The theme of today's board is CHS

Leicestershire Partnership NHS Trust

Public Meeting of the Trust Board
9.30 am Friday 1 November 2019
Venue: Framland Committee Room, County Hall

Public meeting					
Item No.	**Timings**	**Item**	**Purpose**	**Paper Ref**	**Discussion to be led by**
1	**9.30**	Apologies for absence: Gordon King, Cathy Geddes, Mark Farmer (Healthwatch) and welcome: • Ashiedu Joel, NHSI Next Director NED development scheme • Michele Morton, Corporate Affairs support • Kay Rippin, Corporate Affairs Manager • Tracy Ward, Head of Patient Safety • Paul Blakey (Healthwatch) • Paul Fisher			Cathy Ellis
2	10 mins	Patient voice film	Quality Improvement		Rachel Bilsborough
3	9.40	Declarations of interest in respect of items on the agenda			
4		Minutes of the previous meeting, 1 October 2019	Assurance	A	Cathy Ellis
5		Matters arising actions	Assurance	B	Cathy Ellis
6		Chairman's Report	Information	C	Cathy Ellis
7		Chief Executive's Report	Information	D	Angela Hillery
		Governance and Risk			
8	09.50 20 mins	Organisational Risk Register	Assurance	E	Anne-Maria Newham
9	10.10 10 mins	EU Exit Briefing	Assurance	F	Dani Cecchini

Total for section = 50 minutes					
		Strategy and System Working			
10	10.20 20 mins	NHS Long Term Plan and LLR Integrated Community Board update	Assurance	Oral	Rachel Bilsborough
Total for section = 20 minutes					
		Quality Improvement and Compliance			
11	10.40 5 mins	Quality Assurance Committee highlight report 15 October 2019	Assurance	G	Liz Rowbotham
12	10.45 10 mins	Director of Nursing's Report including AHP report	Assurance	H	Anne-Maria Newham
13	11.55 10 mins	Care Quality Commission (CQC) progress Report	Assurance	I	Anne-Maria Newham
14	11.05 15 mins	Break			
15	11.20 10 mins	Safer Staffing Report – September 2019	Assurance	J	Anne-Maria Newham
17	11.30 10 mins	Infection Prevention and Control report	Assurance	K	Anne-Maria Newham
18	11.40 10 mins	"learning from incidents" Death of a patient under the care of the crisis team	Information Assurance	L	Anne-Maria Newham
Total for section = 55 minutes (excluding break)					
		Performance and Assurance			
19	11.50 10 mins	Finance and Performance Committee highlight report 15 October 2019	Assurance	M	Geoff Rowbotham
20	12.00 10 mins	Finance monthly report – month 6	Performance	N	Dani Cecchini

21	12.10 10 mins	Integrated Quality and Performance monthly report Waiting Times Compliance AMH &LD	Performance	Oi Oii	Dani Cecchini
22	12.20 5 mins	Audit and Assurance Committee highlight report 4 October 2019	Assurance	P	Darren Hickman
23	12.25 5 mins	Review of risk – any further risks as a result of board discussion?	Assurance		Cathy Ellis
Total for section = 30 minutes					
24		Information Pack (circulated to Board members only) containing: • Documents Signed Under Seal • Seasonal Flu Vaccination Campaign 2019 -20 Executive Team paper May 2019 • LPT IPC Strategy 2019-22	Information		Cathy Ellis
25		Any other urgent business			Cathy Ellis
26		Public questions on agenda items			Cathy Ellis
27	12.30	**Date of next meeting:** The next public Trust Board meeting will be held on 3 December 2019			Cathy Ellis
It is recommended that, pursuant to Section 1 (2), Public Bodies (Admission to Meetings) Act l960, representatives of the press and other members of the public be excluded from the following meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.					

Leicestershire Partnership NHS Trust

Confidential Trust Board Meeting
1.00pm on Friday 1 November 2019
Venue: Framland Committee Room, County Hall

AGENDA

Item No.	Timings	Item	Purpose	Paper Ref	Discussion to be led by
1	1.00	Apologies for absence: Gordon King, Cathy Geddes			Cathy Ellis
2		Declarations of interest in respect of items on the agenda			Cathy Ellis
3	1.00 30 mins	Staff Voice (representatives from organisations who are supporting delivery of Integrated Care Pathways)			Rachel Bilsborough
4	1.30 5 mins	Minutes of the previous confidential meeting, 1 October 2019	Assurance	AA	Cathy Ellis
5		Matters arising	Assurance	BB	Cathy Ellis
6	1.35 10 mins	Chief Executive's report	Assurance	Oral	Angela Hillery
Total for section = 45 minutes					
		Governance and Risk			
7	1.45 10 mins	Performance Management and Accountability Framework	Assurance	Oral	Dani Cecchini
8	1.55 5 mins	Reportable issues log	Information	CC	Anne-Maria Newham
9	2.00 10 mins	HSE Inspection	Assurance	DD	Dani Cecchini
Total for section = 25 minutes					
		Strategy and System Working			
10	2.10 10 mins	LLR STP 5-year Plan and LPT Planning Update	Information	EE	Angela Hillery Dani Cecchini
11	2.20 10 mins	Mental Health Inpatients Strategic Outline Case	Approval	FF	Dani Cecchini

12	2.30 10 mins	Break			
Total for section = 20 minutes (excluding break of 10 mins)					
		Quality Improvement and Compliance			
13	2.40 5 mins	Pilot Workforce Race Equality Standard (WRES) National Programme	Approval	GG	Angela Hillery
Total for section = 5 minutes					
		Performance and Assurance			
14	2.45 15 mins	Facilities Management Review and Appraisal Options	Performance	HH	Dani Cecchini
15	3.00 10 mins	Financial Turnaround	Assurance	Oral	Dani Cecchini
16	3.10 5 mins	Review of risk – any further risks as a result of board discussion?	Assurance		Cathy Ellis
Total for section = 30 minutes					
17	3.15	Confidential Board information pack: • STP SLT 19 September 2019 meeting confirmed minutes • Leicester Leicestershire and Rutland System Trajectory Letter • LLR Financial Recovery Plan Briefing Pack • Draft LLR Assurance Architecture • CQC Action Plan • Better Care Together LLR 5-year Plan			
18	3.15	Confirmed minutes available to Board members on request (matters have previously been highlighted in the Chairs' reports): • Quality Assurance Committee • Finance and Performance Committee • Audit and Assurance Committee	Assurance		Cathy Ellis
		Board development			
19	3.15 30 mins	CHS QI Developments	Assurance	Oral	Rachel Bilsborough

20	3.45 5 mins	Board development action tracker on priorities	Assurance	II	Cathy Ellis
21	3.50 5 mins	Any Other Business	Assurance	Oral	Cathy Ellis
22	3.55	Close			

UNCONFIRMED

Leicestershire Partnership NHS Trust

Trust Board

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Minutes of the Meeting held in public on Tuesday 01 October 2019, 9.30 am

Leicestershire County Hall, Sparkenhoe Committee Room

Present:

Ms C Ellis, Chair
Mr G Rowbotham, Non-Executive Director/Deputy Chair
Ms Marchington, Non-Executive Director
Professor K Harris, Non-Executive Director
Mrs E Rowbotham, Non-Executive Director
Mr Darren Hickman, Non-Executive Director
Ms Angela Hillery, Chief Executive
Ms D Cecchini, Director of Finance
Ms Anne-Maria Newham, Director of Nursing

In Attendance:

Ms R Bilsborough, Director of Community Health Services
Mr G King, Director of Adult Mental Health Services
Ms H Thompson, Director, Families, Young People & Children Services & Learning Disabilities
Mrs S Willis, Director of Human Resources & Organisational Development
Mr F Lusk, Trust Secretary
Ms Anna Pridmore, Interim Associate Director of Corporate Governance
Mrs Michele Morton (minutes)

		ACTION
TB/19/151	**Apologies and welcome** Apologies for absence had been received from Mr F Hussain Non-Executive Director, Dr Sue Elcock, Medical Director, Ms Cathy Geddes, NHSI Improvement Director and Mr Mark Farmer, Healthwatch The Chair welcomed Mr Gordon King, Kamy Basra (Head of Communications LPT), Mrs Michele Morton, Mrs Marie Bates, and Mrs Suraiya Hassan (members of the public).	
TB/19/152	**Patient Voice**	
	A brief patient voice film was shown that featured Katherine Cooper-	

	Hayes who described her experiences as an outpatient within the CAMHs Unit, and her journey with anxiety. Katherine was unable to attend mainstream school and she felt tired and unwell all the time. After entering the CAMHs Unit she started to feel relaxed and safe. The receptionist was very welcoming and the CAMHs worker introduced himself. Katherine said he was very nice and helped her to fill in a questionnaire during a long first consultation where they talked about everything that made her feel anxious. She started to feel relaxed and things became easier. On a second visit Katherine had a panic attack in the car and she was reassured that she did not have to leave the vehicle, so instead she concentrated on the horses in the nearby field. She talked with her CAMHs worker about volunteering in the stables. The next appointment was easier and then each appointment became easier still. Windows were often opened so that Katherine did not feel trapped and helped her with her anxiety. At one time Katherine was unable to get into a car, but she now worked at the stables volunteering for five hours a day. She had been discharged but knows she could always go back if necessary. She felt free and happy again and she thanked Board members for listening to her story.	
	Ms Ellis said she was impressed by the adjustments made by the CAMHs worker to connect Katherine with horses and the kindness of the receptionist which was so important when patients were feeling anxious.	
	Mr Hickman commended the film and said Katherine should be complimented for presenting in such a structured and articulate way. He queried what the follow-up arrangements were so that Katherine could maintain her health. Ms Thompson replied that once patients were discharged, they were supported within the community. Due to her home schooling the CAMHs worker would have had a conversation with Katherine's teacher and patients were always given an offer of re-referral. If re-referred patients would then move back through the system and due to improvements in access waits 97% of patients were being seen within 13 weeks. A number of other support mechanisms would also be available, for example, on-line counselling, and early intervention services offered by Relate.	
	Ms Hillery said Katherine spoke about how impressed she was with the CAMHs environment and she said it was often easy to under-estimate how much people felt supported by their physical environment. Ms Ellis asked if any appointments would be held in the new CAMHs building. Ms Thompson replied there were no plans for outpatient clinics at the new build. Outpatient appointments would continue mainly at the Valentine Centre and Westcotes House.	

TB/19/153	Declarations of interest All Board members confirmed that they had no conflicts of interest in relation to the agenda items. The Chair reminded all Board members to record any declarations, or a nil return, on the self-service LPT Declare.	
TB/19/154	Minutes of the previous public meeting, 30th July 2019 **Resolved: The minutes of the meeting held on Tuesday 30th July 2019 were confirmed.**	
TB/19/155	Matters arising actions	
	Trust Board members reviewed the list of matters arising actions at Paper B. **893 – All-age mental health transformation:** clarity for the pre-consultation business case timeline from the Executive Team and commissioner buy-in – further discussions on the timetable to be held with Mr Gordon King and action to be updated in November. **896 – Finance Recovery Plan** - risk logged and headline plan was on the Board confidential agenda. **CLOSED**	
	Resolved: The Matters Arising had been reviewed by the Board and sta tus of actions agreed and minuted.	
TB/19/156	Chair's Report	
	The Chair presented Paper C, which provided a report on her activities between 30 July 2019 to 30 September 2019 with patients, staff and stakeholders, and the events/committees she had attended. Also included were the activities of the Non-Executive Directors (NEDs). Of particular note:	
	• A very successful 'tightening the bolt' event for the CAMHS new building on the Glenfield site had been held, with key stakeholders, patients and staff. The new unit will open in August 2020. Considerable patient involvement had helped with the design and the unit would be called 'The Beacon Unit' a suggestion from patients.	
	• The launch of the newly refurbished Involvement Centre and Café at the Bradgate Unit.	
	• The Trust was developing new governance structures for quality and performance which would mean changes for the Trust Board. Much of the assurance work would be undertaken at committees which meant that Board papers would be pitched at a more strategic level and would include less data but more triangulation.	

	A key objective would be to ensure that people were aligned behind the new governance structure and that issues flowed from ward to Board.	
	• Attached to the report were the Trust Board meeting dates for 2020 and the Non-Executive Director portfolios that had been realigned to fit with the new committee structure.	
	Resolved: The Trust Board received the Chair's report.	
TB/19/157	Chief Executive's Environmental Scan	
	Ms Hillery presented paper D that provided an update on areas of focus locally, regionally and nationally. She explained that in future the environmental scan would be replaced with a Chief Executive's report. Of particular note:	
	• Thanks were extended to the staff who played a significant role in taking the Health and Safety Executive through a series of visits and meetings. An informal discussion would be held on 4th October and feedback was expected on the 9th October 2019. • The learning disability and autism transferring care partnership had developed a recovery plan, an area very much in the regional and system spotlight at present. • A successful visit to the Bradgate unit had taken place with staff from the Police and Crime Commissioner's office. • As part of their partnership work a meeting had taken place with the Chief Constable, Mr Simon Cole, Ms Hillery and Mr King. • Very important from a financial point of view, an out of area recovery plan had been developed and programme management established where significant reductions in out of area placements were already being identified.	
	Paper Dii, the Quality Improvement Strategy – Step up to Great was received which built on the 9 agreed organisational priorities. A Quality Improvement Plan for 2019/20 would strengthen the agreed strategic framework, measures of improvement and governance arrangements. In particular: • KPIs – Trust Board members and sub-committees would be clearly sighted on the KPIs. NHS Improvement and CCG colleagues supported the format. Ms Hillery confirmed to Ms Marchington that she would expect the sub-committees to look closely at the different components and ensure they were focused on the relevant areas. Trust Board would then have an overview role. • Milestones on a page 2019/20. • Governance and the development of relationships between relevant committees to improve confidence in the areas of improvement.	
	Further key highlights raised by Ms Hillery included:	

	Long Term Plan – a 5 year piece of work and the importance of noting the timescales the system was working to. Component parts would be fitted into relevant forums. The Long Term Plan was a very challenging piece of work on a national scale. **Co-production of the LPT Vision** – a clear ambition to ensure the LPT Vision was more meaningful and reflective of CQC recommendations. Mrs Basra confirmed that she had commenced a co-production journey with staff, service users and volunteers as part of 'Our Future, Our Culture programme'. A number of initiatives had taken place to develop the vision, for example, change champion sessions, a wide distribution of surveys and a senior leadership group session. Four options had been developed and the preferred option was 'Creating high quality compassionate care and wellbeing for all' as the most inclusive statement. Ms Hillery said the co-production of a Vision would represent a step change for the organisation and would help to create energy. **UHL Capital** – and the positive news they were to receive £450 million for estate developments.	
	System Improvement and Assurance Meeting – and the significant concerns around waiting times. Significant waiting times still existed in the Trust and it was important that the Trust Board recognised the impact of that and how we monitor harm and keep patients safe whilst they are waiting. There was a need to focus on improvements both internally and with external partners.	
	Resolved: The Trust Board received the Environmental Scan report for information only. The report provided an update on areas of focus locally, regionally and nationally.	
	Governance and Risk	
TB/19/158	Corporate Risk Register (CRR) and Board Assurance Framework (BAF) – Risk Management Policy	
	Ms Hillery presented paper Ei that provided a summary of the BAF and the CRR which included the current and residual risk scores. The report was the first of a new template and cycle of risk review and it was proposed that the new CRR mapped against the 'Step up to Great' strategic framework. She felt that the new templates were a step change for the organisation and it would be important for sub-committees to focus on the detail around the risks. The controls and assurances would then become clearer through those committees. The sub-committees would also have an important role in the next steps and a board development session would be held in October to determine the organisation's risk appetite.	
	Mr Rowbotham commended the new style and said there had been a positive engagement process in the development of the new templates. He proposed that the Board looked at all the elements that had been	

	established in order to ensure that the elements aligned and complemented each other. Ms Hillery agreed and said there was a need to ensure the new arrangements worked, that included the way sub-committees considered deep dives in terms of risk, and how they were selected and to understand that some of the risks did not move significantly. It would also be important to realise that the risk management policy would be an important part of the architecture on risk management at every level.	
	Ms Marchington thanked those who had worked on the CRR and BAF and she referred to the assurance framework that sat underneath. At some point she said a discussion was required around the assurances within the relevant reports as the assurance framework was a key part of the whole.	
	The Chair asked if assurance had been gained on the payroll contract (risk number 21). Mrs Willis reported that the move to a new provider had been made on the 1st September and during that period three weekly payroll runs had taken place for 5,500 staff which had been successful. She added some remedial backlog still needed to be worked through but once complete the risk would be closed down. Mr Rowbotham proposed a vote of thanks to Mrs Willis and her team for making the payroll transition run smoothly and he felt the communications surrounding the move had been outstanding.	
	Ms Hillery reminded Board members that the risk register would be submitted to Board at each meeting and provides opportunity for reflection and to decide if risks needed to be adapted or added to.	
	Following her observations at the Northamptonshire Board meeting the previous week, the Chair said that the joint Chief Executive Officer role had been highlighted as a risk so she suggested that the same risk be added to the LPT risk register.	**FL**
	Resolved: The Trust Board: • **Agreed the proposed current CRR** • **Approved the Addition of a cyber security related risk (risk 22)** • **Agreed to a future board development session in October on risk appetite**	
TB/19/159	**EU Exit Briefing**	
	Ms Cecchini presented paper Fi that provided assurance that the Trust was preparing for a no deal EU exit, within the guidance set out by the Department of Health and Social Care. She informed the Board that the Brexit Working Group had been re-established, Chaired by Sharon Murphy, Deputy Director of Finance. The following issues had recently arisen from a regional briefing:	

	• There should be no conflict with Winter pressures and EU Exit pressures.	
	• The importance of getting the communications right for transmission to patients and stakeholders. The Chair pointed out communications would increase as more information was received. Mrs Basra added that a communications plan was in place in line with national guidance and was consistent with other organisations.	
	• Some concern had been expressed on the possible impact on social care, however the contingencies for that would be led nationally.	
	7 day Sitreps were in the process of being established.	
	Resolved: The Trust Board noted the EU exit update briefing.	
TB/19/160	External Governance Reviews	
	Ms Hillery presented paper G that provided assurance on the progress against completion of the recommendations identified in two external reports commissioned by the Trust. She made two comments as follows:	
	• Further discussion was required with the directorates in terms of strengthening and better understanding governance around levels 1 and 2 for Board and sub-committees. •	
	• The importance of maintaining a focus on the SI processes. The policy was currently draft, however significant work continued to strengthen the recommendations. The Director of Nursing and Medical Director were heavily involved in the process that included identifying any learning across the organisation. Learning lessons forums had been established to help with that and the suggestion of a centralised safety team was being explored. The aim was to incorporate the significant improvements to achieve a business as usual position.	
	The Chair said the reports were excellent and they effectively tracked progress against the two reviews. She referred to the section on clinical engagement and asked if there were any proposals to establish a consultant conference as UHL had done. Ms Hillery agreed to pursue that suggestion with the Medical Director. Professor Harris added that the UHL consultant conference had been very effective and well supported by both UHL and their executive team and people found the open forums extremely useful.	**AH**
	Ms Marchington commented that a forum would be an excellent idea for encouraging consultants to become more involved.	

