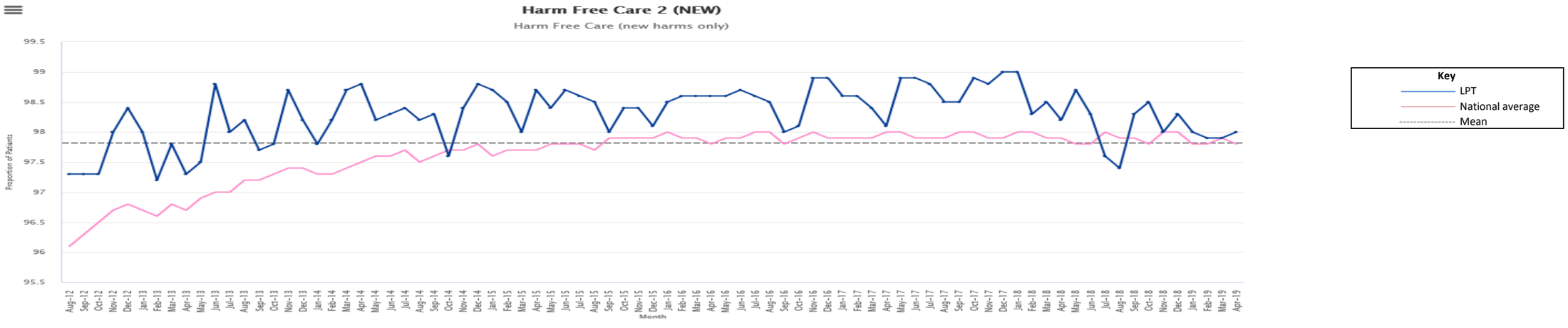
Comments:

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, collected on a specific day; and is not directly comparable to the NRLS harm free rate, which is representative of all harms. Safety Thermometer data is not intended for benchmarking against other organisations.

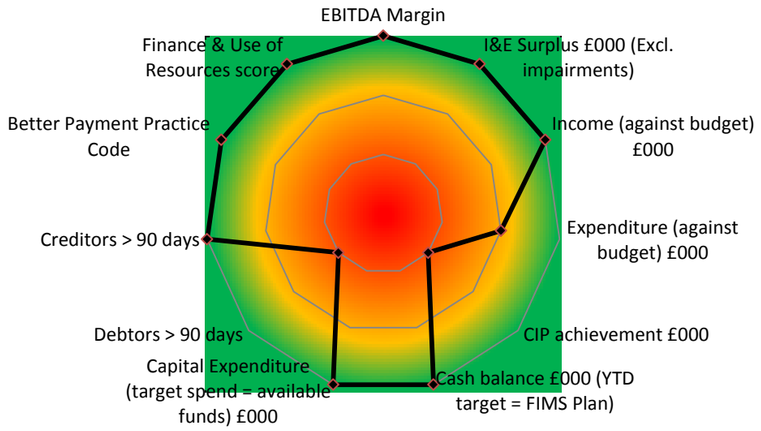


Comments:

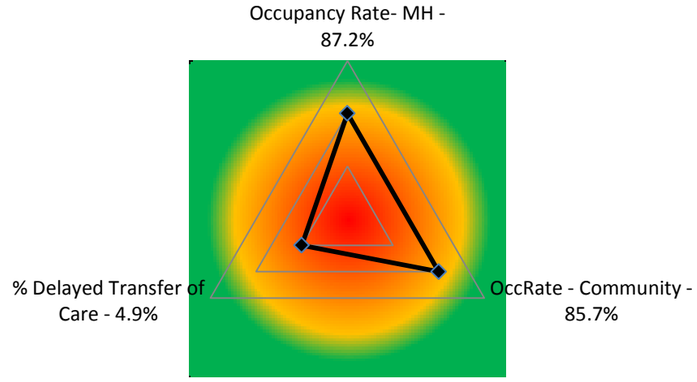
Leicestershire Partnership NHS Trust

Committee Key Performance Measures

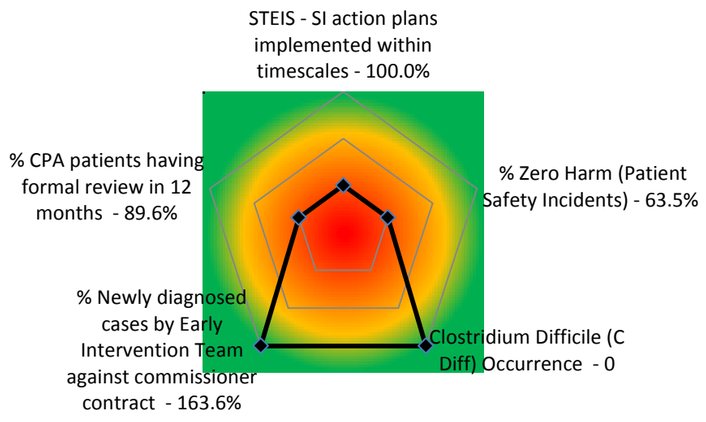
Finance and Performance Committee (Finance)



Finance and Performance Committee (Performance)



Quality and Assurance Committee



Strategic Workforce Group

Key: 3= Green achieved target, 2= Amber Within 5% of Target, 1= Red Failing Target

Quality of Care

		Trust Performance														Current month directorate performance				
		Source	Reporting Frequency	Quality Indicator	Reporting Period (rolling three months)			Sparkline Feb 19 - Apr 19	2018/19	2019/20				Year to Date Position	Year End Target	Adult Mental Health/ Learning Disabilities	Community Health	Families, Young People & Children	Enabling Services	3rd party/ External
					Feb-19	Mar-19	Apr-19		Q4	Q1	Q2	Q3	Q4							
SAFE	Total incidents reported (including near misses) taken from Safeguard	TRUST	Monthly		1313	1364	1419		4316					1419		439	693	181	21	85
	- of which Total Serious Incidents (SIs)	COM	Monthly		3	8	3		14					3		3	0	0	0	0
	STEIS - SI action plans implemented within timescales	COM	Monthly	=100%	100.0%	95.2%	100.0%		96.3%					100.0%	=100%	100.0%	-	100.0%		
	Total patient safety incidents reported (including near misses) (NRLS)	TRUST	Monthly		812	891	857		2753					857		274	445	131	7	
	- of which % Zero Harm (Patient Safety Incidents) (refreshed each month)	TRUST	Monthly	>=70%	65.0%	66.2%	63.5%		65.3%					63.5%	>=70%	82.9%	46.3%	81.7%		
	MRSA Bacteraemia cases - Community	COM	Monthly		0	0	0		0					0	0	0	0	0		
	Clostridium Difficile (C Diff) Occurrence	COM	Monthly	<=12 (per annum)	1	1	0		2					0	12	0	0	0		
	NHSE/NHSI Patient Safety Alerts Outstanding	NHSI	Monthly	=0	0	0	0		0					0	0	0	0	0		
CARING	Total compliments received	TRUST	Monthly		102	67	93		243					93		29	56	6	2	
	Total complaints received	TRUST	Monthly		33	34	43		107					43		14	16	13	0	
	Complaints acknowledged within 3 working days	TRUST	Monthly	=100%	100.0%	100.0%	97.7%		100.0%					97.7%	=100%	100.0%	93.7%	100.0%		
EFFECTIVE	Meeting commitment to serve new psychosis cases by early intervention teams: % newly diagnosed cases against commissioner contract	COM	Monthly	>=95%	136.4%	118.2%	163.6%		145.5%					163.6%	>=95%			163.6%		
	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%	97.3%	100.0%			96.8%					*95.6%	>=95%	100.0%	100.0%	100.0%		
	- All patients discharged from a psychiatric inpatient unit *(national methodology aligned to Quality Account)*	TRUST	Monthly	>=95%	95.1%	100.0%			94.6%					*82.8%	>=95%	100.0%	100.0%	100.0%		
	Care programme approach (CPA) patients: % having formal review within 12 months	TRUST	Monthly	>=95%	87.1%	88.7%	89.6%							89.6%	>=95%	89.5%	93.7%	86.6%		
	Access to Healthcare for All		Monthly	=4	4	4	4		4					4	4					

Comments and Actions:
*** Year to Date position: Indicators in arrears show year to date for 2018/19**

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).

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. 163.6% for the month of April 2019 is the result of 18 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						10.0%	
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						54.0%	
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%	0.0%	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%	75.0%	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.

Leicestershire Partnership NHS Trust

Operational Performance

	Trust Performance														Current month directorate performance		
	Source	Reporting Frequency	Monthly target	Reporting Period (rolling three months)			Sparkline Feb 19 - Apr 19	2018/19	2019/20				Year to Date Position	Year End Target	Adult Mental Health/ Learning Disabilities	Community Health	Families, Young People & Children
				Feb-19	Mar-19	Apr-19		Q4	Q1	Q2	Q3	Q4					
Occupancy Rate - Mental Health Beds	TRUST	Monthly	<=85%	82.9%	83.5%	87.2%		83.4%					87.2%	<=85%	90.1%	85.5%	75.6%
Occupancy Rate - Community	TRUST	Monthly	>=93%	91.3%	86.9%	85.7%		89.4%					85.7%	>=93%		85.7%	
% Delayed Transfer of Care (DTOC)	DOH	Monthly	<=3.5%	3.6%	4.8%	4.9%		4.7%					4.9%	<=3.5%	3.9%	6.2%	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%	60.3%	38.1%	66.2%		67.0%					66.2%	>=95%	66.2%		
Total number of Home Treatment episodes carried out by Crisis Resolution team year to date	COM	Monthly	>=145	210	261	220		743					220	1740	220		

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.

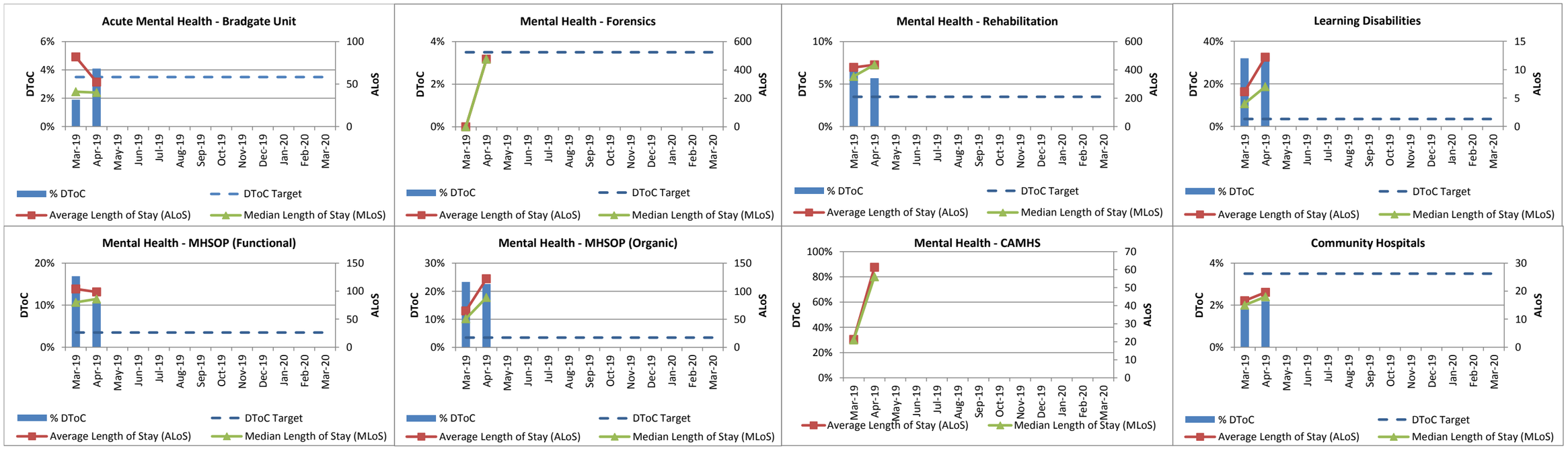
Patients admitted to inpatient services who are given access to Crisis Resolution/ Home Treatment teams in line with best practice standards: This item has been identified as a data quality concern and is not reflective of actual clinical practice. Remedial action is underway to move the Trust to complying against nationally defined standards.

Total number of Home Treatment episodes carried out by Crisis Resolution team year to date: Year to date performance is currently 151.7% which equates to 220 episodes against a pro-rata target of 145.

Leicestershire Partnership NHS
NHS 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.



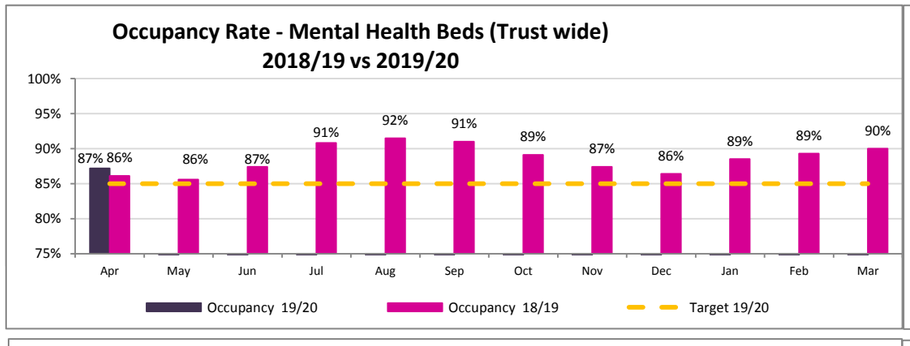
Comments and Actions

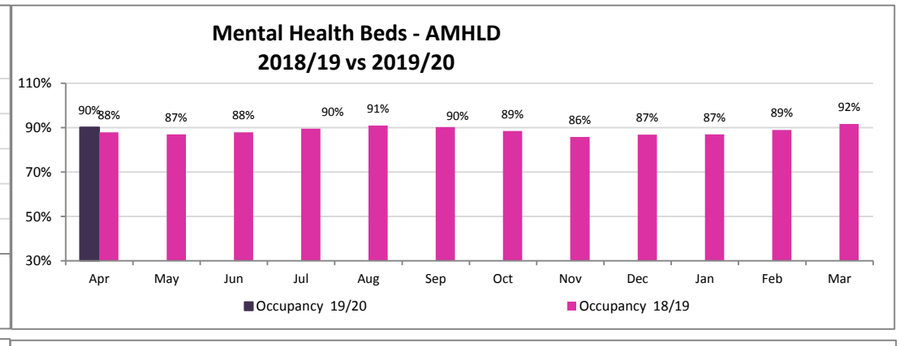
Delayed Transfer of Care (DToC)
The calculation methodology for DToC is*:
Numerator: the number of non-acute patients (aged 18 and over on admission) per day under consultant and non-consultant-led care whose transfer of care was delayed. For example, one patient delayed for five days counts as five.
Denominator: the total number of occupied bed days (consultant-led and non-consultant-led).
Delayed transfers of care attributable to social are included.

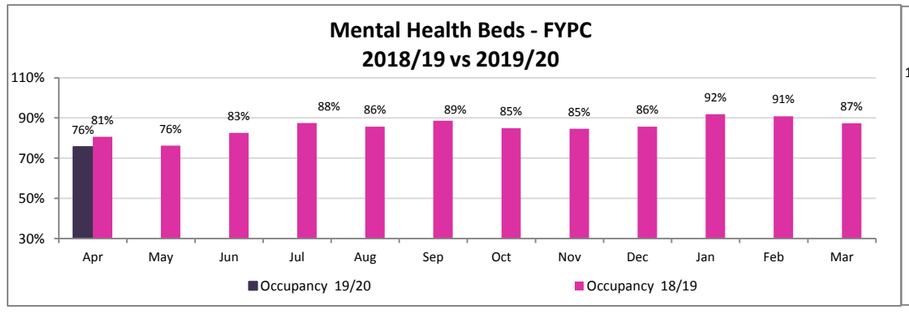
Actions to improve DToC across the Leicester, Leicestershire and Rutland system include:
- implementing an integrated discharge team and trusted assessor model which will be extended to community hospitals and mental health wards during 2017/18 following a pilot at the acute trust;
- improvements in 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.

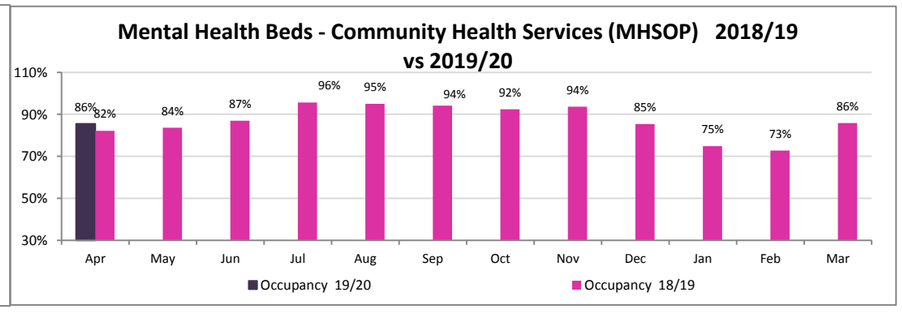
Length of Stay (LoS)
The length of stay displayed is the national operating framework definition, which takes data from Hospital Episode Statistics (HES) and includes ALL services and lengths. LoS is measured from admission to discharge, therefore a ward with no discharges in the period will not have 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

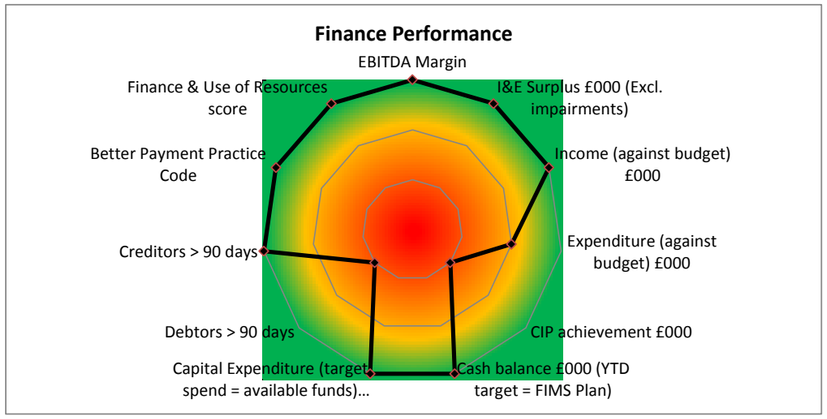
LD - On leave beds counted as admitted
This may result in occupancy rates above 100%

Leicestershire Partnership NHS Trust

Performance - Finance April 2019 (Month 1)

Comments and Actions:

- **Position:** As at 2019/20 month 1, the Trust is achieving the planned year to date surplus of £1k. A year end surplus of £2.1m is forecast based on the receipt of Sustainability and Transformation funding of £2.1m.
- **EBITDA:** The EBITDA margin as at 2019/20 month 1 is 5.2%. 79% of the 2019/20 year to date CIP target was achieved as at April 2019.
- **Cash Balance:** The cash balance at the end of 2019/20 month 1 is £10.2m. However, planned cash for the month end was £7.7m. Debtors over 90 days are 15.5%. Creditors over 90 days are 4.6%.



FINANCE KPIs	TOTAL TRUST				Services											
					AMHLD		COMM SERVICES		FYPC		ENABLING		RESERVES		HOSTED	
	YTD Target (Budget)	YTD Actual	Year end target	Year end forecast	YTD Target	YTD Actual	YTD Target	YTD Actual	YTD Target	YTD Actual	YTD Target	YTD Actual	YTD Target	YTD Actual	YTD Target	YTD Actual
EBITDA Margin	5.1%	5.2%	6.0%	6.0%												
I&E Surplus £000 (Excl. impairments)	1	1	2,148	2,148												
Income (against budget) £000	23,431	23,523	278,567	278,600												
Expenditure (against budget) £000	23,430	23,522	269,305	276,452												
CIP achievement £000	203	160	2,664	2,664	43	0	63	63	49	50	46	45	0	0	2	2
Cash balance £000 (YTD target = FIMS Plan)	7,669	10,246	8,000	8,000												
Capital Expenditure (target spend = available funds) £000	284	284	13,957	13,957												
Debtors > 90 days	5.0%	15.5%	5.0%	5.0%												
Creditors > 90 days	5.0%	4.6%	5.0%	5.0%												
Better Payment Practice Code	95.0%	95.2%	95.0%	95.0%	95.0%	96.2%	95.0%	97.8%	95.0%	98.6%	95.0%	92.3%	100.0%	100.0%	95.0%	98.6%

FINANCE & USE OF RESOURCES SCORE			SCORE	
Risk Assessment Framework	Annual target	Achieved	Annual target	Updated annual forecast
Combined Score	2	2	2	2

RAG rules
Green: On target/exceeding target
Amber: Adverse variance - within 5% target
Red: Adverse variance - distance from target greater than 5%

Human Resources - Workforce Performance

		Trust Performance													Current month directorate performance				
		Source	Reporting Frequency	Monthly target	Reporting Period (rolling three months)			Sparkline Feb 19-Apr 19	2019/20				Year to Date Position	Year End Target	Adult Mental Health/ Learning Disabilities	Community Health	Enabling Services	Families, Young People & Children	Hosted Services
					Feb-19	Mar-19	Apr-19		Q1	Q2	Q3	Q4							
Workforce Profile	Number of WTE Employed	TRUST	Monthly		4612.85	4630.82	4630.40								1137.1	1734.5	466.2	1069.8	222.7
	Substantive Staff Headcount	TRUST	Monthly		5292	5307	5320								1265	2010	514	1298	233
	Bank Only Headcount	TRUST	Monthly		1005	1098	1054												
	% Vacancy Rate	TRUST	Monthly	G: <=7% R: >10%	10.4%	10.1%	8.1%							G: <=7% R: >10%	14.6%	7.3%	7.1%	3.5%	0.0%
	% Staff From a BME Background	TRUST	Quarterly	>=20%	21.8%	22.1%	20.2%							>=20%					
	% of Males Employed	TRUST	Quarterly		17.0%	17.0%	17.1%												
	% Staff Aged 16-29 Years	TRUST	Quarterly	>=12%	12.7%	12.8%	12.6%							>=12%					
Sickness Absence (one month in arrears)	% of Sickness Absence (1 month in arrears)	TRUST	Monthly	<=4.5%	4.7%	4.3%								<=4.5%	4.5%	4.7%	2.8%	4.7%	1.7%
	WTE Days Lost to Sickness (1 month in arrears)	TRUST	Monthly		6119.9	6174.1									1580	2515	400	1560	118
	% Short Term Sickness (1 month in arrears)	TRUST	Monthly		2.1%	2.0%									2.4%	2.2%	1.4%	1.6%	0.7%
	% Long Term Sickness (1 month in arrears)	TRUST	Monthly		2.6%	2.3%									2.1%	2.5%	1.4%	3.1%	1.0%
	Cost of Sickness (£) (1 month in arrears)	TRUST	Monthly		£ 552,610	£ 557,622									£138,644	£211,390	£37,248	£158,869	£11,473
Turnover	% Normalised Workforce Turnover (Rolling previous 12 months)	TRUST	Monthly	G: <=10% R: >12%	10.0%	9.6%	9.3%							G: <=10% R: >12%	10.1%	10.2%	7.9%	8.3%	5.9%
	% Total Workforce Turnover (Rolling previous 12 months)	TRUST	Monthly	G: <=10% R: >12%	10.7%	9.7%	9.6%							G: <=10% R: >12%	10.1%	10.8%	8.1%	8.3%	7.3%
	Executive Team Turnover	TRUST	Monthly		13.3%	13.0%	12.8%												
	Starters minus Leavers (headcount)	TRUST	Monthly		8	5	30						30		11	3	3	6	7
	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%	88.7%	89.6%	90.1%							G: >90% R: <85%	90.9%	88.1%	95.9%	90.0%	95.2%
Temporary Staffing	Bank Costs	TRUST	Monthly		£ 1,259,878	£ 1,785,239	£ 1,232,377						£ 1,232,377						
	Agency Costs (NHSI National 2017/18 Target)	TRUST	Monthly	<=£7.7m (p/a)	£ 796,171	£ 887,952	£ 839,337						£ 839,337	<=£7.7m					
	Agency Costs (LPT Internal Target)	TRUST	Monthly	<=£9.5m	£ 796,171	£ 887,952	£ 839,337						£ 839,337	<=£9m					
	Temporary Staffing Spend as a % of Total Paybill (Inc. bank, agency and additional hours worked)	TRUST	Monthly		12.1%	12.2%	11.7%												
	No of Off Framework Agency Usages	TRUST	Monthly		118	101	85						85						
	No of Breaches to Agency Price Cap	TRUST	Monthly		472	704	674						674						
	Agency volume (number of shifts filled by agency)	TRUST	Monthly		2270	2108	1726						1726						
	Roster approval period (weeks)	TRUST	Monthly	>6	5.11	5.37	5.05												
	% Split of Substantive to Bank to Agency Staff (Nurses band 2-6, inpatient areas only, taken from Safer Staffing portal)	TRUST	Monthly		67.4%, 29.1%, 3.5%	66.8%, 29.7%, 3.5%	69.1%, 27.4%, 3.5%												
	% Split of Qualified to Unqualified Staff (Nurses band 2-6, inpatient areas only, taken from Safer Staffing portal)	TRUST	Monthly		36.9%, 63.1%	36.1%, 63.9%	35.5%, 64.5%												
Organisational Change	Number of Staff Made Redundant	TRUST	Monthly		1	0	0						0		0	0	0	0	0
	Number of Staff on Pay Protection	TRUST	Monthly		24	21	23						23		6	4	5	8	0
Employee Relations	Number of open formal grievances	TRUST	Monthly		2	3	2								0	2	0	0	0
	Number of open bullying and harassment cases	TRUST	Monthly		4	5	1								0	1	0	0	0
	Number of open formal disciplinary cases	TRUST	Monthly		8	7	8								4	3	0	1	0
	Number of open employment tribunals	TRUST	Monthly		2	2	1								0	1	0	0	0
	Concerns raised to an external organisation	TRUST	Monthly		1	0	1						1		0	0	1	0	0
	Concerns raised in house	TRUST	Monthly		7	10	6						6		3	0	0	3	0
Employee Engagement	% Staff recommend LPT as a place to work	TRUST	Quarterly	>=57%	62%	69%	N/A							>=57%					
	% Staff happy with standard of care provided	TRUST	Quarterly	>=67%	58%	61%	N/A							>=67%					
	Pulse and Staff Survey Response Rate	TRUST	Quarterly	>=50%	51%	20%	N/A							>=50%					
Learning and Development Overview	% of Consultants with a completed annual appraisal	TRUST	Monthly	>=90%	96.0%	96.0%	97.0%							>=90%	100%	100%		92%	
	% of Staff with a Completed Annual Appraisal	TRUST	Monthly	>=80%	91.7%	91.6%	92.3%							>=80%	91.5%	93.8%	91.8%	91.1%	90.1%
	% All Mandatory Training Compliance for substantive staff	TRUST	Monthly	>=85%	92.0%	92.4%	92.7%							>=85%	91.0%	93.6%	92.1%	93.4%	90.4%
	% All Mandatory Training Compliance for bank-only nursing staff	TRUST	Monthly	>=75%	77.1%	78.5%	78.6%							>=75%					
	% of new starters who attended Trust Induction on their first day (excluding bank staff)	TRUST	Monthly	>=85%	100.0%	100.0%	100.0%							>=85%					
	% of staff who have undertaken clinical supervision within the last 3 months	TRUST	Monthly		78.0%	79.2%	79.1%								78.0%	82.0%	50.0%	76.2%	100.0%
Learning and Development (Detail for Substantive Staff)	% Core Mandatory Training Compliance	TRUST	Monthly	>=85%	94.9%	95.0%	95.2%							>=85%	94.4%	96.5%	93.2%	95.6%	90.8%
	% Fire Safety training compliance	TRUST	Monthly	>=85%	89.1%	89.1%	89.4%							>=85%	87.3%	91.2%	88.1%	89.8%	84.5%
	% of Information Governance training compliance	TRUST	Monthly	>=95%	89.9%	90.8%	90.9%							>=95%	88.1%	93.6%	91.4%	89.1%	93.1%
	% Clinical Mandatory training compliance	TRUST	Monthly	>=85%	91.6%	92.1%	92.7%							>=85%	92.0%	93.7%	76.4%	92.3%	100.0%
	% Mental Health Act training compliance	TRUST	Monthly	>=85%	80.0%	77.3%	79.6%							>=85%	77.8%	83.4%	66.7%	83.1%	-
Declaration of Protected Characteristics	Declared Disability	TRUST	Monthly	>=85%	78.1%	78.2%	78.3%							>=85%					
	Declared Sexual Orientation	TRUST	Monthly	>=85%	80.0%	80.2%	80.3%							>=85%					
	Declared Religious Belief	TRUST	Monthly	>=85%	79.1%	79.2%	79.2%							>=85%					