	Resolved: The Trust Board noted the progress against completion of the recommendations included in the two external governance reports commissioned by the Trust.	
TB/19/161	Corporate Governance Renewal	
	Ms Hillery presented paper H that addressed the concerns outlined in the CQC report in respect of clear lines of reporting, accountability for quality, finance and performance corporate assurances up to the Quality Assurance Committee (QAC) and Finance and Performance Committee.	
	Ms Hillery explained it was part of strengthening corporate governance overall within the organisation and it illustrated and emphasised the changes being made. The area was complex but it was important that people properly understood their role in governance, in particular the different tiers and levels, and clarification was vital for the implementation of the new arrangements.	
	Ms Newham and Dr Elcock had been involved in a relationship meeting with the CQC where positive support had been received for corporate governance renewal.	
	The Chair said she felt the paper emphasised alignment and the introduction of a quality forum would change the way the QAC worked. Ms Newham replied that having a quality forum would release the QAC to develop an appropriate strategic approach and receive final assurances. Meetings had taken place with directors to ensure that directorate plans fitted within the quality forums and that issues flowed smoothly throughout the organisation.	
	Mrs Rowbotham supported and welcomed the changes. She added it was important to make the changes during October and November 2019 and she offered any support in terms of development of workplans, terms of reference etc. Ms Hillery agreed on the importance of the pace of the work and the Chair added that the changes signaled a shift in the culture of the Trust for all staff.	
	Resolved: The Trust Board approved the renewed Corporate Governance arrangements.	
	Strategy and System Working	
TB/19/162	Better Care Together (BCT) Sustainability and Transformation Partnership (STP) status, and System leadership Team (SLT) Update	
	Ms Hillery presented paper I, an August/September business update for partner boards, governing bodies and members. The update informed the Board on the key business and strategic work programme being	

	discussed and taken forward by SLT.	
	Ms Hillery explained that the report would be included in the Chief Executive's Board report in the future. She made the following points:	
	• Ms Hillery would be acting as Chair for the LLR Mental Health Delivery Board and a draft agenda was in the process of being produced.	
	• It would be important not to underestimate the scale of the financial challenge on a system wide basis.	
	Professor Harris asked what was likely to happen if a general election was held and Ms Hillery replied as yet nothing was clear but confidence must remain that any changes would be planned on a system wide level and any purdah period would be adhered to.	
	The Chair reported that the first meeting of the LLR STP Partnership Board had been held where the terms of reference were agreed. The purpose of the multi-stakeholder group would be to have oversight across the system and hold senior leaders to account for delivery of the Long Term Plan. The final version of the terms of reference was expected in time for the November Trust Board meeting.	
	Ms Marchington said it would be useful to have some reassurance that the relationship with the local authorities was positive. Ms Hillery replied engagement with local authorities had been strengthened, particularly the Health and Wellbeing Boards. Health colleagues had attended scrutiny committees when invited and information on strategies had been shared (the Community Services Redesign Outline Business Case would be shared shortly). A session on the estates strategy was also planned shortly with City partners.	
	Resolved: The Trust Board received the Better Care Together Partnership update for information.	
	Quality Improvement and Compliance	
TB/19/163	Quality Assurance Committee (QAC) Highlight Reports August and September	
	Mrs Rowbotham presented papers Ji and Jii, the QAC highlight reports from the August and September 2019 meetings. Changes were planned to make the report more aligned with the Mortality and Morbidity Surveillance Group, specifically in relation to data analysis. Key highlighted points:	
	CQC Inspection Update – the need was reinforced for continual updating the narrative within the plan as this is used to provide external	

	assurance to the CQC and other stakeholders. Risk assessments would also be included in the next report to QAC. Ms Hillery added that the CQC had provided a clear steer of what they would like to see as they felt LPT was in a much stronger position than indicated in the action plan.	
	Safeguarding Committee – concerns remained over medical leadership and representation. The safeguarding committee had been closed down and responsibilities transferred to a legislative committee. Ms Hillery emphasised the importance of safeguarding and the need for the QAC to identify safeguarding risks and ensure they were at the correct level. A reorganisation of capacity would be taking place. Mrs Rowbotham added that the external review would help with risk categorisation.	
	Mr Rowbotham said it would be important to have a dynamic approach and fully understand the interventions. He was concerned the position might become static. Ms Hillery replied that sub-committees must look at risks, challenge themselves and be well informed on the importance and appropriateness of deep dives. Executive Directors would also be assisting with that.	
	Ms Marchington felt improvements were already taking place in terms of engagement and the establishment of safeguarding risks. Further key areas included:	
	IPC Inspection Report and Action Plan – action being taken to achieve flu vaccination levels and assessment of whether they would be achieved. Also Mill Lodge padding had a temporary solution and a permanent solution agreed and funded.	
	Director of Nursing Update – a new report to be introduced that related to quality surveillance.	
	Resolved: The Trust Board received the QAC highlight reports for the August and September 2019 meetings.	
TB/19/164	Waiting Lists	
	Ms Newham presented paper K on waiting lists on behalf of Dr Elcock, and she explained that it had been clearly identified as a key risk area in the Trust, with a large number of patients waiting across a large number of clinical services. NHS Improvement had given clear guidance that the Trust needed to establish robust harm assurance processes. Two new process were planned:	
	• To introduce a clear set of principles to which all services must adhere to when entering a patient onto a waiting list.	

	• To develop a process to undertake Harm Reviews to monitor and learn about any harms caused to patients whilst on the Trust waiting lists and then act on the learning with a system overview.	
	The report had been well received at a Strategic Improvement and Assurance Meeting where it was acknowledged there were clear processes for cancer patients in acute trusts, but limited processes for mental health patients. Ms Hillery highlighted the following:	
	• Waiting times had been identified as a key risk. • There were 7 priority services in mental health and a trust wide waiting times group had introduced a clear set of priorities. • A process had been developed to undertake harm reviews with an agreed collaborative approach across LLR. • From October onwards a system-wide harm review panel would ensure system oversight.	
	Mrs Rowbotham sought clarification on the 52 week waiters and Ms Hillery said it included every patient waiting over 52 weeks in mental health services.	
	Mr Rowbotham said the whole issue of waiting times was crucial with considerable misunderstanding, both at national and local level around the definitions. It would be important to carry out a mapping exercise as a second tier level of work to better understand the situation. Ms Newham confirmed to Mr Rowbotham that NHS Improvement and the CCGs had also acknowledged the need to be clearer around what was a complex situation. She added that the 422 patients waiting over 52 weeks in LPT had been assessed and were waiting for treatment or the next phase of ongoing treatment.	
	Ms Hillery acknowledged the waiting times work was considered as leading edge; however it had been developed due to the serious nature of the waiting times which was a significant challenge. Performance management would be strengthened to support the work.	
	Ms Newham confirmed to Professor Harris that conversations were being held with patients on how much harm they were experiencing as a result of delays. The Chair queried whether the governance team in Adult Mental Health services was sufficiently aligned for an appropriate focus and Mr King said it was too early to gauge the robustness of the new structures and challenges were linked around the flow of patients in acute wards. Waiting times reduction would be a main focus for the directorate going forward.	
	Ms Hillery concluded by saying the Board needed confidence in the clarity of the data to be able to understand access and internal waits for treatment.	

	Resolved: The Trust Board was: • **Assured that a process was being implemented to manage the entry of patients on to waiting lists robustly.** • **Assured that a process was being commenced to enable the levels of harm occurring to any patients on waiting lists to be measured. The process would continuously develop as learning occurred.**	
TB/19/165	Director of Nursing's Report Including AHP Report	
	Ms Newham presented paper L, a very brief summary of events and horizon scanning that was pertinent to the quality agenda. She highlighted the following:	
	• Strategic Improvement and Assurance meetings had been held on the 23rd July and 27th August (attended by NHS Improvement, CCGs and LPT), where patient waiting lists were discussed and the need to ensure the Board was more sighted on waiting list information.	
	• A new approach towards complaints had been agreed. From 1st October the response rate would be 25 days unless there were exceptional circumstances.	
	Ms Hillery said she welcomed the change in the complaints response times and it would be important to ensure the Trust had the capacity to deliver that.	
	Resolved: The Trust Board noted the summary of events and horizon scanning.	
TB/19/166	Care Quality Commission (CQC) progress Action Plan	
	Ms Newham presented paper M that provided the Board with progress on the implementation of actions that resulted from the last CQC inspection. An excerpt from the action plan had been provided in the Board information pack.	
	The Chair referred to the established CQC progress meetings held on a bi-weekly basis and she said the Trust had previously been criticised for silo working, however the meeting was a forum where everyone came together and was making a huge difference to improvement progress and she thanked the staff engaged in that process.	
	Mr Rowbotham said the month on month progress was impressive and the spot checks were important in order to identify embeddedness. He sought clarification on the timeliness of all the actions and whether the Trust was content that the timescales were being met. Ms Newham replied that some slippage had occurred around some of the actions. Some of the longer term areas would continue to show red, for	

	example, the estates strategy but it was essential that work completed was signed off by the appropriate committee.	
	Resolved: The Trust Board noted the information included in the report and was assured that work to implement actions was progressing.	
TB/19/167	Mortality Surveillance Quarterly Reports	
	Ms Newham presented paper Ni and Nii an update on progress with 'Implementing the Learning from Deaths framework: key requirements for trust boards', an NHS Improvement document produced in July 2017. The following points were noted:	
	• A Learning from Deaths Policy had been agreed and once complete would be implemented within the Trust.	
	• A first written report from the LeDeR was expected and learning would be disseminated accordingly, within the immediate Learning Disability Team and across the Trust where appropriate.	
	• The Trust Suicide Prevention Group would be looking to develop a Trust Strategy and Policy on Suicide Prevention, Self-Harm Management and the implementation of the Trust's Zero Tolerance Ambition for inpatient suicides. Ms Thompson was the lead director for the Trust.	
	In respect of a review of child deaths in FYPC, Ms Thompson confirmed to the Chair that all cases went through the Child Death Overview process and lessons were still being learned from all 10 deaths.	
	Mrs Rowbotham reported that governance arrangements had been reviewed in respect of learning through deaths and that had been transferred to the Head of Patient Safety.	
	Board members noted that the Trust was an outlier nationally in terms of mortality and a number of key priorities had been produced to redress that. Ms Newham confirmed to Ms Marchington that oversight was nationally led.	
	Ms Newham informed Board members that the main focus was all on transferring care and getting people out of institutions.	
	The Chair concluded by saying that the report showed that further data was expected in October. For future reports it would be important to ensure the timing of the Mortality Surveillance Group meeting coincided with the receipt of information.	
	Resolved: The Trust Board: **Received the information related to all deaths in scope for Q4 2018/19 and Q1 2019/20**	

	Noted the priorities for further work as set by MSG.	
TB/19/168	Serious Incidents Quarterly Report	
	Ms Newham presented paper O, a report under development that provided an overview of incidents across the organisation, including the identification of key learning. Key highlights were:	
	• An external Crisis Consultant would be carrying out a review, initially on one SI where a patient took their own life whilst under the care of the crisis team. He would also be considering the model of care to ensure that usefulness was maximised in respect of available resource.	
	• An Associate Medical Director of Quality was now in post and NHS Improvement had developed guidance to identify learning from incidents.	
	• All grade 4 pressure ulcers were to be reported as SIs due to the extent of harm.	
	Ms Newham explained to the Chair that the Trustwide incident data in the report would be shown using statistical process charts for incident reporting and she agreed to ensure there would be no identification of patients.	**AMN**
	The Chair said the deep dive on the Crisis Team would be really important and that the Coroner would appreciate the action being taken as an organisation. Ms Newham said the deep dive would be carried out similar to previous risks by looking at trends, any development areas, opening up conversations and drawing out information, and would be a further step change for the organisation.	
	Ms Hillery said she welcomed the change and that the Trust Board would need to keep a focus on patient safety in addition to the QAC.	
	Resolved: The Trust Board received the Serious Incidents Quarterly Report for quarter 1.	
TB/19/169	Annual Complaints Report 2018/2019	
	Ms Newham presented paper P, the annual complaints report that acted as an effective measure of the Trust's patient experiences and gave an opportunity to learn and improve the services provided. Board members noted:	
	• 497 complaints had been formally registered. • 74% of complaints were responded to in the agreed timeframe. • 59 complainants were unhappy with their response. • 100% of complaints were acknowledged within 3 working day.60% of complaints was partly upheld.	

	• 23 complaints were resolved in 10 working days.	
	One of the themes was the attitude of the nursing staff and that was being addressed as part of the culture changes. Trends and themes were also being identified via the patient experience process. Categories had been reviewed and were now in line with national complaint reporting and the implementation of a new complaints review committee had taken place as part of the quality governance structure. One focus for the future was a self-assessment of the current process.	
	Mrs Rowbotham said she welcomed the investigation into the attitude of staff; however she hoped that would be compared with the areas that worked really well.	
	Mr Hickman commended the report, particularly the case studies, but with respect to ethnicity he felt the results were out of kilter compared to the LLR population. Ms Newham replied that the patient experience team held a development session looking at how to engage with the wider community and ensure their views and complaints were captured.	
	Mr Rowbotham said he liked the report and he queried what would be changed in terms of quality improvement as the themes had remained the same for the previous three years. He asked when information on the outcomes would be added. Ms Hillery replied that information on the outcomes was a very important area and the introduction of a complaints review committee would help to strengthen that process by carrying out thematic analysis. The Complaints Review Committee would identify any learning and understand better how to measure improvements in trajectories in a timely manner. She also felt complaints response times should be added to the risk register.	
	In respect of the ethnicity analysis the Chair said 97 people had not declared their ethnicity which she felt was a lost opportunity to know where complaints came from and more should be done to capture that information.	
	Resolved: The Trust Board received the Annual Complaints Report 2018/2019.	
TB/19/170	Infection prevention Visit NHS Improvement	
	Ms Newham presented paper Q that provided the Trust Board with a robust action plan in response to the recommendations from the visit by Dr Debra Adams, Senior Infection Prevention and Control (IPC) Advisor, NHS England and Improvement, following the findings identified in the CQC report dated February 2019 in relation to IPC. Monitoring and assurance processes were outlined in the report which was reviewed at QAC on the 17th September 2019.	

	Ms Newham said the actions had been added to the CQC action plan and a 6 monthly IPC report would be received at the November Board meeting. An external review of IPC had been commissioned and Dr Adams would be undertaking a follow up visit in January 2020.	
	The Chair referred to the action plan report in the board information pack Board members noted the information had been circulated widely across the whole organisation.	
	Ms Marchington said considerable difficult discussions on IPC had been held at the QAC, particularly the behavioural and cultural issues. Ms Newham agreed and said useful conversations had addressed issues around basic care, cleanliness and the environment.	
	Mr Rowbotham said there was a need to triangulate some of the information between the Board and the committees with cross organisation discussion to reach the root of some problems. Ms Newham added that the report had highlighted some issues the Trust was not aware of, for example, the quality of the cleaning contract and how facilities management worked.	
	In conclusion the Chair said the key thing was to be ready and prepared for the follow up visit in January 2020 and that completion of the actions were evidenced in the CQC action plan. Ms Newham added IPC was everybody's business and the work was a great example of 'Well Led' and matrix working.	
	Resolved: The Trust Board were: • **Assured that actions taken in response to the NHS England and Improvement Infection Prevention visit were robust and:** • **Approved recommendations for future monitoring and assurance.**	
TB/19/171	Guardian of Safe Working Hours (Junior Doctor Contract) Quarterly	
	Ms Newham presented paper R on behalf of Dr Elcock. The report provided assurance to the Trust Board that doctors in training in LPT were safely rostered and had safe working hours that complied with the terms and conditions of service. Of particular note was:	
	• 3 exception reports had been raised during the period. • Information was provided on work schedule reviews and rota gaps. • Information was provided on the implementation of changes to the 2016 TCS as implemented in August 2019.	
	Ms Newham said £60,000 had been received for the improvement of working conditions which had resulted in the purchase of laptops and the refurbishment of the on-call room.	

	In response to a query from the Chair Ms Newham agreed to find out more information about the three exception reports and whether they had been satisfactorily resolved.	**AMN**
	Resolved: The Trust Board were assured that doctors in training at LPT were safely rostered and had safe working hours that complied with the terms and conditions of service.	
	Performance and Assurance	
TB/19/172	Joint Quality Assurance Committee and Finance and Performance Committee September	
	Mrs Rowbotham and Mr Rowbotham jointly presented paper S, an overview report on the Finance and Performance Committee and Quality Assurance Committee joint meeting held on the 17th September 209. Key points of note included:	
	• The committee received an update on Trust performance against local and national waiting times targets. • A process for managing the impact to patients and potential harm whilst waiting for treatment was presented.	
	• A draft high level Estates Strategy was received.	
	Ms Hillery said it was helpful to be able to look across both committee areas and she queried whether waiting times should show as red and not amber. She agreed the Trust had showed some improvement, however the Trust remained a significant national outlier and clarity was still required on the resources needed to meet patients' needs. Mr Rowbotham replied the area was amber due to the focus on the actual harm process but Ms Hillery felt overall the assurance level should still be red. It was agreed to review the rating.	
	Resolved: The Trust Board received and noted the issues raised in the highlight report.	
TB/19/173	Finance and Performance Committee Highlight Report August and September	
	Mr Rowbotham presented paper Ti and Tii, an overview report on the Finance and Performance Committee meeting held on 20th August 2019.	
	The committee was not assured on facilities management around some problem areas. Mrs Rowbotham referred to the ongoing facilities management review and the importance of identifying and being clear about any interim arrangements that might need to be introduced prior to March 2020. Ms Cecchini replied the Trust was now much clearer on delivery against the facilities management arrangements and was	

	beginning to navigate through the escalation process. The facilities management arrangements sat within UHL, both NHS Trusts within the system and a conversation would be held and evidence would be sought for assurance of a safe transition if necessary. Any changes would be handled in a carefully managed way.	
	A conversation was held on the confusion caused that KPIs showed a good cleanliness standard when that was not always the case and also that the specification might be achieved therefore consideration should be given on whether the Trust was spending sufficient resources on services.	
	Ms Hillery questioned whether the IQPR should have an assurance level of red. Mr Rowbotham replied that a revised IQPR would be presented at the next meeting and if the committee did not feel sufficiently assured then the level would turn red.	
	In conclusion the Chair highlighted the key risk areas as facilities management, waiting times, performance oversight and the electronic patient record especially ensuring that staff were trained on SystemOne to improve reporting processes and data management.	
	Resolved: The Trust Board received and noted the issues raised in the highlight reports.	
TB/19/174	Finance Monthly Report – Month 5	
	Ms Cecchini presented paper U that provided assurance that the Trust financial position was intensively monitored and managed, with any perceived adverse impact immediately and clearly highlighted to senior management. Of particular note:	
	• The financial position for the period ended 31 August 2019 (month 5) showed a £482,000 surplus, which was in line with plan.	
	• Operational budgets were currently overspending by £2,077,000, the run-rate overspend for month 5 was £486,000.	
	• £1.5 million capital had been released which was good news and that would be spent on backlog issues.	
	Ms Cecchini reported that the financial position continued to deteriorate and if no change occurred it would be necessary to reflect a deficit against plan by month 7. She drew the Board's attention to the scenarios analysis that demonstrated a summary of the forecast outturn if the situation remained unchanged.	
	Some contingencies had been introduced and an internal formal approach on financial turnaround had been introduced. A turnaround group had been established and themes were being identified by Senior Responsible Officers, with senior management support. Work	

	continued on a number of grip and control actions and sustainability plans were under development to ensure the Trust entered the new year broadly in line with plan. A main focus was on the current year followed by a three year programme for longer sustainability.	
	Professor Harris emphasised the importance of challenging the non delivery of CIPs and to also identify new schemes. He felt there had been some distraction with the CQC action plan and it was now important to start to shift the focus back to key important areas. Ms Hillery acknowledged the level of work required but added opportunity existed to work in smarter and more efficient ways and benchmarking would be a key part of that and to ensure a good balance between quality and safety.	
	Mrs Rowbotham sought reassurance that the Quality Impact Assessment (QIA) process was fully embedded and integrated and that the Board had oversight of the position. Ms Cecchini explained that the QIA formed part of the turnaround group and discussions were held on achieving a balance between finance and quality. Oversight was via the Finance and Performance Committee which would receive reports from the turnaround group.	
	The Chair noted the focus on the reduction of agency staff spend and out of area placement reduction. Board members acknowledged the scale of the financial challenge within the remaining 6 months of the year, and the ambition of the executive team to support that task.	
	Resolved: The Trust Board accepted the reported financial position and supported any further actions designed to improve the year end forecast, as agreed and discussed during the meeting.	
TB/19/175	Integrated Quality and Performance Monthly Report	
	Ms Cecchini presented papers Vi, Vii and Viii that summarised the Trust's performance against key NHS Improvement, Commissioner and other targets. It also provided analysis and commentary on those areas which required additional actions to ensure that the targets and objectives were achieved. The strategic objective measures aligned to the Trust's Step up to Great priorities would be reviewed during 2019/20 and included in a future iteration of the report. The Chair replied that she looked forward to receiving a new version of the report.	
	Resolved: The Trust Board: • **Received assurance with regard to areas of quality and performance where performance improvement action was being undertaken.** • **Received the NHS Improvement compliance segment rating of three.**	

TB/19/176	Charitable Funds Highlight Report (September)	
	• The Chair presented paper W, a highlight report to the Board from the Charitable Funds Committee meeting held on the 10 September 2019. There had been a focus on fund raising and spending on areas of wellbeing for staff and patients as follows: • Staff wellbeing and the refurbishment of staff rooms were being actively supported. • New Beacon Unit and CAMHS appeal fund launched to raise £15,000 for a new sensory room.	
	Recent reprocurement of investment advisors and the delay in transfer of investment funds.	
	Professor Harris asked if any risks existed around the uncertainty of the investment market. The Chair replied a £1.8 million investment had been considered as a small risk beyond the control of the charity and it was mitigated by advice which was always sought from the professional investment advisors.	
	Resolved: The Trust Board received and noted the issues raised in the highlight report.	
TB/19/177	Strategic Workforce Group (SWG) Highlight Report (September)	
	Ms Willis presented paper X, an overview report to the Board from the SWG meeting held on 11 September 2019.	
	Ms Bilsborough referred to the themes identified from Listening to Staff and the difficulties of being fully assured in all of the areas, for example, around culture and ethnicity. Mrs Willis replied that some areas would be scrutinised in more detail by the Quality Improvement Board.	
	Ms Hillery asked if the compliance on bank mandatory training modules posed a safety and quality risk. Mrs Willis replied the QAC received more detailed information around compliance and one action had been to stop bank staff from working until they were compliant and that had resulted in some improvement.	
	Ms Marchington pointed out that target achievements usually showed as green when measured against processes or actions. However she emphasised the importance of being clear about what the Trust was assuring itself on in relation to the outcomes.	
	Resolved: The Trust Board received and noted the issues raised in the highlight report.	
TB/19/178	Receipt of Documents for Information	

	Resolved: The Trust Board confirmed receipt of: • Corporate Risk Register • CQC Action Plan Excerpt • STP SLT meetings confirmed minutes • SLT Business Update August / September 2019 • Annual Infection and Prevention Control Report • Clinical Audit Annual Report • LLR System Plan • NHS Improvement Infection Prevention Visit Action Plan	
TB/19/179	Any Other Urgent Business	
	Recap of Risk Areas	
	The Chair recapped to ensure all the risks highlighted through the meeting were reflected on the risk register:	
	Out of Area Placements – significantly high – Mr King and his team to determine the correct level and whether any reductions could ensue. **Safeguarding** - and required clarity over the risk levels. **Complaints** – a new addition and consideration within the context of the Well Led CQC domain and reaching the 25 day response times target. **Waiting Times** - and consideration of the level of risk. **Joint Chief Executive Officer** - role. **Performance Management** - and IQPR. **Harm review delays** - and backlog clearance of long waits. **Crisis team** – level of incidents **CQC action plan** robustness of spot checking to ensure actions were embedded. **Electronic Patient Record** – volume of training and level of reporting – also to consider the controls and assurances in emerging risks. **CIP** - Delivery. **Hospital Cleanliness.**	
TB/19/180	Public Questions on agenda items	
a.	Complaints Annual Report	
	Within the context of the discussion on engaging a more diverse population to complain Mrs Suraiya Hassan asked if there was any appetite to further explore that issue in order to gain a greater understanding. Ms Newham replied that two groups had been established around equality and diversity for both staff and patients and discussions had been held on what it might feel like to complain at LPT, particularly from a BAME perspective (and all of the protected characteristics).	

b.	Serious Incidents	
	Mrs Bates referred to the serious incident discussion and the self-harm to a patient from a razor blade. She asked what the policy was in terms of being in possession of razor blades. Ms Newham replied that there was a search policy, however if patients were informal and allowed to enter or leave premises at any time it was often difficult to carry out a full search and staff did not have that right as those patients had not been sectioned. Work was ongoing with patients on a regular basis around secreting items such as lighters and smoking implements.	
	Resolved: The Trust Board noted the above.	
TB/19/181	Date of Next Meeting	
	The next public meeting would be held at 9.30 am on Friday 1 November 2019 at County Hall.	

B

Leicestershire Partnership NHS Trust

TRUST BOARD 1 November 2019

MATTERS ARISING FROM THE PUBLIC TRUST BOARD MEETINGS

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

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

Action No	Meeting month and minute ref	Action/issue	Lead Officer	Due date	Outcome/evidence (actions are not considered complete without evidence)
893	July TB/19/127	All-age mental health transformation: Clarity was needed for the pre-consultation business case timeline and this would be considered by the Executive Team. Confirmation of Commissioners buy-in was also key.	Gordon King	3 December 2019	Following further discussions on the timetable with Mr Gordon King the intention is now to bring a business plan and delivery plan to the December Trust Board.
899	October TB/19/158	The joint Chief Executive Officer role had been highlighted as a risk at	Frank Lusk	1 November 2019	NHFT has been contacted for their risk description for consistency in approach. Once their risk has been finalised it will be

Action No	Meeting month and minute ref	Action/issue	Lead Officer	Due date	Outcome/evidence (actions are not considered complete without evidence)
		NHFT so Chair suggested that the same risk be added to the LPT risk register.			shared with LPT for our review, amendment and addition to LPT's Organisational Risk Register.
900	October TB/19/160	Proposals to establish a consultant conference as UHL had done. Ms Hillery agreed to pursue that suggestion with the Medical Director.	Angela Hillery	1 November 2019	The division of psychiatry organizes a yearly consultant day. This is currently in the planning stages for early 2019 and the Chief Executive and Medical Director will be invited.
901	October TB/19/171	Guardian of Safe Working Hours report had three exception matters and Ms Newham agreed to find out more information whether they had been satisfactorily resolved.	Anne-Maria Newham	1 November 2019	All are resolved appropriately. We are starting to engage and consult with the trainees to consider changing the on-call rotas given their intensities.

C

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

Trust Board 1st November 2019

The period covered by this report is from 1st October 2019 to 31st October 2019

Hearing the patient and staff voice	• Chair boardwalk to the Infant Feeding team which connects to my role as UNICEF Baby Friendly Guardian. Observed a clinic appointment and attended the Infant Feeding network training meeting with staff from LPT, UHL and local authorities. • Non-Executive Directors boardwalks to: o FYPC - Health Visiting Hinckley o CHS- Heart Failure nurses o AMH/LD - Community Mental Health Team Rutland • RU OK? at Leicester station meeting members of the public on World Mental Health day to check in on their wellbeing
Connecting for Quality improvement	• Gave opening speech at Allied Health Professional conference for approx. 100 staff. Focused on STEP up to GREAT and linked it to AHP leadership, the culture priorities of our change champions and a patient story highlighting compassionate care by AHPs • Gave opening speech at Learning from Incidents conference for approx. 60 staff. Focused on STEP up to GREAT and linked it to leadership for high standards, promoting a safety culture and a patient story which detailed the experience of a family during an SI investigation • Attended 2 learning forum CQC progress meetings for LPT staff which are led by the Director of Nursing, AHPs & Quality • LPT / NHFT Buddy forum sharing learning opportunities across both organisations
Promoting Equality Leadership & Culture	• Staff long service awards ceremony recognising 123 staff (25, 30 and 40 years) and 34 volunteers (5, 10, 15 and 20 years). Great opportunity to thank staff for their contribution to the NHS and the experience they bring to work everyday. • University of Leicester – honorary appointments ceremony to recognise staff from LPT and UHL and their contribution to teaching and research. • Reverse Mentoring reflection session with other leaders who are being mentored by our BAME staff
Building strong Stakeholder relationships	• CQC engagement meeting to review LPT progress • NHSI System Improvement & Assurance Meeting to review LPT performance • NHSI Midlands Leaders event for Chairs and CEOs • Meeting with Carlton Hayes Charity to review the charitable grants made by them to LPT's Raising Health charity during 2019.
Good Governance	• Board development session on 23rd October which focused on our well-led self-assessment and a workshop to define our risk appetite • Attended Quality Assurance Committee, Finance & Performance Committee – both committees now in transition to new governance structure • Non-Executive Directors mid-year appraisals and team timeout to clarify our collective role in the new governance structure and processes

Abbreviations:

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

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board – 1st November 2019
Paper number	D

Name of Report Chief Executives Report

For approval		For assurance		For information	Y

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

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

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

Assurance : What assurance does this report provide in respect of the Organisational Risk Register?	Links to ORR risk numbers
n/a	None believed to apply

Recommendations of the report
The Board is asked to consider this report and seek clarification or further information pertaining to it as required.

1. Introduction/Background

This paper provides an update on current local issues and national policy developments since the last meeting. The details below are drawn from a variety of sources, including local meetings and information published by NHS Providers and the Trust's regulators.

2. Aim

The aim of this paper is to ensure the Board is updated on national and local developments with the Health and Social care sector.

3. Recommendations

The Board is asked to consider this report and seek any clarification or further information pertaining to it as required. The Board is asked to support the new style of the CEO Report.

4. Discussion

National Developments

The Queens Speech

The Queen's Speech has introduced two bills directly related to health and social care (the Health Service Safety Investigations Bill and the Medicines and Medical Devices Bill), with the possibility of two more (on the NHS long term plan and on adult social care). The government has also committed to continuing to reform the current Mental Health Act.

Subject to political changes, the two confirmed bills will likely be introduced before Christmas. The draft legislation to implement the recommendations of the NHS Long Term Plan is currently expected to be published in January for pre-legislative scrutiny.

New mental health taskforce

NHS England has announced that a new taskforce will be set up to improve current specialist children and young people's inpatient mental health, autism and learning disability services. Children's commissioner Anne Longfield OBE will chair an independent oversight board to scrutinise and support the work of the taskforce. This will track progress and propose rapid improvements in existing services, examine the best approach to complex issues such as inappropriate care, out of area placements, length of stays and oversee the development of genuine alternatives to care, closer to home.

NHS Providers and NAPC to work together to promote effective collaboration between primary care and trusts

The leading membership bodies for trusts and primary care providers have announced their intention to work more closely together. NHS Providers and the NAPC plan to work together in response to the ambitions of the NHS long term plan to champion integration between primary and secondary care.

The two organisations will work together to explore and promote effective collaboration between primary care and trusts with a strong emphasis on learning from NAPC's primary care home model - the model that has influenced national primary care network policy and shown the 'art of the possible'.

NHSE/I Q1 Financial Figures

NHS England and NHS Improvement (NHSE/I) released the **quarter one (Q1) financial figures** for the provider and commissioning sectors. The provider sector is forecasting a deficit of £279.8m, slightly ahead of the planned outturn of a £281.8m deficit. If achieved, this would be a significant improvement on last year's year-end deficit of £575m.

Appointments

- The Care Quality Commission (CQC) has appointed a quality and safety leader from New Zealand to head up its inspection of mental health services. Kevin Cleary, a quality improvement lead for mental health at the largest district health board in New Zealand, has been appointed as deputy chief inspector and mental health lead for CQC. He will take over from Paul Lelliott in September;
- The Medicines and Healthcare products Regulatory Agency has appointed an interim chief executive. June Raine, the MHRA's director of the vigilance and risk management of medicines division, will take over from Ian Hudson. Dr Hudson will be stepping down after six years in the role;

Recent publications:

- The Care Quality Commission (CQC) has published **State of health care and adult social care in England 2018/19**. The report is CQC's annual assessment of health and social care in England and looks at trends in quality, shares examples of good and outstanding care, and highlights where care needs to improve.

- The government has published the first **State of the nation report on children and young people's wellbeing.** The report brings together evidence on children and young people's wellbeing and identifies key trends and drivers, following a commitment made by the government last year to publish an annual report to better understand patterns and issues in young people's mental health. The report collates multiple data sources to report new statistics on wellbeing in children (aged 10 to 15 years) and young people (aged 16 to 24 years) in England, as well as drawing on existing evidence to capture the wider experiences in children and young people's lives which may impact, or be indicators of, their wellbeing. In addition to this report, the government has committed to publishing guidance for schools to help them measure their students' wellbeing and make sure appropriate support is in place. The guidance is currently in development and will include advice for schools on when and how to seek further specialist support for pupils.

- The National Institute for Care Excellence has **published** a quality standard on identifying, assessing and regularly reviewing the care and support needs of people with a learning disability as they grow older. This quality standard describes high-quality care in the following priority areas for improvement: person-centred needs assessment, named lead practitioner, future planning and review, annual health check, and hospital admissions;

- NHS England and NHS Improvement has published the ***Mental Health five year forward view dashboard Q4 2018/19.*** The dashboard is intended to help monitor progress against the delivery of the *Five year forward view for mental health* and is published on a quarterly basis.

- NHS Trusts can now assess where they stand on the new **Freedom To Speak Up index** that highlights workers' views of the speaking up culture in organisations. The FTSU Index was created using four questions from the annual NHS Staff Survey. It enables trusts to see at a glance how their speaking up culture compares with others, providing trust boards with an indicator to learn more about the Freedom to Speak Up culture in their organisation.

  The index highlights that the Trust is performing as average for trusts of a similar type (combined mental health / learning disability and community trust).

Local Developments

LLR Better Care Together Update

The latest edition of Partnership Update, the Leicester, Leicestershire and Rutland Health and Social Care Better Care Together (BCT) newsletter for health and care staff and our community, has been previously circulated to the Board and going forward will be included within this report. The latest System Leadership Team met on 17th October 2019 and whilst we await the next newsletter discussions focused on the following areas:

System quality assurance processes – Appendix 1 highlights final draft proposal for the LLR System Assurance process. The LLR Chief Officers have provided feedback to the regional team

Long Term Plan- Following feedback from NHS England/Improvement on the Long Term Plan and work continues on updating the plan.

Transforming care - Transforming care programme remains a priority area for the region, and locally we continue to work with regulators to meet the trajectory as a region and system.

Ageing Well initiative - LLR has submitted an expression of interest to be an accelerator site for the national initiative "Ageing Well" which aligns with the Community Service Redesign plans, we await the outcome

Recent events

- ***Long Service Awards*** – I was delighted to see so many staff at the recent long service awards on 4th October, it provided a brilliant opportunity to celebrate and recognise our hard-working staff and volunteers – thank you.

- ***World Mental Health Day (10th Oct) –*** It was great to see teams involved in the events that took place across the county to celebrate World Mental Health Day, in particular the RUOK? Event which LPT has led and delivered with partners each year since 2015. Volunteers from across the Trust spent the day at Leicester Train Station, asking RUOK and engaged with around 2,500 commuters, raising awareness of the small acts of kindness we can all take to help raise a mood. This year the RUOK event was rolled out across five other key railway stations for the first time.

- ***AHP Day (14th Oct)*** **–** I was really pleased to see staff coming together and celebrate National AHP Day at the Trusts first ever AHP conference on 11th October 2019. The day included guest speakers from NHS England and Improvement, Health Education England, as well as 2019 AHP leader of the year, Angela Shimada, who ran a workshop on AHPs as leaders and enablers.

- ***October Speak Up Month*** **–** A series of events are taking place throughout the month to raise awareness of speaking up and listening to staff. Our Freedom To Speak Up (FTSU) Lead, Pauline Lewitt, has scheduled in a number of events throughout October at various locations that will provide staff the opportunity to learn more about the FTSU Guardian role, the part FTSU Partners are playing in championing speaking up and raising concerns, and how Pauline can directly support staff in raising concerns.

- ***Senior Leadership Briefings*** – We have recently re-introduced our senior leadership briefing events with 2 events taking place so far and further held focusing on Step Up To Great priorities.

- ***Black History Month*** - October is Black History Month (BHM) and the Trust started the month by launching BHM celebrations at the NSPCC. Further celebrations to celebrate the contribution of our Black, Asian and Minority Ethnic staff, and, notable figures in the course of history who have also made a significant impact in the development of British society are planned throughout the month.

Awards news

- Our congratulations go to Haseeb Ahmad, our Equalities and Diversity Lead as he is named as one of the top 10 most influential people with a disability in the UK on the disability power list 100.

- I am pleased to advise that the workforce e-rostering team were shortlisted for two Allocate awards; Achieving Cultural Excellence and Operational Roster Excellence – whilst we did not win we were highly commended for the “Operational Roster Excellence” category.

- I am proud to share that the Trust are included in the East Midlands winners for the MOD Employee Recognition Scheme Gold Award for 2019 and we look forward to the awards ceremony in November.

- Bradgate-based community police officer PC Craig Smith-Curtis has been recognised with an award from the Leicestershire Force for the success of his partnership working with our Mental Health in-patient teams.

- The Planned Community Nursing teams will be at the Nursing Times awards on October 30th October. The teams have been shortlisted for the "Technology and Data in Nursing" award following a transformation project over the past 18 months. Further information can be found **here**.

Relevant External Meetings attended since last Trust Board meeting

Service visits by Executive Directors since last Trust Baoard

Sept/Oct 2019
Infection Prevention & Control Team
Hospice at Home
HR (Recruitment, Medical Staffing & Centralised Staffing)
Crisis Resolution
Angus Unit – Time Out
Bradgate Unit - Prayer Room
Bradgate Unit – Crisis Team
Bradgate Unit – Ashby Ward

Chief Executive external meetings since last Trust Board

Sept/Oct 2019
System & Assurance Meeting
Quarterly CQC Engagement Meeting
Meeting with Liz Kendall, MP
NHS Provider Conference (Guest Speaker on Panel)
Donna Briggs, Chief Finance Officer and Deputy MD at NHS East Leicestershire and Rutland CCG
John Adler, Chief Executive at University Hospital Leicester
Andy Williams, Incoming joint Chief Executive for Leicester City Clinical Commissioning Group, West Leicestershire Clinical Commissioning Group and East Leicestershire and Rutland Clinical Commissioning Group
Spencer Gay, Chief Finance Officer at West Leicestershire Clinical Commissioning Group
Sue Holden, NHSI/E
Sir Peter Soulsby
Ursula Montgomery, Chair of East Leicester CCG
LLR Mental Health Programme Board pre- meet
* LLR Mental Health Programme Board
* Karamjit Singh

**Scheduled but have not yet taken place at the time this report has been prepared*

5. Conclusions

The Board is asked to consider this report and seek clarification or further information as required.

Appendix 1:

See Confidential Board Information Pack

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board 01 November 2019
Paper number	E

Name of Report: Organisational Risk Register Report

For approval		For assurance	✓	For information	

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

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

Report previously reviewed by	
Committee / Group	Date
Operational Executive Team	14 October 2019
QAC (quality related risk summary)	15 October 2019
FPC (finance and performance related risk summary)	15 October 2019

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

Recommendations of the report
- To note the organisational risk profile - Note the changes being made to operationalise the revised Strategy and Policy - Note the closure and de-escalation of risks from the former BAF/CRR

Organisational Risk Register

1 Introduction

1.1 All risks identified within the Trust are now recorded and categorised as ‘organisational’ (this is the term applied to the merged board assurance framework and corporate risk register), ‘divisional’ or ’locality’ risk. Risks escalated to the Trust Board and its Committees are on what is now termed as the ‘Organisational Risk Register’ (ORR).

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

1.3 The approval process for risks was agreed as part of the approval of the Risk Management Strategy. Any risk proposals will be discussed by the Executive Directors in advance of any recommendations being presented to the Trust Board for approval.

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

2 Discussion

2.1 It is recommended that the Executive Team hold preliminary discussions over potential “deep dive” selection criteria; the following criteria could be applied when considering the prioritisation of risks for deep dive review going forwards:

1. Highest scoring – 20 or above
2. Upwards movement into significant risk score
3. Period of time with no improvement/reduced assurance

This will be confirmed in the next Board update.

2.2 Areas for ongoing review

The Strategic Executive Board continues to review current information relating to local and internal changes which may impact on the ORR. The following risks have been identified and require further discussion before recommending for inclusion onto the ORR

- Shared CEO role

The NHFT Executive Team has recently considered the inclusion of a new risk on the NHFT ORR specifically around the LPT joint CEO/buddy arrangements. Once the final detail has been agreed it will be shared with LPT. The Trust will then be able to consider through the Senior Executive Board an appropriate risk for recommendation for inclusion on the ORR.

- Violence and Aggression

Following a review of the Trust's action plan for the Health and Safety Executive after the recent inspection, it is being proposed that a risk is included on the ORR around the weaknesses in systems and management of violence and aggression across the organisation. This will be discussed by the Senior Executive Board and a recommendation around inclusion on the ORR will be presented to the next Board meeting.

- Climate change

The EPRR core standards and deep dive external review was undertaken 08/10/2019 by NHSE/I. The panel was satisfied that the Trust's self-assessment is a true and accurate reflection of the 'Fully Assured' criteria. As part of the deep dive into "Severe Weather" the question regarding long term adaptation planning and risk assessment identified an expectation that all organisations should have a climate change risk assessment and that this would be incorporated into the organisation's risk register.

The Trust does not currently have a climate change risk assessment and therefore this question was self-assessed as Amber. A climate change risk assessment will be considered at the October 2019 Sustainability Champions Group with a view to completing an assessment within the Ulysses system prior to the August 2020 self-assessment process. Following this, a discussion will be held at the Senior Executive Board and an appropriate recommendation will be made to the Trust Board.

2.3 Existing risk

There have been no changes to risk scores for existing risks, and no escalations or new risks added to the ORR this month.

2.4 Progress with implementing the Policy

In order to operationalise the revised Policy and Strategy, the following changes have been made:

- In Ulysses, the T1 register has been re-named as 'directorate'

- T3 has been re-named as ‘local’
- The facility to create a risk at T2 level has been removed. All the existing risks at that level remain and will be mapped to either the local or directorate level registers. This mapping will be presented at directorate governance meetings for approval.
- The escalation facility has been restricted to key staff including risk and governance teams.
- Labels on the matrix have had undergone minor change:
- The guidance on severity and likelihood has been taken down and replaced with guidance on likelihood and consequence.
- The powerpoint guidance on the Ulysses homepage has been removed and will be replaced with revised guidance.
- A new committee report template has been used to populate risk reports for FPC and QAC in October 2019
- Training needs analysis for risk and governance teams complete. Bid for training funding being submitted.
- Implementation of a new risk review group. This is an informal group aimed at assessing new risk, escalating risk and establishing Trust-wide oversight.

Next steps

- The revised Risk Management Policy and Strategy will replace the former one on the intranet homepage
- Creation of risk assessment escalation level (for risks with no action plan in place).
- Transfer where applicable local risks to risk assessment.
- Removal of tolerated status
- Mapping of T2 risks to either directorate / local / or risk assessment
- E-learning training, ad hoc training and flow diagram for staff
- Guidance document
- Training schedule being determined
- Map risk reporting to the new governance structure.