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
Vacancy Rate and Agency Costs for March 2019 will not be available until mid-April 2019, this is due to the financial year end

Leicestershire Partnership NHS Trust

DETAILED EXCEPTION REPORT - Clostridium Difficile (C Diff) Cases

Responsible Director	Anne Scott
Responsible Committee	QAC

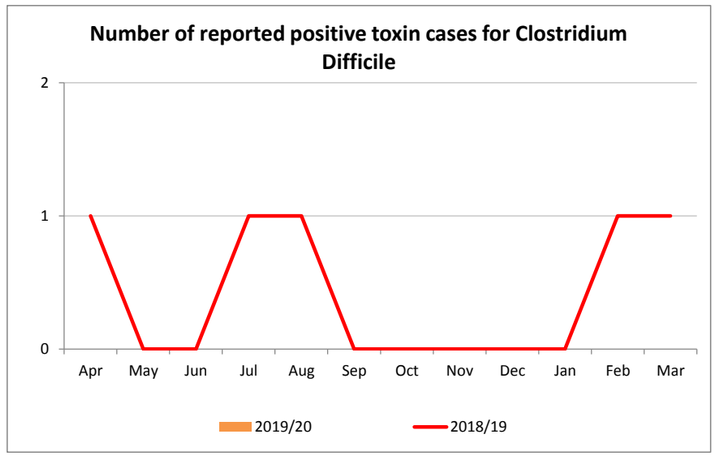
Responsible Services	All
KPI Reference ID	MSP.02

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**
Wards	-												



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)

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	

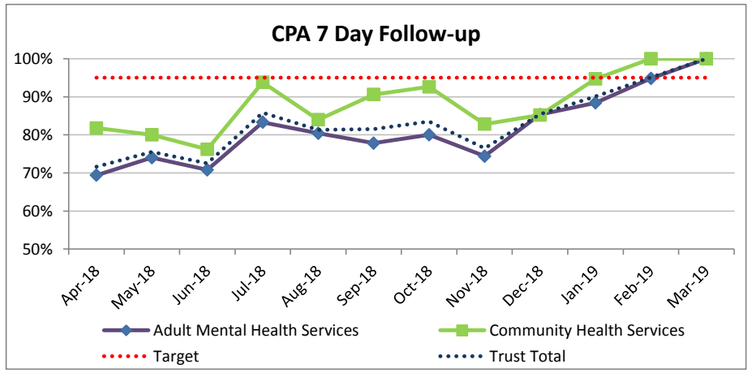
Risk Reference	
Risk Owner	

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 (%)	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Adult Mental Health Services	69.4%	74.0%	70.8%	83.3%	80.4%	77.8%	80.0%	74.4%	85.3%	88.4%	94.8%	100.0%
Community Health Services	81.8%	80.0%	76.2%	93.8%	84.0%	90.6%	92.6%	82.8%	85.2%	94.7%	100.0%	100.0%
Trust Total	71.6%	75.5%	72.5%	85.8%	81.3%	81.5%	83.5%	76.5%	85.4%	90.1%	95.1%	100.0%

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. Weekly performance reports will be reviewed by the business team with escalations made to the business manager for relevant action.

The new processes will be incorporated into the existing standard operating process (SOP) in March 2019.

Leicestershire Partnership NHS Trust

DETAILED EXCEPTION REPORT - CPA 12 Month Review

Responsible Director	Helen Thompson, Rachel Bilsborough
Responsible Committee	QAC

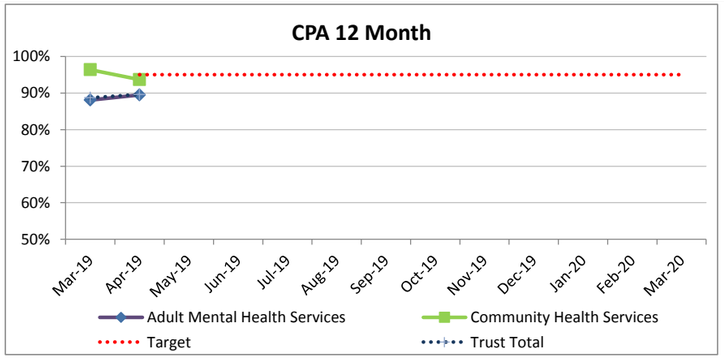
Responsible Services	AMH, CHS
KPI Reference ID	

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%											
Community Health Services	96.4%	93.7%											
Trust Total	88.7%	89.6%											



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.

DETAILED EXCEPTION REPORT - % Delayed Transfer of Care (DToC)

Responsible Director	Rachel Bilsborough, Helen Thompson
Responsible Committee	FPC

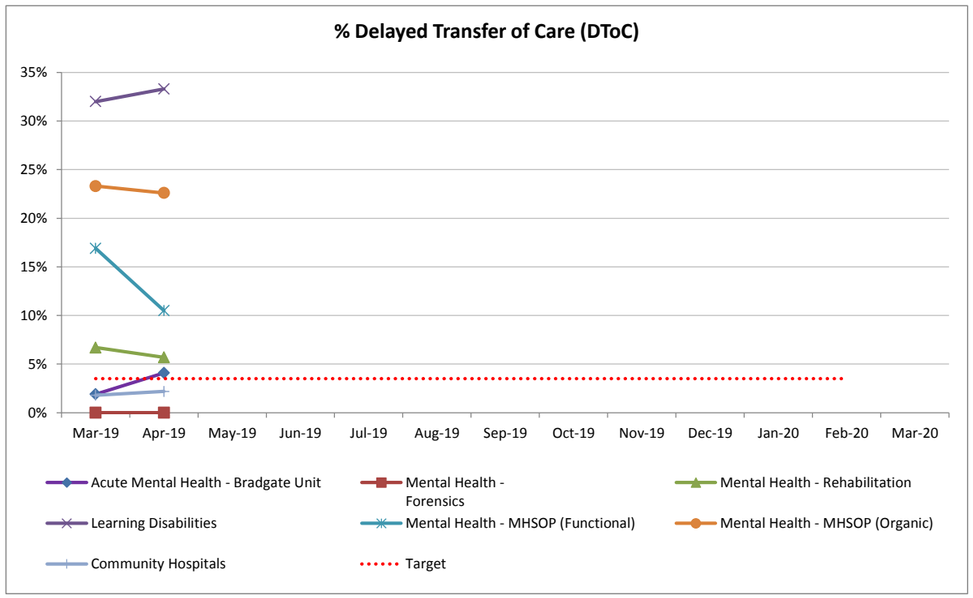
Responsible Services	AMH
KPI Reference ID	QEFS.06

Risk Reference	2403
Risk Owner	Sue Elcock

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

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%											
Mental Health - Forensics	<=3.5%	0.0%	0.0%											
Mental Health - Rehabilitation	<=3.5%	6.7%	5.7%											
Learning Disabilities	<=3.5%	32.0%	33.3%											
Mental Health - MHSOP (Functional)	<=3.5%	16.9%	10.5%											
Mental Health - MHSOP (Organic)	<=3.5%	23.3%	22.6%											
Community Hospitals	<=3.5%	1.8%	2.2%											
TRUST TOTAL	<=3.5%	4.8%	4.9%											



LLR System DTOC figures are reported nationally in arrears, they are shown below for illustrative purposes

			Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
LLR SYSTEM TOTAL *(inc UHL, out of area patients etc.)*	<=3.5%		2.2%	1.7%	2.0%	2.1%	2.2%	2.2%	2.6%	2.3%	2.7%	2.7%	2.3%	

Comments and Actions:

% DToC - Mental Health: Patients delayed during discharge for the month of April 2019 are the result of the following top four categories : Social Services (16.1%), Homes (12.9%), Joint (12.9%), Rehabilitation (11.2%) and all other reasons (46.7%).

% DToC - Community: Delays for community hospital patients during the month of April 2019 are the result of five categories: Patient or Family Choice - Non-acute NHS Care (28.5%), Patient or Family Choice - Care package in own home (28.5%), Awaiting residential care home placement (14.2%), Awaiting community equipment, telecare and/or adaptations (14.2%) and Awaiting nursing care home placement (14.2%).

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

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	0	0	0	0	0	0	0	0	0	0	0
- of which patient choice	*4*	*11*	*8*	*9*	*1*	*2*	*1*	*7*	*30*	*31*	*16*	*8*	*11*	*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 (%)	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%											

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%											

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											

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)

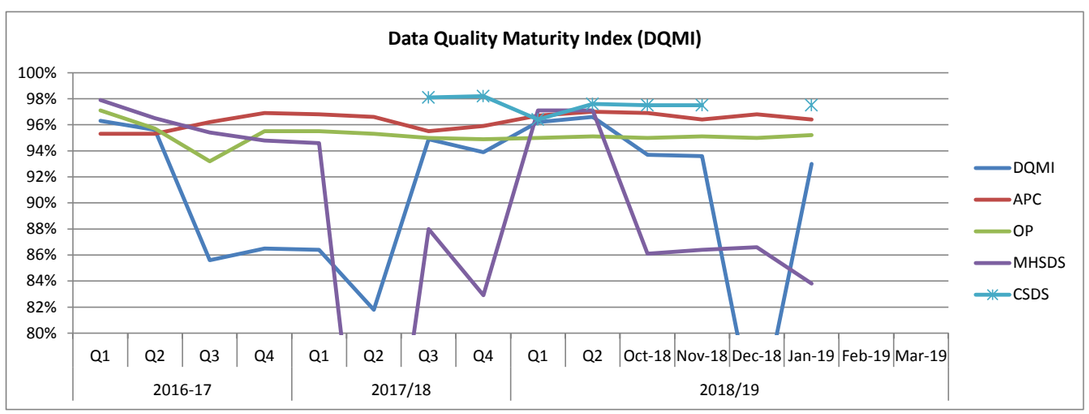
Responsible Director	Dani Cecchini
Responsible Committee	FPC

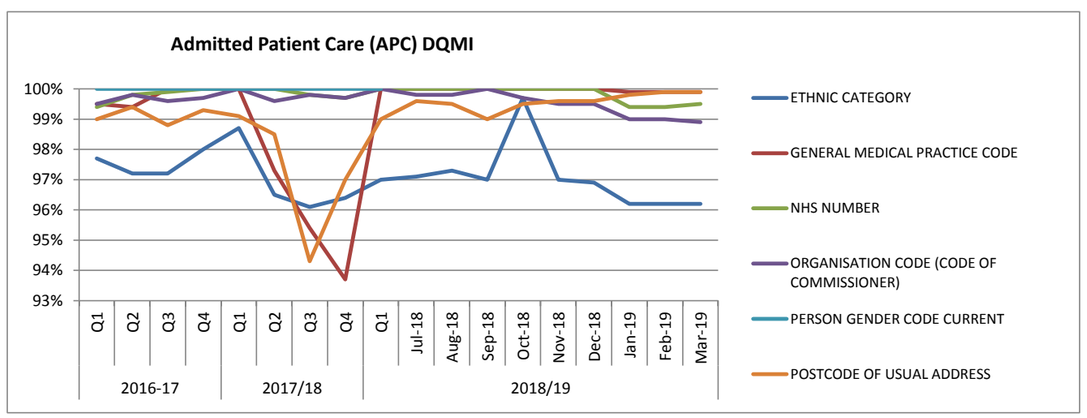
Responsible Services	AMH, CHS, FYPC
KPI Reference ID	

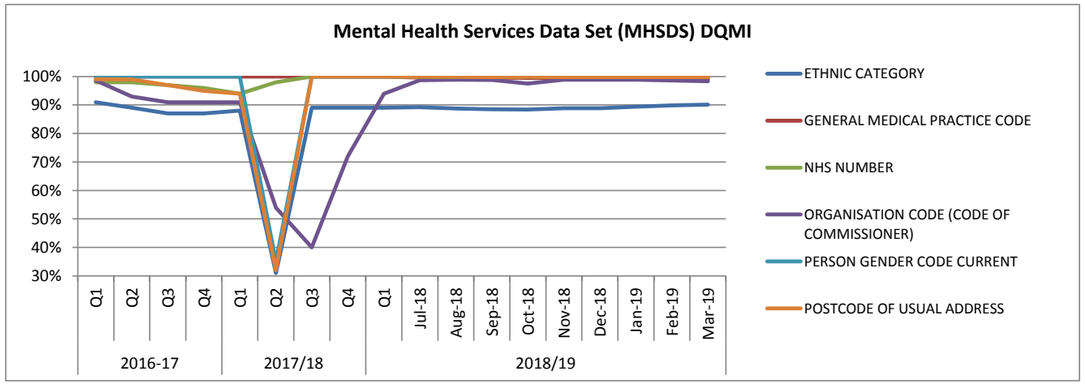
Risk Reference	1119
Risk Owner	Dani Cecchini

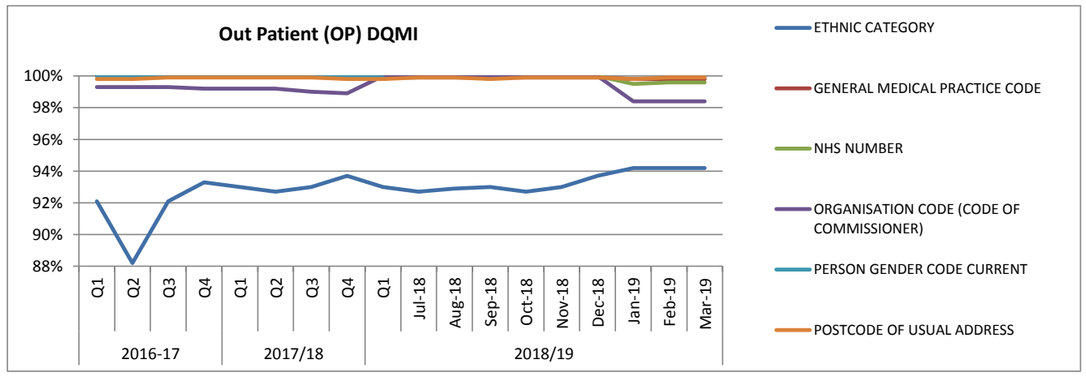
Risk Description: There is a risk we cannot assure ourselves of the accuracy and validity of all information we provide from our patient information systems; which could adversely affect patient outcomes where information is required to make decisions.

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

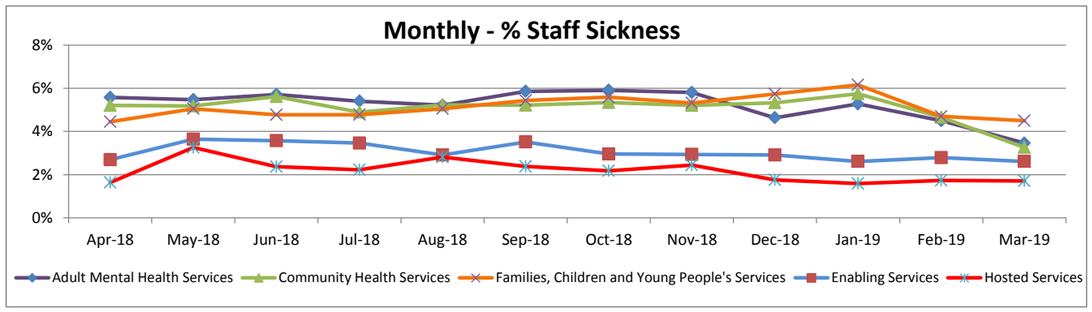
Responsible Services	AMH, CHS, FYPC, Enabling
KPI Reference ID	

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-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Adult Mental Health Services	<=5.6%	5.6%	5.5%	5.7%	5.4%	5.2%	5.9%	5.9%	5.8%	4.6%	5.3%	4.5%	3.5%
Community Health Services	<=4.8%	5.2%	5.2%	5.6%	4.9%	5.2%	5.2%	5.3%	5.2%	5.3%	5.8%	4.7%	3.3%
Families, Children and Young People's Services	<=4.3%	4.5%	5.1%	4.8%	4.8%	5.1%	5.4%	5.6%	5.3%	5.7%	6.2%	4.7%	4.5%
Enabling Services	<=2.3%	2.7%	3.6%	3.6%	3.5%	2.9%	3.5%	3.0%	2.9%	2.9%	2.6%	2.8%	2.6%
Hosted Services	<=2.3%	1.6%	3.3%	2.4%	2.2%	2.8%	2.4%	2.2%	2.4%	1.8%	1.6%	1.7%	1.7%



Comments and Actions:

% Sickness Absence:

AMH.LD - sickness is showing significant improvement from last year. The cumulative rate for the year is holding at 5.6% (on target) . HR support has been made available to focus on supporting, training and coaching Managers. All areas have now started target setting for staff who reach the Trust triggers and if breached formal action will be taken. New ward matrons are in place for a number of areas which is having a positive impact on absence management and absence rates. Amica and Occupational Health have informed HR that due to the complexity of the client group there is an expectation that AMH.LD will continue to have higher sickness absence. There is a monthly teleconference for managers, HR and the Director to discuss actions being taken to tackle sickness absence. The AMH.LD HR Team have been asked to focus 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 decrease in sickness absence although still remains Red. 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 another decrease in sickness absence and is now showing as green . All absence is being appropriately managed within the services with support from HR.

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

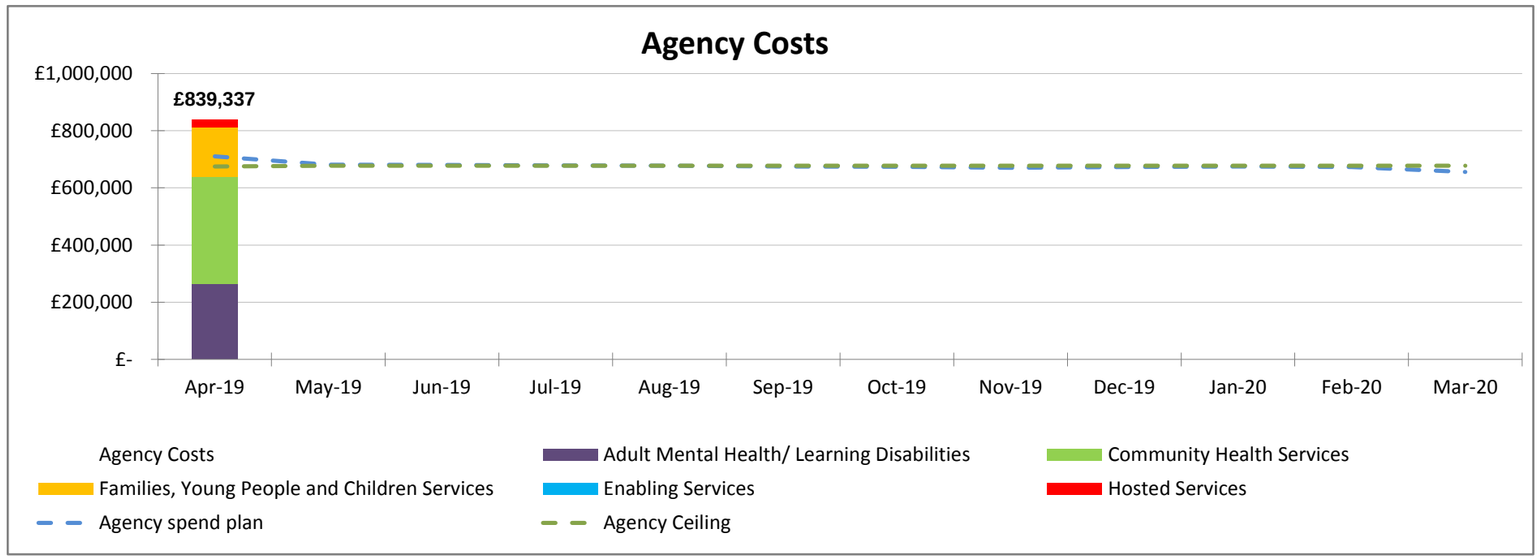
Risk Reference	1932	**Risk Description:** Inability to achieve sufficient workforce supply to deliver the workforce requirements set out within the Trust business plan and people strategy. . Links to risks 1037, 1038, 2515 and the safer staffing risk.
Risk Owner	Sarah Willis	

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	£ 263,695	£ 216,493
Community Health Services	£ 375,015	£ 377,640
Families, Young People and Children Services	£ 172,136	£ 191,963
Enabling Services	£ 1,320	£ 60,374
Hosted Services	£ 27,171	£ 41,482



Comments and Actions:
Cumulative year-to-date Trust agency costs were £839K as at 30 April 2019 (month 1). This is above the planned spend of £710k for the same period.

The April 2019 year-to-date NHSI agency ceiling target is £675k. This Trust is exceeding this limit by £164k.

Trust had planned to achieve the full year NHSI ceiling target; however, based on initial data for April 2019, forecast spend is now likely to be significantly higher and achievement of the NHSI ceiling target may not be possible. This is mainly due increasing agency costs within the FYPC directorate linked to the management of the CAMHS wait times for which a detailed trajectory on costs and impact on reducing the wait times has been established and shared within the Trust. A revised forecast will be made available next reporting period.