2.5 Closing down the former Board Assurance Framework / Corporate Risk Register

For each of the 20 existing risks in the Ulysses system on the previous board assurance framework and corporate risk register, the following have been approved by the relevant committee (QAC and FPC);

- Closed and superseded by a new risk included in the revised organisational risk register (11)
- Closed as addressed (1)

- Closed, validated and deemed not a risk (1)
- De-escalated to a directorate risk register(s) (7)

These are detailed in the table below;

2018/19 BAF/CRR			Treatment	2019/20 ORR	
Risk No.	Owner	Risk descriptor		*ORR no. /* Ulysses no.*	Risk Descriptor
729	DoF	There is a risk that insufficient capacity and capability within the Information Team will impact on the ability to respond at pace to the existing/ emerging reporting against local, contractual and mandatory information requirements; which could adversely affect patient outcomes where information is required to make decisions.	De-escalated to directorate risk register (enabling).	--	--
1119	DoF	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.	De-escalated to directorate risk register (enabling).	*23* / 4287	*Related corporate risk Failure to deliver the EPR system and demonstrate the benefits of the system*
2130	DoF	Risk to fundamental financial stability due to failure to identify and deliver agreed Cost Improvement Programme savings (CIPs). The overall efficiency savings target for 2019/20 is £7.5m, £3.5m of which is made up of directorate-managed CIP schemes, with a further £3.5m achieved Trust-wide through managing growth and price-inflation within existing budgets. A further £0.5m CIP target is included, which has been set in order to deliver an increased surplus requested by NHS Improvement in May 2019.	Closed – superseded.	*17* / 4264	Failure to meet financial plan and statutory breakeven duty
2131	DoF	Risk of loss of business income, through under-performance, decommissioning or contractual penalties.	De-escalated to directorate risk	*17* / 4264	*Related corporate risk Failure to meet financial plan and*

		Also includes CQUIN risk, and income risk due to data quality issues. Agreement of 2019/20 contract with CCGs has reduced some elements of this compared to last month. However, ongoing Community Service Redesign work could lead significant future decommissioning.	register (enabling).		*statutory breakeven duty*
2132	DoF	Risk of insufficient funding to support development / investment and to meet the costs of price/volume growth	De-escalated to directorate risk register (enabling).	*17* / 4264	*Related corporate risk* *Failure to meet financial plan and statutory breakeven duty*
2135	DoF	The estate is not fit for purpose owing to the age and state of the buildings. This has the potential to impact on efficient and effective service provision.	Closed – superseded.	*10* / 4259 *11* / 4260	Failure to implement planned and reactive maintenance of the estate leading to an unacceptable environment for patients to be treated in. The current estate configuration is not fit for the delivery of modern mental health, community and LD services
2651	DoF	Risk to delivery of 2018/19 financial plan, including the control total target surplus of £3.3m. Plan can be confirmed as achieved once the draft accounts have been submitted at the end of April. All significant risks have now been fully mitigated, and there is very high expectation that the financial plan will be delivered.	Closed as addressed.		
3589	DoF	Risk that FM services are not provided in a manner that ensures premises are adequately maintained, cleaned and serviced to allow safe care and treatment to be provided.	Closed – superseded.	*9* / 4256 *10* / 4259	Failure to maintain the level of cleanliness required within the Hygiene Standards. Failure to implement planned and reactive maintenance of the estate leading to an

					unacceptable environment for patients to be treated in.
1991	DD	The following seclusion rooms in the Trust do not meet good practice environmental standards for seclusion rooms - Ashby Ward, Aston Ward, Bosworth Ward and Watermead Ward at the Bradgate Unit, both of the seclusion rooms on Belvior Unit, Acacia and Maple Wards at The Willows and the room at the Agnes Unit.	De-escalated to directorate risk register (AMH/LD).	*11* / 4260	*Related corporate risk* *The current estate configuration is not fit for the delivery of modern mental health, community and LD services*
1356	DD	When Adult Mental Health bed demand outstrips capacity, there can be a delay in identifying and accessing an acute bed. The delay impacts on both patient safety and patient experience.	De-escalated to directorate risk register (AMH/LD).	*29* / 4274 *28* / 4273	*Related corporate risks* *Failure to achieve the Out of Area Placement trajectory by the end of 20/21 will result in local people not having timely access to a local acute mental health bed.* *Failure to deliver timely access to assessment and treatment which could impact on patient safety and outcomes*
1467	DoN	There is a risk that within the patient records, assessments, patient-centred risk assessments, and care plans are not updated consistently in line with changes to patients' needs or risks. This could lead to patient harm and have a detrimental impact on the Trust's reputation due to related complaints, concerns, incidents and inability to extract evidence to inform investigations.	Closed – superseded.	*1* / 4155 *13* / 4280	There is a risk that the Trust's systems and processes for the management of patients may not be sufficiently effective and robust to provide harm free care on every occasion that the Trust provides care to a patient. The Trust does not increase the number of service users that are positively participating in their care, treatment and service improvement
1863	DoN	Patient's capacity to consent to admission, treatment,	De-escalated to	*2* / 4252	*Related corporate risk*

		and / or care, and best interest decisions, are not consistently demonstrated by staff.	directorate risk registers		*There is a risk that the Trust's safeguarding systems do not fully safeguard patents*
1964	DoN	If the trust's restrictive intervention reduction programme is not sufficiently well led and embedded staff may not work in a positive and pro-active way. Failure to implement the programme may result in the inappropriate use of restrictive practices and non-compliance with the guidance set out by the Department of Health in Positive and Proactive Care. (2014).	Closed – not a valid risk	--	
3604	DoN	Lessons are being learnt from Safeguarding enquiries, investigations and reviews but there is a lack of a consistent approach to how these lessons learnt are disseminated across the clinical directorates through to front line staff. There are inconstancies in how the assurances of lessons learnt are embedded and communicated.	Closed – superseded.	*2* / 4252 *3* / 4253	There is a risk that the Trust's safeguarding systems do not fully safeguard patents There is a risk that the Trust does not demonstrate learning from incidents and events and does not effectively share that learning across the whole organisation.
3791	DoN	Some patients who use LPT Mental Health and Learning Disability Inpatient Services have a risk of self-harm behaviour related to the use of fixed or non-fixed ligatures. There is a risk that whilst receiving inpatient care patients may attempt to ligature causing themselves harm.	Closed – superseded.	*1* / 4155	There is a risk that the Trust's systems and processes for the management of patients may not be sufficiently effective and robust to provide harm free care on every occasion that the Trust provides care to a patient.
1037	DoHR	Without effectively engaging and supporting our staff we may be unable to deliver high quality services and support transformational change.	Closed – superseded.	*25 /* 4270	Failure to create a culture of collective leadership that empowers staff to improve the services we provide.
1038	DoHR	Inability to create high quality management and	Closed –	*25* / 4270	Failure to create a culture of

		leadership capabilities may impact on the delivery of efficient and effective services.	superseded.		collective leadership that empowers staff to improve the services we provide
1260	DoHR	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	Closed – superseded.	*26* / 4271	Insufficient staffing levels to meet capacity and demand and provide quality services
1932	DoHR	Inability to achieve sufficient workforce supply (new recruits) to deliver the workforce requirements set out within the Trust business plan and people strategy.	Closed – superseded.	*26* / 4271 *4* / 4277	Insufficient staffing levels to meet capacity and demand and provide quality services There is a risk that services do not have the right number of staff with the right skills at the right time.
2515	DoHR	Inability to retain a workforce to support services that the Trust delivers will damage ability of Trust to deliver operational success, whilst making opportunity and other costs to provide services more expensive.	Closed – superseded.	*27* / 4272	Failure to improve the health and well-being of our staff.

* Risks were initially given a holding number on the ORR, these have now been allocated risk numbers within the Ulysses system; the Ulysses numbers will be used going forward.

2.6 Revised organisational risk register

Of the 32 risks on the organisational risk register, the Quality Assurance Committee has responsibility/joint responsibility for the oversight of 21 and the Finance and Performance Committee has 11. These are summarised below, and have been provided to the relevant committee reports for October 2019.

As at 7th October 2019 there are no changes from the presentation of risk at the 1st October 2019 Board meeting. An up to date organisational risk register pack will be available at the Strategic Executive Board.

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

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

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

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

2.7 Heat Map

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

Current risk levels given the existing set of controls.

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

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

Residual risk levels remaining once additional controls are implemented.

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

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

LPT RISK APPETITE (to follow)

MATURITY MATRIX

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

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

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

Likelihood descriptors

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

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

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

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

Leicestershire Partnership NHS Trust

Meeting name and date	Trust Board – 1 November 2019
Paper reference	**F**

Name of Report Brexit update

For approval		For assurance	X	For information	

Presented by	Danielle Cecchini, Director of Finance Business and Estates	Author (s)	Sharon Murphy Deputy Director of Finance & Procurement

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

Report previously reviewed by	
Committee / Group	Date
Similar updates provide to Trust Board and Strategic Executive Team	1st October 4th October
FPC	15th October

Assurance: What assurance does this report provide in respect of the Board Assurance Framework Risks?	Links to BAF risk numbers
This report provides assurance regarding the 'Risk of disruption to services and detrimental impact on patient safety as a result of EU exit' on the BAF	G15

Recommendations of the report
The Trust Board is asked to take assurance on the Trust's EU exit preparedness.

Brexit Update Report
Finance and Performance Committee 15 October 2019

National Key areas status:
The DH issued a key areas checklist before the March EU exit date. The Trust is using this as a basis for ongoing risk assessment.
The status as at 2nd October:
Communications and Escalation – no issues identified
Reporting, assurance & Information – no issues identified
Supply of medicines & vaccine – no issues identified
Supply of medical devices & consumables – no issues identified
Supply of non clinical consumables, goods & services – no issues identified
Workforce – no issues identified
Research & clinical trials – no issues identified
Reciprocal Healthcare – no issues identified; however the Trust will need to do more work in this area in future
Data sharing, processing & access – no issues identified
Finance - no additional costs due to Brexit identified

Comms plan:
Nationally, there is a focus on communications and the fact that these will need to be more detailed this time round and we need to be really focused on communications to the patient directly:
Frontline staff must be fully briefed this time because they will need to convey confidence to the patient.
There are comms packages being developed and regional comms workshops taking place.
Senior Responsible Officers must be identified for each area and communicated.
LPT have restarted assurance messages to staff and will develop a comms plan in the next Brexit meeting.

Recent Submissions:
A self assurance template was submitted to NHSE on 24th September. Additional questions asked this time around food supply and links to social care. The only amber rated area for LPT was food, as UHL can't predict what food shortages they will need to manage and how that would impact vulnerable patients. UHL catering do view food substitution as business as usual and will expect to continue to do this after Brexit.

Sitrep reporting:
Daily sit rep reporting will restart on 21st October. 4 LPT contacts are responsible for these submissions. From 1st November, sit rep reporting will be extended to 7 days. For LPT, this will be undertaken by the director on call at weekends.

Guidance issued:
No new guidance issue has been issued.

LPT Meetings:
The LPT meetings continue fortnightly, currently until the end of November. This will be kept under review.

G

Leicestershire Partnership NHS Trust

TRUST BOARD – 1st November 2019

QUALITY ASSURANCE COMMITTEE held 15th OCTOBER 2019

HIGHLIGHT REPORT

The key headlines/issues and levels of assurance are set out below, and are graded as follows:

Strength of Assurance	Colour to use in 'Strength of Assurance' column below
Low	Red - there are significant gaps in assurance and/or not properly assured as to the adequacy of action plans/controls
Medium	Amber - there is reasonable level of assurance but some issues identified to be addressed.
High	Green – there are no gaps in assurance and there are adequate action plans/controls

Report	Assurance level*	Committee escalation	ORR Risk Reference
Draft integrated quality and performance report (IQPR)		Received assurance of areas where performance improvement action is being undertaken. Concerns raised re the lack of consistency related to CPA performance. Further work being undertaken by the CPA working group overseen by CEG. Revision of the IQPR awaited in line with the revised performance management framework.	20 28
Organisational risk register		Noted and discussed the quality related strategic risk profile (including nature of risks and risk scores) and approved the treatment of the risks from the former BAF/CCR. Monthly risk review meeting to be introduced to detail mapping. QAC will at future meetings assess the levels of assurance provided. Sub groups will undertake detailed assessment of the actions to be taken to mitigate specific risks. Risks were review at the end of the meeting and it was agreed that all were contained within the current ORR.	All
Care Quality Commission (CQC) Inspection update		Received assurance about CQC related activity including delivery against the actions identified following the 2018/2019 inspection findings and proactive work in readiness for the 2019/2020 inspection regime. Improvements have been seen. Risks areas identified where there is likely to be a non-achievement of all actions due to the long	5 18 19

Report	Assurance level*	Committee escalation	ORR Risk Reference
		nature of plans eg. dormitory accommodation.	
Quality Improvement Board update		Noted the progress in the delivery of the Trust Quality Improvement Plan. KPI's and Milestones remain in draft but work underway to complete. PMO support secured.	31 32
Buddy Relationship update		Confirmed that the Buddy Forum will be report into the Quality Assurance Committed. Noted the progress on work streams.	18 25
Patient Safety Improvement Group		From November 2019, this Group will report into the Quality Forum Meeting. Improved monitoring described including outcomes with regard to VTE's, monitoring management of policies, monitoring patient safety alerts and naso gastric tube placement including additional risk assessments.	1 3
Quality Monitoring Report – serious incidents		Report received including progress on how to deliver learning from pressure ulcer incidents including a review of pressure ulcer incident investigations and deep dives where appropriate.	1 3
Self-regulation update		Report received confirming the replacement of self-regulation for inpatient areas with ward accreditation schemes. Concerns expressed that the structure to be introduced for non-ward areas is not clear. Further clarity requested from the executive team	1 18
Clinical Effectiveness Group		This group will report to the quality forum from November 2019. Report received giving positive assurance on work streams with the exception of CPA (see above) In addition concern expressed regarding role of new Policies Committee to oversee new policies and the responsibility of the role of Chair for each committee in overseeing the policies related to each meeting	1
Medicines Management Group		This group will report to the Quality Forum from November 2019 Positive assurance received re the completion of the CQC actions plans. Confirmed that not all spot checks had been completed but plans in place to do so (confirmed in CQC update report).	1 18
Trust Wide Clinical Audit Forward Plan		LPT Clinic Audit Forward Plan 2019/2020 approved. Provides more alignment with 'Step up to Great' bricks. Forward planning approved with streamlining for the following	1 31

Report	Assurance level*	Committee escalation	ORR Risk Reference
		year.	
R&D Quarterly Awareness Performance Report & CQC Research Briefing Paper		Update received re quarterly progress against the R&D strategy with rating of key milestones. Majority progressing to plan. Briefing also received related to the research related well led component of CQC inspections. Dissemination of this to be progressed through the CQC progress group.	18
Director of Nursing AHPs & Quality Update Report		Recommended to note the summaries of events and horizon scanning. Discussions held around clarity on Transforming Care issues which will be included in December 2019 QAC Meeting and issues/problems with regard to Estates including Health & Safety issues.	8 18 27
FYPC Directorate Highlight Report		QAC requested to note the assurances provided via the All Day Business Meeting, consider the areas raised for escalation. Discussion centered around issues with Estates and heating, safeguarding in terms of time taken to implement safeguarding not being recognized particularly in respect of HealthVisitors & School Nurses.	2 10
Implementation of New Governance Structure		Implementation of new governance structure updated . QAC to receive highlight reports from reporting committees from November 2019 onwards . New report templates provided now in use. At next meeting revised Terms of Reference for QAC and its subcommittees to be received and approved. All committees and subcommittees have now confirmed chairs, meeting dates and are working on forward plans. Intention agreed to move to bimonthly QAC meetings from the New year with a review in February and April .	18
Accessible Information Standard Audit Report		Noted that the Trust is complying with the Accessible Information Standard, has made progress towards capturing the needs of disabled patients and is working towards needs being met. In addition, to note the continued work to ensure the accessible information and communication needs of disabled patients and carers are being appropriately met. This report will go to the Equality & Diversity Group in the future	12

Chair	Liz Rowbotham

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board – 1 November 2019
Paper number	H

Name of Report October Director of Nursing AHPs and Quality Update report

For approval		For assurance		For information	x

Presented by	Anne-Maria Newham Director of Nursing AHPs and Quality	Author (s)	Anne-Maria Newham Director of Nursing AHPs and Quality

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

Report previously reviewed by	
Committee / Group	Date
This report has not been to any previous committees	

Assurance : What assurance does this report provide in respect of the Organisational Risk Register?	Links to ORR risk numbers
The report provides an update in respect of quality and safety	**18**

Recommendations of the report
The Board are asked to note the content. Further clarification can be sought on any items

Director of Nursing AHPs & Quality update report for October 2019 Trust Board presented on 1 November 2019

Welcome

I'd like to welcome the Board to the DON AHPs and Quality update report. I plan to give very brief summaries of events and horizon scanning that is pertinent to the Quality agenda.

9th September 2019 – Complaint review meeting

Unfortunately we are not achieving very well against our response rate target. Our response rate for complaints for 18/19 was 74%. This target contributes to our well led domain from the CQC and thus contributed to us getting inadequate. Today we are sitting at 64% with a downward trajectory meaning we are heading for a worse response rate.

In 2016 there was a review of complaints in the Trust and at that point it was agreed there would be 4 response timeframes: 10 days, 25 days, 40 days and 60 days. This has led to some confusion and means we are not responding in a timely fashion often opting for the 60 day option.
As of the 1st October 2019 we have moved to 25 days for all complaint responses.
The only time we can deviate from the 25 days is if there has been an agreement with the complaints manager (Matt Smith), and then if agreed a conversation with the complainant.

10th September 2019 – Joint Health and Oversight Scrutiny Committee (City County & Rutland)

I attended this large meeting to present a report on our latest position against the CQC report, action plan and progress. This is a meeting in public which is filmed and put on you-tube for everyone to view. There was a lot of challenge around 'they have heard this all before' and there has been no improvement to date. I felt the meeting overall went really well. Whilst there was a lot of fair challenge I was able to answer all their questions as openly and honest as I could. They thanked me and said they were assured by me and what I had said.

12th September 2019 – Transforming Care

This was a meeting with LPT and CCGs. Leicestershire is an outlier in respect of LD patients being transferred into appropriate community/home settings. We are over trajectory; even with the current recovery plan in place we will still miss the LLR trajectory. Helen Thompson has now become the lead for LPT at the TCP Programme Board.

13th September 2019 – Head of Nursing (HON) Interviews for FYPC

I was privileged to be involved in the FYPC HON interviews. We had a great selection to shortlist from. We interviewed 3 candidates who were all very good. The unanimous vote from both panels was for Laura Belshaw who was offered the post and accepted. Laura is currently the lead nurse for Mental Health Services for older people. FYPC have not had a HON before and so this post will make a huge difference to the many nursing staff in that directorate.

16th September 2019 – Roles and responsibilities across AMH and LD

I facilitated this meeting with the senior leadership team in AMH/LD to look at the clinical medical and managerial structures. It has become apparent that the structures have developed over a period of years often to address issues at that time such as CQC inspections, out of area patients etc.

Several recommendations have been made which are being discussed with Gordon King the new Director for Mental Health.

16th September 2019 – Meeting Public Health Nursing Lead

I met with the PH Nursing lead to discuss the proposed reduction by Leicestershire of the Healthy Together contract. Rutland is seeking no change. City contract is up for review in July 2020. Leicestershire are planning a 10% reduction which equates to £500k. We are planning a redesign of what the offer looks like now with the planned reduction. This an area of concern, attrition issues, recruitment problems, numbers are as bad now as they were pre 'call to action'.

17th September 2019 – UHL CQC inspection

I have been working with Carolyn Fox Chief Nurse at UHL to support them with their CQC inspection. CQC were particularly keen on ligatures and staff understanding of Mental Health issues. We have sent 2 teams to UHL, one into paediatrics and one into the Glenfield site to support ligature risk assessments.

19th September 2019 – CQC progress meeting

I'm very grateful to the Chair of the Trust for supporting this meeting. She is a regular attendee which shows good engagement and oversight. We covered, blanket restrictions, ligatures, estate, AMAT a new audit framework, medicines management and a comms update. We had a really good session on the difference between assurance and re-assurance to support attendees in providing evidence.

20th September 2019 – Continuous Quality Improvement

I attended a workshop aimed at DONs and Medical Directors on 'developing a culture of continuous quality improvement'. They talked about trusts that are outstanding having a systematic approach to QI. It often takes something that creates a lot of unease to bring about the change for example a homicide. They talked about going for awards correlates to staff experience. I was particularly interested in the session on 'psychological safety' which Angela has spoken about at the Senior Leadership Group. The arch enemy of psychological safety is fear and blame.

23rd September 2019 – Meeting 1st and 2 year students at Leicester University

Together with the Chief Nurse from UHL we did separate presentations for the 1st and 2nd year students. It was their first day. It was great to talk about the trust and what they can expect to experience when they start here. This is an area of importance as we want to keep the students when they qualify.

23rd September 2019 – Review of Lead Nurse role

I facilitated a session to review the lead nurse role across LPT. We have 3 lead nurses in CHS, 2 in AMH/LD and 1 in FYPC (currently vacant). This was a helpful meeting and recommendations that have come from this was to go ahead with recruitment for the lead nurse in MHSOP which will become vacant soon and go ahead with the recruitment of the lead nurse in FYPC which is vacant now. All Lead nurses will be line managed by the Heads of Nursing which we have 1 in each directorate. We have also agreed to change the title of the lead nurse to deputy Head of Nursing. This is because there is confusion with titles.

24th September 2019 – Strategic Improvement Assurance Meeting (SIAM)

There was a deep dive on children's eating disorders; this was covered by Helen Thompson. They were concerned at the increase in demand that had been experienced over the last 3 months. There has been a significant rise in referrals from 8 per month in 2016 to 19 per month in 2018 and a 121% increase in demand over the past 3 years. There continues to be a focus on waiting times.

27th September 2019 – CQC engagement meeting

This is a quarterly meeting that is well attended by the CQC and LPT. CQC determine the agenda which covers any concerns, SI's, Media related issues, and general discussion against the CQC action plan. Before the meeting Kate Dyer and Helen Abel cover off the CQC action plan in fine detail so we do not get into that at this meeting. There is still concern around the neuro developmental waits within the action plan. CQC have a new DCI Kevin Leary who has a Mental Health background. They are focussing in on medicines and MHA act at the moment. The state of Care is just about to come out. This meeting was held at Mill Lodge so that they could also have a tour, the next meeting will be held at the Agnes unit. Overall the meeting went really well. They have fed back that there is a noticeable change in LPT, energy, passion and the quality of the communication.

30th September 2019 – Buddy Forum

This is a monthly meeting with NHFT and LPT, our CEO is the chair of the meeting, in attendance are the 2 chairs, the DON's, the 2 comms leads, the 2 chairs of the quality committees. Gordon King is now in post from NHFT as Director of Mental Health, David Williams is supporting 1 day a week as strategic lead for new care models and the alliance. Its been suggested we link our staff with staff from NHFT who have been CQC inspected so they can get a sense of what the CQC are looking at. We will take this forward via the CQC progress meetings.

2nd October 2019 – Meeting with De Montford University senior team.

This was my first meeting with De Montford and it was a pleasure to meet a keen enthusiastic team. They have a new interim Vice Chair Kaushika Patel who was very welcoming. Their keen to set up regular meetings with myself which could include UHL Chief Nurse.

14th October 2019 – AMH/LD Governance team

As of the 14th October the AMH/LD Governance team have moved over into enabling. The team will continue to do what they were its just a change of line management for their Governance Lead, under Kate Dyer (Head of Quality Governance).

15th October 2019 – Meeting with Assistant Practitioners.

During one of Angela Hillery's CEO briefings a member of staff approached her to discuss their issues with being a B4 Assistant practitioner in LPT. LPT employs approximately 40 Assistant Practitioners at B4, mainly in CHS. They are a group of staff that have done an additional 2 year training course and have come out with 120 points at level 5 practitioner level. There have been several cohorts first starting in 2014 and the last one finishing in 2018. There is currently no mechanism for them to do the nurse training without entering the Associate Nursing training. This would mean an additional 2 years of training to have the same B4 at the end. I am going to explore with the universities and LPT what their options are.

16th October 2019 – Nursing with Leadership joint oversight Board

This is a meeting with the University of Leicester, UHL and myself. The university have introduced a new Masters with leadership programme that is only offered in 5 universities across England. The first intake of 9 students started in September 2018. They have just finalised the cohort for 2019 of 22 students. We are planning a recruitment campaign together utilising wall space and footfall, particularly across our community hospitals. We currently second 2 lecturers to UoL between UHL and LPT each year. They are practicing clinicians doing half time lecturing and half time in LPT. The idea is to encourage students to be more aligned to us and want to work for us at the end of their course.
Next year is the Year of the Nurse and Year of the Midwife, were looking to do some joint work on celebrating this.

FLU

Week commencing 14th October 2019 we have received communication from NHSi that's states **'**your trust has been identified as being in the lowest quartile for 2018/19 and the National Team are now asking that you begin reporting HCW flu vaccination uptake'. We have submitted our data 16th October. Our forms are inputted by the Occupational Health Team at UHL, currently there is a backlog of inputting. This means our position will improve and show we are on track.

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board – 1 November 2019
Paper number	I

Name of Report: Care Quality Commission Report

For approval		For assurance	✓	For information	

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

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

Report previously reviewed by	
Committee / Group	Date
Quality Assurance Committee	15 October 2019

Assurance: What assurance does this report provide in respect of the Organisational Risk Register Risks?	Links to ORR risk numbers
This report links across the framework. In particular, 'there is a risk that the Trust does not routinely achieve regulator standards which impacts on the achievement of the step up to great objective set by the Trust'	Whole ORR 4283 Well Led

Recommendations of the report
To receive assurance over CQC related activity, including delivery against the actions identified following the 2018/19 inspection findings and proactive work in readiness for the 2019/20 inspection regime.

Leicestershire Partnership NHS Trust

Care Quality Commission Report

1. Aim

1.1 To provide an update on Care Quality Commission (CQC) related activity, including delivery against the actions identified following the 2018/19 inspection findings and proactive work in readiness for the 2019/20 inspection regime.

2. Introduction / Background

2.1 The CQC report published in February 2019 relates to the inspection dated 19th November 2018 to 13th December 2018. The report describes the CQC's judgement of the quality of care provided with respect to the Trust's well led framework and an inspection of five of our core services. The CQC issued a Warning Notice to the Trust on the 30th January 2019. The CQC carried out a re-inspection in June 2019 and found that significant improvement had been made. Any areas requiring on-going action are captured within the CQC action plan.

3. Discussion

3.1 There are currently 89 actions on the CQC element of the regulatory action plan. Of these, 64 are classed as warning notice or must do actions; 25 are classed as should do actions.

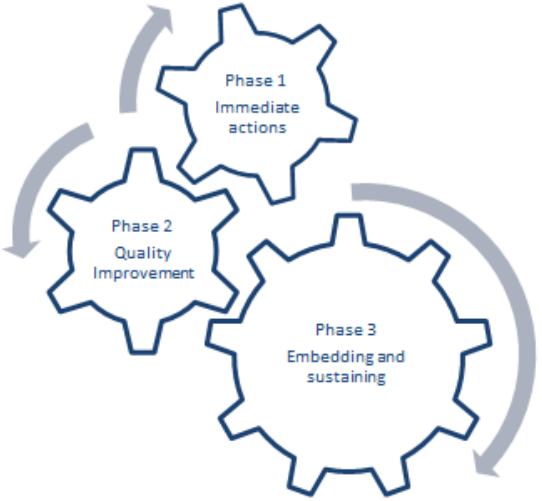
% actions complete – October 2019

- Warning notice and must do actions are 92% complete (last month was 83%)
- Should do actions are 56% complete (last month was 36%).

% spot checks complete – October 2019

- Warning notice and must do spot checks are 50% complete (last month was 47%).
- Should do spot checks are 14% complete (last month was 0%).

3.2 Summary of progress against each phase of delivery.



Phase 1. The immediate actions phase is the initial response taken by the Trust to protect the safety of patients and develop an initial action plan.

Actions relating to the issues identified in the warning notice were prioritised. Transactional actions were completed within the first three months. There are currently four warning notice actions remaining (out of 51), these include;

- W1 and W5. The number of children and young people waiting for assessment has reduced significantly and is reporting to be in a sustainable position. The treatment waiting list (excluding neuro-developmental patients) has reduced further than the anticipated trajectory. The neuro-developmental waiting list has not met the trajectory; this has been escalated in section 3.4 and the action therefore remains on-going. The service has a recovery plan, an associated risk on the organisational risk register and a related quality improvement plan.
- W38. The seclusion policy and paperwork has been updated as per the initial action. This has not yet been closed because we are awaiting the completion of a second PDSA cycle for the use of seclusion documentation. The output of this cycle will determine whether this action can be closed, or whether this needs to be escalated in the November 2019 report.
- W49 – this relates to the revision of corporate governance arrangements; this is on track for completion in November 2019.

Phase 2. A sustainable response to the weaknesses identified. This will require a more systemic response, which integrates with our quality improvement work streams.

There is a quality improvement plan for each brick within the Step up to Great framework; these have been mapped to the CQC action plan. Where an action is linked to a wider systemic response, it has been escalated in section 3.5 and the relevant quality improvement plan has been provided.

Phase 3. The embedding phase is the process by which any changes made in the previous phases are supported to be future proof. This will involve a closing of the loop in terms of auditing and assessing impact and outcomes.

Spot checks in phase 3 can only be completed once the action has been completed, and signed off by the relevant committee (see section 5). Therefore, the % complete will always be slower, and later than the completion of the actions. In addition, spot checks will be delayed to ensure that change resulting from the completion of an action has had sufficient time to embed. It is important that phase 3 tests the embeddedness and sustainability of changes implemented.

The table below highlights the level of completion for warning notice, must and should do actions, and corresponding spot checks.

Table 1: Completion of actions by theme (as at 1st October 2019)

Step up to Great	Theme	Warning Notice and Must Do % Completion		Should Do % Completion		Escalated (section 3.4)
		Action	**Spot Check**	**Action**	**Spot Check**	
S High Standards	Privacy and dignity	100%	100%			
	Risk assessments	100%	67%			
	Infection Control	83%	80%			
	Seclusion environments/ paperwork	88%	25%			
	Fire safety	100%	50%	100%	0%	
	Physical healthcare	100%	40%	0%	0%	
	Medicines mgt / medical devices	100%	71%	100%	50%	
	CTO			0%	0%	
	Safeguarding			0%	0%	
	Workforce			50%	13%	
E Environments	Environmental / estates	80%	20%	50%	50%	✓

Step up to Great	Theme	Warning Notice and Must Do % Completion		Should Do % Completion		Escalated (section 3.4)
		Action	**Spot Check**	**Action**	**Spot Check**	
	Patient Involvement			100%	0%	
	Care planning	100%	100%	100%	0%	
	Governance	83%	0%	100%	0%	
	Meet diverse need (S26)			0%	0%	
	Access	67%	33%	33%	0%	✓
	Total number (%)	59 / 64 (92%)	28 / 56* (50%)	14/25 (56%)	3/24**(14%)	

*Eight warning notice / must do actions do not require a spot check / ** One should do action does not require a spot check.

3.4 Escalation

There are some actions on the CQC action plan which may not be achieved in a timely way, or where action taken may not fully address the original recommendation made by the CQC. These have been escalated below and relate to the 'Environment' and 'Access' components of the Trust's strategic framework.

<table>
<tr>
<td rowspan="2"> 
</td>
<td>Estates Maintenance

W16 To strengthen our internal governance arrangements and clarify the escalation process for unsatisfactory delays.

This action has been rated green on the action plan because internal operational arrangements have been strengthened at the Bradgate Unit. However, action taken does not resolve the escalation process for unsatisfactory delays across the whole Trust, and doesn't resolve the provision of resource to support the operational management of issues. This also links to a longer term review of the facilities management provider.

Organisational Risk Register: Risk 4295 - Failure to implement planned and reactive maintenance of the estate leading to an unacceptable environment for patients to be treated in. Current risk score 16, residual risk score 12.

Quality Improvement Plan:

We will improve the quality of our buildings and ensure they are safe clean and welcoming by:
•Ensuring all buildings are maintained to appropriate standards of safety and cleanliness.
•Enhancing the efficiency and effectiveness of our estate and our estate management and governance arrangements.

To progress these priorities in 2019/20 we will:
•Refresh our estates strategy to ensure it meets the current and future needs of our patients
•Ensure that our estate backlog maintenance programme is prioritised to meets the needs of our most high risk areas
•Continue to rationalise the estate
•Review our facilities management arrangements to ensure that our estate remains clean and safe on a day to day basis.</td>
</tr>
<tr>
<td>Dormitory Accommodation

M3 Dormitory accommodation to be reviewed as part of the work to look at the re-provision of the four older wards

This action is rated red. The long term plan for dormitory accommodation is for resolution through the Inpatient re-provision SOC. The Estates and Medical Equipment Strategy Group (EMESG) has formed a sub-group to look at scope of works and possible impact on bed numbers for an interim solution. Scope and outline costs to be finalised by Dec 2019 to ensure works reflected in 2020/21 capital plan.

This has been escalated because, while work continues to determine a short and longer term solution, the Trust needs a clear plan mitigate privacy and dignity in the meantime and clarity around how the board is sighted on the impact of dormitory accommodation.</td>
</tr>
</table>

	Organisational Risk Register: Risk 4260 - The current estate configuration is not fit for the delivery of modern mental health, community and LD services. Current and residual risk score 20. Quality Improvement Plan: **We will improve the quality of our buildings and ensure they are safe clean and welcoming by:** •Eliminating all dormitory style accommodation in our acute and older peoples mental health inpatient and replace with en-suite single rooms by 2030. •Developing a business case for an interim solution •Ensuring mitigations are in place to manage privacy, dignity and safety in the existing dormitory accommodation **To progress these priorities in 2019/20 we will:** •Refresh our estates strategy to ensure it meets the current and future needs of our patients •Develop the Strategic Outline Business Case for the replacement of our adult and older peoples mental health beds

	**ND assessment and treatment waiting times** Warning Notice ref. W1, W3 The Neuro-Developmental Waiting List is not meeting the trajectory. This has been escalated because achievement of this action is dependent on the success of the Trust's recovery plan. This includes; - Regular validation of waiting lists - Diversion of cases to Community Paediatrics - Scheduled ND focussed weeks - Continue to monitor productivity through twice weekly ND focussed PTL - 'Go live' of new CAMHS referral form to include supporting school information for ND assessments Corporate Risk Register: Risk 4273 - Failure to deliver timely access to assessment and treatment which could impact on patient safety and outcomes. Current risk score 16, residual risk score 12. Quality Improvement Plan: **We will make it easier for people to access our services by reducing our waiting times through:** •Determining our priority services for waiting time improvements using a risk based approach •Developing demand and capacity capability and a schedule of demand and capacity reviews across our services •Engaging with our commissioners to review access targets to ensure they are safe, appropriate and deliverable •Reviewing, amending and publishing a revised LPT Patient Access Policy •A relentless focus on data quality improvements •Providing the services with performance dashboards to support service level performance management •Executive oversight through our revised performance management

	processes **We will ensure equality of access for all our patients by:** •Ensuring accurate and robust data collection to identify our patients diverse needs. •Reviewing this data on an on-going basis and ensuring we make reasonable adjustments to support access to healthcare services. •Collecting and reviewing patient feedback to ensure we are listening and acting upon concerns raised.

4. Preparing for the 2019/20 Inspection

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

The Trust's CQC progress meeting occurs on a bi-weekly basis. This aims to address overall improvement and pace of delivery from the 2018/19 inspection, and preparedness for the forthcoming inspection for 2019/20. A guidance poster and booklet have been developed for Trust staff, these will continue to be circulated.

5. Governance

The RAG rating for the completion of actions is determined by the relevant group / committee; these are listed against each action. When an action owner has sufficient evidence to demonstrate that an action, and / or a spot check has been completed with a positive outcome, the relevant assurance is provided. Once the relevant group / committee has approved an action or spot check to be rated as complete (green), the evidence, and the group / committee approval is sent to the central compliance team. The rating is updated on the central spreadsheet in time for the reporting cycle. The action plan is presented at the Executive Team Meeting, and the Quality Improvement Board. A report is compiled and presented to the Quality Assurance Committee. It is subsequently sent to the Trust Board, the Clinical Quality Review Group, and the Systems Improvement and Assurance Meeting.

6. Compliance with fundamental standards (2019/20 Quality Schedule indicator T1a and T1b)

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

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

7. Conclusion

The Trust continues to make progress against the CQC inspection action plan (action plan available in the Board information pack). The Trust has implemented a CQC progress meeting to address pace and preparedness for the forthcoming inspection.

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board – 1 November 2019
Paper number	J

Name of Report - **SAFE STAFFING - SEPTEMBER 2019 REVIEW**

For approval		For assurance	☑	For information	

Presented by	Anne-Maria Newham	Author (s)	Emma Wallis

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

Report previously reviewed by		
Committee / Group	Date	Assurance obtained (Significant/Limited/None)
Direct report to Trust Board		

Assurance: What level of assurance does this report provide in respect of the Board Assurance Framework Risks? (Significant / Limited / No Assurance)	Links to ORR risk numbers
Significant Processes are in place to monitor and ensure staffing levels are safe and that patient safety and care quality is maintained.	4,26

Recommendations of the report
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.

Leicestershire Partnership NHS Trust

TRUST BOARD – 1 NOVEMBER 2019

SAFE STAFFING – SEPTEMBER 2019 REVIEW

Introduction/Background

1 This report will provide an overview of the nursing safe staffing during the month of September 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.

4 The Quality Schedule methods of measurement are;
- A – Each shift achieves the safe staffing level 100%
- B – Less than 6% of clinical posts to be filled by agency staff

Compliance for the above indicators is RAG rated in Appendix 1.

Aim

5 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

6 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 September 2019

Right Staff

- Overall the planned staffing levels were achieved across the Trust.
- Temporary worker utilisation rate decreased overall this month by 2.2%; reported at 31.9%. This is partially attributed to Dalgleish Ward temporary closure for refurbishment and substantive staff redeployment, resulting in a reduction in community hospital temporary worker utilisation. There were also a number of Wards that requested significantly less shifts this month due to reduced acuity and improved sickness rates.

- Trust wide agency usage decreased this month by 0.6% to 4.2% overall. The following wards utilised above 6% agency staff; Belvoir, Griffin, Heather, Beechwood, Feilding Palmer, Dalgleish, St Lukes Ward 3, North and East.
- The total number of Trust wide Registered Nurse (RN) vacancies reported this month is 196.24 w.t.e posts (118.9 inpatients and 77.34 community). This is a decreased position this month by 2.15 w.t.e RN posts.
- The total number of Trust wide Health Care Support Worker (HCSW) vacancies reported this month is 91.65 w.t.e. posts (72.59 in-patients and 19.06 community). This is a increased position this month by 4.24 w.t.e posts.
- As of 1 October 2019 there are 70.6 w.t.e candidates in the recruitment pipeline, expected to join the Trust over the next few months.
- There are eleven hotspot inpatient areas, hotspots have been identified either by; exception to planned fill rates, high percentage of temporary worker utilisation or by the Lead Nurse 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 nine community team hot spots areas. 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 1 October 2019 Trust wide;
    - Appraisal sustained GREEN at 93.1%
    - Clinical supervision AMBER increased from 80.0% to 84.5%
    - Of the now 30 core and clinical mandatory compliance subjects with the addition of falls training; all are GREEN with the exception of eight topics; one new topic RED; falls and seven at AMBER.
    - Compliance with mandatory training for bank staff remains lower than that of substantive staff. Following targeted action there is continued improvement in bank staff compliance all GREEN with the exception of seven topics; two at RED and one at AMBER with improving compliance.

Right Place

- The fill rates for the percentage of actual HCSWs over 100% 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 10.93 CHPPD in September 2019, with a range between 4.5 (Skye Wing) and 37.2 (Agnes Unit) CHPPD. The variation in range reflects the diversity of services, complex and specialist care provided across the Trust.
- Analysis of the CHPPD has not identified any significant 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 September 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%
July 19	104.2%	205.9%	109.3%	187.9%	33.9%
Aug 19	103.0%	200.2%	110.3%	193.8%	34.1%
Sept 19	**100.2%**	**201.9%**	**107.0%**	**179.6%**	**31.9%**

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 decreased overall this month by 2.2%; reported at 31.9%. This is partially attributed to Dalgleish Ward temporary closure for refurbishment and substantive staff redeployment, there were also a number of Wards that requested significantly less shifts this month;

- Belvoir – requested 114 fewer shifts than previous month – due to reduced acuity
- Griffin – requested 102 fewer shifts than previous month – due to reduced acuity
- Gwendolen – requested 203 fewer shifts than previous month – due to reduced acuity
- City Planned Care West – requested 192 fewer shifts than previous month – long term sick returners

Collectively this has resulted in a reduction in community temporary worker utilisation

4 Trust wide agency usage decreased this month by 0.6% to 4.2% overall. The following wards utilised above 6% agency staff; Belvoir, Griffin, Heather, Beechwood, Feilding Palmer, Dalgleish, St Lukes Ward 3, North and East.

Summary of staffing hotspots – Inpatients

Hot spot wards	July 2019	Aug 2019	Sept 2019
Hinckley and Bosworth - East Ward	X	X	X
Beechwood		X	X
Feilding Palmer	X	X	X
St Lukes Ward 3	X	X	X
Short Breaks - The Gillivers	X	X	X
Short Breaks – Rubicon Close			
Mill Lodge	X	X	
Kirby			

Coleman	X	X	X
Gwendolen	X	X	
Belvoir	X	X	X
Heather			X
Griffin	X	X	X
Watermead		X	X
Agnes Unit			
Langley		X	X
Ward 3 Coalville (CAMHS)			

Table 2 – In-patient staffing hotspots

5 Beechwood, Coleman, East, Feilding Palmer and Gillivers, 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 Heather Wards are hot spots due to utilising over 50% temporary staff. The high utilisation is associated with sickness cover and increased patient acuity to maintain safe staffing.

7 Griffin ward is still considered a hotspot due to patient acuity and risk, staff sickness and vacancies and high use of bank and agency staff.

8 St Lukes Ward 3, East and Feilding Palmer remain hot spots due to concerns relating to vacancies, staff sickness, maternity leave and the ability to fill additional shifts.

9 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 analysis and review the Trust thresholds are indicated below;

- Planned levels is >80% Green
- Temporary worker utilisation (bank and agency); green indicates threshold achieved, amber is above 20% utilisation and red above 50% utilisation.

10 The NSIs that capture outcomes most affected by nurse staffing levels are presented in conjunction with patient experience feedback. This report indicates if there has been an increase or decrease in the indicator against the previous month.

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

Acute Inpatient Wards

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					
Ashby	20	93.9%	123.3%	93.3%	126.7%	19.5%	5.2	14.4%	0↓	2↑	1↑	83.30 %
Aston	18	81.1%	185.8%	86.7%	266.7%	43.5%	6.8	13.6% ↓	2↑	1	0↓	100%

Beaumont	21	89.9%	155.0%	96.7%	340.0%	42.2%	5.9	15.8%	0↓	1	0	nil
Belvoir Unit	10	95.8%	340.8%	130.0%	338.3%	61.6%	19.7	42.4% ↓	1↑	0	0	nil
Bosworth	19	81.7%	171.7%	98.3%	163.3%	33.8%	5.9	20.3% ↑	0	0	1	100%
Heather	17	95.8%	218.3%	93.3%	396.7%	53.9%	8.7	13.7% ↑	2↑	1	2↑	nil
Thornton	18	94.1%	208.3%	96.7%	138.3%	47.4%	7.6	24.8%	3↑	4↑	0	nil
Watermead	19	88.9%	210.8%	89.8%	366.7%	42.0%	7.7	9.5%	5↑	2	1↓	nil
Griffin F PICU	5	208.3%	320.0%	187.1%	156.7%	32.2%	18.3	22.7% ↓	3↑	2↑	1↑	nil
TOTALS									**16↑**	**13↑**	**6↑**	

Table 3 - Acute inpatient ward safe staffing

11 All wards met the thresholds for RN and HCSW planned staffing in September 2019.

12 Temporary worker utilisation is Red for Belvoir and Heather Wards 61.6% and 53.9% respectively. The high utilisation is associated with both vacancies and increased patient acuity and higher levels of staffing required to meet enhanced levels of observation.

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, reviewed at the twice weekly staffing meeting and daily safety huddle.