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

	<target	>=target	target			
	Reliable	Valid	Timely	Complete	Accurate	Relevant
Care Programme Approach (CPA) follow up - proportion of discharges from hospital followed up within 7 days	Y	Y	Y	Y	Y	Y

Paper J3

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	Feb-19	Mar-19	Apr-19	Referrals Trendline (Rolling 12 Months)	Feb-19	Mar-19	Apr-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	Feb-19	Mar-19	Apr-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	Feb-19	Mar-19	Apr-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	145	121	104		94	97	86		136	6	0	11	0	95%	98.1%	98.0%	95.8%		82	4	0	10	0	95%	94.5%	97.1%	95.3%						
MH02	Assertive Outreach	6 Weeks	Referral to Assessment	4	4	3		2	3	1		3	0	0	0	0	95%	100.0%	100.0%	100.0%		0	0	0	0	0	95%	77.8%	100.0%	N/A						
MH06	Personality Disorders	13 Weeks	Referral to Assessment	75	89	96		32	38	61		260	247	0	38	0	95%	53.3%	49.0%	51.3%		24	35	0	39	0	95%	48.5%	63.4%	40.7%						
MH07	Dynamic Psychotherapy	13 Weeks	Referral to Assessment	23	25	28		13	11	6		48	0	0	0	0	95%	100.0%	100.0%	100.0%		17	0	0	0	0	95%	100.0%	100.0%	100.0%						
MH08	Perinatal Mental Health Service	4 Weeks	Referral to Assessment	72	68	79		69	67	59		67	36	0	13	0	95%	88.0%	56.7%	65.0%		41	17	0	12	0	95%	83.3%	80.4%	70.7%						
		2 Working Days		22	22	28		17	23	27		1	3	0	1	0	95%	25.0%	0.0%	25.0%		18	6	0	1	0	95%	100.0%	90.9%	75.0%						
		4 Hours		1	1	0		1	1	0		0	0	0	0	0	95%	N/A	N/A	N/A		0	0	0	0	0	95%	100.0%	0.0%	N/A						
MH09	Psycho-oncology (Routine and Urgent)	4 Weeks	Referral to Assessment	35	31	23		21	13	16		26	72	0	33	0	95%	56.3%	33.0%	26.5%		7	11	0	18	0	95%	38.5%	61.5%	38.9%						
		48 Hours		9	5	5		4	2	2		2	2	0	8	0	95%	100.0%	100.0%	50.0%		2	1	0	3	0	95%	66.7%	100.0%	66.7%						
MH10	Liaison - Psychiatry	1 Working Day	Referral to Assessment	25	40	31		22	42	27		2	0	0	0	0	95%	71.4%	100.0%	100.0%		27	4	0	0	0	95%	70.0%	77.3%	87.1%						
		13 Weeks		23	38	13		14	44	36		39	16	1	29	53	95%	73.2%	76.6%	69.6%		25	9	0	36	0	95%	91.7%	70.4%	73.5%						
MH11	Cognitive Behavioural Therapy	13 Weeks	Referral to Assessment	52	51	48		45	57	39		108	1	0	14	0	95%	96.9%	94.1%	99.1%		40	3	0	15	0	95%	100.0%	97.8%	93.0%						
MH13	Forensic - Community and Out Patients	8 Weeks	Referral to Assessment	22	24	25		11	13	8		36	6	0	14	0	95%	84.8%	83.3%	85.7%		17	1	0	9	0	95%	85.7%	100.0%	94.4%						
MH18	Adult General Psychiatry - Community Mental Health Teams and Outpatients - Treatment	6 Weeks	Referral to Assessment	404	428	404		355	358	458		572	618	9	51	106	95%	50.8%	49.8%	47.7%		166	148	0	51	0	95%	45.9%	53.0%	52.9%						
		5 Days		11	9	11		17	9	12		2	0	0	0	0	95%	40.0%	0.0%	100.0%		9	0	0	0	0	95%	77.8%	88.9%	100.0%						
MH20	Mett Day Centre and Linnaeus Nursery	4 Weeks	Referral to Assessment	11	16	25		9	9	10		13	0	0	0	0	95%	100.0%	100.0%	100.0%		17	2	0	5	0	95%	90.0%	94.1%	89.5%						
MH21	Huntington's Disease	4 Weeks	Referral to Assessment	1	1	1		2	0	2		0	2	0	8	0	95%	100.0%	50.0%	0.0%		1	1	0	7	0	95%	100.0%	N/A	50.0%						
MH23	Adult ADHD Service Consultant-Led Service	National incomplete target 92%: 18 Weeks	Referral to Treatment	111	111	98		33	43	66		383	3	0	20	0	92%	97.0%	99.7%	99.2%		82	6	0	20	0	95%	59.0%	81.6%	93.2%						
MH24	Homeless Service	1 Week	Referral to Assessment	37	36	35		53	33	34		10	11	0	10	0	95%	15.4%	27.8%	47.6%		20	10	0	8	0	95%	48.0%	76.7%	66.7%						
MH25	Aspergers Assessment Consultant-Led Service	National incomplete target 92%: 18 Weeks	Referral to Treatment	36	34	52		24	15	34		137	8	0	40	0	92%	97.0%	95.5%	94.5%		33	4	0	33	0	95%	64.0%	97.3%	89.2%						
MH48	Crisis Intervention (Crisis Level 1 and 2)	4 Hours	Referral to Assessment	4	1	0		5	1	0		0	0	0	0	0	95%	N/A	N/A	N/A		0	0	0	0	0	95%	50.0%	0.0%	N/A						
		24 Hours		231	326	273		229	313	270		7	0	0	0	0	95%	100.0%	100.0%	100.0%		254	13	0	0	0	95%	89.5%	86.3%	95.1%						
MH49	Mental Health Triage Team	1 Hour	Referral to Assessment	346	347	351		316	321	339		0	0	0	0	0	95%	N/A	N/A	N/A		172	177	0	0	0	95%	47.8%	64.3%	49.3%						
		Emergency 2 Hours	Referral to Assessment	346	347	351		316	321	339		6	16	1	38	54	95%	33.3%	33.3%	26.1%		243	106	0	0	0	95%	69.4%	64.3%	69.6%						
		Crisis 4 Hours	Referral to Assessment	54	101	69		43	91	66		2	16	0	48	0	95%	39.4%	16.7%	11.1%		58	11	0	0	0	95%	72.3%	82.7%	84.1%						
MH16	Adult General Psychiatry-Acute Recovery Team	3 Working Days																																	
		48 hours																																	
		7 days																																	

Comments and Actions:

MH16 - 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 (days unless otherwise agreed unless otherwise stated)	Wait Time Measure	Feb-19	Mar-19	Apr-19	Referrals Trendline (Rolling 12 Months)	Feb-19	Mar-19	Apr-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	Feb-19	Mar-19	Apr-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	Feb-19	Mar-19	Apr-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	541	435	560		409	370	793		529	1287	0	50	0	95%	35.0%	27.1%	29.1%																
		Level 1 Assessment																				7	52	0	50	0	95%	21.5%	21.3%	11.9%						
CHS04	Respiratory Specialist Service	Urgent 3 Working Days	Referral to first clinically relevant face to face contact	9	6	7		8	6	4		1	0	0	0	0	95%	N/A	100.0%	100.0%		6	0	0	0	0	95%	100.0%	66.7%	100.0%						
		Routine 20 Working Days		163	170	177		124	141	191		130	9	0	6	0	95%	88.1%	92.6%	93.5%		165	24	0	19	0	95%	82.3%	87.0%	87.3%						
		Palliative 10 Working Days		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						
CHS07	Heart Failure Service	Urgent 3 Working Days	Referral to first clinically relevant face to face contact	11	13	17		13	13	13		0	0	0	0	0	95%	0.0%	100.0%	N/A		20	0	0	0	0	95%	91.7%	81.8%	100.0%						
		Routine 20 Working Days		184	197	178		113	169	141		121	1	0	6	0	95%	99.2%	97.0%	99.2%		149	4	0	11	0	95%	97.9%	98.1%	97.4%						
		Palliative 10 Working Days		0	0	0		0	1	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						
CHS10	Physiotherapy	Routine 4 Weeks	Referral to first clinically relevant contact	0	0	0		1503	1474	1462		12	467	0	29	0	95%	2.1%	2.3%	2.5%		24	385	0	28	0	95%	20.7%	9.3%	5.9%						
		Urgent 5 Working Days		0	0	0		350	369	370		0	0	0	0	0	95%	N/A	0.0%	N/A		0	0	0	0	0	95%	81.3%	0.0%	N/A						
		Non self Urgent RTT 5 Working Days	Referral to Treatment	103	76	56		11	23	42		2	7	0	3	0	92%	100.0%	31.6%	22.2%		51	10	0	7	0	95%	98.7%	95.0%	83.6%						
		Non self Routhine RTT 30 Working Days		735	595	390		65	87	156		403	690	0	13	0	92%	100.0%	62.1%	36.9%		185	96	0	12	0	95%	100.0%	94.6%	65.8%						
		Self Referrals Urgent RTT 5 Working Days		290	407	381		18	43	116		61	55	0	4	0	92%	100.0%	25.0%	52.6%		284	44	0	3	0	95%	98.8%	96.6%	86.6%						
		Self Referrals Routine RTT 30 Working Days		1275	1430	1683		78	139	330		669	554	0	13	0	92%	100.0%	63.5%	54.7%		1375	99	0	12	0	95%	100.0%	99.0%	93.3%						
CHS19	Podiatry	Routine 20 Working Days	Referral to first clinically relevant face to face contact	1215	1305	1327		1763	1032	1555		1060	26	0	31	0	95%	99.2%	97.9%	97.6%		1261	66	0	32	0	95%	96.1%	94.2%	95.0%						
		Urgent 5 Working Days		25	22	34		14	8	12		5	0	0	0	0	95%	25.0%	50.0%	100.0%		21	0	0	0	0	95%	76.5%	77.8%	100.0%						
CHS22	Speech Therapy	Routine 4 Weeks	Referral to first clinically relevant face to face contact	269	308	300		263	252	277		201	42	0	27	0	95%	84.5%	81.9%	82.7%		258	65	0	23	0	95%	84.2%	83.2%	79.9%						
		Urgent 10 Working Days		37	24	35		47	45	39		15	0	0	0	0	95%	88.9%	90.0%	100.0%		23	6	0	4	0	95%	82.5%	85.7%	79.3%						
CHS69/70/80	Community Therapy	3 Working Days (P1)*	Referral to first clinically relevant contact	172	171	154		175	164	144		16	1	0	0	0	95%	80.0%	92.6%	94.1%		147	17	0	5	0	95%	86.8%	92.6%	89.6%						
		20 Working Days (P2)*		583	617	620		525	594	542		475	446	0	15	0	95%	55.6%	53.9%	51.6%		251	282	0	20	0	95%	52.0%	44.8%	47.1%						
		60 Working Days (P3)*		86	114	89		90	74	58		224	56	0	20	0	95%	88.2%	87.3%	80.0%		34	17	0	23	0	95%	57.8%	54.9%	66.7%						
CHS87	Stroke & Neuro	3 Working Days	Referral to first clinically relevant contact	5	6	4		8	1	6		0	0	0	0	0	95%	100.0%	N/A	N/A		5	0	0	0	0	95%	66.7%	100.0%	100.0%						
		20 Working Days		209	188	199		184	187	186		158	150	0	20	0	95%	50.4%	45.7%	51.3%		118	130	0	22	0	95%	35.5%	30.9%	47.6%						
MH37	MHSOP Community Teams	High Priority 4 Weeks	Referral to first clinically relevant face to face contact	22	15	9		16	13	19		6	5	0	7	0	95%	82.4%	90.0%	54.5%		11	2	0	7	0	95%	80.0%	90.9%	84.6%						
		Routine 6 Weeks		108	133	112		118	99	106		104	17	0	10	0	95%	88.5%	83.3%	86.0%		89	24	0	12	0	95%	78.7%	81.6%	78.8%						
MH40	MHSOP - Memory Clinics	RTT 18 Weeks	Referral to Treatment	205	195	187		148	173	127		674	90	0	44	0	92%	88.4%	86.6%	88.2%		132	48	0	45	0	95%	71.0%	79.5%	73.3%						
		High Priority 4 Weeks	Referral to first clinically relevant face to face contact	0	0	0		8	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		1	14	9		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	1		3	2	4		0	1	0	8	0	95%	100.0%	50.0%	0.0%		1	0	0	0	0	95%	66.7%	50.0%	100.0%						
		Routine 6 Weeks		126	106	138		99	133	122		150	35	0	16	0	95%	84.1%	78.3%	81.1%		93	17	0	49	0	95%	83.6%	83.3%	84.5%						
CHS05a	Planned End of Life Care Service (Hospice at Home)	2 Weeks	Referral to first clinically relevant face to face contact	5	2	3		5	2	4		0	0	0	0	0	95%	N/A	N/A	N/A		3	0	0	0	0	95%	100.0%	100.0%	100.0%						
		24 Hours		113	97	98		108	103	67		2	0	0	0	0	95%	100.0%	N/A	100.0%		89	2	0	20	0	95%	96.0%	89.7%	97.8%						
		2 Hours		71	84	66		67	88	67		0	0	0	0	0	95%	N/A	N/A	N/A		58	3	0	0	0	95%	95.6%	88.3%	95.1%						
MH55	Integrated Care – Mental Health	15 Working Days	Referral to first clinically relevant face to face contact	22	33	31		24	29	26		23	1	0	4	0	95%	66.7%	93.8%	95.8%		23	3	0	4	0	95%	46.9%	71.4%	88.5%						
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:

CHS03 - Continence Nursing Service
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 Level 1 complete pathway and thus a drop in compliance.

CHS69/70/80 - Community Therapy Waiting Times Label:
P1 – 3 working days
P2 – referrals with a start date before 1st February 2018 will be on P2 - 10 working days and all new referrals triaged on P2 will be P2 - 20 working days
P3 – referrals with a start date before 1st February 2018 will be on P3 - 20 working days and all new referrals triaged on P3 will be P3 - 60 working days

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	Feb-19	Mar-19	Apr-19	Referrals Trendline (Rolling 12 Months)	Feb-19	Mar-19	Apr-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	Feb-19	Mar-19	Apr-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	Feb-19	Mar-19	Apr-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	456	470	471		363	408	348		334	0	0	0	0	99%	100.0%	100.0%	100.0%		372	2	0	31	0	92%	99.8%	100.0%	99.5%						
CHS24	Childrens Occupational Therapy	18 Weeks	Referral to Treatment	34	35	31		37	39	44		67	0	0	0	0	92%	100.0%	100.0%	100.0%		33	0	0	0	0	92%	100.0%	100.0%	100.0%						
CHS25	Childrens Physiotherapy	18 Weeks	Referral to Treatment	10	21	10		8	12	19		57	4	0	27	0	92%	97.9%	91.0%	93.4%		22	0	0	0	0	92%	85.7%	88.9%	100.0%						
CHS27	Childrens Speech & Language Therapy	18 Weeks	Referral to Treatment	271	269	219		188	235	326		742	2	0	25	0	92%	98.7%	99.1%	99.7%		325	5	0	29	0	92%	99.6%	98.4%	98.5%						
CHS29	LNDS & HENS Domiciliary	4 Weeks	Referral to Assessment	193	141	134		188	151	170		84	82	0	13	0	95%	68.1%	47.6%	50.6%		81	75	0	11	0	92%	49.2%	61.2%	51.9%						
	LNDS & HENS Outpatients	18 Weeks	Referral to Assessment	339	427	400		254	199	323		857	40	0	36	0	95%	65.5%	88.8%	95.5%		319	19	0	39	0	92%	79.7%	95.5%	94.4%						
CHS34	Community Paediatrics	18 Weeks	Referral to Treatment	121	117	89		59	40	76		268	13	1	46	54	92%	99.1%	99.1%	95.0%		69	5	0	25	0	92%	98.6%	98.3%	93.2%						
MH19	PIER - First Episode in Psychosis Service	National complete target 53%: 2 Weeks	Referral to Treatment	48	56	49		41	38	48		15	5	0	8	0	53%	60.0%	62.5%	75.0%		15	4	0	7	0	53%	66.7%	92.3%	78.9%						
MH30	CAMHS Young People's Team	13 weeks	Referral to Treatment	22	29	26		11	21	38		30	0	0	0	0	92%	100.0%	100.0%	100.0%		28	0	0	0	0	92%	100.0%	100.0%	100.0%						
MH31	CAMHS Learning Disabilities	18 weeks	Referral to Treatment	10	16	12		7	14	6		21	1	0	28	0	92%	88.0%	89.7%	95.5%		10	0	0	0	0	92%	100.0%	100.0%	100.0%						
MH33	CAMHS Paediatric Psychology	18 weeks	Referral to Treatment	28	27	34		25	23	29		76	14	0	30	0	60%	97.5%	91.8%	84.4%		17	5	0	25	0	60%	84.2%	91.3%	77.3%						
MH47	CAMHS - Eating Disorders	Routine 4 Weeks	Referral to face to face assessment	20	20	10		17	18	11		4	2	0	6	0	60%	100.0%	100.0%	66.7%		4	2	0	8	0	60%	63.6%	33.3%	66.7%						
		Urgent 1 Week	Referral to face to face assessment	2	3	1		1	0	2		0	0	0	0	0	60%	N/A	N/A	N/A		1	0	0	0	0	60%	100.0%	75.0%	100.0%						
MH47	CAMHS - Eating Disorders	Commissioner: Routine 6 Weeks	Referral to NICE Concordant Treatment	20	20	10		17	18	11		6	1	0	34	0	95%	80.0%	91.7%	85.7%		10	2	0	8	0	95%	85.7%	90.0%	83.3%						
		Commissioner: Urgent 4 Weeks		2	3	1		1	0	2		0	0	0	0	0	95%	N/A	N/A	N/A		1	0	0	0	0	95%	66.7%	100.0%	100.0%						
MH47	CAMHS - Eating Disorders	National monitoring: no target Routine 4 Weeks	Referral to NICE Concordant Treatment	20	20	10		17	18	11		4	3	0	34	0		40%	75%	57%		10	2	0	8	0		76%	55%	83%						
		National monitoring: no target Urgent 1 Week		2	3	1		1	0	2		0	0	0	0	0		N/A	N/A	N/A		1	0	0	0	0		0%	75%	100%						
MH50	CAMHS Access and Outpatients	4 weeks	Referral to first clinically relevant contact	64	50	43		39	33	51		17	1	0	5	0	92%	95.6%	90.0%	94.4%		43	13	0	7	0	92%	92.5%	91.3%	76.8%						
		13 weeks		228	286	179		135	160	350		176	70	0	49	0	95%	38.1%	53.2%	71.5%		233	163	10	51	55	92%	74.5%	76.7%	57.4%						
MH51	CAMHS Crisis and Home Treatment	24 Hours	Referral to first clinically relevant contact	79	117	87		38	29	56		0	10	0	5	0	92%	0.0%	0.0%	0.0%		47	23	0	5	0	95%	68.1%	76.3%	67.1%						
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.

Methodologies:

RTT Methodology
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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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Leicestershire Partnership NHS Trust

TRUST BOARD – 23 May 2019

AUDIT AND ASSURANCE COMMITTEE – 3 May 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
BAF/Corporate Risk Register		The next steps for the Committee having enhanced oversight of the BAF processes were set-out.	Revised BAF and governance process to the next committee.	July 2019
Matters Arising		Sharper focus on outstanding issues has seen an elimination of almost all matters outstanding.	Remain vigilant to ensuring matters arising are dealt with in a timely way.	July 2019
Internal Audit Progress Report		The progress to date closing down the 2018/19 plan was reviewed and the early work for 2019/20 plan considered.	Next report to committee	July 2019
External Auditors Progress report		A summary of KPMG's work since March 2019 was received, with positive progress was reported.	Next report to committee	July 2019
Going Concern		The report was reviewed.	Final report to EGM	May 2019 EGM
Review of Annual Governance Statement		Information for adding was debated such as the recent change to Segment Assessment by NHS Improvement, Never Event	Review of revised draft by Executive Team and final report to EGM.	May 2019 EGM
Review of Head of Internal Audit		Concerns raised over the inaccuracy of the Risk and control environment	Review of revised draft by Executive	May 2019 EGM

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
Opinion		descriptions despite a current risk management report assessment being at the final draft stage, and other further minor factual errors.	Team and final report to EGM.	
Committees' Annual Report Reviews: Mental Health Act Assurance Committee Strategic Workforce Group Charitable Funds Committee		Three Board committee draft annual reports were presented by the Chairs. Debate considered their risk and assurance arrangements, focus for 2019/20 given the strategic priorities review for 2019/20, and formal membership so as to ensure depth and experience in the assurance challenge process.	Finalised annual reports to be produced by Committee Chairs/Executive leads ahead of submission to the Trust Board.	July 2019 Trust Board
Deep Dive – External Governance Review and CQC Actions Oversight		A presentation focused upon the committee's areas of interest in the External Governance Review was received. The CQC Oversight arrangements for addressing actions were outlined.	The Executive Team would now be developing a response to the Review. The Trust Board would continue to receive update reports on CQC actions progress.	Determined by response by Executive Team Not Applicable

Recommendation	The Trust Board receives and reviews the issues raised in the highlight report.
Author	Frank Lusk, Trust Secretary
Presented by (Chair of Committee)	Darren Hickman, Non Executive Director

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NHS
Leicestershire Partnership
NHS Trust

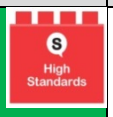
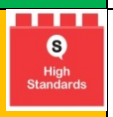
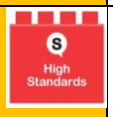
TRUST BOARD 23 May 2019

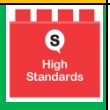
Strategic Workforce Group (SWG) 16 May 2019

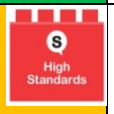
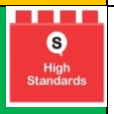
OVERVIEW REPORT TO BOARD

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 • Mandatory Training Report • Role Essential Training Report Clinical Supervision Report		Compliance remains good for substantive, bank staff there are concerns Role essential training register updated with Storm, Suicide Awareness and Modified westcotes individualised outcome measure training. and approved Clinical supervision report received	Workforce groups to review clinical supervisions rates	Ongoing Ongoing
Mandatory Training Report - Bank Staff		Concerns regarding bank staff training compliance.	Further focused work on bank staff training compliance to be done.	July 2019
Workforce Resourcing, Attraction and Retention		Report received noted improvements in time taken to recruit and vacancy rate has decreased. The	Workforce and operational groups to consider the additional options	July 2019

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
• Recruitment • Retention		recruitment approach was reviewed.	put forward on recruitment approach.	
Learning and Development Annual Plan 2019-20		Plan was noted and agreed further alignment with step up to great would be included in the plan.	The OD section of the plan will be updated after the discovery phase of the culture and leadership programme.	July 2019
Culture & Leadership Programme (Our Future Our Way)		Received an update on the programme with positive messages regarding the numbers of Change champions 82 now active. The board interviews are taking place and the leadership survey is out.	Continue with Phase 1 discovery	September 2019
OD Quarterly Performance Report • Career Development • Talent Management Strategy • Appraisal		Noted the quarterly update and numbers of staff attending programmes.	ongoing	
Trust Priorities		Received and agreed would move to using a front sheet with the blocks of step up to great aligned to them.	Front sheet template to be used	July
Staff Engagement Dashboard		Received the new dashboard and the reviewed approach to staff engagement building on the NHS employers guidance.	Agreed to refine the approach and align with step up to great priorities	July 2019
WRES Action Plan		Progress on action received. Cultural competence workforce running in June Reverse mentoring programme launched Interview skills training for BAME staff taking place in May and June. LIA on career progression 10 June.	Continue to progress actions with PACE	July 2019
Sickness Absence Management Update and Approach		Review of the approach discussed and agreed to continue doing what we are. FYPC sickness has increased. AMH/LD has improved.	Further targeted support in fypc. Directorate targets to be reviewed.	July 2019
Temporary Staffing Dashboards		Received reports and actions are on track. Noted increase in agency due to camhs additional resources.	ET to continue to review off framework use 2 weekly.	
Receive Assurance on		Received and assured.		

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
Off-Payroll Use and IR35				
Consultant Job Planning Audit Report		Audit report received. Confirmation that job plans are in place but not annually up to date.	Further work to implement annual job planning underway.	July 2019.
AHP and Nursing Revalidation Report		Progress and compliance noted. The professional standard reports was also considered including reviewing themes around falling asleep and escort duties.	Key learning points poster is being published also HALT campaign around taking a break.	May 2019
IQPR – Workforce Section		Noted		
CRR Risks		Noted and will be updated in line with changes to BAF and culture and leadership work		
Celebratory Acknowledgements		Numbers of change champions 0-19 smile awards Chat health award for innovation.		
Learning & Organisational Development Group TOR and Workplan 19-20		Noted and assurance reports to come to SWG.		May 2019

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)	Pete Miller – Chief Executive Officer

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Leicestershire Partnership NHS Trust

TRUST BOARD – 23 MAY 2019

SAFE STAFFING – APRIL 2019 REVIEW

Introduction/Background

1 This report will provide an overview of the nursing safe staffing during the month of April 2019, triangulating productivity, workforce metrics, quality and outcomes linked to Nurse Sensitive Indicators (NSIs) and patient experience feedback.

2 Part one refers to inpatient areas and part two relates to community teams.

3 Actual staff numbers compared to planned staff numbers are collated for each inpatient area. A summary is available in Appendix 1.

Aim

4 The aim of this report is to provide the Trust Board with assurance that arrangements are in place to safely staff our services with the right number of staff with the right skills at the right time. Including an overview of staffing hot spots, potential risks and actions to mitigate the risks, to ensure that safety and care quality are maintained.

Recommendations

5 The Trust Board is recommended to receive assurance that processes are in place to monitor and ensure the inpatient and community staffing levels are safe and that patient safety and care quality are maintained.

Trust level highlights for April 2019

Right Staff

- Overall the planned staffing levels were achieved across the Trust. Where inpatient staffing actual fill rate is less than 80% and or 50% substantive staff are utilised this is a moderate risk, referred to as a 'tipping- point' indicating a Lead Nurse review of staffing establishments and staff deployment.
- Temporary worker utilisation rate slightly decreased this month by 2.3%; reported at 30.9%. Utilisation is associated with meeting planned staffing levels where there are vacancies and sickness. It is also associated with increases in patient acuity and dependency requiring additional staff to maintain quality of care and patient safety.
- Agency usage remains at 3.5%, sustained position since January 2019.
- The total number of Trust wide Registered Nurse (RN) vacancies reported this month is 185.47 w.t.e posts (114.31 inpatients and 71.16 community). This is a increased position this month by 11.62 w.t.e RN posts with the increase noted in community.

- The total number of Trust wide Health Care Support Worker (HCSW) vacancies reported this month is 74.59w.t.e. posts (58.15 in-patients and 16.44 community). This is an increased position this month by 5.25 w.t.e posts.
- As of the 1 May 2019 there are 36.2 w.t.e candidates in the recruitment pipeline, expected to join the Trust over the next few months.
- Future workforce planning; collaborative work to address nursing vacancies continues, the majority of new nurses qualify through pre-registration education, the Trust has submitted an expression of interest to NHS Improvement Workforce to access placement infrastructure funding, to develop plans to grow clinical placement capacity by 25% for the 2019 intake, and support students in practice to reduce attrition and improve retention.
- There are twelve hotspot inpatient areas across the Trust, five of the twelve did not meet the threshold for planned staffing at all times and six of the nine are hot spots linked to the higher use of temporary workers to achieve staffing safely. Ward 3, CAMHS is an emerging hot spot area due to concerns relating to increased acuity, high risk patients, staff sickness, ability to fill additional shifts and the impact to safe and effective care. There are also eight community team hot spots areas across CHS and FYPC
- Where community teams are considered a hot spot, staffing and case-loads are reviewed and risk assessed across teams using patient prioritisation models to ensure appropriate action is taken.
- A review of the Trust's NSIs and patient feedback has not identified any correlation between staffing and impact to quality and safety of patient care/outcomes.