14 A review of the NSIs and patient feedback has identified an increase in medication errors, falls and complaints across the wards in September 2019. Analysis is currently taking place to consider any staffing impact on the quality and safety of patient care/outcomes for all wards.

Learning Disabilities (LD) 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)
3 Rubicon Close	3	115.0%	167.2%	73.3%	166.7%	35.1%	18.4	5.1%↓	0	1	0	100%
Agnes Unit	7	259.4%	724.3%	216.7%	766.7%	46.5%	37.2	16.2%↓	0	1↑	0	100%
The Gillivers	2	96.7%	138.3%	46.7%	160.0%	14.3%	26.3	13.7%↑	0	0	0	100%
The Grange	2	-	184.4%	#DIV/0!	216.7%	30.2%	21.6	35.4%	0	1↓	0	100%
TOTALS									**0**	**3↓**	**0**	

Table 4 - Learning disabilities safe staffing

15 Short breaks met the planned staffing levels with the exception of Gillivers that only met the planned RN level on nights 46.7% of the time. Patients do not always require RN support and skill mix is adjusted according to patient needs utilising HCSWs who are trained to administer medication and carry out delegated health care tasks. Night RN cover can be shared across the site as the homes are situated next to each other.

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

Low Secure Services – Herschel Prins

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)
HP Phoenix	10	109.2%	127.3%	96.7%	148.3%	12.9%	9.1	4.1%↓	0	0	0	20%

Table 5- Low secure safe staffing

17 Phoenix Ward achieved the planned staffing thresholds for all shifts.

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)
Skye Wing	29	115.8%	146.7%	200.0%	111.7%	41.1%	4.5	-1.6%	1↑	4↑	0	nil
Willows Unit	29	102.1%	154.0%	113.3%	225.6%	22.6%	7.8	3.4%↑	0	1↑	0	85.7%
Mill Lodge	13	98.3%	244.2%	91.7%	158.3%	36.4%	10.6	8.6%	0	3	0	nil
TOTALS									**1↑**	**8↑**	**0**	

Table 6 - Rehabilitation service safe staffing

19 All ward/units met the planned staffing thresholds for all shifts including Mill Lodge meeting planned RN levels on nights.

20 There has been an increase in falls on Skye Wing this month analysis has shown these involved five different patients. Most of the falls were as a result of patients placing themselves on the floor with two related to trips. The falls pathway was followed when required and medication reviewed.

21 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	DAY	NIGHT	NIGHT	Temp	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	Workers%	Care Hours Per Patient Day	Vacancy Factor				
FP General	7	117.8%	67.2%	89.8%	-	31.7%	6.9	40.1%	2↑	2	0	nil
MM Dalgliesh	-	-	-	-	-	-	-	-	-	-	-	-
Rutland	12	105.8%	120.9%	100.0%	136.7%	10.4%	7.3	16.5%↓	0	2↑	0	96%
SL Ward 1	13	105.9%	196.6%	100.0%	101.7%	21.3%	11.5	20.5%↓	1↓	1↓	0	83.3%
SL Ward 3	10	100.8%	125.8%	196.7%	100.0%	36.0%	8.8	35.8%	0	4↑	0	100%
CV Ellistown 2	16	105.0%	179.2%	203.3%	98.3%	7.4%	8.9	4.4%↓	1↑	5	0	92.9%
CV Snibston 1	14	120.8%	180.0%	103.3%	143.3%	13.0%	11.2	32.4%	0	2	0	100%
HB East Ward	18	76.6%	206.7%	100.0%	105.0%	25.5%	8.3	8.2%↓	3↑	3↓	0	95.8%
HB North Ward	17	119.2%	173.3%	100.0%	101.7%	22.2%	7.2	20.5%↑	0	6↑	0	100%
Swithland	22	100.0%	194.2%	100.0%	200.0%	10.6%	7.0	25.8%↓	0↓	4↓	0	95.8%
CB Beechwood	21	78.0%	260.8%	100.0%	100.0%	27.8%	8.9	24.1%	0↓	7↑	0	88.5%
CB Clarendon	21	84.7%	232.5%	100.0%	150.0%	14.6%	6.6	16%↓	4↑	8↑	1	75%
TOTALS									**11↑**	**44↑**	**1**	

Table 7 - Community hospital safe staffing

22 East and Beechwood wards are hot spots as they only met the planned RN level during the day 76.6 and 78% of the time. The ward runs with two RNs on occasion, which meets safer staffing parameters. Feilding Palmer did not meet the planned levels for HCSWs on days. The HCSW staffing levels were adjusted according to the bed occupancy.

23 Dalgleish Ward temporarily closed all beds on 12 August 2019 through to September 2019 as such there is no data this month.

24 A review of the NSIs for the community hospital wards has identified that there was an increase in falls incidents on St Lukes Ward 3, North, Beechwood and Clarendon Wards and an increase in medication errors on Feilding Palmer, East and Clarendon Wards. Review of the increased incidences has not identified any direct correlation between staffing and the impact to quality and safety of patient care/outcomes.

25 Feilding Palmer and Beechwood Ward are hot spots associated with increased temporary workforce usage due to vacancies, maternity leave and sickness.

26 Ward 3 St Luke's remains a hotspot due to vacancies and sickness that includes clinical leadership roles. Additional support is provided from an experienced Ward Sister and Matron.

Mental Health Services for Older People (MHSOP)

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					

BC Kirby	19	89.0%	221.7%	98.3%	121.7%	32.2%	6.8	23.9%↑	1↑	4↓	0	nil
BC Welford	21	82.0%	214.2%	93.3%	105.0%	24.8%	5.9	19.2%↑	2↑	0↓	0	nil
Coleman	21	78.0%	260.8%	100.0%	100.0%	35.3%	7.4	11.5%↓	0↓	7↑	0	nil
Gwendolen	21	84.7%	232.5%	100.0%	150.0%	22.2%	9.4	23.2%	0	5↑	0	100%
TOTALS									**3↑**	**16↓**	**0**	

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

27 Coleman is a hotspot as they only met the threshold for planned staffing on days 78% of the time. Analysis has shown there were seven shifts with only one RN, on these occasions the ward were supported by the Charge nurse, Medication Administration Technician (MAT) and qualified staff from Gwendolen ward to support safe staffing

28 Increased utilisation of temporary staff to meet planned staffing levels where there are vacancies and sickness and also due to increased patient acuity and level 1 observation.

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

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	11	87.2%	245.8%	96.7%	188.3%	53.0%	12.1	-8.1%	1↑	0↓	0	100%
CV Ward 3 - CAMHS	8	153.2%	278.5%	152.5%	250.0%	30.7%	16.2	13.6%↑	1↑	0	0	nil
TOTALS									**2↑**	**0↓**	**0**	

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

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

31 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

32 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	1.0	7.9	1.0	0	1.0	0
CHS (Community Hospitals)	50.0	13.5	4.0	0	4.0	13.0
MHSOP	19.3	8.6	1.0	0	2.0	7.6
AMH/LD	48.6	42.59	7.0	2.0	4.0	3.0
Trust Total September 2019	**118.9**	**72.59**	**13.0**	**2.0**	**11.0**	**23.6**
Trust Total August 2019	**123.57**	**64.59**	**12.0**	**2.0**	**22.0**	**24.6**

Table 10 - Recruitment summary in-patients

33 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.

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

35 Increased work experience placements and increased recruitment of clinical apprentices

36 Recruitment for the next three cohorts of trainee nursing associates has commenced. LLR wide there are 133 places for 2019/20 with the next cohort due to commence in December 2019. To date 27 trainees have passed the recruitment stage from LPT.

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	July 2019	August 2019	Sept 2019
City East Hub- Community Nursing	X	X	X
City West Hub- Community Nursing	X	X	X
East Central Hub – Community Nursing	X	X	X
Hinckley and Bosworth – Community Nursing	X	X	X
Healthy Together – City (School Nursing)	X	X	X
Healthy Together – East	X	X	X
Health Together - West	X	X	X
Looked After Children team	X	X	
CAMHS City - FYPC			
CAMHS County - FYPC	X	X	X
CAMHS Crisis - FYPC	X	X	X
City West CMHT - MHSOP	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 in total.There remains a number of vacancies across the community planned care nursing hubs with City East and West and East Central carrying the largest number. Hinckley and Bosworth Hub is also a hotspot as they have four registered nurses on maternity leave.

39 City West CMHT (MHSOP) remains a hot spot due to increased registered nurse sickness and lack of bank or agency to backfill. Internal moves have been secured to support the clinical risk and activity. The service continues to pilot an additional team lead in the city community teams and have recruited to the Band 7 post.

40 Healthy Together City (School Nursing only), East and West Healthy Together , County Outpatient 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.

41 There are no hot spots in September 2019 for AMH/LD Community. The crisis team has had a big recruitment drive to prepare for a planned service expansion, and the recruitment has been successful and is on track.

Recruitment

42 The current Trust wide nurse vacancy position for community teams 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
CHS – Community Nursing Hubs	24.0	6.79	6.6	1.0	9.9	0
CHS - ICS	9.22	4.57	1.0	0	0	0
MHSOP	3.0	0	0	0	0	0
AMH/LD	15.57	5.9	0	0	7.5	0
FYPC	25.55	1.8	2.0	1.0	2.0	0
Trust Total September 2019	**77.34**	**19.06**	**9.6**	**2.0**	**19.4**	**0**
Trust Total August 2019	**74.82**	**22.82**	**12.0**	**0**	**24.0**	**0**

Table 13 - Recruitment summary community

Retention

43 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.

Conclusion

44 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 and reported to NHS England (NHSE) via mandatory national returns on a site-by-site basis.

45 Each directorate has a standard operating procedure for the escalation of safer staffing risks and any significant issues are notified to the Director of Nursing, AHPs and Quality on a weekly basis.

46 In light of the triangulated review of fill rates, nurse sensitive indicators and patient feedback, the Director of Nursing, AHPs and Quality 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-Maria Newham – Director of Nursing, AHPs and Quality
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

September 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 – 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%	-	-	>= 80% (based on 1:8 plus 60:40 split)	<20%	-	-	
AMH Bradgate	Ashby	21	20	93.9%	123.3%	93.3%	126.7%			80.0%	19.5%	18.0%	1.5%	5.2
	Aston	19	18	81.1%	185.8%	86.7%	266.7%			47.8%	43.5%	42.1%	1.4%	6.8
	Beaumont	21	21	89.9%	155.0%	96.7%	340.0%			75.6%	42.2%	38.7%	3.6%	5.9
	Belvoir Unit	10	10	95.8%	340.8%	130.0%	338.3%			88.9%	61.6%	44.6%	17.0%	19.7
	Bosworth	20	19	81.7%	171.7%	98.3%	163.3%			56.7%	33.8%	32.1%	1.7%	5.9
	Heather	18	17	95.8%	218.3%	93.3%	396.7%			72.2%	53.9%	44.0%	9.9%	8.7
	Thornton	20	18	94.1%	208.3%	96.7%	138.3%			77.8%	47.4%	46.1%	1.3%	7.6
	Watermead	20	19	88.9%	210.8%	89.8%	366.7%			70.0%	42.0%	40.3%	1.7%	7.7
	Griffin Female PICU	6	5	208.3%	320.0%	187.1%	156.7%			97.8%	32.2%	17.8%	14.5%	18.3
AMH Other	HP Phoenix	10	10	109.2%	127.3%	96.7%	148.3%			97.8%	12.9%	11.8%	1.2%	9.1
	SH Skye Wing	30	29	115.8%	146.7%	200.0%	111.7%			100.0%	41.1%	40.8%	0.4%	4.5
	Willows Unit	31	29	102.1%	154.0%	113.3%	225.6%			77.8%	22.6%	22.1%	0.5%	7.8
	ML Mill Lodge (New Site)	14	13	98.3%	244.2%	91.7%	158.3%			85.6%	36.4%	31.7%	4.6%	10.6
CHS City	BC Kirby	24	19	89.0%	221.7%	98.3%	121.7%			72.2%	32.2%	28.6%	3.6%	6.8
	BC Welford	24	21	82.0%	214.2%	93.3%	105.0%			60.0%	24.8%	22.2%	2.6%	5.9
	CB Beechwood	24	21	78.0%	260.8%	100.0%	100.0%	100.0%	95.7%	66.7%	27.8%	19.8%	8.0%	8.9
	CB Clarendon	23	21	84.7%	232.5%	100.0%	150.0%			70.0%	14.6%	11.0%	3.6%	6.6
	EC Coleman	21	19	64.4%	256.7%	93.3%	125.0%			28.9%	35.3%	35.1%	0.2%	7.4
	EC Gwendolen	20	14	95.0%	229.5%	86.7%	155.0%			77.8%	22.2%	21.5%	0.7%	9.4
CHS East	FP General	7	7	117.8%	67.2%	89.8%	-	100.0%	100.0%	57.8%	31.7%	17.9%	13.8%	6.9
	MM Dalgleish	-	-	-	-	-	-	-	-	-	-	-	-	-
	Rutland	15	12	105.8%	120.9%	100.0%	136.7%			92.2%	10.4%	6.8%	3.6%	7.3
	SL Ward 1 Stroke	16	13	105.9%	196.6%	100.0%	101.7%	92.4%	96.6%	98.9%	21.3%	18.4%	2.9%	11.5
	SL Ward 3	11	10	100.8%	125.8%	196.7%	100.0%	100.3%	101.2%	88.9%	36.0%	27.1%	8.9%	8.8
CHS West	CV Ellistown 2	20	16	105.0%	179.2%	203.3%	98.3%	101.4%	100.0%	97.8%	7.4%	5.2%	2.2%	8.9
	CV Snibston 1	15	14	120.8%	180.0%	103.3%	143.3%	92.8%	96.3%	97.8%	13.0%	10.2%	2.8%	11.2
	HB East Ward	20	18	76.6%	206.7%	100.0%	105.0%	99.8%	100.0%	53.3%	25.5%	16.7%	8.8%	8.3
	HB North Ward	19	17	119.2%	173.3%	100.0%	101.7%			96.7%	22.2%	13.3%	8.9%	7.2
	Lough Swithland	24	22	100.0%	194.2%	100.0%	200.0%	99.1%	100.1%	100.0%	10.6%	7.8%	2.7%	7.0
FYPC	Langley	13	11	87.2%	245.8%	96.7%	188.3%	100.2%	-	74.4%	53.0%	51.0%	2.0%	12.1
	CV Ward 3	10	8	153.2%	278.5%	152.5%	250.0%			100.0%	30.7%	24.9%	5.8%	16.2
LD	3 Rubicon Close	4	3	115.0%	167.2%	73.3%	166.7%			85.6%	35.1%	35.1%	0.0%	18.4
	Agnes Unit	12	7	259.4%	724.3%	216.7%	766.7%			97.8%	46.5%	44.6%	1.9%	37.2
	The Gillivers	5	2	96.7%	138.3%	46.7%	160.0%			71.1%	14.3%	14.3%	0.0%	26.3
	The Grange	5	2	-	184.4%	#DIV/0!	216.7%			95.6%	30.2%	30.2%	0.0%	21.6
Trust Total				**100.2%**	**201.9%**	**107.0%**	**179.6%**			**79.7%**	**31.9%**	**27.7%**	**4.2%**	

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board – 1 November 2019
Paper number	K

Name of Report
Infection Prevention Biannual Report to Trust Board

For approval		For assurance	x	For information	

Presented by	Anne-Maria Newham Director of Nursing, AHP and Quality	Author (s)	Emma Wallis Amanda Hemsley

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

Report previously reviewed by	
Committee / Group	Date
Direct to Trust Board Report	

Assurance: What assurance does this report provide in respect of the Board Assurance Framework Risks?	Links to ORR risk numbers
This six monthly report provides assurance from the Director of Infection Prevention and Control (DIPaC) that the Trust has a robust, effective and proactive infection prevention and control strategy and work programme in place, that demonstrates compliance with the Health and Social Care Act 2008 (updated July 2015) also referred to as the Hygiene Code. The report provides an update on actions identified	1,9,18

following the NHS England & Improvement (NHSE&I) Infection Prevention Control (IPC) visit to meet recommendations, including a GAP analysis against the hygiene code. The report outlines completion of the Healthcare worker flu vaccination best practice management checklist for public assurance via Trust boards by December 2019. Appendices for the report: Appendix 1: NHSE & I Updated action plan Appendix 2: GAP analysis against the Hygiene Code Appendix 3: Flu Best Practice Checklist	

Recommendations of the report
The Trust Board is recommended to receive assurance that processes are in place to monitor and ensure compliance against the Health and Social Care Act 2008 (updated July 2015) and actions are in place to address gaps in compliance.

Infection Prevention Biannual Report to Trust Board

1. Introduction

1.1 This six monthly report provides assurance from the Director of Infection Prevention and Control (DIPaC) that the trust has a robust, effective and proactive infection prevention and control strategy and work programme in place, that demonstrates compliance with the Health and Social Care Act 2008 (updated July 2015) also referred to as the Hygiene Code.

1.2 The report provides an update on actions identified following the NHS England & Improvement (NHSE&I) Infection Prevention Control (IPC) visit to meet recommendations, including a GAP analysis against the hygiene code.

1.3 The report outlines completion of the Healthcare worker flu vaccination best practice management checklist for public assurance via trust boards by December 2019.

1.4 Leicestershire Partnership NHS Trust (LPT) is committed to promoting the highest standards of infection prevention and control by ensuring that appropriate measures are in place to reduce/remove the risk of acquisition of an infection for a patient who recieves any form of healthcare within LPT.

1.5 The Infection Prevention and Control (IPC) team is currently made of 4.3 WTE Infection Prevention and Control Nurses.

2. Aim

2.1 The aim of this report is to provide the Trust Board with assurance there is a robust, effective and proactive infection prevention and control programme in place, that demonstrates compliance with the Health and Social Care Act 2008 (updated July 2015).

3. Recommendations

3.1 The Trust Board is recommended to receive assurance that processes are in place to monitor and ensure compliance against the Health and Social Care Act 2008 (updated July 2015) and actions are in place to address gaps in compliance.

4. NHS England &Improvement (NHSE& I) IPC visit and action plan

4.1 On 7 August 2019, Dr Debra Adams, Senior Infection Prevention and Control Advisor for NHSE&I visited the trust following findings identified in the CQC inspection in 2018. The visit included a review of three of our service areas including; Adult Mental Health Services (Inpatients) Learning Disability services (group home) and Mental Health Services for Children and Young People (Outpatients).

4.2 The review included evaluation of Infection Prevention and Control policies, documents, discussions with staff and visits to three clinical areas. Whilst the

Trust received lots of positive feedback; staff adhering to Bare below the elbows (BBE), wearing the appropriate Personal Protective Equipment (PPE) and good hand hygiene. There were significant key themes that required attention and actions were developed to address these concerns.

4.3 A copy of the updated action plan is included (Appendix 1). In summary; all actions are complete with the exception of;

- Oversight and governance – RAG rated AMBER as the IPC Committee (IPCC) Terms of Reference require review to strengthen the assurance framework and reflect the new Trust governance structure. To be agreed at the Infection Prevention and Control Committee (IPCC) on the 5 November 2019.
- Estates works; Agnes Unit Tap part replacement – rated RED as replacement is broken again, escalated to the Director of Estates and Facilities 15 October 19.
- Cleaner's cupboard and radiator cleaning Westcoates House; spot check completed on the 16 October 2019 and actions post visit not completed, escalated to the Trust Property and Facilities manager to be completed and will be re spot checked.

5. Infection Prevention and Control Code of Practice GAP analysis and self-assessment tool

5.1 A key recommendation of the NHSE & I visit; to undertake a GAP Analysis/self-assessment against the IPC Hygiene Code of Practice. The self-assessment was completed initially on 20 August 2019, with the IPC team, Associate Director of Nursing & Professional Practice, Directorate IPC leads and Estates & Facilities Property Manager. Post assessment the Antimicrobial criterion was checked by the Trust pharmacy/AMR lead.

5.2 The full GAP analysis data is included (Appendix 2). This includes Trust percentage compliance against the ten criterions and an overall summary position outlined in the table below;

Criterion Number	Sections	Your Trusts Score	Maximum Score	Percentage Compliance
Criteria 1	Systems to manage and monitor the prevention and control of infection	33	42	79%
Criteria 2	Clean and appropriate environment that facilitates the prevention and control infection	13	14	93%
Criteria 3	Antimicrobial use to optimize patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	5	8	63%
Criteria 4	Provide suitable accurate information on infection in a timely fashion	2	2	100%
Criteria 5	Identification of people who have or are at risk of developing an infection	3	3	100%
Criteria 6	Staff responsibilities in in the process of prevention and controlling infection	5	6	83%
Criteria 7	Provide or secure adequate isolation facilities	3	3	100%
Criteria 8	Adequate access to laboratory support	3	3	100%
Criteria 9	Policies which will help to prevent and control	24	25	96%

	infections			
Criteria 10	Occupation health needs and obligations of staff in relation to infection	19	19	100%

5.3 Actions to improve compliance;

- To identify a process to capture data to provide assurance that every in-patient has a risk assessment with respect to IPC.
- To review and understand potential gaps identified due to the Trust not having a stand-alone Antimicrobial (AMR) stewardship committee. The Trust works in partnership and has representation at the LLR AMR working party.
- AMR consumption is not currently reported directly to Public Health England (PHE); to be reviewed with the Trust AMR lead and IPC Lead Nurse in conjunction with the Leicester Leicestershire & Rutland (LLR) PHE consultant and invite the LLR PHE representative to the IPCC.
- To identify a reporting structure for AMR consumption and audit compliance to include prescribing decisions and inappropriate practices to the IPCC (currently direct report to QAC).
- To enhance and agree all trust IPC metrics for 6 monthly board reporting including infection rates, cleanliness and audits.
- Sufficient resources to secure the effective prevention of infection – scoring in reference to (not limited) environmental constraints of the estate.
- Premises from which the organisation provides care are suitable for the purpose, kept clean and maintained in good physical repair and condition – scoring associated with the recent concerns escalated in relation to cleaning, cleaner's rooms and estate repairs and condition.
- To complete a review of procedures that require aseptic technique and identify staff training options and current available training, so that all staff who undertake procedures are adequately trained. To be presented to the IPCC meeting in February 2020
- To develop a policy for immunisation of service users. To be presented to the IPCC meeting in February 2020

6. External review with Northamptonshire NHS Foundation Trust IPC Lead Nurse

6.1 An external review was completed on the 16 October 2019 by the Lead Infection Prevention and Control Nurse from our 'buddy' trust Northamptonshire NHS Foundation Trust and Amanda Hemsley, Lead Infection Prevention and Control Nurse, LPT. The visit included review of two clinical in-patient areas; Langley and Kirby Ward, Bennion Centre. Review and sharing of Trust board reports, strategy, CQC service information report and IPCC Terms of Reference.