Right Skills

- In consideration of ensuring staff have the 'right skills', a high level overview of clinical training, appraisal and supervision for triangulation is presented. As of the 1 May 2019 Trust wide;
    - Appraisal is at 92.3% - rated Green.
    - Clinical supervision is at 79.1% - rated Amber with robust action plans in place
    - Clinical mandatory training for substantive staff rated Green with the exception of; ALS, MAPPA Disengagement and High risk, SCIP – UK, Dementia Capable Care and Mental Health Act Nursing all Amber with robust actions in place
    - Clinical mandatory training for bank only workers; three of the eighteen clinical mandatory topics are rated Green. Improvement seen in compliance against only one topic since all bank only workers were written to, reminding them of their personal responsibility to ensure that they are up to date with all mandatory training. Risk matrix to stopping bank only staff working clinically if they are non-compliant with topics to be agreed at the Lead Nurse and Therapy meeting in May 2019, given the high proportion of temporary staff utilised across services and the need to ensure that they have the right skills.

Right Place

- The increased fill rates for the percentage of actual HCSWs reflects the high utilisation and deployment of additional temporary staff in response to patient acuity and increased levels of therapeutic observation in order to maintain safety of all patients.
- The total Trust CHPPD average (including ward based AHPs) is reported at 10.84 in April 2019, with a range between 5.0 (Skye Wing) and 34.5 (Agnes Unit). The variation in range reflects the diversity of services, complex and specialist care provided across the Trust. Analysis of the CHPPD has not identified variation at service level, indicating that staff are being deployed productively across services.

Part One – In-patient Staffing

1 The overall trust wide summary of planned versus actual hours by ward for registered nurses (RN) and health care support workers (HCSW) in April 2019 is detailed below:

	DAY		NIGHT		
	% of actual vs total planned shifts RN	% of actual vs total planned shifts care HCSW	% of actual vs total planned shifts RN	% of actual vs total planned shifts care HCSW	Temp Workers%
Feb 19	103.2%	202.4%	108.0%	184.6%	32.6%
Mar 19	101.4%	209.6%	108.1%	184.6%	33.2%
April 19	**104.9%**	**216.0%**	**107.6%**	**194.5%**	**30.9%**

Table 1 - Trust level safer staffing

2 Overall the planned staffing levels were achieved across the Trust. The increased fill rates for the percentage of actual HCSWs reflects the high utilisation and deployment of additional temporary staff in response to patient acuity and increased levels of therapeutic observation in order to maintain safety of all patients.

3 Temporary worker utilisation rate slightly decreased this month by 2.3%; reported at 30.9%. Utilisation is associated with meeting planned staffing levels where there are vacancies and sickness. It is also associated with increases in patient acuity and dependency requiring additional staff to maintain quality of care and patient safety.

4 Agency usage remains at 3.5%, sustained position since January 2019, reduced from 3.9% in December 2018.

Summary of safer staffing hotspots – Inpatients

Planned staffing and/or high utilisation of temporary workers	February 2019	March 2019	April 2019
Hinckley and Bosworth - East Ward	X	X	X
Short Breaks - The Gillivers	X	X	X
Short Breaks – Rubicon Close		X	X
Mill Lodge	X	X	X
Welford			
Kirby	X		
Coleman	X	X	X
Gwendolen	X		
Belvoir			X
Griffin	X	X	X
Agnes Unit	X		X
Langley		X	X
Feilding Palmer		X	X
St Lukes Ward 3		X	X
Ward 3 Coalville (CAMHS)			X

Table 2 - Safer staffing hotspots

5 East and Coleman Wards, Mill Lodge and Short Breaks are hot spot areas as they did not meet the threshold for planned staffing across all shifts, on these occasions staffing was reported to be within safe parameters for all areas.

6 Langley, Belvoir and the Agnes Unit are hot spots due to utilising over 50% temporary staff. The high utilisation is associated with both vacancies and increased patient acuity.

7 Griffin ward is a hot spot due to concerns regarding patient care and staff support resulting in a review of incidents by the safeguarding and patient safety teams and further investigations. As a result of these concerns and not being able to meet the Trust safe staffing levels, the ward closed two beds to admissions and a contingency plan was put in place to provide additional staffing and support to the ward.

8 Community Hospitals have identified both Feilding Palmer and St Lukes Ward 3 as hot spots due to the high numbers of vacancies and high utilisation of temporary workers

9 On 30 April 2019 Lead Nurse, FYPC escalated concerns in relation to staffing and patient safety on Ward 3, Coalville (CAMHS) to the Chief Nurse, Directorate senior managers and clinical directors. During the month it was noted that the acuity and dependency of patients had increased with a number of high risk patients requiring high levels of therapeutic observation, increased staff sickness and increased concerns related to standards of practice. In response a number of actions were taken to ensure safe staffing;

- Worked with Centralised Staffing Solutions (CSS) to secure and support regular bank and agency staff to increase continuity of care
- Closing available beds to admissions, reviewed daily, individual patient needs and risk managed accordingly
- Assessing the acuity and dependency daily to identify planned staffing numbers
- Matron and Ward Sister deployed into the planned staffing at least 75% of their time to work and support the teams providing senior clinical support to patients and staff
- Overtime/additional hours offered to substantive staff
- Temporarily stop any non-mandatory training

The position of closing to admissions was held for 24 hours to allow the Matron and Ward Sister to review staffing and support those returning from sickness. After 24 hours it was agreed the Matron screens admissions based on patient dependency and staffing, the situation continues to be reviewed daily with a plan to return to normal following the transfer of a particularly high risk patient to a more suitable environment.

10 Number of occupied beds, planned staffing levels versus actual staffing levels and percentage of temporary staff utilised is presented in the tables below per in-patient area by service and directorate. For planned versus actual levels; Green indicates threshold achieved and red indicates an exception.

- For temporary workers; green indicates threshold achieved, amber is above 20% utilisation and red above 50% utilisation.
- The NSIs that capture care or outcomes most affected by nursing staffing levels are also presented in conjunction with patient experience feedback. This report indicates if there has been an increase or decrease in the indicator position against the previous month for the NSIs and patient experience feedback.
- In line with NHS Improvement guidance; revised definition and measurement of pressure ulcers (2018) from April 2019 organisations must cease reporting avoidable/unavoidable pressure ulcers. New reporting measurement categories have been added to the incident reporting system, all incidents are to be investigated to support organisational/system learning. Whilst the new system of reporting is established and embedded, pressure ulcers have been suspended from the in-patient dashboard reports.

Adult Mental Health and Learning Disabilities Services (AMH/LD)

Acute Inpatient Wards

Ward	Occupied beds	DAY % of actual vs total planned shifts RN	DAY % of actual vs total planned shifts care HCSW	NIGHT % of actual vs total planned shifts RN	NIGHT % of actual vs total planned shifts care HCSW	Temp Workers%	CHPPD Care Hours Per Patient Day	Vacancy Factor	Medication errors	Falls	Complaints	FFT Promoter % (arrears)
Ashby	19	100.5%	129.8%	114.5%	141.9%	21.7%	5.4	4.7%	0↓	0↓	0	90.9%
Aston	19	91.4%	146.8%	98.4%	229.0%	27.2%	6.2	15.2%	1↓	2	0	nil
Beaumont	21	91.9%	141.1%	100.0%	216.1%	39.3%	5.5	11.8%	0	0	0↓	nil
Belvoir Unit	10	106.6%	295.1%	190.3%	285.2%	52.4%	17.6	36.8%	0	0	0	nil
Bosworth	18	88.7%	178.2%	95.2%	174.2%	30.7%	6.2	22.8%	1↑	4↑	0	nil
Heather	18	87.5%	137.1%	91.9%	158.1%	24.2%	6.0	22.2%	1↑	2↑	0↓	100%
Thornton	18	85.5%	156.5%	100.0%	108.1%	25.8%	5.8	8.9%	0↓	0↓	4↑	100%
Watermead	20	89.8%	196.0%	100.0%	312.9%	33.0%	7.0	13.5%	1	0	0	nil
Griffin F PICU	4	187.1%	475.8%	190.3%	312.9%	61.8%	23.4	43.6%	0↓	1↓	0	nil
TOTALS									**4↓**	**9↓**	**4↑**	

Table 3 - Acute inpatient ward safer staffing

11 All wards met the threshold for planned staffing across all shifts.

12 Temporary worker utilisation is Amber for all wards with the exception of Belvoir and Griffin Ward both rated Red at 52.4% and 61.8% respectively. The increased utilisation is due to a combination of high nurse vacancy factor, increased staff sickness and increased levels of patient acuity requiring observation support.

13 To mitigate the risks associated with utilising higher numbers of temporary staff and the impact on quality and patient experience , the service block book regular bank and agency RNs and HCSWs across the acute inpatient wards, substantive staff are also moved across areas dependant on the skill mix and patient need . This enables safe staffing levels to be maintained or risk assessed within a safe parameter and also to improve continuity of patient care.

14 A review of the NSIs and patient feedback has not identified any staffing impact on the quality and safety of patient care/outcomes for all wards with the exception of Griffin Ward; concerns regarding patient care and staff support have been escalated resulting in a review of incidents by the safeguarding and patient safety teams and further investigations. As a result of these concerns and not being able to meet the Trust safe staffing levels, the ward closed two beds to admissions and a contingency plan was put in place to provide additional staffing and support to the ward. This is reviewed twice a week and commenced on the 5 April 2019 and was still in place at the 30 April 2019.

Learning Disabilities (LD) Services

Ward	i e d	DAY	DAY	NIGHT	NIGHT	Temp	CHPPD		. . o n	a — —	. — a . .	e r %

		% of actual vs total planned shifts RN	% of actual vs total planned shifts care HCSW	% of actual vs total planned shifts RN	% of actual vs total planned shifts care HCSW	Workers %	Care Hours Per Patient Day	Vacancy Factor				
3 Rubicon Close	3	95.2%	185.7%	67.7%	161.3%	25.7%	19.7	6.6%	0	0	0	nil
Agnes Unit	8	170.0%	763.3%	134.8%	669.6%	51.2%	34.5	17.7%	0	0↓	0	100%
The Gillivers	4	100.0%	166.2%	67.7%	151.6%	16.9%	18.8	-0.4%	0↓	3↑	0	nil
The Grange	3	-	166.7%	-	196.8%	13.1%	20.7	30.0%	0↓	1	0	nil
TOTALS									**0↓**	**4**	**0**	

Table 4 - Learning disabilities safer staffing

15 Short break homes continue to utilise a high proportion of HCSWs who are trained to administer medication and carry out delegated health care tasks. The Gillivers and the Grange support each other with RN day cover. Night cover is shared across the site as the homes are situated next to each other in conjunction with utilisation of additionally trained HCSWs.

16 A review of the NSIs and patient feedback has not identified any staffing impact on the quality and safety of patient care/outcomes as not all patients require Registered Nurses but do require staff training in specific care and treatment tasks.

Low Secure Services – Herschel Prins

Ward	Occupied beds	DAY	DAY	NIGHT	NIGHT	Temp Workers%	CHPPD	Vacancy Factor	Medication errors	Falls	Complaints	FFT Promoter % (arrears)
		% of actual vs total planned shifts RN	% of actual vs total planned shifts care HCSW	% of actual vs total planned shifts RN	% of actual vs total planned shifts care HCSW		Care Hours Per Patient Day					
HP Phoenix	11	97.6%	155.6%	100.0%	153.2%	35.5%	9.0	27.8%	0	0	0	88.9%

Table 5- Low secure safer staffing

17 Phoenix Ward achieved the thresholds for safer staffing. High levels of temporary workers continue to be utilised to cover vacancies, sickness and a high number of level one and level two patient observations.

18 A review of the NSIs and patient feedback has not identified any staffing impact on the quality and safety of patient care/outcomes.

Rehabilitation Services

Ward	Occupied beds	DAY % of actual vs total planned shifts RN	DAY % of actual vs total planned shifts care HCSW	NIGHT % of actual vs total planned shifts RN	NIGHT % of actual vs total planned shifts care HCSW	Temp Workers%	CHPPD Care Hours Per Patient Day	Vacancy Factor	Medication errors	Falls	Complaints	FFT Promoter % (arrears)
SH Skye Wing	27	108.1%	155.2%	190.3%	143.5%	37.7%	5.0	6.2%	0	5↑	0	nil
Willows Unit	33	148.0%	204.9%	118.5%	223.5%	16.0%	9.1	7.2%	2	2↓	0	nil
ML Mill Lodge	12	96.0%	237.1%	53.2%	196.8%	41.8%	11.9	24.5%	2	1	0	nil
TOTALS									**4**	**7↑**	**0**	

Table 6 - Rehabilitation service safer staffing

19 Mill Lodge remains a hot spot for meeting planned RN levels on nights only 53.2% of the time and has utilised 41.8% of temporary workers to sustain safe staffing levels. The service adopts a staffing model based on a risk assessment of patient acuity and dependency and staff skills and competencies, increasing the number of HCSWs and sharing RN support with Stewart House. A further review of staffing levels at night at Mill Lodge will take place in May 2019, however this may change due to full recruitment to vacancies at the unit.

20 A review of the NSIs and patient feedback has not identified any staffing impact on the quality and safety of patient care/outcomes.

Community Health Services (CHS)

Community Hospitals

Ward	Occupied beds	DAY % of actual vs total planned shifts RN	DAY % of actual vs total planned shifts care HCSW	NIGHT % of actual vs total planned shifts RN	NIGHT % of actual vs total planned shifts care HCSW	Temp Workers%	CHPPD Care Hours Per Patient Day	Vacancy Factor	Medication errors	Falls	Complaints	FFT Promoter % (arrears)
FP General	6	134.6%	89.9%	126.1%	-	25.3%	8.7	31.9%	1↓	2↑	0	100%
MM Dalgliesh	14	99.2%	127.4%	100.0%	177.4%	34.6%	7.7	9.2%	0	0↓	0	91.7%
Rutland	11	107.8%	132.5%	98.3%	103.2%	12.2%	7.3	20.4%	0↓	2↓	0	93.3%
SL Ward 1	12	102.4%	184.7%	91.9%	91.9%	12.3%	11.0	21.9%	0	1↓	0	100%
SL Ward 3	10	92.7%	120.2%	196.8%	106.5%	27.2%	8.6	19.8%	0↓	5↑	0	100%
CV Ellistown 2	19	116.1%	174.2%	193.5%	108.1%	10.5%	7.1	1.2%	0	1↓	0	95.2%
CV Snibston 1	13	112.1%	195.2%	103.2%	138.7%	5.6%	12.1	11.2%	0	3↓	0	83.3%
HB East Ward	18	71.4%	200.0%	100.0%	98.4%	27.3%	7.7	8.7%	0↓	5↑	0	nil

HB North Ward	14	101.6%	187.1%	103.2%	132.3%	27.8%	8.4	8.2%	0	5↑	0	nil
Loughborough Swithland	19	100.0%	196.8%	100.0%	196.8%	11.0%	8.1	20.7%	0	3↓	0	100%
CB Beechwood	18	85.0%	210.9%	100.0%	108.1%	22.6%	9.1	15.3%	0↓	4↑	1	nil
CB Clarendon	17	88.4%	196.0%	100.0%	103.2%	14.3%	7.3	15.5%	2	3↓	0	nil
TOTALS									**3↓**	**34↓**	**1**	

Table 7 - Community hospital safer staffing

21 East Ward remains a hot spot as it only met the planned RN level during the day 71.4% of the time. The ward runs with two RNs on occasion, which meets safer staffing parameters.

22 A hotspot for staffing with increased usage of temporary workforce is Dalgleish Ward with 34.6%, Ward 3 St Luke's Hospital and East Ward Hinckley & Bosworth Community Hospital, with 27.2%-27.8% of temporary workforce being used and Feilding Palmer Hospital with 25.3%, this is due to vacancies and sickness. Staff are moved across the service dependant on skill mix and mix of substantive and temporary staff.

23 A review of the NSIs for the community hospital wards has identified that there has been an increase in medication incidents during April 2019 on Feilding Palmer Ward and North Ward, Hinckley and Bosworth Community Hospital. Ward 3 St Luke's Hospital have had an increase in the number of patient falls from March 2019 to April 2019, however the review has not identified any direct correlation between staffing and impact to quality and safety of patient care/outcomes.

Mental Health Services for Older People (MHSOP)

Ward	Occupied beds	DAY % of actual vs total planned shifts RN	DAY % of actual vs total planned shifts care HCSW	NIGHT % of actual vs total planned shifts RN	NIGHT % of actual vs total planned shifts care HCSW	Temp Workers%	CHPPD Care Hours Per Patient Day	Vacancy Factor	Medication errors	Falls	Complaints	FFT Promoter % (arrears)
BC Kirby	22	80.6%	234.4%	100.0%	112.9%	29.3%	6.0	23.9%	1↑	8↑	0	nil
BC Welford	22	80.0%	246.0%	98.4%	133.9%	28.2%	7.3	16.8%	1↓	3↓	0↓	nil
Coleman	19	64.5%	351.6%	95.2%	237.1%	52.6%	9.2	9.1%	0	10	0	nil
Gwendolen	13	104.8%	396.0%	91.9%	327.4%	26.6%	14.7	23.2%	0↓	9↓	1↑	100%
TOTALS									**2**	**30↓**	**1**	

Table 8 - Mental Health Services for Older People (MHSOP) safer staffing

24 Coleman ward is a hotspot in April 2019 as they achieved the planned RN levels on day shifts 64.5% of the time, the Ward also utilised 52.6% of temporary staff this is associated with increased patient acuity and level 1 observations.

25 The service reported a number of shifts where there was only one RN on duty; Coleman 7 shifts, Gwendolen 8 shifts, Kirby 4 shifts and Welford 3 shifts. This is a red flag for safe staffing. On those occasions support was provided by the adjacent wards following risk

assessment by charge nurses and matrons. A review of the NSIs and patient feedback has not identified any staffing impact on the quality and safety of patient care/outcomes.

26 The service has a rolling recruitment advert for RNs and interviews are scheduled for HCSW on 15 May2019. MHSOP is also developing a peripatetic team to reduce reliance on bank and agency and trialling the role of Mental Health Practitioner on one of the inpatient wards, a Band 6 post open to both nursing and AHPs.

Families, Young People and Children's Services (FYPC)

Ward	Occupied beds	DAY % of actual vs total planned shifts RN	DAY % of actual vs total planned shifts care HCSW	NIGHT % of actual vs total planned shifts RN	NIGHT % of actual vs total planned shifts care HCSW	Temp Workers%	CHPPD Care Hours Per Patient Day	Vacancy Factor	Medication errors	Falls	Complaints	FFT Promoter % (arrears)
Langley	10	94.8%	254.0%	100.0%	235.5%	60.5 %	14.2	0.3%	1↑	0	0	100%
CV Ward 3 - CAMHS	8	150.5%	176.9%	125.5%	135.3%	35.2 %	13.2	11.1%	0	0↓	0	nil
TOTALS									**1↑**	**0↓**	**0**	

Table 9 - Families, children and young people's services safer staffing

27 Both wards continue to utilise an increased number of temporary workers to manage increases in patient acuity and maintain patient safety.

28 A review of the NSIs and patient feedback has not identified any staffing impact on the quality and safety of patient care/outcomes.

Recruitment, Retention and Workforce planning

Recruitment

29 The current Trust wide nurse vacancy position for inpatient wards as reported real time by the lead nurses is detailed below. Staff identified as starters/pipeline, are staff that have been interviewed and in the recruitment process of which may or may not have a start date.

Area	Vacant Posts		Potential Leavers		Starters/Pipeline	
	RN	HCSW	RN	HCSW	RN	HCSW
FYPC	2.0	2.0	0	0	0	3.0
CHS (Community Hospitals)	41	16	1.6	0	7.0	3.0
MHSOP	14.3	5.0	0	1.0	4.0	1.0
AMH/LD	57.01	35.15	3.0	3.0	2.0	4.0
Trust Total April 2019	**114.31**	**58.15**	**4.6**	**4.0**	**13.0**	**11.0**
Trust Total March 2019	115.21	57.2	4.0	1.0	14.61	9.0

Table 10 - Recruitment summary in-patients

30 Rolling adverts for all RN posts including implementation of Trust incentivised schemes for hard to recruit areas. Accessing recruitment fairs at local universities, schools and colleges.

31 Rotational posts across Trust services and graduate frail older people's rotation programme in partnership with UHL

32 Increased work experience placements and increased recruitment of clinical apprentices

Retention

33 There is a Trust wide Retention group with a number of initiatives linked to health and well-being programmes, learning and development, a Trust wide Preceptorship programme for all newly registered staff, leadership and professional development programmes, time out days and career development opportunities.

Workforce planning

34 The government has committed to increasing the number of nursing undergraduate places in the NHS Long Term Plan as the majority of new nurses qualify through pre-registration education. The Trust has submitted an expression of interest to NHS Improvement Workforce to access placement infrastructure funding, to develop plans to grow clinical placement capacity by 25% for the 2019 intake, and support students in practice to reduce attrition and improve retention.

35 The Trust is committed to a local, system wide, partnership approach to ensuring high quality student learning and placement experience. Working collaboratively with providers, including the local acute Trust; University Hospitals of Leicester (UHL) and our HEIs; DeMontfort University, University of Leicester and the Open University working in partnership to acquire a better understanding of attrition factors and interventions to reduce attrition and improve retention.

36 The NHS Long Term Plan seeks to widen access routes to pre-registration nursing including nursing associates. The Trust continue to support training of Nursing Associates and the Trust second staff to complete the Open University nursing course. In addition the Trust new roles development group continue to review new roles, workforce planning methods and commitment to a 'Grow Our Own' strategy.

Part Two

Trust level summary community teams

37 The current Trust wide position for community hot spots as reported by the lead nurses is detailed in the table below.

Community team hot spots	February 2019	March 2019	April 2019
City East CMHT			
Charnwood CMHT			
Mental Health Triage			
City East Hub- Community Nursing	X	X	X
City West Hub- Community Nursing	X	X	X
Charnwood Hub – Community Nursing	X		
Hinckley and Bosworth – Community Nursing		X	X
South Leicestershire CMHT (MHSOP)			
West Leicestershire CMHT (MHSOP)			

City West CMHT (MHSOP)			
Healthy Together – City (School Nursing)	X	X	X
Healthy Together – East	X	X	X
Health Together - West		X	X
Looked After Children team	X	X	X
CAMHS City	X		
CAMHS County	X		
CAMHS Crisis	X	X	X
Eating Disorders	X	X	

Table 11 – Community Hot Spot areas

38 There are 29 community nursing teams that work together in zones called 'hubs'. There are 8 hubs which in the main are made up of 3 nursing teams, who work together and support the patient needs within the geographical location.

There remains a number of vacancies across the community planned care nursing hubs with the two Hubs carrying the largest numbers of vacancies, those being City East and City West. The impact of this is even more significant due to poor bank and agency fill. Hinckley and Bosworth Hub is an emerging hotspot as they have now have four qualified nurses on maternity leave. However Charnwood is no longer a hot spot due to four of the five staff having returned from maternity leave.

A rolling cycle of recruitment remains in place. This is about to be supported, in the city area, with the introduction of the band 5 Retention Prema. In additon a more robust induction programme for all new starters, is being embeded, to support staff to transition in to their new role and teams.

Whilst the transformation and Autoplanner continue to embed, the service is also subject to the on going commissioners community service redesign programme. This has created uncertainty and staff are becoming increasingly unsettled with a number leaving for new opportunities both within and outside of the Trust. The oversight for the impact of this is via weekly staffing meetings, with hubs working in an increasingly collaborative way, with their ICS colleagues, to minimise the affect on direct patient care.

39 Looked After Children team and Healthy Together City (School Nursing only), East and West and CRISIS teams are hot spot areas within FYPC Community; they are rated to be at Amber escalation level due to only 70% of the established team being available to work.

Mitigation plans are in place within the service for moving staff internally where possible, overtime offered and vacant posts are being proactively advertised, locum support recruited to and additional hours in place for existing substantive staff where possible to increase capacity. Risks continue to be monitored internally on a weekly basis.

40 Whilst there are no Adult Community Mental Health Teams identified as hotspots this month, it is noted that staffing remains very tight in both the Crisis Resolution and Home and Mental Health Triage teams, safe staffing is maintained utilising overtime, bank and agency staff.

Recruitment

41 The current Trust wide position for community teams as reported real time by the lead nurses is detailed below.

Area	Vacant Posts		Potential Leavers		Starters/Pipeline	
	RN	HCSW	RN	HCSW	RN	HCSW
CHS – Community Nursing Hubs	14.6	6.74	4.0	0	7.2	0
CHS - ICS	6.4	2.0	5.0	0	0	0
MHSOP	2.8	0	2.0	0	1.0	0
AMH/LD	29.68	6.7	3.0	0	1.0	0
FYPC	17.68	1.0	1.0	0	0	3.0
Trust Total April 2019	**71.16**	**16.44**	**15.0**	**0**	**9.2**	**3**
Trust Total March 2019	**58.64**	**22.64**	**8.7**	**0**	**16.8**	**2.0**

Table 13 - Recruitment summary community

Conclusion

42 The Trust continues to demonstrate compliance with the National Quality Board (NQB) expectations to publish safer staffing information each month. The safer staffing data is being regularly monitored and scrutinised for completeness and performance by the Chief Nurse and reported to NHS England (NHSE) via mandatory national returns on a site-by-site basis. Learning from participation in a number of NHS Improvement (NHSI) development programmes is ongoing.

43 Each directorate has a standard operating procedure for the escalation of safer staffing risks and any significant issues are notified to the Chief Nurse on a weekly basis.

44 In light of the triangulated review of fill rates, nurse sensitive indicators and patient feedback, the Chief Nurse is assured that there is sufficient resilience across the Trust not withstanding some hot spot areas, to ensure that every ward and community team is safely staffed.

Presenting Director: Anne Scott – Interim Chief Nurse
Author(s): Emma Wallis – Associate Director of Nursing and Professional Practice

*Disclaimer: This report is submitted to the Trust Board for amendment or approval as appropriate. It should not be regarded or published as Trust Policy until it is formally agreed at the Board meeting, which the press and public are entitled to attend.

Appendix
Appendix 1 – In-patient Safer staffing supporting information - scorecard

April 2019

Ward Group	Ward name	Average no. of Beds on Ward	Average no. of Occupied Beds	Fill Rate Analysis (National Return) – Actual Hours Worked divided by Planned Hours: Nurse Day (Early & Late Shift) – Average % fill rate registered nurses	Nurse Day (Early & Late Shift) – Average % fill rate care staff	Nurse Night – Average % fill rate registered nurses	Nurse Night – Average % fill rate care staff	AHP Day – Average % fill rate registered AHP	AHP Day – Average % fill rate non-registered AHP	Skill Mix Met (NURSING ONLY)	% Temporary Workers (NURSING ONLY) – Total	Bank	Agency	Overall CHPPD (Nursing and AHP)
				>= 80%	>= 80%	>= 80%	>= 80%	-	-	(based on 1:8 plus 60:40 split) >= 80%	<20%	-	-	
AMH Bradgate	Ashby	20	19	100.5%	129.8%	114.5%	141.9%			92.2%	21.7%	20.3%	1.4%	5.4
	Aston	19	19	91.4%	146.8%	98.4%	229.0%			78.9%	27.2%	24.3%	2.9%	6.2
	Beaumont	22	21	91.9%	141.1%	100.0%	216.1%			83.3%	39.3%	38.5%	0.7%	5.5
	Belvoir Unit	10	10	106.6%	295.1%	190.3%	285.2%			100.0%	52.4%	41.1%	11.3%	17.6
	Bosworth	20	18	88.7%	178.2%	95.2%	174.2%			73.3%	30.7%	30.7%	0.0%	6.2
	Heather	18	18	87.5%	137.1%	91.9%	158.1%			80.0%	24.2%	19.2%	5.0%	6.0
	Thornton	20	18	85.5%	156.5%	100.0%	108.1%			72.2%	25.8%	25.4%	0.4%	5.8
	Watermead	20	20	89.8%	196.0%	100.0%	312.9%			82.2%	33.0%	30.5%	2.5%	7.0
	Griffin Female PICU	5	4	187.1%	475.8%	190.3%	312.9%			92.2%	61.8%	45.5%	16.3%	23.4
AMH Other	HP Phoenix	11	11	97.6%	155.6%	100.0%	153.2%			98.9%	35.5%	33.0%	2.5%	9.0
	SH Skye Wing	31	27	108.1%	155.2%	190.3%	143.5%			95.6%	37.7%	37.5%	0.2%	5.0
	Willows Unit	33	30	148.0%	204.9%	118.5%	223.5%			86.7%	16.0%	16.0%	0.0%	9.1
	ML Mill Lodge (New Site)	14	13	96.0%	237.1%	53.2%	196.8%			54.4%	41.8%	39.6%	2.2%	11.9
CHS City	BC Kirby	24	22	80.6%	234.4%	100.0%	112.9%			66.7%	29.3%	27.7%	1.6%	6.0
	BC Welford	24	22	80.0%	246.0%	98.4%	133.9%			57.8%	28.2%	27.1%	1.1%	7.3
	CB Beechwood	19	18	85.0%	210.9%	100.0%	108.1%	100.1%	96.4%	71.1%	22.6%	14.7%	7.9%	9.1
	CB Clarendon	20	17	88.4%	196.0%	100.0%	103.2%			84.4%	14.3%	7.8%	6.5%	7.3
	EC Coleman	21	19	64.5%	351.6%	95.2%	237.1%			38.9%	52.6%	52.3%	0.3%	9.2
	EC Gwendolen	20	13	104.8%	396.0%	91.9%	327.4%			95.6%	26.6%	26.5%	0.2%	14.7
CHS East	FP General	7	6	134.6%	89.9%	126.1%	-	101.4%	100.0%	68.9%	25.3%	14.7%	10.6%	8.7
	MM Dalgleish	17	14	99.2%	127.4%	100.0%	177.4%	92.9%	99.4%	96.7%	34.6%	33.8%	0.8%	7.7
	Rutland	15	11	107.8%	132.5%	98.3%	103.2%			91.1%	12.2%	10.0%	2.2%	7.3
	SL Ward 1 Stroke	16	12	102.4%	184.7%	91.9%	91.9%	93.7%	99.8%	98.9%	12.3%	9.7%	2.5%	11.0
	SL Ward 3	13	10	92.7%	120.2%	196.8%	106.5%	102.4%	102.4%	90.0%	27.2%	17.8%	9.5%	8.6
CHS West	CV Ellistown 2	24	19	116.1%	174.2%	193.5%	108.1%	98.0%	100.0%	97.8%	10.5%	6.1%	4.4%	7.1
	CV Snibston 1	15	13	112.1%	195.2%	103.2%	138.7%	96.5%	100.4%	96.7%	5.6%	5.0%	0.6%	12.1
	HB East Ward	20	18	71.4%	200.0%	100.0%	98.4%	93.4%	99.4%	42.2%	27.3%	19.8%	7.5%	7.7
	HB North Ward	16	14	101.6%	187.1%	103.2%	132.3%			95.6%	27.8%	16.2%	11.6%	8.4
	Lough Swithland	24	19	100.0%	196.8%	100.0%	196.8%	100.8%	100.6%	100.0%	11.0%	8.1%	2.9%	8.1
FYPC	Langley	13	10	94.8%	254.0%	100.0%	235.5%	100.3%		86.7%	60.5%	59.6%	0.9%	14.2
	CV Ward 3	9	8	150.5%	176.9%	125.5%	135.3%	113.8%		93.3%	35.2%	30.3%	4.9%	13.2
LD	3 Rubicon Close	4	3	95.2%	185.7%	67.7%	161.3%			87.8%	25.7%	25.7%	0.0%	19.7
	Agnes Unit	12	8	170.0%	763.3%	134.8%	669.6%			100.0%	51.2%	46.5%	4.6%	34.5
	The Gillivers	5	4	100.0%	166.2%	67.7%	151.6%			77.8%	16.9%	16.9%	0.0%	18.8
	The Grange	5	3	-	166.7%	-	196.8%			98.9%	13.1%	13.1%	0.0%	20.7
Trust Total				**104.9%**	**216.0%**	**107.6%**	**194.5%**			**83.6%**	**30.9%**	**27.4%**	**3.5%**	

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Leicestershire Partnership NHS Trust

Care Quality Commission Update_10th May 2019

1.1 The Trust responded to the weaknesses identified in the 2018/19 CQC inspection report and warning notice by developing an action plan and strengthening the governance arrangements for the oversight and scrutiny of progress. The Warning Notice action plan has been appended.

1.2 The RaG rating applied to the action plan indicates which actions have been completed and do not need further work (Green) and those where work is on-going (Red).

1.3 Status as at 10/05/19

Warning Notice theme	Complete	On-going	Total
Access to treatment	1 (17%)	5 (83%)	6
Mixed Sex Accommodation	8 (89%)	1 (11%)	9
Environmental issues	1 (33%)	2 (67%)	3
Risk assessments	1 (17%)	5 (83%)	6
Fire safety	5 (71%)	2 (29%)	7
Medicines management	5 (83%)	1 (17%)	6
Seclusion environments and paperwork	5 (71%)	2 (29%)	7
Physical healthcare	3 (60%)	2 (40%)	5
Governance	2 (50%)	2 (50%)	4

1.4 Progress is being made against the warning notice action plan (see appendix A).

Last month (as at 26th April 2019) four of the nine themes had 70% or more actions completed. The remaining five themes were less than 50% complete The Trust reviewed these on the 3rd May 2019 to identify and resolve any barriers to completion. Additional resource has been identified to support internal staff with the completion of actions. An external senior mental health nurse will be supporting the smoke free agenda and additional areas as required.

Since the last update, some actions have been merged, deleted or had new actions included, therefore there is no direct comparison available to demonstrate progress between the 26th April and the 10th May 2019.

Currently (as at 10th May 2019) six of the nine themes have 50% or more actions completed. The remaining three are less than 50% complete.

The Trust is currently designing a programme of spot check work to ensure that change resulting from the action plan has had the right impact, and has resulted in sustainable improvement (see appendix B). Examples of impact have been included, along with results of audit / spot checking.

Appendix A. Phase 1: Warning Notice Action Plan (as at 10/05/19)

Ref No:	Subject	Service	Area	Regulatory Warning	Improvement/ Objective	Action	Achievement to Date	Approving Committee	Status and RaG Rating
W1	Access to Treatment	FYPC	CAMHS Access Treatment and Neurodevelopmental Specialist Assessment	Access to treatment for specialist community mental health services for children and young people	Ensure patient waiting times for assessment and treatment meet commissioned targets and the NHS constitution for children and young people.	Agree a trajectory and resourcing model to deliver significant improvement and increase capacity for assessment and treatment including neurodevelopmental specialist assessment	Demand and capacity modelling complete. Additional £315k secured from commissioners to end March 2019. Approved and funded additional 18 WTE by 4th March. Agreed targets for 27th May and trajectories for achievement of 18 week wait with ET on the 11.03.2019. Funding for 2019/20 fyr agreed @ c. £1.5m Access waiting list: 04/02/19 was 556 at 03/05/19 its 256 Average access wait: 11/03/19 was 22weeks at 03/05/19 its 10 weeks Over 30week wait for access: 04/02/19 was 239 at 03/05/19 its 10 Treatment waiting list No's (inc. ND): 04/02/19	FYPC Sustainability meeting	R

							was 1042 at 03/05/19 its 1076 Average treatment wait (inc. ND): 04/02/19 was 31weeks at 03/05/19 its 20 weeks Waiting for ND specialist assessment: 04/02/19 was 452 at 03/05/19 its 485 Waiting over 12 months for ND specialist assessment: 11/03/19 was 202 at 03/05/19 157 Average wait for ND specialist assessment: 11/03/19 was 47weeks at 03/05/19 its 30 weeks Trajectories agreed for 18week wait achievement by; Access May 2019 Treatment Aug 2021 Neurodevelopmental Dec 2020		

W2	Access to Treatment	FYPC	CAMHS Access Treatment and Neurodevelopmental Specialist Assessment	Access to treatment for specialist community mental health services for children and young people	Ensure patient waiting times for assessment and treatment meet commissioned targets and the NHS constitution for children and young people.	Implement robust governance arrangements to manage reduction in number of children and young people waiting.	Daily PTL in place led by Assistant Director and Head of Service with dedicated information analyst support. Twice weekly ND PTL meeting in place led by Head of Service. Overview of progress monitored at FYPC Sustainability Meeting. Reviewed service offer and capacity expectations on clinicians with outstanding neighbouring CAMHS provider.	FYPC Sustainability-Meeting	G
W3	Access to Treatment	FYPC	CAMHS Access Treatment and Neurodevelopmental Specialist Assessment	Access to treatment for specialist community mental health services for children and young people	Ensure patient waiting times for assessment and treatment meet commissioned targets and the NHS constitution for children and young people.	Ensure staffing establishment is sufficient to meet trajectory requirements in regard to specialist skills and capacity	Locum clinicians and additional sessions/hours from LPT staff. Process started 08/02/19 Adverts out for permanent nursing staff with an ETA end of May 2019. 5 nursing staff, additional psychologist staff for ND work, three support workers to increase group work, new service manager and two clinical leads	FYPC Sustainability Meeting	R

							appointed awaiting pre-employment checks. Impact: Increased access clinic capacity from c. 35 per week slots to c. 75, with 180 appointments completed in Access Week w/c 8/4/19. See above reductions in numbers of C&YP waiting and average length of wait for access and treatment. Access Waiting list has reduced to 256 (target of 252 by 27/05) . Locum resource in Access to be reallocated to support CAMHS Crisis Team		
W4	Access to Treatment	FYPC	CAMHS Access Treatment and Neurodevelopmental Specialist Assessment	Access to treatment for specialist community mental health services for children and young people	Ensure patient waiting times for assessment and treatment meet commissioned targets and the NHS constitution for children and young people.	Secure additional capacity from sub-contracted partner for neurodevelopmental specialist assessments.	Due diligence process undertaken awaiting feedback on clarification questions by 26/4/19. Waiver form completed by Head of Service. IG governance processes being finalised for contract sign-off by CEO w/c 6/5/19. Due diligence process complete pending second reference.	FYPC Sustainability meeting	R

							Waiver submitted to procurement team. IG sign-off complete. Specification development for procurement for October to December service provision underway.		
W5	Access to Treatment	FYPC	CAMHS Access Treatment and Neurodevelopmental Specialist Assessment	Access to treatment for specialist community mental health services for children and young people	Ensure patient waiting times for assessment and treatment meet commissioned targets and the NHS constitution for children and young people.	Progress large scale change programme to maximise longer term sustainability of service.	CAMHS Improvement Board 2018/19 project end report completed and signed off by FYPC Sustainability meeting 18/4/19. 2019/20 improvement priorities agreed at FYPC Sustainability Meeting 18/4/19 for CAMHS operational management team to take forward alongside senior leadership team support for access work. CAMHS Improvement Team meeting scheduled for 13th May 2019. 1. Clinical Pathways 2. Discharge Pathways 3. Crisis Improvement 4. ND Pathway 5. Routine Outcome Measures 6. Estates 7. Leadership	FYPC Sustainability meeting	R

							Developments 8. Geographical Alignment Family Service Manager recruited on 5th April 2019 Advert issued for second Family Service Manager Associate Medical Director recruitment panel scheduled for 14th May 2019		
W6	Access to Treatment	FYPC	CAMHS Crisis	Access to treatment for specialist community mental health services for children and young people	The specialist community mental health services for children and young people crisis team to meet their commissioned target to telephone patients within two hours and assess them within 24 hours	Review of existing systems and processes to identify opportunities for improvement and implement changes	Improvement plan in place led by Head of Service including action progressed on; increasing staffing with locum and recruitment, change in leadership, scheduling, review of KPIs with commissioners and improved data validation, process redesign and protocols to support staff for 2 hour and 24 hour contacts. New processes to be implemented to help Crisis Team meet 2 hour and 24 hour KPI targets. Structured scheduling of appointments to have	FYPC Sustainability meeting	R

							sufficient assessment slots available each day and coverage on telephone triage at all times- (new structure to be implemented and trialled later this week 08/05/19) New referral script has been reviewed and agreed by team when receiving referrals. The new script is being used this week to allow the service to receive sufficient information on all referrals and ascertain whether the referral is appropriate for the service. Additional locum support to increase capacity to offer assessments. Additional Locum support to offer 2 assessments per day on top of teams current capacity.		

W7	Maintaining the privacy and dignity of patients and concordance with mixed sex accommodation	AMHLD	Short Breaks	Mixed sex breaches	Cease mixed sex breaches by maintaining male and female weeks and not accepting emergency patients / accommodating family preferences	Liaison with families and re-booking patients who will breach male and female weeks	All pre-booked breaks have been rebooked to ensure no breaches. Process in place to ensure new bookings will not breach. No breaches since 11th February 2019. All families informed of changes. Monitoring of compliance is standing agenda item at LD quality and safety meeting. Programme of ongoing spot checks underway. Change sustained and reviewed at April LD Governance meeting.	LD Business and Governance Meeting	G
W8	Maintaining the privacy and dignity of patients and concordance with mixed sex accommodation	AMHLD	Short Breaks	Mixed sex breaches	Cease mixed sex breaches by maintaining male and female weeks and not accepting emergency patients / accommodating family preferences	Revise the SOP for emergency requests for short breaks.	SOP revised to eliminate mixed sex breaches in an emergency. SOP communicated to staff and made available for reference.	LD Business and Governance Meeting	G

W9	Maintaining the privacy and dignity of patients and concordance with mixed sex accommodation	AMHLD	Short Breaks	Mixed sex breaches	Cease mixed sex breaches by maintaining male and female weeks and not accepting emergency patients / accommodating family preferences	Not admitting patients in an emergency that will breach mixed sex guidelines.	All staff informed of revised SOP regarding action to take in the event of any emergency admission requests. Printed version of SOP available on relevant wards for information. Checks so far identify SOP being followed. No breaches since 11th February 2019. Change sustained and reviewed at April LD Governance meeting.	LD Business and Governance Meeting	G
W10	Maintaining the privacy and dignity of patients and concordance with mixed sex accommodation	AMHLD	Short Breaks	Mixed sex breaches	Cease mixed sex breaches by maintaining male and female weeks and not accepting emergency patients / accommodating family preferences	Communicate the revisions to practice to families, with clear rationale.	Letter distributed to all relevant families. No complaints have followed.	LD Business and Governance Meeting	G
W11	Maintaining the privac	AMHLD	Short Breaks	Mixed sex breaches	Cease mixed sex breaches by maintaining male and female	To notify CCG Commissioning Lead of change in process with	CCG Commissioning Lead notified of change in process by email on 06.02.2019. CCG	AMH.LD All Day Business Meeting	G

	y and dignity of patients and concordance with mixed sex accommodation				weeks and not accepting emergency patients / accommodating family preferences	immediate effect.	confirmed support by email on 06.02.2019.		
W12	Maintaining the privacy and dignity of patients and concordance with mixed sex accommodation	AMHLD	Bradgate Unit	Mixed sex breaches	Strengthen the process for agreeing a clinically required breach of mixed sex guidelines	Revise the bed management SOP.	Bed management SOP drafted. First draft revised and piloted in April 2019. Feedback from Bed Management Team, on call Manger and Directors led to further revisions of SOP. Now with Executive Team for approval, week commencing 6th May 2019.	AMH.LD All Day Business Meeting	G
W13	Maintaining the privacy and dignity of patien	AMHLD	Bradgate Unit	Mixed sex breaches	Strengthen the process for agreeing a clinically required breach of mixed sex guidelines	Confirm the internal and external reporting of mixed sex breaches	Agreed with commissioners that we will externally report on all breach types - justified and unjustified. Regarding internal reporting, the IQPR includes reports of ALL	Trust PCEG	G

	ts and concordance with mixed sex accommodation						breaches – not just sleep breaches.		
W14	Maintaining the privacy and dignity of patients and concordance with mixed sex accommodation	AMHLD	Bradgate Unit	Mixed sex breaches	Strengthen the process for agreeing a clinically required breach of mixed sex guidelines	Review and amend the Trust Policy on Same Sex Accommodation.	Policy currently being drafted to take to 15th May 2019 Clinical Effectiveness Group and then QAC 21st May 2019 for adoption.	Trust CEG	R

W15	Maintaining the privacy and dignity of patients and concordance with mixed sex accommodation	AMHLD	Cedar & Acacia Wards - The Willows	Mixed sex when accessing laundry room	Walk by mixed sex breaches will not occur as a result of accessing laundry facilities.	To establish clear practice guidance on the use of laundry facilities by males and females at the Willows	As an interim measure on Cedar and Acacia, male patients accessed the laundry facilities using an alternative entrance or used the facilities on Sycamore which is male only. Communications were sent to staff and patients. Following consultation with patients, Acacia Ward has subsequently been turned into an all-female ward. Acacia Ward is now female only so the laundry issue is no longer relevant. Regarding the planning, communication and service user consultation this included: • 3 – 5 April 2019 - Staff feedback questionnaire completed on same sex accommodation • 16 April 2019 – Meeting with senior team including team leaders to discuss the move and plan how to inform staff and patients • 16– 19 April 2019 – Staff teams informed of the move by team	AMH.LD All Day Business Meeting	G

							leaders • 23 April 2019 – Patients informed of ward changes by the Head of Nursing and team leaders. • 25 April 2019 – Patients in Acacia ward round asked by their consultant about their feelings regarding the change		
W16	Environmental Issues	AMHLD	Repairs maintenance and cleaning	Repairs maintenance and cleaning	Establish a co-ordinated and responsive repairs and maintenance process to quickly address and resolve issues promptly	All outstanding repairs and maintenance issues highlighted within the regulatory notices will be fixed and resolved	All repairs and maintenance issues highlighted within the regulatory notices have been fixed or resolved, with the exception of providing alternative bedroom furniture to three wards that can be safely fixed to the walls. All new wardrobes for Ashby & Bosworth Wards will be installed by 31st May 2019. Thornton Ward wardrobes have been ordered and will be replaced from May	AMH.LD All Day Business Meeting	R

							2019. Aston ward broken bedside cabinets replaced from May 2019. Stewart House - All doors have now been replaced. - The tile in the OT kitchen has been replaced. BMHU - Ashby windows have all been replaced and has all new lighting in place. - Bosworth's lighting has been replaced. - Aston & Thornton have had all of their 'high absconsion risk' windows replaced. The remaining windows are scheduled to be replaced during the refurbishment of the wards (Q2 2019). All lighting checked and those not working have been reported to estates. Upgrade to lighting planned as part of refurbishment works Q2 2019.		

W17	Environmental Issues	AMHLD	Repairs maintenance and cleaning	Repairs maintenance and cleaning	Establish a co-ordinated and responsive repairs and maintenance process to quickly address and resolve issues promptly	Appoint two new Property Managers to coordinate repairs and maintenance.	Two Property Managers appointed and awaiting start dates (one confirmed as 20/05/19 and the other to be arranged for beginning of June 2019). Interim Building and Security Manager providing support for Acute / Forensic and Rehab Inpatient Units until end May 2019.	AMH.LD All Day Business Meeting	G
W18	Environmental Issues	AMHLD	Repairs maintenance and cleaning	Repairs maintenance and cleaning	Establish a co-ordinated and responsive repairs and maintenance process to quickly address and resolve issues promptly	To strengthen our internal governance arrangements and clarify the escalation process for unsatisfactory delays	This is managed by the Buildings and Security Manager (BSM) for acute, forensic and rehab until recruitment completed for substantive property managers in all areas. Escalation will be either directly to the on-site maintenance staff or to the Property Officer. • Confirmed current maintenance reporting route into Helpdesk with cc to BSM to ensure oversight and tracking. • BSM oversees a maintenance log for each ward and keeps track on response (escalation) and completion in conjunction with Estates Manager.	AMH.LD All Day Business Meeting	R

							• BSM receives updates on local improvement works / new works each ward area is progressing. • BSM is planning an AMH Inpatients 2019/2020 Programme of New Works in conjunction with Estates. Rehab: Locally agreed process of a log being held by receptionists at each area. Staff report any estates or works issues to the receptionist who will log it as a job, obtain a job number and will update when completed. Admin manager reviews every week and chases outstanding issues as well as bringing to monthly admin meeting.		
W19	Risk Assessment	AMHLD	Ligature risk assessments	Ligature risks and learning	Ligature risk assessments to be tailored and include actions. To ensure that systems and processes are in place to enable timely and adequate response to	Head of Health and Safety will co-ordinate the completion of a physical review of all ligature risk assessments across BMHU and Rehab	Maple Ward: Football table has now been moved to the recreation room which patient's only access under staff supervision as this is a locked area. Stewart House Dining Room: The ligature risk assessment has been	Trust Health and Safety Meeting	G

					actions		reviewed and updated with appropriate controls for all unlocked patient areas		
W20	Risk Assessment	AMHLD	Ligature risk assessments	Ligature risks and learning	Ligature risk assessments to be tailored and include actions. To ensure that systems and processes are in place to enable timely and adequate response to actions	Ward sister / charge nurses will ensure there is a ward based clinical mitigation plan in place for each of the risks identified	All ward ligature risk assessments reviewed with Health and Safety Staff, Ward Sisters and Matrons. Ligature risk assessments including ward mitigations for any ligature risks available on wards from 04/04/19. All Ward Sisters/ Charge Nurses sent Ligature Risk Summary to complete to ensure easy guide for current and new/ bank staff to be discussed at all handovers. Spot checks to commence week beginning 6th May 2019 to ensure staff are aware of ligature risk assessments, ligature summary is in place and used in handover.	AMH.LD Health and Safety Meeting	R
W21	Risk Assessment	AMHLD	Ligature risk assessments	Ligature risks and learning	Ligature risk assessments to be tailored and include actions. To ensure that systems and processes are in	Ward sister / charge nurses will ensure that the ligature risks for each individual patient is assessed through the risk assessment process	MDT to review individual risk assessments to identify if individual ligature care plans are required and complete care plans.	Local Business and Governance meetings	R

					place to enable timely and adequate response to actions	and where required a person centred ligature care plan is in place	Spot checks to commence week beginning 6th May 2019 to ensure that MDT are reviewing individual patients and creating ligature care plans if required.		
W22	Risk Assessment	AMHLD	Ligature risk assessments	Ligature risks and learning	Ligature risk assessments to be tailored and include actions. To ensure that systems and processes are in place to enable timely and adequate response to actions	Head of Health and Safety will ensure that all of the ligature risks identified through the risk assessment are collated on a central database.	All AMHLD Inpatient ligature risk assessments have been reviewed and uploaded onto Ulysses along with ward mitigation plans.	Trust Health and Safety Meeting	R
W23	Risk Assessment	AMHLD	Ligature risk assessments	Ligature risks and learning	Ligature risk assessments to be tailored and include actions. To ensure that systems and processes are in place to enable timely and adequate response to actions	To introduce a RAG rating for each room on the Bradgate Unit wards to support staff in knowing which rooms have fixed ligature points.	Pilot of colour coded chart on Ashby Ward complete - feedback from staff 08.04.19. This is a visual display board to provide an at a glance display to keep people ligature aware and to quickly identify 'hot spots'. It also identifies the locations of the ligature cutters. Agreement that the trial has worked and will be implemented across the other AMH wards by 17th May 2019.	Trust Health and Safety Meeting	R