6.2 Post review report including shared good practice recommendations to be presented through the Trust Quality Surveillance report and to the IPCC.

6.3 Findings from this visit will be incorporated into the current NHSE & I action plan.

7. Reporting and Monitoring of HCAI Infections

7.1 There are four infections that are mandatory for reporting purposes:

- Meticillin Resistant Staphylococcus Aureus (MRSA) bloodstream infections.
- Clostridioides difficile infection (previously known as Clostridium difficile)
- Meticillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections.
- Gram Negative bloodstream infections (GNBSI)

7.2 **MRSA Blood stream infection rates**

The National trajectory is set at zero. LPT's performance for MRSA bacteraemia from April 2019 to September 2019 is zero.

7.3 **Clostridium difficile infection rates**

The agreed trajectory for 2019/20 is 12 and is set internally by the CCG (identified as EIA toxin positive CDI). LPT is not breaching the threshold set by the CCG. The table below outlines current data.

LPT CDT Data	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	**Total to date**
	0	0	**1**	0	**1**	**1**	**3**

7.4 Currently our figures for MRSA and CDI are within trajectory, however work continues to look at service improvements to reduce or maintain this position. All episodes of MRSA bacteraemia and CDI are identified and are subject to an RCA investigation. All action plans developed as part of this process are presented through the divisional IPC meetings which support the sign off of the completed actions.

7.5 The Trust CDT policy has been reviewed to include the national changes to the CDI reporting algorithm (NHS Improvement, 2019), and the recommended review tool has also been adopted to capture and interpret the data and care delivery information.

7.6 **MSSA Blood stream infection rates**

There is no identified trajectory for LPT for MSSA. However the monthly data on for this infection rate is submitted to the Clinical Quality Reporting Group as part of the quality schedule.

7.7 **Gram Negative Blood Stream Infection (GNBSI) rates**

In 2017 the Secretary of State for Health launched an important ambition to reduce healthcare associated Gram-negative bloodstream infections by 50% by 2021 and reduce inappropriate antimicrobial prescribing by 50% by 2021.

From April 2018 the Gram Negative Bloodstream Infection rates include:

- E-Coli
- Klebsiella pneumonia
- Pseudomonas aeruginosa

7.8 There is no LPT trajectory for GNBSI, however monthly data for this infection rate is submitted to the Clinical Quality Report Group (CQRG) as part of the quality schedule reporting (Please note this captures E-Coli infection rates only).

7.9 All partner organisations review their approach to reducing *E.coli* BSI by carrying out a self-assessment of progress against core standards. LPT is currently mapping position against the core standards (and include actions already addressed above). This information is shared and discussed at the LLR MADG group to share best practice and learning. The Lead IPC nurse for LPT attends this meeting.

7.10 LPT Lead IPC Nurse is a member of the national working group and participated in the NHS Improvement: Gram-negative Bloodstream Infection (GNBSI) group to develop a national policy (practice guide) for hand hygiene. This is now complete and was presented at the Chief Nursing Officer Conference. The next phase of the project includes development of a suite of national hand hygiene campaign resources, a national competency tool, compliance monitoring competency resource(s); and a standardised hand hygiene audit tool with quality metrics for measuring the effectiveness of a system-wide hand hygiene programme.

8. Reducing the Incidences of Catheter Associated Urinary Tract Infections (CAUTI)

8.1 In collaboration with University Hospitals Leicester (UHL) LPT participated in the Urinary Tract Infection (UTI) NHS Improvement (NHSi) CAUTI project. However due to position at the time of an increase in patients with multi drug resistance and the impact on time management for IPC issues, it was agreed with NHSi to delay presentation of the work to the national group. Work identified through the improvement project forms part of the ongoing work and agenda to reduce UTIs.

8.2 The catheter passport, updated management of urinary catheter patient leaflet and policy were launched in May and June 2019. Monitoring of the impact of this work is proposed to be included in the future IPC Quality Improvement programme.

8.3 A Urinary Catheter e-learning package has been developed and is now live for staff to access. All new starters and preceptees (with urinary catheterisation role essential) will complete the training package, competency assessment and attend a face to face study event prior to undertaking urinary catheterisation.

9. Sepsis

9.1 LPT continues to work towards achieving compliance with the national Sepsis agenda, and has developed an action plan to support implementation against the NICE guidance for Sepsis, based on the baseline assessment tool and GAP analysis.

9.2 The LPT action plan will form the LPT section of the wider LLR Sepsis improvement plan. A number of actions are in progress or completed including:

- Development of a policy for the recognition and management of patients with a potential sepsis diagnosis
- Patient leaflet for safety netting (as part of the LLR work stream)
- Identification of Sepsis champions in key in patient areas
- Training needs analysis to inform the required level of awareness training for staff in the organisation.

10. Hand hygiene

10.1 Currently, all in-patient areas are required to undertake and report monthly hand hygiene audits, with quarterly reporting for community teams.

10.2 Submission and compliance is varied across the services; in part due to the collection system of data recognised as labour intensive. Observational audit forms require manual data inputting, with no centralised service to complete this task. Data received has identified areas of compliance and areas for improvement, a process which is supported by the Trust IPC link workers.

10.2 To strengthen assurance and improve data collection a hand hygiene audit electronic application (app) has been developed and launched on 4 October 2019. The app will enable real time capture of hand hygiene audits, all data entered will be captured in a centralised database, from which compliance reports will be generated, identifying gaps, capture staff groups, categories and the reasons why a staff member failed enabling the Trust to focus on areas which require improvement.

11. Trust five markers

11.1 The Trust IPCC opted to focus on five key markers of good infection prevention and control in the environment, audited monthly, recommended in all in-patient wards and clinics. Compliance data as with hand hygiene has been varied across services.

11.2 The aim was to add the trust five markers to the electronic application, however due to clinics being utilised by different teams this has not been successful due to the lack of audit trail and accountability. The plan is to continue to report manually whilst the AMAT system is considered for these audits.

12. Cleaning and Decontamination

12.1 **Cleaning**

Cleaning scores are audited monthly and reported quarterly through the IPCC, this will change to bi-monthly from 2020. Exceptions are highlighted and mitigation and actions to remedy are reported. Work is on-going to ensure that clinical leaders are present at the time of audit to confirm and challenge.

12.2 The NHSE& I action plan reflects actions taken and shared at the CQC progress meetings in relation to cleanliness and an updated toy cleaning guidance and assurance process.

12.3 The Trust has a twelve month rolling deep clean programme in place and progress is monitored at the IPCC and LPT monthly cleaning meeting.

12.4 PLACE assessments were delayed nationally due to a change in system reporting and are currently underway for the month of October 2019.

12.5 **Decontamination**
The Trust medical devices group meets monthly with representation from IPC to ensure that equipment and items purchased for the trust meet the needs of the service and are able to be cleaned and decontaminated as per trust policy.

12.6 The implementation of traceability for podiatry instrumentation is in place within the Trust Podiatry Service. Development of the hub and spoke system of cleaning and decontamination for podiatry instruments is to be reviewed at the IPCC on 5 November 19 in line with best practice requirements for transportation of instruments.

13. Water Management

13.1 The Trust Water Safety Group is a formal sub-group of the IPCC. A meeting was held in October 19 with the newly appointed Authorised Engineer.

13.2 Key actions included review of the current Trust Water Management policy to be replaced with an overarching water policy and separate water management plan. Terms of reference have been agreed for dissemination to the IPCC on 5 November 19.

13.3 Legionella awareness has now been added to the IPC Level 2 e-learning training.

14. Season Flu vaccination programme

14.1 LPT is required to deliver an annual seasonal flu campaign, offering all staff the opportunity to have the seasonal flu vaccine. The aim of the campaign which runs from October to February is to protect patients and other staff from seasonal flu.

14.2 NHS England recommends that Trust Flu groups meet monthly from September through to March. The LPT Flu group has met monthly since February 2019. It is noted that Directorate attendance has not been consistently maintained throughout the year, we ask for support to ensure attendance is prioritised to support ownership of the Trust action plan and maintain momentum and drive.

14.3 The LPT 2019/20 seasonal flu vaccination programme for staff 2019/20 was launched on 1 October 2019. The vaccination is available to all LPT staff. There is a Trust CQUIN to vaccinate 80% of Frontline Healthcare Workers

(FHCWs). The baseline denominator is 4,609 staff. 80% equates to 3,688 staff.

14.4 Vaccine uptake data is to be collected and reported internally by Occupational Health on a weekly basis. All Trusts are responsible for submitting uptake data on the vaccination of FHCWs involved with direct patient care on a weekly basis to NHS Improvement (NHSi) and on a monthly basis to Public Health England (PHE), starting from the 1 November 2019 through to March 2020.

14.5 Training sessions for peer vaccinators was delivered by a core group of LPT staff over August, September & October 2019, a total of 28 training sessions (compared to three last season by Occupational Health).

14.6 A total of 82 staff have accessed the peer vaccinator training (compared to 58 last season). Three have dropped out leaving a total of 79 peer vaccinators, however 30 staff have yet to return their competency framework and written instruction a requirement in order to peer vaccinate.

14.7 From 1 October 19 to the 17 October 19 we have delivered 18 flu clinics across services including team meetings and large events. A flu calendar is currently being populated by peer vaccinators and requests to be advertised through communications and flu messages.

14.8 One WTE roving peer vaccinator commences on 28 October 2019, together with a number of bank peer vaccinators the aim is to widen access to clinics in evenings and weekends to improve access and uptake.

14.9 All Trusts are required to complete the Healthcare worker flu vaccination best practice management checklist for public assurance via trust boards by December 2019. Completed by the Trust Flu Group (Appendix 3).

15. Conclusions

This six monthly report provides assurance from the Director of Infection Prevention and Control (DIPaC) that the trust has a robust, effective and proactive infection prevention and control strategy and work programme in place (see Board Information Pack), that demonstrates compliance with the Health and Social Care Act 2008 (updated July 2015) also referred to as the Hygiene Code.

The report has provided progress against the actions taken in response to the NHS England & Improvement (NHS E& I) Infection Prevention Control visit and recommendations, including a GAP analysis against the hygiene code and subsequent improvement actions.

The report also outlines completion of the Healthcare worker flu vaccination best practice management checklist for public assurance via trust boards by December 2019.

Appendix 1

Action plan in response to the NHS Improvement Infection Prevention (IP) visit; 7th August 2019.
Version 2- Updated 17.10.19

NHS E & I- IPC recommendation	Action	Initial action/s taken	Overall Lead/s	Local Lead/s	Timeline	Progress	Evidence	RAG
The public facing web site is reviewed to ensure that the public can easily access IP data as required in Criterion 4.	• To review the new IPC web page content and accessibility • To review content monthly for accuracy	Out of date information removed from the web site (6 August 2019)	Amanda Hemsley & Kamy Basra	Anita Patel/ Andy Knock – IPC and Christina Marshall	Sept 2019	Meeting on 14 October 19 to develop an IPC web page Action complete	Website page now active	
To complete a GAP analysis against the hygiene code and present to the board.	• GAP analysis to be completed by the Trust IPC team and Directorate IPC leads • Findings and actions to be presented to the board	• GAP analysis tool received from Dr Adams • Review meeting set 20 August 2019 • GAP analysis tool completed. • Confirmation required for AMR stewardship, DIPC and microbiology • Initial actions	Emma Wallis/Amanda Hemsley	Sarah Latham-CHS Jane Martin-AMH/LD Katie Willetts - FYPC	October 2019	• Final version of GAP analysis complete • Gaps identified and actions identified to be monitored through the IPC committee highlighted in the 6 month board report	Paper to Trust Board November 2019 outlining the results and actions to be taken FinalCopy o IPCC-HSCA Con	

NHS E & I- IPC recommendation	Action	Initial action/s taken	Overall Lead/s	Local Lead/s	Timeline	Progress	Evidence	RAG
		identified • To confirm and challenge as part of the external review • Progress meeting set 3 October 19						
Oversight and governance is strengthened.	• To review and benchmark the Trust IPC governance framework, committee TOR, work plan and annual report with the Trust buddy organisation as part of an external IPC review		Emma Wallis	Amanda Hemsley	October 2019	External review date: 16 October 2019 Findings to be reported post review and included in the Quality Surveillance report	Paper to Trust Board November 2019 Revised IPCC TOR to go to IPCC 5.11.19	
To ensure the QAC and Trust Board receive assurance against the hygiene code and compliance data	• To review the work plan as part of the GAP analysis against the hygiene code • To review and ensure compliance data reporting for all IPC KPIs including Saving lives, Essential Steps and Sepsis • To review the service reporting template for	• GAP analysis completed and actions developed for the gaps • Surveillance in place for national indicators to review and agree all metrics at the	Emma Wallis/Amanda Hemsley	Sarah Latham-CHS Jane Martin-AMH/LD Katie Willetts – FYPC Helen Walton – Estates &	October 2019	External review date: 16 October 2019 Gap analysis completed Compliance and surveillance data reviewed,	Paper to Trust Board November 2019	

NHS E & I- IPC recommendation	Action	Initial action/s taken	Overall Lead/s	Local Lead/s	Timeline	Progress	Evidence	RAG
	compliance and assurance reports to both the IPCC and QAC • To review the annual report to provide assurance against the hygiene code and compliance data	IPC Committee 5 November 2019		Facilities		metrics to be agreed at the IPC committee 5 November 2019		
To ensure that the IPC work plan and strategy include reference to compliance with the Gram negative ambition and water safety	• To review the current IPC strategy and work plan to include national Gram negative ambition and water safety.		Emma Wallis/Amanda Hemsley	IPC team Helen Walton	October 2019	IPC strategy and work plan updated to be presented to the IPC committee 5 November 2019	Strategy to be presented to Trust Board with the first six monthly report in November 2019	
To update the Trust CDI policy to reflect the new national definitions of what is trust attributable.	Policy to be amended and updated accordingly	Policy currently being reviewed and updated	Amanda Hemsley	Mel Hutchings	31 August 2019	Review and update complete	Updated Policy	
To develop a cleaning SOP for carpets and	To develop a cleaning SOP for carpets and soft furnishing.	Draft SOP developed	Amanda Hemsley	Mel Hutchings	Sept 2019	SOP completed	New SOP	

NHS E & I- IPC recommendation	Action	Initial action/s taken	Overall Lead/s	Local Lead/s	Timeline	Progress	Evidence	RAG
soft furnishings.								
To develop a toy cleaning assurance process.	• To develop toy cleaning assurance process. • To update the cleaning and decontamination policy	Assurance process and policy currently being reviewed	Amanda Hemsley	Mel Hutchings	Sept 2019	Policy and assurance process updated and complete	Updated policy and clear assurance process	
Westcoates House actions • Bio hazard wipes required. • Eye protection required.	• Acquire bio hazard wipes and eye protection		Amanda Hemsley	Viki Elliott	31 August 2019	Review visit 21 August 2019 Complete	Spot check audit	
• Radiators dirty • Cleaners room dirty. • No hand sanitizer in cleaners' room.	• Clean all radiators • Clean the cleaners room and ensure sanitizer is available		Helen Walton	Marion Cockeram	31 August 2019	Spot check by IPC nurse on 16 October 19 actions outstanding. Site lead to action and complete a further spot check	Spot check audit	
Agnes Unit actions • Out of date hibiscrub- 2013.	• All out of date products removed	Out of Date items removed 7 August 2019	Amanda Hemsley	Jane Martin	Complete	Action complete	Spot check audit	

NHS E & I- IPC recommendation	Action	Initial action/s taken	Overall Lead/s	Local Lead/s	Timeline	Progress	Evidence	RAG
• Out of date saline 2012. • Out of date BNF 2018. • Gross body fluid ingress on mattress in "clean room". • Kit under U bend; hand towels. • Advise danicentre in clinical room. • Dining table dirty. • Damaged tap. **Agnes Unit actions continued**	• Clinic room checks to include the checking of all cupboards/cabinets • Soiled mattress removed • Ward Sister to arrange replacements with medical devices • Ward Sister to ascertain current mattress checking schedule and that this includes opening the mattress to inspect interior and send check form to Matron • Hand towels removed	JM to send clinic room check form to Ward Sister and agree regular checks of the clinic rooms Mattress removed at the time and taken to secure disposal. All other mattresses checked on the unit on 7 August 19 and arrange any replacements	Amanda Hemsley Amanda Hemsley Amanda Hemsley Amanda Hemsley	Jane Martin Jane Martin Jane Martin/Judith Pither Jane Martin/Judith Pither	31 August 2019 Complete Action complete 8 Sept 2019	Unlocked cupboard where products found has been secured and taken out of use Action complete Four mattresses replaced on 14 August 2019	 Agnes Unit.m Mattress checking schedule	

NHS E & I- IPC recommendation	Action	Initial action/s taken	Overall Lead/s	Local Lead/s	Timeline	Progress	Evidence	RAG
	from under the sink • Danicentre to be ordered and fitted • Dining table to be cleaned		Amanda Hemsley Amanda Hemsley Amanda Hemsley	Jane Martin/Judith Pither Jane Martin/Judith Pither Jane Martin/Judith Pither Jane Martin/	31 August 2019 Sept 2019 7 August 2019	Complete Complete Complete	Spot check audit Spot check audit Spot check audit	
Agnes Unit actions continued	• Damaged tap to be repaired or replaced	Replaced and broken again	Helen Walton	Judith Pither	Sept 2019	Escalated to the Director of Estates and Facilities on 11.10.19 as despite Helen chasing no response from UHL estates team	Works completed	
Rubicon Close actions • Cleaning schedule. • Laundry shared with sluice. Process	• Laundry process to be reviewed and risk assessment completed	Dirty and clean laundry now separated. Dirt laundry bins with wipe able lids now in each	Amanda Hemsley	Jane Martin	31 August 2019	Action complete	Spot check audit	

NHS E & I- IPC recommendation	Action	Initial action/s taken	Overall Lead/s	Local Lead/s	Timeline	Progress	Evidence	RAG
needs full review and risk assessment. • Laundry floor dirty. • Linen airer very dusty. • Suction machine very dusty - no assurance process. • Torn bed bumpers. • Dirty bed bumpers. • No toy cleaning schedule. • Toys dirty. • Toilet rolls do not fit dispenser. • Toilet roll dispenser soiled. • Pull cord very dirty. • Inappropriate posters in	• Laundry floor cleaned • Equipment cleaning and schedule reviewed to include; o Linen airer o Suction machine o Bed bumpers o Toys o Toilet roll dispenser o Fans o Equipment trolley • Equipment to be removed; o Rusty shower chair o Pull cord to be changed o Kit under the Ubend o Torn bed bumpers	bedroom Floor cleaned Shower chair replacement ordered	Amanda Hemsley Amanda Hemsley Amanda Hemsley	Jane Martin Jane Martin Jane Martin	7 August 2019 31 August 2019 31 August 2019	Action complete whole area deep cleaned Action complete Action complete 5 September 2019	Revised schedule and spot check audit Spot check	

NHS E & I- IPC recommendation	Action	Initial action/s taken	Overall Lead/s	Local Lead/s	Timeline	Progress	Evidence	RAG
toilet used by relatives. • Rusty shower chair. • Fan dirty. • Dirty equipment trolley in bathroom. • Kit under U bend.								