W24	Risk assessment of patients	AMHLD	Rehabilitation	Risk assessments are not fully completed and not updated following incidents.	To ensure risk assessments are robust and completed and updated following incidents.	To ensure risk assessments are robust and completed and updated following incidents.	Risk assessments are routinely updated following incidents due to greater oversight by the Ward Sisters/Charge Nurses. Further work being undertaken by a Task and Finish Group to embed good risk assessment practice in rehab services. PDSA started on Maple Ward - to embed into routine practice and transfer learning.	AMH.LD All Day Business Meeting	R
W25	Fire Safety Issues	AMHLD	Smoking cessation	Safe evacuation in the event of a fire	To provide clear guidance to staff and patients on alternatives to smoking and maintain safe, cleaner and healthy environment	AMH Head of Service to review the Smoke Free Policy to ensure clarity for staff and patients about expectations	Updated policy going to the LPT Smoke Free Action Group 14/05/19 and CEG for approval on 15/05/19. The policy now includes detail re vaping only being permitted in the unit gardens and Section 17 arrangements.	Trust Health and Safety Meeting	R
W26	Fire Safety Issues	AMHLD	Smoking cessation	Safe evacuation in the event of a fire	To provide clear guidance to staff and patients on alternatives to smoking and maintain safe, cleaner and healthy environment	Explore options to improve communication about Smoke Free via website / leaflets / signage	New No Smoking posters for internal signage designed and approved by LPT Smoke Free Action Group on the 15/04/19. Posters being distributed week beginning 20/05/19.	Trust Health and Safety Meeting	R

W27	Fire Safety Issues	AMHLD	Smoking cessation	Safe evacuation in the event of a fire	To provide clear guidance to staff and patients on alternatives to smoking and maintain safe, cleaner and healthy environment	Head of Estates to organise the removal of discarded cigarette ends within the courtyard areas of all inpatient services.	BMHU ward garden clean up completed on 18/04/19. On-going spot checks are in place.	Trust Health and Safety Meeting	G
W28	Fire Safety Issues	AMHLD	Evacuation Multiple Areas	Safe evacuation in the event of a fire	Safe evacuation in the event of a fire. Disabled patients will have a personal emergency escape plan in the event of fire	Fire Safety Management Policy to be revised to include information about General Emergency Evacuation Plan and Personal Emergency Evacuation Plan	Fire Safety Management Policy revised. Agreed by H & S Committee and adopted by QAC in March 2019.	Trust Health and Safety Meeting	G
W29	Fire Safety Issues	AMHLD	Evacuation Multiple Areas	Safe evacuation in the event of a fire	Safe evacuation in the event of a fire. Disabled patients will have a personal emergency escape plan in the event of fire	Ward Sister to send AMH PEEP and guidance sheet to all Ward Sister/charge nurses and to be point of contact for any queries. To flag those patients with a PEEP on nursing handover	All current disabled patients have a PEEPS in place. The need for a PEEP has been added to the admission check list and handover agenda. Email and attachment sent to all AMH/LD Ward Sisters/Charge Nurses and process is consistent across the Directorate. System of spot checks in place.	Trust Health and Safety Meeting	G

W30	Fire Safety Issues	AMHLD	Evacuation Multiple Areas	Safe evacuation in the event of a fire	Safe evacuation in the event of a fire. Disabled patients will have a personal emergency escape plan in the event of fire	A flag to be introduced into SystmOne to identify patients who require a PEEP.	SystmOne will be in use by 2020. Interim measure includes a PEEP risk assessment on RiO. Completed.	Trust Health and Safety Meeting	G
W31	Fire Safety Issues	AMHLD	Evacuation Multiple Areas	Safe evacuation in the event of a fire	Safe evacuation in the event of a fire. Disabled patients will have a personal emergency escape plan in the event of fire	All disabled patients who require a greater level of support than the standard horizontal fire evacuation procedures admitted to an acute, rehab or PICU ward will have a PEEP.	All disabled patients at the Bradgate Unit and the Rehab Wards now have a PEEP in place.	Trust Health and Safety Meeting	G
W32	Medicines Management	AMHLD	Multiple Areas	Medicine management	Strengthen medicines management systems and processes to comply with standards and policy	Head of Pharmacy to contact a Head of Pharmacy in an outstanding Trust to establish a different approach to medication labelling for start/ end/ do not use after/ medications	Complete new labelling to be implemented in March 2019. Date opened labels due for despatch on 21st March 2019. • New product labels developed with Midco – delivered 21/03/2019 • All appropriate products to be pre-labelled via Hospital Pharmacy – Implementation 25/03/2019 • LPT Pharmacy dispensary guidance developed and team briefed on new requirements -	MMRSG	G

							25/03/2019 • Good practice guide for wards (poster) developed and distributed by email / hard copy for clinic rooms - 05/04/2019 • Initial spot check at the Bradgate unit showed 100% completion of date opened on new labels where in use.		
W33	Medicines Management	AMHLD	Multiple Areas	Medicine management	Strengthen medicines management systems and processes to comply with standards and policy	Head of Pharmacy to review current process and equipment for medication returns to Pharmacy	Current process reviewed and alternative medication returns bins have been ordered for each inpatient ward funded from ward medication budget. Confirmation bins have been ordered received on 14th March 2019. • Product research complete and solution identified (iBIN) – 05/03/2019 • Order placed with supplier / goods received – 12/04/2019 • Standard operating procedure developed and implemented (attached to iBIN) – 16/04/2019 • Portering leads	MMRSG	G

							briefed on requirement – 16/04/2019 • iBINs distributed to all inpatients wards – 17/04/2019 • Inpatient comms sent to all users – 17/04/2019		
W34	Medicines Management	AMHLD	Multiple Areas	Medicine management	Strengthen medicines management systems and processes to comply with standards and policy	Head of Pharmacy to establish improvement in the safe administration and recording of controlled drugs (CD).	To reduce human error, a computerised CD register and administration support system will be implemented which links with the Trust's current Prescription tracker system. E-CD registers being piloted on 3 wards at the Bradgate from 7th May and will roll out to all wards reviewed by CQC from the week after if pilot raises no problems.	MMRSG	R

W35	Medicines Management	AMHLD	Multiple Areas	Medicine management	Strengthen medicines management systems and processes to comply with standards and policy	Head of Pharmacy to improve safe storage of medication in ward clinic rooms at the Bradgate Unit. Two Assistant Pharmacy Technicians (Band 3) will be employed to check medication storage, ensure cleanliness and support pharmacy requests and deliveries	2 internal candidates have started a 12 month secondment starting on 7th May 2019.	MMRSG	G
W36	Medicines Management	AMHLD	Multiple Areas	Medicine management	Strengthen medicines management systems and processes to comply with standards and policy	Head of Nursing for AMH and Head of Pharmacy, in the interim period of the above actions a safe storage and administration of medication briefing will be issued and Ward Sisters/ Charge Nurses will take responsibility for a weekly check of ward Clinic rooms	Briefing by Medication newsletter developed and sent to all senior nurses for distribution within their teams confirming processes and policies. Checks of ward clinic rooms added to new environmental ward checks and signed off by Ward Sister/ Charge Nurse commenced 15.04.19.	MMRSG	G
W37	Medicines Management	AMHLD	Multiple Areas	Medicine management	Strengthen medicines management systems and processes to comply with standards and policy	Matron to identify Band 6 Registered Nurses at Stewart House and Willows, to take responsibility for medication management procedures with support from	Band 6 Registered Nurses identified at Stewart House and The Willows.	MMRSG	G

						Pharmacy.			
W38	Seclusion environments and seclusion paperwork	AMHLD	All inpatient areas with seclusion areas	Seclusion paperwork/ process	Seclusion paperwork/ process Ensure compliance with the Seclusion Policy and the Mental Health Act Code of Practice	Head of Nursing for AMH put in place an initial action plan following the MHA and CQC inspection in November 2018: Confirm the current Seclusion Policy and seclusion documentation is being used in the Willows Rehabilitation Unit	New packs of up to date seclusion paperwork implemented on the 4th December 2018.	Trust Patient Safety Group	G
W39	Seclusion environments and seclusion paperwork	AMHLD	All inpatient areas with seclusion areas	Seclusion paperwork/ process	Seclusion paperwork/ process Ensure compliance with the Seclusion Policy and the Mental Health Act Code of Practice	Review the current assurance process for seclusion documentation to ensure it is fit for purpose	Reviewed with Ward Sisters/ Charge Nurses and Team Managers at Positive and Safe Meeting 29.11.18. Confirmed monitoring and assurance process for approval of seclusion documentation at Patient Safety Group in May 2019 then to QAC in May 2019 for adoption.	Trust Patient Safety Group	G

W40	Seclusion environments and seclusion paper work	AMHLD	All inpatient areas with seclusion areas	Seclusion paperwork/ process	Seclusion paperwork/ process Ensure compliance with the Seclusion Policy and the Mental Health Act Code of Practice	Head of Nursing for AMH to review Seclusion Policy including the recording process and documentation for incidents of seclusion – test of policy/ documentation prior to sign off	Meetings held with senior clinical staff to review and revise policy and documentation. Pilot of new forms ended on 18/04/19. This has taken a PDSA approach now and learning from the new forms on 25th April 2019 at the Trust wide Positive and Safe meeting has led to further revisions and additions to the policy. The draft policy will be circulated on week commencing 6th May 2019 and approved at PSG on 15 May 2019. To be taken to QAC for adoption in May 2019.	Trust Patient Safety Group	R
W41	Seclusion environments and seclusion paper work	AMHLD	All inpatient areas with seclusion areas	Seclusion paperwork/ process	Seclusion paperwork/ process Ensure compliance with the Seclusion Policy and the Mental Health Act Code of Practice	Matrons to complete a review of all seclusions and documentation 1 month after the implementation of the new policy and documentation	Anticipated date of implementation of policy and forms is May 2019, full review scheduled for June 2019. The service has completed one PDSA cycle with the forms, now planning in the second.	Trust Patient Safety Group	R
W42	Seclusion environments and seclus	AMHLD	Rehab Wards	Seclusion Facilities	Ensure seclusion policy includes adequate seclusion room checks	Ensure seclusion policy includes adequate seclusion room checks will be included in the action above related	Guidance on room checks re-confirmed to rehabilitation wards and is included in policy review.	Trust Patient Safety Group	G

	ion paper work					to the Seclusion Policy review			
W43	Seclusion environments and seclusion paper work	AMHLD	Rehab Wards	Seclusion Facilities	Ensure seclusion policy includes adequate seclusion room checks	Ensure sink fittings identified in Acacia ward seclusion room as a ligature and safety hazard are replaced	New anti-ligature sink fitted on 18th April 2019.	AMH.LD All Day Business Meeting	G
W44	Seclusion environments and seclusion paper work	AMHLD	Rehab Wards	Seclusion Facilities	Ensure seclusion policy includes adequate seclusion room checks	Re-sealing of flooring in Maple ward seclusion room by estates	Floor resealed.	AMH.LD All Day Business Meeting	G
W45	Physical Health care	AMHLD	Bradgate and PICU	All patients admitted to Rehabilitation Wards will have a physical health examination	All patients admitted to Rehabilitation Wards will have a physical health examination	Matrons to confirm the correct checking process is in place for equipment and the Trust calibration schedule includes the equipment	Equipment is held on the Trust central database and there is an annual service check of this equipment by a specialist company. Ward staff complete weekly checks outside of this annual check. The checks are signed off by the Ward Sister/ Charge Nurse weekly and a brief compliance report with any actions will go to the Inpatient Governance meeting.	Ward Sisters meeting	G

W46	Physical Health care	AMHLD	Rehabilitation area	Physical health needs will be met in partnership with primary care/Ensure patients privacy and dignity is maintained when receiving physical health observations	All patients admitted to Rehabilitation Wards will have a physical health examination	Consultant and ward sister / charge nurse to review the current admission process to ensure all patients receive a physical health examination by a doctor on admission to rehabilitation wards and nursing staff complete the cardio-metabolic physical health form. Establish a monitoring process to ensure compliance	Admission checklist amended to include: • Nursing staff to carry out baseline observations. • Full Physical examination (Completed by medical staff) • Cardio metabolic Form (Completed by Mauro Silva) Completed admission checklist's are submitted to ward sisters to check before scanned onto RIO. Email sent to all staff informing them of change to admission checklist and was discussed in Stewart House staff meeting on the 14.03.19 RGN identified to review all patients at The Willows to ensure that they have had a Physical Health examination on admission, baseline observations have been recorded and all patients have Physical Health Care Plans in place and all long Term Conditions are reviewed/monitored	Rehab Business and Governance Meeting	G

							appropriately Email sent from Ward Sisters to all staff informing them of change to the Admission Checklist.		
W47	Physical Health care	AMHLD	Rehabilitation area	Physical health needs will be met in partnership with primary care/Ensure patients privacy and dignity is maintained when receiving physical health observations	All patients admitted to Rehabilitation Wards will have a physical health examination	Most current physical health examinations are being recorded in the RIO progress notes: Head of Nursing for AMH to resolve the RIO EPR technical glitch which occurs when Doctors try to complete the physical health form within the core MH assessment	The RiO software fix has been completed at the Willows and Stewart House. There is a piece of work being undertaken with clinical staff and HIS to rectify a residual issue with the template on RiO. In the interim a contingency plan has been developed for implementation – word form used as a template for patient notes.	IT group	R
W48	Physical Health care	AMHLD	The Willows	Ensure patients privacy and dignity is maintained when receiving physical health observations	Physical health needs will be met in partnership with primary care	Matron will ensure the Willows recruit 0.2 WTE RGN to work alongside the GP once a week to run clinics and focus on physical health care planning and health promotion	Stewart House now has an RGN in post who dedicates one day a week to focus on individualised physical health care plans	AMH.LD All Day Business Meeting	G

W49	Physical Healthcare	AMHLD	Ward Areas	Ensure patients privacy and dignity is maintained when receiving physical health observations	Ensure patient's privacy and dignity is maintained when receiving physical health observations	Ward Sisters/ Charge Nurses to establish clear written guidelines for where and how physical health observations are completed on their wards and how any exemptions to the guidelines are recorded: Guidelines to be approved by the Matrons	Bradgate now has clear written guidance, to be shared with Rehab Guidance poster on wards for staff and checks on practice to commence week starting 6th May 2019.	AMH.LD All Day Business Meeting	R
W50	Governance	Governance	Well-Led	Not always focused on the most important aspects of quality / issues	Objective Governance - Not always focussed on the most important aspects of quality / issues	Commission external reviews of governance arrangements to support the ET review of corporate governance	Two external governance reviews have been commissioned and undertaken. - A review of the governance and assurance processes for the delivery of the 2017 CQC actions published in the 2018 CQC report presented to Board in April 2019. - An examination of processes and procedures within LPT for reporting, investigation and learning from serious incidents requiring investigations. Presented to the Board in May 2019.	Executive Team Meeting	G

							Both authors of these reports have been contracted to work with the Trust to support the implementation of actions.		
W51	Governance	Governance	Well-Led	Not always focused on the most important aspects of quality / issues	Objective Governance - Not always focussed on the most important aspects of quality / issues	Heads of Service to review the systems and processes in place to share information and learning to and from front-line to Directorate level and ensure effective oversight of workforce, finance, performance and quality and safety	Heads of Service have reviewed governance processes for all services with Clinical Governance Lead. Proposal developed to review governance meetings structures and to align services to review quality and safety and share lessons learned. Terms of reference to be written.	AMH.LD All Day Business Meeting	R
W52	Governance	Governance	Well-Led	Not always focused on the most important aspects of quality / issues	Objective Governance - Not always focussed on the most important aspects of quality / issues	NHSI advocated a Director to work part time for the Trust. Recruit a new acting Associate Director focussed on remedial improvement. Recruit a Deputy Nursing Lead for in-patient services	NHSI appointed Director has started. A Deputy Nursing Lead for AMH being recruited. National advert out week commencing 23/04/19. Interim support via contract with an external Senior Nurse arranged from 1st May 2019. Head of Patient Safety in post.	AMH.LD All Day Business Meeting	R

W53	Gover nance	Governa nce	Well-Led	Not always focused on the most important aspects of quality / issues	Communications. Engage with staff well	Head of Communications to develop a central communications plan. Planning for communication with staff through forums to occur for the week of the 4th March 2019.	CQC briefing sent to all staff. Directors attended staff forums in all areas	AMH.LD All Day Business Meeting	G

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Leicestershire Partnership NHS Trust

Trust Board – 23rd May 2019

LPT Zero Ambition for Suicides of Inpatients

Introduction

1. Leicester Partnership Trust's (LPT) philosophy is that suicide is not inevitable and the Trust works with a recovery model to reduce suicide. The Trust recognises that its Inpatient settings should be places of safety that should provide a safe setting to therapeutically work with vulnerable patients and patients in crisis to support their recovery and prevent harm.
2. LPT acknowledges that the approach to Zero Suicide in Inpatient settings is both multi-faceted and multi-agency and requires LPT staff to work collaboratively with partner statutory and third sector agencies. The Trust also acknowledges the key role of relatives and carers to achieve safe outcomes from Inpatient stays.
3. LPT is part of the Leicester, Leicestershire and Rutland (LLR) Suicide Audit Prevention Group (SAPG). This is a multi-agency forum with agreed conjoined approaches to reducing suicide. The Trust has signed up as a partner to the LLR Suicide Prevention Plan as well as developing its own plan.
4. The purpose of the LLR Suicide Prevention Strategy is to bring together coherent, co-ordinated suicide prevention work across the geographical area (STP). It is supported by an annual action plan which is developed and reviewed by the SAPG.
5. One of the key actions for the LLR SAPG for 2017-2020 is work to prevent suicide in health care settings. The Zero Suicide approach is a US model based on the belief that all suicide in health care settings is preventable. Prevention should be based on good assessment and management of people known to health care providers especially those with a recent history of self-harm.
6. This series of Recommendations (Appendix A) is based on current research into suicide and suicide prevention as well as learning from the National Confidential Inquiry into Homicide and Suicide. It also draws on learning from suicides that have occurred within the Inpatient settings within LPT. Inpatient suicides include those where the patient was not physically on the ward at the time of death and includes patients on authorised or unauthorised leave.

Aim

7. Leicester Partnership NHS Trust is fully committed to a Zero Suicide Ambition for all Inpatient areas by the end of March 2020 and the attached

recommendations will form the plan that details the Trust's approach to achieving this ambition.

Recommendations

8. Approve the approach to the LPT Zero Ambition Suicide for Inpatients

Discussion

National Context

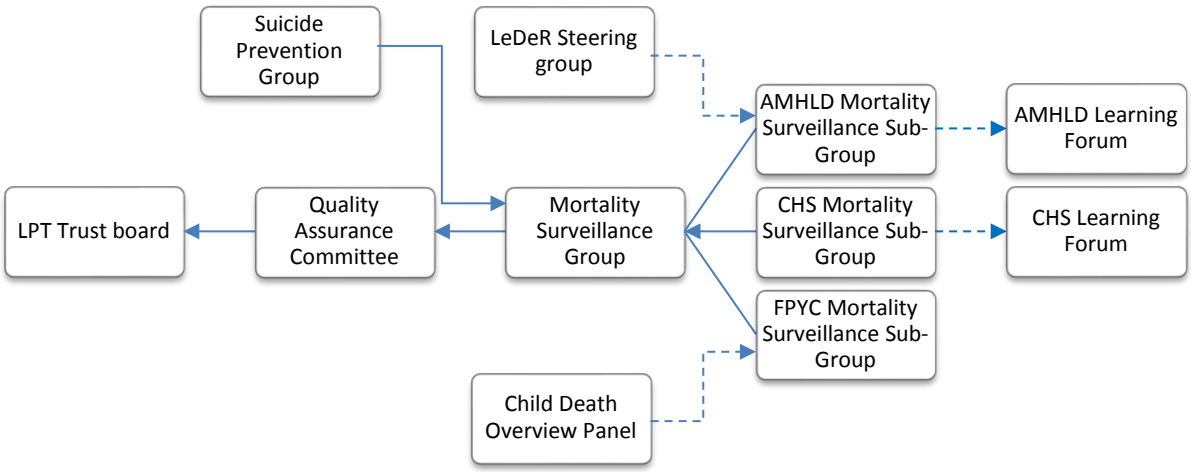
9. Data specific to mental health is drawn from the ongoing national study conducted by the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). Due to the iterative structure of the study, information is published covering a 10 year time frame, ending 2 years prior to date of publication
10. 28% of suicides in the UK between 2006 and 2016 involved mental health patients (NCISH, 2018).
11. The most common method of suicide by patients in 2016 was hanging/strangulation, accounting for 776 deaths UK-wide, almost half of all patient suicides.
12. The second most common method of suicide among patients in the same period was self-poisoning, accounting for 365 deaths, almost a quarter of patient suicides. The main substances taken in fatal overdose were opiates and the main source (where known) was by prescription.
13. There were 106 suicides by inpatients in the UK in 2016, around 7% of all patient suicides.
14. There were 227 suicides in the 3 months after hospital discharge in 2016, 17% of all patient suicides. The highest risk was in the first 2 weeks after discharge and the highest number of deaths occurred on day 3 post-discharge.
15. The risk factors for suicide are multi-factorial and is different for every individual; it is often the combination of factors rather than one single factor that leads to a poor outcome. Mental ill health and distress is one of the major factors associated with suicide and is associated with an increased risk of completed suicide.

Leicester Partnership Context

16. The Trust has a Zero Suicide Ambition for Inpatient as well as a longer term commitment to reducing community suicides of patients open to LPT services. The Trust recognises that this aspiration is challenging but also believes that no suicide is inevitable and each suicide is a human tragedy which has implications beyond the individual patients. The Trust recognises that each suicide affects families, friends, work colleagues, health care professionals and wider communities. The Trust also acknowledges the impact of suicide on families means that as part of any plan the Trust needs to include support for bereaved families.

17. The Trust has a newly appointed Suicide Prevention Group (SPG) that will oversee this plan and drive the Trust's work in relation to suicide prevention. This will include training in suicide prevention across LPT. The Trust recognises that all staff have a part to play in suicide prevention.
18. An Associate Medical Director for Quality is to be recruited and part of their remit will be to lead the Trust's work on Suicide Prevention. In addition a business case has been agreed for a dedicated Learning from Deaths and Suicide Prevention clinician. A prime responsibility for this role will be preventing avoidable deaths by focusing on high quality care standards; listening to feedback; learning and sharing lessons across the Trust. It will be their responsibility to facilitate the learning from deaths process resulting in sustained change and improvement where needed. They will be expected to develop strong links with the Coroner's Office
19. The SPG has clinical representation from across all of the Trust's Directorates. The governance of the Suicide Prevention Group will be via the Trust's Mortality Surveillance Group which in turn reports to the Trust Board (See Chart 1)

Chart 1



20. In the development of these recommendations, LPT has reviewed Suicides that have occurred either as Inpatients on the ward or on leave, patients under a Community Treatment Order, patients who have been discharged within the last 10 days and patient's under the care of the Crisis Team that have occurred in the years 2015, 2016, 2017 and 2018. See table 1 below:

Table 1

	On the ward	Off ward on planned leave	Off ward unplanned leave/AWOL	Community Treatment Orders	Within 10 days of discharge	Under the care of crisis team
2015	0	1	0	0	0	3
2016	1	1	0	0	2	2
2017	0	3	0	0	0	0
2018	0	0	0	0	2	6
2019 to date	0	1	0	0	0	4

21. All deaths reported and included in the table above were subject to a Serious Incident Investigation, (NHSE 2015) and when completed and signed off by Commissioners were shared with families and staff involved in the patient's care.
22. The Trust recognises the need for compliance with safer staffing levels as well as the desire for a low turnover of staff to enhance the patient experience and the general skill base of the staff is above the minimum levels for high quality care.
23. Due to the nature of the different client groups, safer staffing is considered across the organisation in different ways and by using different tools. These are however, triangulated with other Quality measures.
24. Currently on the Adult Mental Health Inpatient Unit, work is being undertaken to strengthen the process of risk assessment and care planning in conjunction with patients. LPT also recognise families should be considered a potential valuable source of information, advice and support and therefore should be viewed as potential partners in suicide prevention.
25. The duty of confidentiality is no justification for not listening to the views of family members and friends, who may offer insight into the individual's state of mind. This can aid risk assessment as well as care and treatment.
26. Good practice includes providing families with non-person specific information in their own right, such as how to access services in a crisis plus support services for carers. The Zero Suicide Ambition requires a holistic approach to the care and support of individuals.

Consensus statement on Information Sharing.

27. When a health care professional is satisfied that a suicidal patient lacks capacity to make a decision about sharing information related to their suicidal risk, LPT will fully support the health care professional in the use of their professional judgement to determine what is in the patient's best interest.
28. LPT consider a well justified, well recorded rationale to share information in the best interest of a patient who is in suicidal crisis is consistent with professional bodies codes of practice.

29. LPT will emphasise this approach to empower all staff to make the most appropriate decisions for individual patients.

Development of the Zero Suicide Ambition

30. In the development of this ambition, the Trust has used the NCISH 10 Ways to Improve Safety as an overarching framework for benchmarking current safety measures in place within clinical directorates.
31. The 10 Ways to Improve Safety consists of the following headings:

32. The recommendations relate to all Mental Health Inpatient areas and this includes working age adults, older persons, children and young people, male and female intensive care units and a low secure forensic unit.
33. The resulting Action Plan will include further capital developments and refurbishments of existing estate within the Estates Strategy work.

Conclusion

34. LPT is fully committed to a Zero Suicide Ambition for all Inpatient areas and to achieve this ambition, they have established a Suicide Prevention Group to act on the recommendations below and to oversee the resulting Action Plan as well as drive the Trust's work in relation to wider Suicide Prevention. The group reports into the Mortality Surveillance Group which in turn reports to the Trust Board.
35. The Action Plan will be based on the NCISH 10 ways to improve safety and will form the basis for benchmarking the current safety measures. It will also ensure that the future development and refurbishments of the estate comply with current best practice guidance for Suicide Prevention.
36. The Trust's Suicide Prevention Plan will be a dynamic document that will be constantly under review and will draw on the experiences of and invite collaboration from various stakeholders within and external to LPT. The Trust

has strong links with LLR Suicide Audit Prevention Group, the multi-agency forum for Leicester, Leicestershire and Rutland.

37. A series of recommendations have been developed from national and local learning and best practice. These recommendation will be developed into an Action Plan to be overseen by the Suicide Prevention Group.

Presenting Director: Dr Sue Elcock

Authors: Tracey Ward, Head of Patient Safety
Jo Nichols, Trust Lead for Quality and Patient Safety

May 2019

References

Self-harm and Suicide Prevention Competence Framework

https://www.ucl.ac.uk/pals/self-harm-and-suicide-prevention-competence-framework

The National Confidential Inquiry into Suicide and Safety in Mental Health

https://sites.manchester.ac.uk/ncish/

Appendix A

LPT Inpatient Zero Suicide Ambition Recommendations 2019-2020

Recommendations
Well Led
1. Evaluating current suicide and self-harm prevention training to identify gaps in training and formulate a robust training needs analysis.
2. Reviewing the training in line with the Health Education England's Suicide Prevention Competencies.(see reference below) Reviewing training programme within the Regional Suicide Prevention Group to ensure consistency across the region
3. Developing and rolling out of training specifically to manage personality disorder patients
4. Reviewing the Trust's current e-Learning package with a view to making it mandatory for all nursing staff, both qualified and unqualified, Allied Health Professionals and Medical staff.
5. Arranging delivery of training to the identified cohort of staff.
6. Including Pharmacy in the membership of the Suicide Prevention Group.
7. Requesting Pharmacy to consider the safe prescribing of opiates and anti-depressants. (page 22 toolkit)
8. Ensuring that all investigations throughout the Trust are carried out using a Just Culture methodology and are conducted in line with these recommendations..
9. Giving training support and guidance to staff in line with the Consensus Statement of Information Sharing and Suicide Prevention.
10. The Suicide Prevention Group to lead an LPT self-review using the toolkit for specialist Mental Health services and Primary Care to ensure accurate baseline data.
Safe
1. Reviewing Ligature Risk Assessments to ensure a clinical focus.
2. Using Nerve Centre to record the level of observation and ensure a clear handover for each patient
3. Using evaluation and assessment of therapeutic interventions (not the observations) in the In Patient areas to reduce risk and harm.
4. Re-introducing the Star and Safe Wards initiative on the Bradgate Unit to improve Patient Safety.
5. Requesting the Suicide Prevention group to review the last 12 months Inpatient suicides where the patient completed suicide whilst on leave from the ward or within 10 days of discharge.
6. Reviewing the Trust's Self Harm Policy to consider a specific section on Self Harm Minimisation in Inpatient settings
7. Reviewing the existence and quality of personal safety plans within Inpatients
8. Sign-posting patients to the "Staying Alive App" prior to discharge and showing them how to utilise it.

9. Developing a Trust wide format for recording and reviewing high risk service users and patients.
10. Reviewing the discharge planning and Early Discharge Pathways (EDP) to ensure they are robust and person centred.
11. Reducing through the EDP the number of long leave periods from Inpatient settings
12. Reviewing relative and carer involvement in the development of personal safety plans.
13. AMH/LD looking at the model developed within MHSOP of a peer support and lived experience network to reduce anxiety in patients about to be discharged, with a view to extending it to AMH/LD patients using the Involvement Centre.
Effective
1. Continuing phone or face to face within 72 hrs of discharge in line with the CQUIN.
2. Monitoring documentation for accuracy and quality of contact.
3. Developing guidance for safe discharge planning
4. Recruiting to the newly created post of Suicide Prevention and Learning from Deaths Clinician.
5. Benchmarking and developing skills of the Suicide Prevention Group so that they can become the Safe from Suicide Team.
Responsive
1. The Suicide Prevention Group reviewing in real time all investigations into actual or suspected suicide and escalating any emerging themes to the Trust Board
2. Gaining lived experience stories from survivors of suicide, families and carers
3. Considering creating the role of a Family Liaison Officer with a view to maintaining and supporting family involvement in investigative processes
Considering the possibility and the approach of conducting post inpatient suicide reviews within 2 weeks
4. Analysing absconsions within Inpatient settings to identify reasons i.e. substance misuse/social factors. Identifying any actions that could be taken to reduce absconsions including engagement with patients regarding their reason for wanting to leave the ward.
5. Considering the therapeutic environment of the ward and if this is conducive to patients well-being and recovery.
6. Considering a wider consultation with survivors of suicide and bereaved families, employees of the Trust and external Stakeholders including the lead Commissioner, to help underpin the ongoing plan for Zero Ambition of Suicide.
Caring
1. Devising a plan to engage survivors of suicide, families and carers in the investigative and learning processes
2. Involving families fully in investigations into suspected or actual suicides

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Leicestershire Partnership NHS Trust

TRUST BOARD – 23rd May 2019

Guardian of Safe Working Hours Quarterly Report February 2019 to April 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 one exception report has been raised in this period

iii) Gives information on work schedule reviews and rota gaps.

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.

One exception report has been received in this quarter after a trainee was unable to take sufficient rest during a 24 hour on call period due to the clinical workload. Both the Clinical Supervisor and Guardian of Safe Working Hours have investigated the matter. TOIL was taken the next day and the matter subsequently resolved without formal action.

6. Rota Gaps and re-design

Gaps in the current rotation (December 2018 – April 2019);

- GP x 1 covered by LAS (Locum Appointment Service)
- CT1-3 x 8 Three posts covered by LAS
- F2 x1 no cover
- StR Adult x 6 no cover
- StR OA x1 no cover
- StR CAMHS x4 no cover
- StR LD x 1 no cover

Each service area is managing the gaps in Junior Doctor placements to meet clinical need.

7. Engagement

Continuing efforts to engage the junior doctors has taken place through the following measures:

- Meet new trainees at the Junior Doctor Induction Day – Dr Jesu met with the new doctors on 3/4/19 explaining the role of guardian
- Increase awareness of the new contract and role of the guardian through handouts and information on Exception Reporting- Dr Jesu trying to engage more with the trainees utilising first Friday of every month when trainees have a session to meet with AMD for Post graduate education.
- Regular attendance at Junior Doctor Forum meetings- Invitation has been sent to trainees encouraging attendance at the next JDF scheduled for 1/5/19.
- Email and telephone access 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
Ashley Jackson, Medical Staffing Advisor

Appendices

Appendix A	Locum Hours – Internal Bank and Agency (1st February 2019 – 30th April 2019)
Appendix B	12 month summary data Exception reports

Appendix A

Locum Hours (Internal Bank and Agency)
1st February 2019 – 30th April 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	68	68	0	0
Evington	52	52	0	0
Central Duty Rota	18	18	0	0
StR East	3	3		0
StR West	12	12		0
Total	153	153	0	

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 *	95	95	0	0
Sickness	31	31	0	0
Maternity	13	13	0	0
Special Leave	14	14	0	
Temporary removal of trainee from rota**			0	0
Total	153	153	0	0

* 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	Apr'18 – July'18 rotation period	Aug'18 – Dec'18 rotation period	Jan'19 – Apr'19 rotation period
Working Hours	1 (ward round, TOIL)	0	1 (rest, TOIL)
Training issue	0	0	0
Other reason	0	0	0
Total	1	0	1

Leicestershire Partnership NHS Trust

TRUST BOARD – 23 May 2019

Annual Self-Certification
NHS Provider Licence Conditions 2018/19

1. Introduction/Background

1.1 NHS trusts are required to self-certify that they can meet the obligations set out in the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution) and that they have complied with governance requirements.

1.2 Although NHS trusts are exempt from needing a Provider Licence, directions from the Secretary of State require NHS Improvement (NHSi) to ensure that NHS trusts comply with conditions equivalent to the licence as it deems appropriate.

1.3 The Trust must self-certify the following after the financial year-end:

- Condition G6 - the provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution. The sign off on self-certification for this condition must be by 31 May with publication no later than 30 June.
- Condition FT4 - the provider has complied with required governance arrangements. Sign off on self-certification should be no later than 30 June.

2. Aim.

2.1 For the Board to determine if the above licence conditions have, or have not, been satisfied for the financial year 2018/19 in order that it may publish a public declaration of compliance/non-compliance with the applicable NHS provider licence conditions.

3. Discussion

3.1 As a result of the CQC Inspection visit November/December 2018 the Trust was issued with a Warning Notice in its findings that were published in February 2019. This was served under section 29A of the Health and Social Care Act 2008.

3.2 NHSi has subsequently in early May 2019 decided to move the Trust to Segment 3 under the NHSI Operating Framework. Segment Level 3 means Providers receive mandated support for significant concerns as there is an actual/suspected breach of the licence (or equivalent for NHS trusts).

3.3 The Chief Executive has now signed a letter of undertakings to NHSi (attached). A key element of the undertakings is the development of a Trust “Quality Improvement Programme Plan” with relevant support from NHSi for delivery.

3.4 As part of the move to segment 3 NHSi will now increase the frequency of LPT Performance Review Meetings to a monthly basis and Trust representation expected is the Chief Executive, Director of Nursing, Medical Director, Director of Finance, Operations Directors, and HR Director.

3.5 The Head of Internal Audit has given a draft opinion for 2018/19 on the overall arrangements for gaining assurance through the Board Assurance Framework, and on the controls reviewed as part of Internal Audit's work. The opinion issued has given Moderate Assurance that there is a generally sound system of governance, risk management and control but that controls are generally not being applied consistently.

.Given the opinions and findings described the Board is asked to authorise self-certification on the following basis:

NHS provider licence condition	Confirmed	Not confirmed
Condition G6 – The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution.		✓
Condition FT4 – The provider has complied with required governance arrangements.		✓

4. Conclusion

4.1 This evidence provided concludes that the two NHS Provider licence conditions G6 and F4 have not been met for the financial year 2018/19.

Annex: Undertakings Letter to NHSi signed CEO

Appendix – NHSi Licence Conditions

Presenting Director: Anne Scott, Interim Chief Nurse
Author: Frank Lusk, Trust Secretary

Paper Qii

UNDERTAKINGS

NHS TRUST:

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

DECISION:

On the basis of the grounds set out below and pursuant to its powers exercisable by NHS Improvement under or by virtue of the National Health Service Act 2006 and the TDA Directions, NHS Improvement has decided to accept undertakings from the trust.

DEFINITIONS:

In this document:

"the conditions of the Licence" means the conditions of the licence issued by Monitor under Chapter 3 of Part 3 of the Health and Social Care Act 2012 in respect of which NHS Improvement has deemed it appropriate for NHS trusts to comply with equivalent conditions, pursuant to paragraph 6 of the TDA Directions;

"NHS Improvement" means the National Health Service Trust Development Authority;

"TDA Directions" means the "National Health Service Trust Development Authority Directions and Revocations and the Revocation of the Imperial College Healthcare National Health Service Trust Directions 2016".

GROUNDS:

1. The trust

   The trust is an NHS Trust all of whose hospitals, facilitates and establishments are situation in England.

2. Issues and need for action

   NHS Improvement has reasonable grounds to suspect that the trust has provided and is providing health services for the purposes of the health service in England whilst failing to comply with the following conditions of the Licence: FT4(4)(a) and (c),(5)(c),(6)(a-b)(d)(f).

2.1. In particular:

Quality

2.1.1. An inspection of the trust by the CQC during November and December 2018 resulted in the trust being given an overall rating by the CQC of 'Requires Improvement' with the well-led domain being rated 'Inadequate'.

2.1.2. The overall concerns were focused on the trust's 'Long stay or rehabilitation mental health wards for working age adults' and 'Acute wards for adults of working age and psychiatric intensive care units' which were rated as 'Inadequate'. Further details are contained within the CQC's report dated 27 February 2019 ('the CQC report').

2.1.3. The CQC also identified specific concerns in relation to waiting times for assessment and treatment not meeting commissioned targets and the NHS constitution for children and young people; and provision for children and young people with attention deficit hyperactivity and autism spectrum disorders and the need to reduce service waiting times in the children and young people's service.

Operational performance

2.1.4. The trust has not achieved CPA 7 day since July 2017. Its latest reported position is 81.6% against 90% standard.

2.1.5. The trust is required to address patient waiting times for assessment and treatment to meet commissioned targets and the NHS constitution for children and young people; the trust is also required to review their service provision for children and young people with attention deficit hyperactivity and autism spectrum disorders and reduce service waiting times in the children and young people's service, in line with CQC MUST DO's within the CQC report.

2.2. Failures and need for action

These failings by the trust demonstrate a failure of governance arrangements and quality management including, in particular:

2.2.1. Failure to establish and effectively implement systems of processes:

2.2.1.1. for timely and effective scrutiny and oversight by the Board of the trust's operations;
2.2.1.2. to ensure compliance with healthcare standards binding on the trust;
2.2.1.3. to ensure that the trust's services are safe and of sufficient quality.

2.3. Need for action:

NHS Improvement believes that the action which the trust has undertaken to take pursuant to these undertakings, is action required to secure that the

failures to comply with the relevant requirements of the conditions of the Licence do not continue or recur.

UNDERTAKINGS:

NHS Improvement has agreed to accept and the trust has agreed to give the following undertakings:

1. Quality Improvement

   1.1. The trust will develop an action plan to address the concerns in the CQC report ("the CQC Action Plan") which includes clear timescales and where appropriate trajectories for improvement.

   1.2. The trust will implement the CQC Action Plan in accordance with the timescales in that plan, unless otherwise agreed with NHS Improvement.

   1.3. The trust will revise the CQC Action Plan to include any subsequent concerns raised by the CQC that NHS Improvement specifies should be addressed in the CQC Action Plan. If the trust is required to update the CQC Action Plan under this sub-paragraph 1.2, all references in these undertakings to the CQC Action Plan will be to the CQC Action Plan as revised under this sub-paragraph.

   1.4. The trust will ensure that its oversight and assurance process in relation to the CQC Action Plan is robust.

2. Operational Performance

   2.1. The trust will develop a "Quality Improvement Plan" which will include actions required to ensure that all patients within the specialist community mental health services for children and young people and children and young people with attention deficit hyperactivity disorder (ADHD) and autism spectrum disorder (ASD) are able to access the service they need, in line with national standards. The Quality Improvement Plan will also include actions required to ensure patients receive a CPA 7d in line with national standards. This will include clear trajectories for improvement and processes for monitoring progress against the identified improvement trajectories.

3. Programme Management

   3.1. The trust will at a date to be agreed with NHS Improvement, develop a "Quality Improvement Programme Plan" to address the actions arising out of sub-paragraphs 1.2 (the CQC Action Plan) and 2.1 (the Quality Improvement Plan). The Quality Improvement Programme Plan will be reviewed and approved by the trust's chief executive and will be developed in collaboration with key stakeholders within the local health and social care system and will include clear timescales for implementation.

3.2. The trust will implement the actions in the Quality Improvement Programme Plan within the timescales in that plan, unless otherwise agreed with NHS Improvement.

3.3. To support delivery of the above actions, the NHS Improvement regional team will identify relevant support for the trust. The trust is required to work collaboratively with the individuals identified to provide this support.

4. Meetings and reports

4.1. The trust will provide regular reports to NHS Improvement on its progress in meeting these undertakings and will attend any meetings, or, if NHS Improvement stipulates, conference calls, that NHS Improvement may require. These meetings will take place once a month unless NHS Improvement otherwise stipulates, at a time and place to be specified by NHS Improvement and with attendees specified by NHS Improvement.

4.2. The trust will on request provide NHS Improvement with details of any assurances on which the Board has relied in relation to the trust's progress in delivering these undertakings.

4.3. The trust will comply with any additional reporting or information requests made by NHS Improvement.

Any failure to comply with the above undertakings may result in NHS Improvement taking further regulatory action. This could include giving formal directions to the trust under section 8 of the National Health Service Act 2006 and paragraph 6 of the TDA Directions.

THE TRUST
Signed:

Chair or Chief Executive of trust

Dated: 9/5/19.

NHS IMPROVEMENT
Signed:

Locality Director (Central Midlands) and member of the Regional Support Group
Dated:

NHS Provider Licence Standard Conditions

CONTENTS

Section 1 – General Conditions

Condition G1 – Provision of information

1. Subject to paragraph 3, and in addition to obligations under other Conditions of this Licence, the Licensee shall furnish to Monitor such information and documents, and shall prepare or procure and furnish to Monitor such reports, as Monitor may require for any of the purposes set out in section 96(2) of the 2012 Act.

2. Information, documents and reports required to be furnished under this Condition shall be furnished in such manner, in such form, at such place and at such times as Monitor may require.

3. In furnishing information documents and reports pursuant to paragraphs 1 and 2 the Licensee shall take all reasonable steps to ensure that:

   (a) in the case of information or a report, it is accurate, complete and not misleading;

   (b) in the case of a document, it is a true copy of the document requested; and

4. This Condition shall not require the Licensee to furnish any information, documents or reports which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.

Condition G2 – Publication of information

1. The Licensee shall comply with any direction from Monitor for any of the purposes set out in section 96(2) of the 2012 Act to publish information about health care services provided for the purposes of the NHS and as to the manner in which such information should be published.

2. For the purposes of this condition “publish” includes making available to the public, to any section of the public or to individuals.

Condition G3 – Payment of fees to Monitor

1. The Licensee shall pay fees to Monitor in each financial year of such amount as Monitor may determine for each such year or part thereof in respect of the exercise by Monitor of its functions for the purposes set out in section 96(2) of the 2012 Act.

2. The Licensee shall pay the fees required to be paid by a determination by Monitor for the purpose of paragraph 1 no later than the 28th day after they become payable in accordance with that determination.

Condition G4 – Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions)

1. The Licensee shall ensure that no person who is an unfit person may become or continue as a Governor, except with the approval in writing of Monitor.

2. The Licensee shall not appoint as a Director any person who is an unfit person, except with the approval in writing of Monitor.

3. The Licensee shall ensure that its contracts of service with its Directors contain a provision permitting summary termination in the event of a Director being or becoming an unfit person. The Licensee shall ensure that it enforces that provision promptly upon discovering any Director to be an unfit person, except with the approval in writing of Monitor.

4. If Monitor has given approval in relation to any person in accordance with paragraph 1, 2, or 3 of this condition the Licensee shall notify Monitor promptly in writing of any material change in the role required of or performed by that person.

5. In this Condition an unfit person is:

   (a) an individual;

      (i) who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged; or

      (ii) who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it; or

      (iii) who within the preceding five years has been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him; or

      (iv) who is subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986; or

   (b) a body corporate, or a body corporate with a parent body corporate:

(i) where one or more of the Directors of the body corporate or of its parent body corporate is an unfit person under the provisions of sub-paragraph (a) of this paragraph, or

(ii) in relation to which a voluntary arrangement is proposed under section 1 of the Insolvency Act 1986, or

(iii) which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act) appointed for the whole or any material part of its assets or undertaking, or

(iv) which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act, or

(v) which passes any resolution for winding up, or

(vi) which becomes subject to an order of a Court for winding up.

Condition G5 – Monitor guidance

1 Without prejudice to any obligations in other Conditions of this Licence, the Licensee shall at all times have regard to guidance issued by Monitor for any of the purposes set out in section 96(2) of the 2012 Act.

2 In any case where the Licensee decides not to follow the guidance referred to in paragraph 1 or guidance issued under any other Conditions of this licence, it shall inform Monitor of the reasons for that decision.

Condition G6 – Systems for compliance with licence conditions and related obligations

1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:

   (a) the Conditions of this Licence,

   (b) any requirements imposed on it under the NHS Acts, and

   (c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:

   (a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and

   (b) regular review of whether those processes and systems have been implemented and of their effectiveness.

3. Not later than two months from the end of each Financial Year, the Licensee shall prepare and submit to Monitor a certificate to the effect that, following a review for the purpose of paragraph 2(b) the Directors of the Licensee are or are not satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with this Condition.

4. The Licensee shall publish each certificate submitted for the purpose of this Condition within one month of its submission to Monitor in such manner as is likely to bring it to the attention of such persons who reasonably can be expected to have an interest in it.

Condition G7 – Registration with the Care Quality Commission

1. The Licensee shall at all times be registered with the Care Quality Commission in so far as is necessary in order to be able lawfully to provide the services authorised to be provided by this Licence.

2. The Licensee shall notify Monitor promptly of:

   (a) any application it may make to the Care Quality Commission for the cancellation of its registration by that Commission, or

   (b) the cancellation by the Care Quality Commission for any reason of its registration by that Commission.

3. A notification given by the Licensee for the purposes of paragraph 2 shall:

   (a) be made within 7 days of:

      (i) the making of an application in the case of paragraph (a), or

      (ii) becoming aware of the cancellation in the case of paragraph (b), and

   (b) contain an explanation of the reasons (in so far as they are known to the Licensee) for:

      (i) the making of an application in the case of paragraph (a), or

      (ii) the cancellation in the case of paragraph (b).

Condition G8 – Patient eligibility and selection criteria

1. The Licensee shall:

   (a) set transparent eligibility and selection criteria,

   (b) apply those criteria in a transparent way to persons who, having a choice of persons from whom to receive health care services for the purposes of the NHS, choose to receive them from the Licensee, and

   (c) publish those criteria in such a manner as will make them readily accessible by any persons who could reasonably be regarded as likely to have an interest in them.

2. "Eligibility and selection criteria" means criteria for determining:

   (a) whether a person is eligible, or is to be selected, to receive health care services provided by the Licensee for the purposes of the NHS, and

   (b) if the person is selected, the manner in which the services are provided to the person.

Condition G9 – Application of Section 5 (Continuity of Services)

1. The Conditions in Section 5 shall apply:

   (a) whenever the Licensee is subject to a contractual or other legally enforceable obligation to provide a service which is a Commissioner Requested Service, and

   (b) from the commencement of this Licence until the Licensee becomes subject to an obligation of the type described in sub-paragraph (a), if the Licensee is an NHS foundation trust which:

      (i) was not subject to such an obligation on commencement of this Licence, and

      (ii) was required to provide services, or was party to an NHS contract to provide services, as described in paragraph 2(a) or 2(b);

for the avoidance of doubt, where Section 5 applies by virtue of this subparagraph, the words "Commissioner Requested Service" shall be read to include any service of a description falling within paragraph 2(a) or 2(b).

2. A service is a Commissioner Requested Service if, and to the extent that, it is:

   (a) any service of a description which the Licensee, being an NHS foundation trust with an authorisation date on or before 31 March 2013, was required to provide in accordance with condition 7(1) and Schedule 2 in the terms of its authorisation by Monitor immediately prior to the commencement of this Licence, or

   (b) any service of a description which the Licensee, being an NHS foundation trust with an authorisation date on or after 1 April 2013, was required to provide pursuant to an NHS contract immediately before its authorisation date, or

   (c) any other service which the Licensee has contracted with a Commissioner to provide as a Commissioner Requested Service.

3. A service is also a Commissioner Requested Service if, and to the extent that, not being a service within paragraph 2:

(a) it is a service which the Licensee may be required to provide to a Commissioner under the terms of a contract which has been entered into between them, and

(b) the Commissioner has made a written request to the Licensee to provide that service as a Commissioner Requested Service, and either

(c) the Licensee has failed to respond in writing to that request by the expiry of the 28th day after it was made to the Licensee by the Commissioner, or

(d) the Commissioner, not earlier than the expiry of the [28th] day after making that request to the Licensee, has given to Monitor and to the Licensee a notice in accordance with paragraph 4, and Monitor, after giving the Licensee the opportunity to make representations, has issued a direction in writing in accordance with paragraph 5.

4. A notice in accordance with this paragraph is a notice:

(a) in writing,

(b) stating that the Licensee has refused to agree to a request to provide a service as a Commissioner Requested Service, and

(c) setting out the Commissioner's reasons for concluding that the Licensee is acting unreasonably in refusing to agree to that request to provide a service as a Commissioner Requested Service

5. A direction in accordance with this paragraph is a direction that the Licensee's refusal to provide a service as a Commissioner Requested Service in response to a request made under paragraph 3(b) is unreasonable.

6. The Licensee shall give Monitor not less than [28] days' notice of the expiry of any contractual obligation pursuant to which it is required to provide a Commissioner Requested Service to a Commissioner for which no extension or renewal has been agreed.

7. If any contractual obligation of a Licensee to provide a Commissioner Requested Service expires without extension or renewal having been agreed between the Licensee and the Commissioner who is a party to the contract, the Licensee shall continue to provide that service on the terms of the contract (save as agreed with that Commissioner), and the service shall continue to be a Commissioner Requested

Service, for the period from the expiry of the contractual obligation until Monitor issues either:

(a) a direction of the sort referred to in paragraph 8, or

(b) a notice in writing to the Licensee stating that it has decided not to issue such a direction.

8. If, during the period of a contractual or other legally enforceable obligation to provide a Commissioner Requested Service, Monitor issues to the Licensee a direction in writing to continue providing that service for a period specified in the direction, then for that period the service shall continue to be a Commissioner Requested Service.

9. No service which the Licensee is subject to a contractual or other legally enforceable obligation to provide shall be regarded as a Commissioner Requested Service and, as a consequence, no Condition in Section 5 shall be of any application, during any period for which there is in force a direction in writing by Monitor given for the purposes of this condition and of any equivalent condition in any other current licence issued under the 2012 Act stating that no health care service provided for the purposes of the NHS is to be regarded as a Commissioner Requested Service.

10. A service shall cease to be a Commissioner Requested Service if:

(a) all current Commissioners of that service as a Commissioner Requested Service agree in writing that there is no longer any need for the service to be a Commissioner Requested Service, and Monitor has issued a determination in writing that the service is no longer a Commissioner Requested Service, or

(b) Monitor has issued a determination in writing that the service is no longer a Commissioner Requested Service; or

(c) it is a Commissioner Requested Service by virtue only of paragraph 2(a) above and 3 years have elapsed since the commencement of this Licence; or

(d) it is a Commissioner Requested Service by virtue only of paragraph 2(b) above and either 3 years have elapsed since 1 April 2013 or 1 year has elapsed since the commencement of this Licence, whichever is the later; or

(e) the contractual obligation pursuant to which the service is provided has expired and Monitor has issued a notice pursuant to paragraph 7(b) in relation to the service; or

(f) the period specified in a direction by Monitor of the sort referred to in paragraph 8 in relation to the service has expired.

11. The Licensee shall make available free of charge to any person who requests it a statement in writing setting out the description and quantity of services which it is under a contractual or other legally enforceable obligation to provide as Commissioner Requested Services.

12. Within [28] days of every occasion on which there is a change in the description or quantity of the services which the Licensee is under a contractual or other legally enforceable obligation to provide as Commissioner Requested Services, the Licensee shall provide to Monitor in writing a notice setting out the description and quantity of all the services it is obliged to provide as Commissioner Requested Services.

13. Unless it is proposes to cease providing the service, the Licensee shall not make any application to Monitor for a determination in accordance with paragraph 10(b):

(a) in the case of a service which is a Commissioner Requested Service by virtue only of paragraph 2(a) above, in the period of 3 years since the commencement of this Licence or

(b) in the case of a service which is a Commissioner Requested Service by virtue only of paragraph 2(b), in the period until the later of 1 April 2016 or 1 year from the commencement of this Licence.

14. In this Condition “NHS contract” has the meaning given to that term in Section 9 of the 2006 Act.

Section 2 – Pricing

Condition P1 – Recording of information

1. If required in writing by Monitor, and only in relation to periods from the date of that requirement, the Licensee shall:

   (a) obtain, record and maintain sufficient information about the costs which it expends in the course of providing services for the purposes of the NHS and other relevant information, and

   (b) establish, maintain and apply such systems and methods for the obtaining, recording and maintaining of such information about those costs and other relevant information,

   as are necessary to enable it to comply with the following paragraphs of this Condition.

2. From the time of publication by Monitor of Approved Reporting Currencies the Licensee shall maintain records of its costs and of other relevant information broken down in accordance with those Currencies by allocating to a record for each such Currency all costs expended by the Licensee in providing health care services for the purposes of the NHS within that Currency and by similarly treating other relevant information.

3. In the allocation of costs and other relevant information to Approved Reporting Currencies in accordance with paragraph 2 the Licensee shall use the cost allocation methodology and procedures relating to other relevant information set out in the Approved Guidance.

4. If the Licensee uses sub-contractors in the provision of health care services for the purposes of the NHS, to the extent that it is required to do so in writing by Monitor the Licensee shall procure that each of those sub-contractors:

   (a) obtains, records and maintains information about the costs which it expends in the course of providing services as sub-contractor to the Licensee, and establishes, maintains and applies systems and methods for the obtaining, recording and maintaining of that information, in a manner that complies with paragraphs 2 and 3 of this Condition, and

   (b) provides that information to Monitor in a timely manner.

5. Records required to be maintained by this Condition shall be kept for not less than six years.

Section 2 – Pricing

6. In this Condition:

"the Approved Guidance"	means such guidance on the obtaining, recording and maintaining of information about costs and on the breaking down and allocation of costs by reference to Approved Reporting Currencies as may be published by Monitor;
"Approved Reporting Currencies"	means such categories of cost and other relevant information as may be published by Monitor;
"other relevant information"	means such information, which may include quality and outcomes data, as may be required by Monitor for the purpose of its functions under Chapter 4 (Pricing) in Part 3 of the 2012 Act.

Condition P2 – Provision of information

1. Subject to paragraph 3, and without prejudice to the generality of Condition G1, the Licensee shall furnish to Monitor such information and documents, and shall prepare or procure and furnish to Monitor such reports, as Monitor may require for the purpose of performing its functions under Chapter 4 in Part 3 of the 2012 Act.

2. Information, documents and reports required to be furnished under this Condition shall be furnished in such manner, in such form, at such place and at such times as Monitor may require.

3. In furnishing information documents and reports pursuant to paragraphs 1 and 2 the Licensee shall take all reasonable steps to ensure that:

   (a) in the case of information or a report, it is accurate, complete and not misleading;

   (b) in the case of a document, it is a true copy of the document requested; and

4. This Condition shall not require the Licensee to furnish any information, documents or reports which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.

Condition P3 – Assurance report on submissions to Monitor

1. If required in writing by Monitor the Licensee shall, as soon as reasonably practicable, obtain and submit to Monitor an assurance report in relation to a submission of the sort described in paragraph 2 which complies with the requirements of paragraph 3.

2. The descriptions of submissions in relation to which a report may be required under paragraph 1 are:

   (a) submissions of information furnished to Monitor pursuant to Condition P2, and

   (b) submissions of information to third parties designated by Monitor as persons from or through whom cost information may be obtained for the purposes of setting or verifying the National Tariff or of developing non-tariff pricing guidance.

3. An assurance report shall meet the requirements of this paragraph if all of the following conditions are met:

   (a) it is prepared by a person approved in writing by Monitor or qualified to act as auditor of an NHS foundation trust in accordance with paragraph 23(4) in Schedule 7 to the 2006 Act;

   (b) it expresses a view on whether the submission to which it relates:

      (i) is based on cost records which have been maintained in a manner which complies with paragraph 2 in Condition P1;

      (ii) is based on costs which have been analysed in a manner which complies with paragraph 3 in Condition P1, and

      (iii) provides a true and fair assessment of the information it contains.

Condition P4 – Compliance with the National Tariff

1. Except as approved in writing by Monitor, the Licensee shall only provide health care services for the purpose of the NHS at prices which comply with, or are determined in accordance with, the national tariff published by Monitor, in accordance with section 116 of the 2012 Act.

2. Without prejudice to the generality of paragraph 1, except as approved in writing by Monitor, the Licensee shall comply with the rules, and apply the methods, concerning charging for the provision of health care services for the purposes of the NHS contained in the national tariff published by Monitor in accordance with, section 116 of the 2012 Act, wherever applicable.

Condition P5 – Constructive engagement concerning local tariff modifications

1. The Licensee shall engage constructively with Commissioners, with a view to reaching agreement as provided in section 124 of the 2012 Act, in any case in which it is of the view that the price payable for the provision of a service for the purposes of the NHS in certain circumstances or areas should be the price determined in accordance with the national tariff for that service subject to modifications.

Section 3 – Choice and Competition

Condition C1- The right of patients to make choices

1. Subsequent to a person becoming a patient of the Licensee and for as long as he or she remains such a patient, the Licensee shall ensure that at every point where that person has a choice of provider under the NHS Constitution or a choice of provider conferred locally by Commissioners, he or she is notified of that choice and told where information about that choice can be found.

2. Information and advice about patient choice of provider made available by the Licensee shall not be misleading.

3. Without prejudice to paragraph 2, information and advice about patient choice of provider made available by the Licensee shall not unfairly favour one provider over another and shall be presented in a manner that, as far as reasonably practicable, assists patients in making well informed choices between providers of treatments or other health care services.

4. In the conduct of any activities, and in the provision of any material, for the purpose of promoting itself as a provider of health care services for the purposes of the NHS the Licensee shall not offer or give gifts, benefits in kind, or pecuniary or other advantages to clinicians, other health professionals, Commissioners or their administrative or other staff as inducements to refer patients or commission services.

Condition C2 – Competition oversight

1. The Licensee shall not:

   (a) enter into or maintain any agreement or other arrangement which has the object or which has (or would be likely to have) the effect of preventing, restricting or distorting competition in the provision of health care services for the purposes of the NHS, or

   (b) engage in any other conduct which has (or would be likely to have) the effect of preventing, restricting or distorting competition in the provision of health care services for the purposes of the NHS,

   to the extent that it is against the interests of people who use health care services.

Section 4 – Integrated care

Condition IC1 – Provision of integrated care

1. The Licensee shall not do anything that reasonably would be regarded as against the interests of people who use health care services by being detrimental to enabling its provision of health care services for the purposes of the NHS to be integrated with the provision of such services by others with a view to achieving one or more of the objectives referred to in paragraph 4.

2. The Licensee shall not do anything that reasonably would be regarded as against the interests of people who use health care services by being detrimental to enabling its provision of health care services for the purposes of the NHS to be integrated with the provision of health-related services or social care services by others with a view to achieving one or more of the objectives referred to in paragraph 4.

3. The Licensee shall not do anything that reasonably would be regarded as against the interests of people who use health care services by being detrimental to enabling it to co-operate with other providers of health care services for the purposes of the NHS with a view to achieving one or more of the objectives referred to in paragraph 4.

4. The objectives referred to in paragraphs 1, 2 and 3 are:

   (a) improving the quality of health care services provided for the purposes of the NHS (including the outcomes that are achieved from their provision) or the efficiency of their provision,

   (b) reducing inequalities between persons with respect to their ability to access those services, and

   (c) reducing inequalities between persons with respect to the outcomes achieved for them by the provision of those services.

5. The Licensee shall have regard to such guidance as may have been issued by Monitor from time to time concerning actions or behaviours that might reasonably be regarded as against the interests of people who use health care services for the purposes of paragraphs 1, 2 or 3 of this Condition.

Section 5 – Continuity of Services

Condition CoS1 – Continuing provision of Commissioner Requested Services

1. The Licensee shall not cease to provide, or materially alter the specification or means of provision of, any Commissioner Requested Service otherwise than in accordance with the following paragraphs of this Condition.

2. If, during the period of a contractual or other legally enforceable obligation to provide a Commissioner Requested Service, or during any period when this condition applies by virtue of Condition G9(1)(b), Monitor issues to the Licensee a direction in writing to continue providing that service for a period specified in the direction, then the Licensee shall provide the service for that period in accordance with the direction.

3. The Licensee shall not materially alter the specification or means of provision of any Commissioner Requested Service except:

   (a) with the agreement in writing of all Commissioners to which the Licensee is required by a contractual or other legally enforceable obligation to provide the service as a Commissioner Requested Service; or

   (b) at any time when this condition applies by virtue of Condition G9(1)(b), with the agreement in writing of all Commissioners to which the Licensee provides, or may be requested to provide, the service as a Commissioner Requested Service; or

   (c) if required to do so by, or in accordance with the terms of its authorisation by, any body having responsibility pursuant to statute for regulating one or more aspects of the provision of health care services in England and which has been designated by Monitor for the purposes of this condition and of equivalent conditions in other licences granted under the 2012 Act.

4. If the specification or means of provision of a Commissioner Requested Service is altered as provided in paragraph 3 the Licensee, within [28] days of the alteration, shall give to Monitor notice in writing of the occurrence of the alteration with a summary of its nature.

5. For the purposes of this Condition an alteration to the specification or means of provision of any Commissioner Requested Service is material if it involves the delivery

or provision of that service in a manner which differs from the manner specified and described in:

(a) the contract in which it was first required to be provided to a Commissioner at or following the coming into effect of this Condition; or

(b) if there has been an alteration pursuant to paragraph 3, the document in which it was specified on the coming into effect of that alteration; or

(c) at any time when this Condition applies by virtue of Condition G9(1)(b), the contract, or NHS contract, by which it was required to be provided immediately before the commencement of this Licence or the Licensee's authorisation, as the case may be.

Condition CoS2 – Restriction on the disposal of assets

1. The Licensee shall establish, maintain and keep up to date, an asset register which complies with paragraphs 2 and 3 of this Condition ("the Asset Register")

2. The Asset Register shall list every relevant asset used by the Licensee for the provision of Commissioner Requested Services.

3. The Asset Register shall be established, maintained and kept up to date in a manner that reasonably would be regarded as both adequate and professional.

4. The obligations in paragraphs 5 to 8 shall apply to the Licensee if Monitor has given notice in writing to the Licensee that it is concerned about the ability of the Licensee to carry on as a going concern.

5. The Licensee shall not dispose of, or relinquish control over, any relevant asset except:

   (a) with the consent in writing of Monitor, and

   (b) in accordance with the paragraphs 6 to 8 of this Condition.

6. The Licensee shall furnish Monitor with such information as Monitor may request relating to any proposal by the Licensee to dispose of, or relinquish control over, any relevant asset.

7. Where consent by Monitor for the purpose of paragraph 5(a) is subject to conditions, the Licensee shall comply with those conditions.

8. Paragraph 5(a) of this Condition shall not prevent the Licensee from disposing of, or relinquishing control over, any relevant asset where:

   (a) Monitor has issued a general consent for the purposes of this Condition (whether or not subject to conditions) in relation to:

      (i) transactions of a specified description; or

      (ii) the disposal of or relinquishment of control over relevant assets of a specified description, and

   the transaction or the relevant assets are of a description to which the consent applies and the disposal, or relinquishment of control, is in accordance with any conditions to which the consent is subject; or

(b) the Licensee is required by the Care Quality Commission to dispose of a relevant asset.

9. In this Condition:

"disposal"	means any of the following: (a) a transfer, whether legal or equitable, of the whole or any part of an asset (whether or not for value) to a person other than the Licensee; or (b) a grant, whether legal or equitable, of a lease, licence, or loan of (or the grant of any other right of possession in relation to) that asset; or (c) the grant, whether legal or equitable, of any mortgage, charge, or other form of security over that asset; or (d) if the asset is an interest in land, any transaction or event that is capable under any enactment or rule of law of affecting the title to a registered interest in that land, on the assumption that the title is registered, and references to "dispose" are to be read accordingly;
"relevant asset"	means any item of property, including buildings, interests in land, equipment (including rights, licenses and consents relating to its use), without which the Licensee's ability to meet its obligations to provide Commissioner Requested Services would reasonably be regarded as materially prejudiced;
"relinquishment of control"	includes entering into any agreement or arrangement under which control of the asset is not, or ceases to be, under the sole management of the Licensee, and "relinquish" and related expressions are to be read accordingly.

10. The Licensee shall have regard to such guidance as may be issued from time to time by Monitor regarding:

(a) the manner in which asset registers should be established, maintained and updated, and

(b) property, including buildings, interests in land, intellectual property rights and equipment, without which a licence holder's ability to provide Commissioner Requested Services should be regarded as materially prejudiced.

Condition CoS3 – Standards of corporate governance and financial management

1. The Licensee shall at all times adopt and apply systems and standards of corporate governance and of financial management which reasonably would be regarded as:

   (a) suitable for a provider of the Commissioner Requested Services provided by the Licensee, and

   (b) providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern.

2. In its determination of the systems and standards to adopt for the purpose of paragraph 1, and in the application of those systems and standards, the Licensee shall have regard to:

   (a) such guidance as Monitor may issue from time to time concerning systems and standards of corporate governance and financial management;

   (b) the Licensee's rating using the risk rating methodology published by Monitor from time to time, and

   (c) the desirability of that rating being not less than the level regarded by Monitor as acceptable under the provisions of that methodology.

Condition CoS4 – Undertaking from the ultimate controller

1. The Licensee shall procure from each company or other person which the Licensee knows or reasonably ought to know is at any time its ultimate controller, a legally enforceable undertaking in favour of the Licensee, in the form specified by Monitor, that the ultimate controller ("the Covenantor"):

   (a) will refrain for any action, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will refrain from any action, which would be likely to cause the Licensee to be in contravention of any of its obligations under the 2012 Act or this Licence, and

   (b) will give to the Licensee, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will give to the Licensee, all such information in its possession or control as may be necessary to enable the Licensee to comply fully with its obligations under this Licence to provide information to Monitor.

2. The Licensee shall obtain any undertaking required to be procured for the purpose of paragraph 1 within 7 days of a company or other person becoming an ultimate controller of the Licensee and shall ensure that any such undertaking remains in force for as long as the Covenantor remains the ultimate controller of the Licensee.

3. The Licensee shall:

   (a) deliver to Monitor a copy of each such undertaking within seven days of obtaining it;

   (b) inform Monitor immediately in writing if any Director, secretary or other officer of the Licensee becomes aware that any such undertaking has ceased to be legally enforceable or that its terms have been breached, and

   (c) comply with any request which may be made by Monitor to enforce any such undertaking.

4. For the purpose of this Condition, subject to paragraph 5, a person (whether an individual or a body corporate) is an ultimate controller of the Licensee if:

   (a) directly, or indirectly, the Licensee can be required to act in accordance with the instructions of that person acting alone or in concert with others, and

(b) that person cannot be required to act in accordance with the instructions of another person acting alone or in concert with others.

5. A person is not an ultimate controller if they are:

(a) a health service body, within the meaning of section 9 of the 2006 Act;

(b) a Governor or Director of the Licensee and the Licensee is an NHS foundation trust;

(c) any Director of the Licensee who does not, alone or in association with others, have a controlling interest in the ownership of the Licensee and the Licensee is a body corporate; or

(d) a trustee of the Licensee and the Licensee is a charity.

Condition CoS5 – Risk pool levy

1. The Licensee shall pay to Monitor any sums required to be paid in consequence of any requirement imposed on providers under section 135(2) of the 2012 Act, including sums payable by way of levy imposed under section 139(1) and any interest payable under section 143(10), by the dates by which they are required to be paid.

2. In the event that no date has been clearly determined by which a sum referred to in paragraph 1 is required to be paid, that sum shall be paid within 28 days of being demanded in writing by Monitor.

Condition CoS6 – Co-operation in the event of financial stress

1. The obligations in paragraph 2 shall apply if Monitor has given notice in writing to the Licensee that it is concerned about the ability of the Licensee to carry on as a going concern.

2. When this paragraph applies the Licensee shall:

   (a) provide such information as Monitor may direct to Commissioners and to such other persons as Monitor may direct;

   (b) allow such persons as Monitor may appoint to enter premises owned or controlled by the Licensee and to inspect the premises and anything on them, and

   (c) co-operate with such persons as Monitor may appoint to assist in the management of the Licensee's affairs, business and property.

Condition CoS7 – Availability of resources

1. The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.

2. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.

3. The Licensee, not later than two months from the end of each Financial Year, shall submit to Monitor a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms:

   (a) "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate."

   (b) "After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services".

   (c) "In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate".

4. The Licensee shall submit to Monitor with that certificate a statement of the main factors which the Directors of the Licensee have taken into account in issuing that certificate.

5. The statement submitted to Monitor in accordance with paragraph 4 shall be approved by a resolution of the board of Directors of the Licensee and signed by a Director of the Licensee pursuant to that resolution.

Section 5 – Continuity of Services

6. The Licensee shall inform Monitor immediately if the Directors of the Licensee become aware of any circumstance that causes them to no longer have the reasonable expectation referred to in the most recent certificate given under paragraph 3.

7. The Licensee shall publish each certificate provided for in paragraph 3 in such a manner as will enable any person having an interest in it to have ready access to it.

8. In this Condition:

"distribution"	includes the payment of dividends or similar payments on share capital and the payment of interest or similar payments on public dividend capital and the repayment of capital;
"Financial Year"	means the period of twelve months over which the Licensee normally prepares its accounts;
"Required Resources"	means such: (a) management resources, (b) financial resources and financial facilities, (c) personnel, (d) physical and other assets including rights, licences and consents relating to their use, and (e) working capital as reasonably would be regarded as sufficient to enable the Licensee at all times to provide the Commissioner Requested Services.

Section 6 – NHS Foundation Trust Conditions

Condition FT1 – Information to update the register of NHS foundation trusts

1. The obligations in the following paragraphs of this Condition apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.

2. The Licensee shall ensure that Monitor has available to it written and electronic copies of the following documents:

   (a) the current version of Licensee's constitution;

   (b) the Licensee's most recently published annual accounts and any report of the auditor on them, and

   (c) the Licensee's most recently published annual report,

   and for that purpose shall provide to Monitor written and electronic copies of any document establishing or amending its constitution within 28 days of being adopted and of the documents referred to in sub-paragraphs (b) and (c) within 28 days of being published.

3. Subject to paragraph 4, the Licensee shall provide to Monitor written and electronic copies of any document that is required by Monitor for the purpose of Section 39 of the 2006 Act within 28 days of the receipt of the original document by the Licensee.

4. The obligation in paragraph 3 shall not apply to:

   (a) any document provided pursuant to paragraph 2;

   (b) any document originating from Monitor; or

   (c) any document required by law to be provided to Monitor by another person.

5. The Licensee shall comply with any direction issued by Monitor concerning the format in which electronic copies of documents are to be made available or provided.

6. When submitting a document to Monitor for the purposes of this Condition, the Licensee shall provide to Monitor a short written statement describing the document and specifying its electronic format and advising Monitor that the document is being sent for

the purpose of updating the register of NHS foundation trusts maintained in accordance with section 39 of the 2006 Act**.**

Condition FT2 – Payment to Monitor in respect of registration and related costs

1. The obligations in the following paragraph of this Condition apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.

2. Whenever Monitor determines in accordance with section 50 of the 2006 Act that the Licensee must pay to Monitor a fee in respect of Monitor's exercise of its functions under sections 39 and 39A of that Act the Licensee shall pay that fee to Monitor within 28 days of the fee being notified to the Licensee by Monitor in writing.

Condition FT3 – Provision of information to advisory panel

1. The obligation in the following paragraph of this Condition applies if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.

2. The Licensee shall comply with any request for information or advice made of it under Section 39A(5) of the 2006 Act.

Condition FT4 – NHS foundation trust governance arrangements

1. This condition shall apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.

2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall:

   (a) have regard to such guidance on good corporate governance as may be issued by Monitor from time to time; and

   (b) comply with the following paragraphs of this Condition.

4. The Licensee shall establish and implement:

   (a) effective board and committee structures;

   (b) clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and

   (c) clear reporting lines and accountabilities throughout its organisation.

5. The Licensee shall establish and effectively implement systems and/or processes:

   (a) to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;

   (b) for timely and effective scrutiny and oversight by the Board of the Licensee's operations;

   (c) to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;

(d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);

(e) to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;

(f) to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;

(g) to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and

(h) to ensure compliance with all applicable legal requirements.

6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:

(a) that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;

(b) that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;

(c) the collection of accurate, comprehensive, timely and up to date information on quality of care;

(d) that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;

(e) that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and

(f) that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

Section 6 – NHS Foundation Trust Conditions

7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.

8. The Licensee shall submit to Monitor within three months of the end of each financial year:

   (a) a corporate governance statement by and on behalf of its Board confirming compliance with this Condition as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks; and

   (b) if required in writing by Monitor, a statement from its auditors either:

      (i) confirming that, in their view, after making reasonable enquiries, the Licensee has taken all the actions set out in its corporate governance statement applicable to the past financial year, or

      (ii) setting out the areas where, in their view, after making reasonable enquiries, the Licensee has failed to take the actions set out in its corporate governance statement applicable to the past financial year.

Section 7 – Interpretation and Definitions

Condition D1 – Interpretation and Definitions

1. In this Licence, except where the context requires otherwise, words or expressions set out in the left hand column of the following table have the meaning set out next to them in the right hand column of the table.

"the 2006 Act"	the National Heath Service Act 2006 c.41;
"the 2008 Act"	the Health and Social Care Act 2008 c.14;
"the 2009 Act"	the Health Act 2009 c.21;
"the 2012 Act"	the Health and Social Care Act 2012 c.7;
"the Care Quality Commission"	the Care Quality Commission established under section 1 of the 2008 Act;
"clinical commissioning group"	a body corporate established pursuant to section 1F and Chapter A of Part 2 of the 2006 Act;
"Commissioner Requested Service"	a service of the sort described in paragraph 2 or 3 of condition G9 which has not ceased to be such a service in accordance with paragraph 9 of that condition;
"Commissioners"	includes the NHS Commissioning Board and any clinical commissioning group;
"Director"	includes any person who, in any organisation, performs the functions of, or functions equivalent or similar to those of, a director of: (i) an NHS foundation trust, or (ii) a company constituted under the Companies Act 2006;
"Governor"	includes any person who, in any organisation, performs the functions of, or functions equivalent or

	similar to those of, a Governor of an NHS foundation trust as specified by statute;
"the NHS Acts"	the 2006 Act, the 2008 Act, the 2009 Act and the 2012 Act;
"NHS Commissioning Board"	the body corporate established under section 1E of, and Schedule A1 to, the 2006 Act;
"NHS foundation trust"	a public benefit corporation established pursuant to section 30 of, and Schedule 7 to, the 2006 Act.

2. Any reference in this Licence to a statutory body shall be taken, unless the contrary is indicated, to be a reference also to any successor to that body.

3. Unless the context requires otherwise, words or expressions which are defined in the 2012 Act shall have the same meaning for the purpose of this Licence as they have for the purpose of that Act.

4. Any reference in the Licence to any provision of a statute, statutory instrument or other regulation is a reference, unless the context requires otherwise, to that provision as currently amended.