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Compliance statement	Instructions for scoring	Your score	Max score
An annual statement on infection prevention control is published	0 for no annual statement, 1 for less than annual, 2 for annual	2	2
There is a single lead for infection prevention (including cleanliness) accountable directly to the Chief Executive	1 for Y	1	1
Sufficient resources are available to secure the effective prevention of infection	1 for Y	0	1
All staff receive suitable and sufficient information on, and training and supervision in, the measures required to prevent the risks of infection	1 for Y	1	1
Assurance is in place to ensure that key policies and practices are being implemented, updated and adhered to appropriately	2 for more frequently than quarterly, 1 for quarterly, 0 for less	1	2
There is a named decontamination lead	1 for Y	1	1
There is a water safety group and water safety plan in place	1 for either one or the other, 2 for both	2	2
Every patient has a risk assessment with respect to infection prevention	0 for <70% / 1 for 71-90% / 2 for 91-100% of all patients	1	2
The organisation has identified risks, taken steps to reduce or control those risks, implemented and monitors steps taken	1 for Y	1	1
The Director of Infection Prevention and Control provides assurance directly to the board	0 for N, 1 via Director, 2 via CEO, 3 if DIPC is a board member	3	3
The DIPC leads the infection prevention team	1 for Y	1	1
The DIPC oversees local infection prevention policies and their implementation	1 for Y	1	1
The DIPC is a i) full member of the infection prevention team and ii) antimicrobial stewardship committee and i) regularly attend its infection prevention meetings	1 for any statement, 2 for any 2 and 3 for all 3 statements	2	3
The DIPC actively challenges inappropriate practice and inappropriate antimicrobial prescribing decisions	1 for either statement, 2 for both statements	0	2
The DIPC sets and actively challenges standards of cleanliness	1 for Y	1	1
The DIPC actively assesses the impact of all existing and new policies on infections and makes recommendations for change	1 for Y	1	1
The DIPC is an member of the organisation's clinical governance and patient safety teams and the water safety group	1 for either statement, 2 for both statements	2	2
The DIPC publishes an annual report	1 for Y	1	1
The trust board receives regular reports on infection trends, antimicrobial resistance, antimicrobial prescribing and complaince with audits	1 for Y	0	1
The trust board receives regular reports from clinical directors and/or matrons on locally agreed metrics eg. PLACE, cleanliness scores etc.	1 for Y	0	1
Mandatory and voluntary surveillance data is reviewed (including outbreaks, serious incidents)	1 for Y	1	1
There is an audit programme to ensure that IPC policies are implemented	1 for Y	1	1
There is documented evidence of compliance with Health and Safety Regulations	1 for Y	1	1
Progress against the infection programme including cleanliness objectives is reported in the DIPC's annual report	1 for Y	1	1
There is a multidisciplinary infection prevention team that includes the DIPC	0 for no team, 1 for team without DIPC, 2 for team with DIPC	2	2
There is an active multidisciplinary antimicrobial stewardship team	1 for Y	1	1
There is 24-hour access to a named qualified infection control doctor or consultant in health protection and communicable disease control	1 for 24-hour access	2	2
There is evidence of joint working between teams providing infection control advice, bed allocation & staff involved in the transfer of patients between care providers	1 for Y	1	1
Infection status is always provided when a service users is tranferred from the care provider to another care settings	0 for <70% / 1 for 71-90% / 2 for 91-100% of all patients	1	2
There is a named lead for environmental cleaning and decontamination of equipment used for diagnosis and treatment	1 for either statement, 2 for both statements	2	2
Directors of Nursing, Matrons and the infection prevention team are involved in all aspects of cleaning services	1 for Y	1	1
Matrons or persons of a similar standing have personal responsibility and accountability for maintaining a safe and clean care environment	1 for Y	1	1
The nurse or other person in charge of any patient area has direct responsibility for ensuring that cleanliness standards are maintained throughout that shift	1 for Y	1	1
All parts of the premises from which the organisation provides care are suitable for the purpose, kept clean and maintained in good physical repair and condition	1 for Y	0	1
The cleaning arrangements detail the standards of cleanliness required in each part of the premises and there is a schedule of cleaning responsibility and frequency	1 for either statement, 2 for both statements	2	2
There is adequate provision of suitable hand washing facilities and antimicrobial hand rubs (where appropriate)	1 for Y	1	1
There are effective arrangements for the appropriate cleaning of equipment that is used at the point of care, for example hoists, beds and commodes	1 for Y	1	1
The storage, supply and provision of linen and laundry are appropriate for the level and type of care provided in all areas	1 for Y	1	1
There are policies on infection prevention and cleanliness that apply to all premises	1 for Y	1	1
There are designated staff with responsibility for and relevant policies to cover cleaning arrangements	1 for Y	1	1
There is a comprehensive decontamination policy covering all aspects of environment, linen, equipment, staff training and record-keeping	1 for Y	1	1
There is an an antibiotic stewardship (AMS) committee responsible for developing, implementing and monitoring the organisation's stewardship programme	1 for Y	0	1
The AMS committee reports directly to the trust board via the DIPC or person of similar standing	1 for Y	0	1
There is an AMS policy covering diagnosis, prophylaxis and treatment of common infections	1 for Y	1	1
Adherence to the AMS policy is monitored and data is fed back to prescribers	1 for Y	1	1
Microbiological diagnosis, susceptibility testing and reporting of results is available within 48 hours	1 for longer than 48 hours, 2 for within 48 hours	2	2
Local antimicrobial susceptibility data (drug-bug combinations) and information on antimicrobial consumption is reported back to Public Health England	1 for Y	0	1

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Local antimicrobial susceptibility data (drug-bug combinations) and information on antimicrobial consumption is used to guide local prescribing policy	1 for Y	1	1
Information on infection prevention and control is available for service users and visitors	1 for Y	1	1
Information on infection prevention and control is always given to those providing further nursing or medical care when the service user is transferred	1 for Y	1	1
There is a mechanism in place for rapidly identifying those people who have or at risk of developing an infection	1 for Y	1	1
Outbreaks and serious incidents relating to IPC are always reported to the local health protection team	1 for Y	1	1
Responibility for infection prevention is effectively devolved to those groups of staff delivering care to patients	1 for Y	1	1
Infection prevention is included in the job descriptions of all employees (including volunteers)	1 for Y	1	1
Infection prevention is included the induction programme and staff updates of all employees (including volunteers)	1 for Y	1	1
Contractors working in clinical areas are made aware of any issues with regard to infection prevention and are required to obtain 'permission to work'	1 for Y	3	3
All staff who undertake procedures, which require skills such as aseptic technique, are trained and need to demonstrate proficiency before working independently	1 for Y	0	1
There are adequate isolation precautions and facilities to prevent or minimise the spread of infection allowing the physical separation of service users	1 for Y	1	1
There is a policy for the allocation of patients to isolation facilities, based on a local risk assessment.	1 for Y	1	1
There are always sufficient staff available to care for the service users in isolation facilities safely	1 for Y	1	1
The laboratory used to provide a microbiology service has a policy for investigation and surveillance of antimicrobial resistance and HCAIs	1 for Y	1	1
The laboratory used to provide a microbiology service has standard laboratory operating procedures for the examination of specimens	1 for Y	1	1
The laboratory used to provide a microbiology service provides timely reports	1 for Y	1	1
Policy - Standard infection prevention and control precautions	1 for Y	1	1
Policy - Aseptic technique	1 for Y	1	1
Policy - Outbreaks of communicable infection	1 for Y	1	1
Policy - Isolation of service users with an infection	1 for Y	1	1
Policy - Safe handling and disposal of sharps	1 for Y	1	1
Policy - Prevention of occupational exposure to blood-borne viruses (BBVs) including prevention of sharps injuries	1 for Y	1	1
Policy - Management of occupational exposure to BBVs and post-exposure prophylaxis	1 for Y	1	1
Policy - Closure of rooms, wards, departments and premises to new admissions	1 for Y	1	1
Policy - Disinfection	1 for Y	1	1
Policy - Decontamination of reuseable medical devices	1 for Y	1	1
Policy - Single-use medical devices	1 for Y	1	1
Policy - Antimicrobial prescribing	1 for Y	1	1
Policy - Reporting of infection to Public Health England or local authority and mandatory reporting of healthcare associated infection to Public Health England	1 for Y	1	1
Policy - Control of outbreaks and infections associated with specific alert organisms (see table below for specific organisms)	1 for Y but only if **ALL** specific organisms covered	1	1
Policy - CJD/vCJD (follows guidance from Advisory Committee on Dangerous Pathogens (ACDP) TSE working group)	1 for Y	1	1
Policy - Safe handling and disposal of waste	1 for Y	1	1
Policy - Packaging, handling and delivery or laboratory specimens	1 for Y	1	1
Policy - Care of deceased persons	1 for Y	1	1
Policy - Use and care of invasive devices	1 for Y	1	1
Policy - Purchase, cleaning, decontamination, maintenance and disposal of equipment	1 for Y	1	1
Policy - Surveillance and data collection	1 for Y	1	1
Policy - Dissemination of information	1 for Y	1	1
Policy - Isolation facilities	1 for Y	1	1
Policy - Uniform and dress code	1 for Y	1	1
Policy - Immunisation of service users	1 for Y	0	1
All staff can access occupational health services or access appropriate occupational health advice	1 for Y	1	1
Occupational health policies on the prevention and management of communicable infections in care workers are in place	1 for Y	1	1
Vaccines are available free-of-charge to employees if a risk assessment indicates that it is needed	1 for Y	1	1
There is a record of relevant immunisations for all staff	0 for <70% / 1 for 71-90% / 2 for 91-100% of all staff	2	2
The principles and practice of prevention of infection (including cleanliness) are included in induction and training programmes for all new staff	1 for Y	1	1
There is appropriate ongoing education for existing staff (including support staff, volunteers, agency/locum staff and staff employed by contractors	1 for Y	1	1

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There is a record of IPC training and updates for all staff	0 for <70% / 1 for 71-90% / 2 for 91-100% of all staff	2	2
The responsibilities of every member of staff for the prevention of infection are reflected in their job description and in any personal development plan or appraisal	0 for <70% / 1 for 71-90% / 2 for 91-100% of all staff	2	2
Conditional offers of employment and ongoing health surveillance include risk-based screening for communicable diseases and assessment of immunity to infection	1 for Y	1	1
Immunisation status of care workers is regularly reviewed	1 for Y	1	1
Staff are vaccinated as necessary in line with Immunisation against infectious disease ('The Green Book') and other guidance from Public Health England	1 for Y	1	1

Appendix 3

Healthcare worker flu vaccination best practice management checklist – for public assurance via trust boards by December 2019

A	**Committed leadership** (number in brackets relates to references listed below the table)	**Trust self-assessment**
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.	Completed at Trust Board November 2019 meeting
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers	Occupational Health ordered 3,000 vaccines, we require 4,609 vaccines to achieve 100%
A3	Board receive an evaluation of the flu programme 2018/19, including data, successes, challenges and lessons learnt	Paper to Executive Team 31 May 2019 – see Board Information Pack
A4	Agree on a board champion for flu campaign	Director of Nursing, AHPs and Quality
A5	All board members receive flu vaccination and publicise this	Completed on 1 October 2019 and publicised
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	Yes
A7	Flu team to meet regularly from September 2019	Meet monthly throughout the year
B	**Communications plan**	
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	Launched including message by DoN/AHPs

B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	Clinics advertised in weekly newsletter. Plan to publicise on Facebook
B3	Board and senior managers having their vaccinations to be publicised	Complete
B4	Flu vaccination programme and access to vaccination on induction programmes	Planned clinics at the NSPCC
B5	Programme to be publicised on screensavers, posters and social media	Comms plan in place including staff stories, podcasts
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	Occupational Health to provide weekly figures
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	79 Peer vaccinators across services currently being mapped to locations
C2	Schedule for easy access drop in clinics agreed	Requests for clinics through a designated Flu email address. To date (add in number of clinics requested)
C3	Schedule for 24 hour mobile vaccinations to be agreed	Peer vaccinators in areas to give any time and roving peer vaccinator to provide flexible clinics
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this	Completed
D2	Success to be celebrated weekly	To publicise once weekly reporting commences

Leicestershire Partnership NHS Trust

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

Name of Report; Patient Story Mr S

For approval		For assurance	x	For information	x

Presented by	Anne Maria Newham	Author (s)	T.Ward Head of Patient Safety

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

Report previously reviewed by	
Committee / Group	Date
AMH directorate Serious Incident Sign off group	05/19
Executive sign off	10/19

Assurance : What assurance does this report provide in respect of the Organisational Risk Register?	Links to ORR risk numbers
This report provides the assurance that there has been a thorough and transparent investigation that has involved the patient's family. Actions have been taken to listen and learn from this incident Careful consideration has been given to the recommendations and work has begun to support the Crisis team to address the areas identified. The crisis team have been recognised as underfunded. Additional funding has been awarded. This funding does however have clearly defined deliverables not necessarily aligned to the areas identified in this Serious Incident report	1 3 4

Recommendations of the report
This report is provided to assure that robust and transparent Serious Incident investigations are undertaken and that patients families views are sought and listened to in order to identify lessons to be learned. To assure further that this is undertaken in a just way with an understanding of the system issues rather than those of individuals. To inform of the areas identified that require improving wider than the crisis team. Particularly in relation to culturally competent care. This area is being considered by the patient experience group

Patient story Mr S from Serious Incident investigation 2019/1481

Mr S was referred to the Crisis Response and Home Treatment (CRHT) Team on the 2nd January 2019. Mr S's first language was Punjabi the first full assessment was completed on the 3rd January at Mr S's home with an interpreter present. This was Mr S's first episode of mental ill health and first contact with mental health services Mr S took his own life on the 21st January 2019 having left the family home and walked in front of a lorry.

The key contributory factor identified by this investigation was that no one person or the Multi-Disciplinary Team (MDT) had overall oversight in this case, policies and procedures in place were not always followed and as a result the patient's deterioration was not identified and appropriate action taken.

If the patient records had been reviewed by the MDT or Keyworker it would be expected that the deterioration could have been identified along with increasing risk verbalised by the patient in relation to his thoughts of suicide.

The contributory factors were themed as the following:

Continuity of care, during his time under the care of the CRHT team Mr S saw 9 different professionals from the team in 11 visits. None were allocated as key worker to Mr S. It is acknowledged that the CRHT has a high number of referrals and covers a large geographical area. This reduces the team's ability for patients to be seen consistently by one member of the team. In order to mitigate the risks the team have processes in place to provide oversight of each case ensuring a consistent approach: MDT, Care Planning and Keyworker role. However in this investigation these mitigating processes were found to have not been followed or not robust in their application.

Interpreter services, it was identified at the point of referral and on first assessment that the first language of Mr S was Punjabi and that his level of English was poor as confirmed by the family. Mr S himself requested that an interpreter be used or indeed his son be home to support him. An interpreter or language line was not used in all visits. Clinical records show that staff felt comfortable discussing complex themes around mental health with Mr S but in the records and through interview it has not been evident that staff sufficiently assessed the level of Mr S's understanding.

There was evidence in the notes that staff had suggested the need to obtain a copy of written information in Punjabi. Through the investigation it was identified that written information is not readily available in Punjabi.

The family of Mr S confirmed that he had a very basic grasp of the English language, that he had little need to utilise English in his day to day life.

The medication review, this was delayed. The medication review was undertaken on the phone with Mr S and the patient communicated with the Consultant (Hindi speaking) and Mr S responded in a combination of Punjabi and Hindi. However this was the first contact with a Dr from mental health services and it would have been preferable to be face to face. Whilst face to face was offered it was apparently not possible to facilitate when his son was able to support him.

Communication issues, have been highlighted in the investigation, these relate to**:** MDT, recording of the outcomes of the MDT was poor; actions agreed did not identify a responsible person to complete the action. As a result the action agreed in the first MDT was not undertaken; this being a referral to the crisis house. The medical assessment entry was not comprehensive with no diagnosis or risk assessment.

The reason for not making the referral has been reported as the patients proposed trip to Dubai. This is not clearly recorded and once it was known that the patient was not going to Dubai no action was documented around not making the referral.

The system of escalation to the MDT is not robust and there was no written evidence that issues escalated were always discussed and actions allocated.

Communication between the team was not robust, staff were reliant on previous entries in the clinical record to identify previous patient presentation and risk. There was an inconsistent approach to recording the outcome of visits in the patient notes.

The family reported that they did not receive feedback appropriately when raising concerns, they did not feel that they had been engaged in their fathers care. The family reported that they felt staff did not believe them or Mr S when escalating their concerns or when Mr S was reporting suicidal ideation.

Following this investigation, the following recommendations have been made:

1. Report to be shared with the relatives, once signed off by commissioners.

2. Report to be shared with staff involved in the incident.

3. Learning from this investigation to be shared within the AMH&LD directorate

4. The crisis team should develop a process to support rostering of visits to work towards reducing the number of different staff seeing a single patient.

- A review of the visit bookings should be undertaken so consideration is given to requests by the patient for times and location of visits.
- This should be regularly reviewed and patient satisfaction considered.

5. Team to develop a standardised format for case note entries to ensure consistent format and clear actions are recorded.

6. Team to develop a standardised format for recording entries when patients or their relatives call to ensure consistent format and clear actions/ requests are recorded.

7. All staff need to be aware that the Key worker Standard Operating Procedure is mandatory and that compliance is monitored and recorded within clinical supervision and every effort made to ensure the key worker is available or deputy appointed

8. The Keyworker SOP should be reviewed, ensuring oversight assuring that the clinical review is undertaken, and that there is a clear escalation process where this review has not been undertaken.

9. The Keyworker standard operating procedure should form part of the CRHT induction

10. The Keyworker should meet the patient. Ensuring the responsiveness and effectiveness of patient care. Ensuring that patient and family have a point of

contact. (Consideration should be given to the initial assessing practitioner being allocated as key worker)

11. The process for MDT needs to be reviewed. The MDT needs to be consistent ensuring the following:

- Rationale for incomplete actions should be recorded.
- Completion of agreed actions with clearly identified leads to ensure actions are taken.
- Actions agreed in MDTs should have clearly defined timeframes for completion.
- Where concerns are raised with the MDT the outcome of discussion is documented

12. Staff must read and follow patients individualised care plan and evaluate care in relation to this.

13. The crisis team must ensure they deliver culturally competent care and are able to recognise psychosocial factors that may be contributing factor.

14. The Crisis team need to review the process for ensuring patient records are updated with their communication needs and the compliance with the agreed plan should be monitored.

15. The Patient Experience group to consider a trust wide approach to ensuring that there is accessible information appropriate to the needs of our service users.

16. Patients who are currently not open to Mental Health services who are accepted for Crisis Home treatment should have a face to face medical review to confirm diagnosis treatment and plan of care

M

Leicestershire Partnership NHS Trust

FINANCE AND PERFORMANCE COMMITTEE – 15 OCTOBER 2019

HIGHLIGHT REPORT

The key headlines/issues and levels of assurance are set out below, and are graded as follows:

Strength of Assurance	Colour to use in 'Strength of Assurance' column below
Low	Red - there are significant gaps in assurance and/or not properly assured as to the adequacy of action plans/controls
Medium	Amber - there is reasonable level of assurance but some issues identified to be addressed.
High	Green – there are no gaps in assurance and there are adequate action plans/controls

Report	Assurance level*	Committee escalation	ORR / Risk Reference
STP Long Term Plan 		The Better Care Together Five Year Plan in LLR 2019 was presented for assurance This document set out the narrative plan to achieve the STP deadline and executive directors were reviewing the sections relevant to them. FPC received an update on the STP Long Term Plan key planning assumptions and messages. Key points to note of the approach to the financial plan for the next 5 years were; • Single LLR financial model for all NHS organisations. • Co-production across finance teams to populate / agree assumptions. • Nationally driven assumptions included pay and non-pay cost inflation and tariff inflation and efficiency. • Local assumptions had been made around demographic growth and Mental Health Investment Standard. Growth had not been put against mental health as £10m would be invested which would be higher. However, it was still unclear how much of this LPT would receive but it would be monitored during the detailed planning discussions. • There was significant investment coming into LPT especially for community services but the Trust needed to be sure the numbers aligned between the STP and LPT's plan. • The numbers showed there was an initial £82m financial gap across the system but this was prior to any central funding being received. • NHSI had confirmed its expectations for financial delivery for 2020/21, this included some financial recovery which would need to be factored in. • There was a £4.5m CIP requirement for LPT which was felt to be low, NHSI might ask for this to be increased. • LPT still needed to factor in internal assumptions for CAMHS waiting list, estates and facilities management costs.	4262

Report	Assurance level*	Committee escalation	ORR / Risk Reference
		• The NHSI financial trajectory target surplus for 2020/21 for LPT was £1.4m. The Committee agreed that additional narrative on a number of aspects was required in the STP plan before submission to Trust Board on 1 November, these included capital investment, estate issues and Step up to Great. The Committee had a limited level of assurance based on the ongoing risk of the financial gap and control total.	
Procurement Strategy Update 		An update on achievements since the Procurement Team had been awarded level 1 procurement standards was received. The team was now working in a category management function and had short term (driven by national initiatives), medium term (what LPT wanted to do) and long term (aspirational) priorities. Assurance was received that the strategy would be aligned with Step up to Great priorities. The Committee agreed the focus of procurement should be on supporting patient care as well as making financial savings.	
(BAF and Review of Organisational Finance Risk Register (ORR) 		The ORR as at 7 October 2019 was presented as part of an ongoing review process. This report was the first of the new template and cycle of risk review, and proposed the new ORR mapped against the Step up to Great strategic framework. The committee welcomed the proposal and thanked those for the considerable work undertaken. It noted its responsibility/oversight for 11 of the present 32 risks. The Committee approved the recommended closure and de-escalation of the 20 risks from the former BAF/CRR. FPC discussed and agreed to now quickly develop a shared approach with QAC on the implementation and embedding of the assurance process for the ORR. On this basis the committee had a limited level of assurance.	All
Finance Report Month 6 2019/20 		• The run-rate overspend for month 6 was £495k which was a deterioration from the month 5 position. Month 7 was likely to be the month where central reserves would no longer be sufficient to offset the operational deficit if it continued at the same rate. • AMH services' budgets showed the highest level of overspend (£1,192k), the positions for FYPC and CHS were stabilising. The estates position was static and enabling was the only operational directorate which was reporting an underspend. • All areas were maintaining the forecast outturn position with the exception of AMH. • During the month, the level of confidence regarding the receipt of the Mill Lodge VAT reclaim of £730k had	4264

Report	Assurance level*	Committee escalation	ORR / Risk Reference
Financial Turnaround Plan		reduced slightly and a 50% estimate had been reflected in the risks and pressures forecast. • The Committee noted the unrealistic outturn position for AMH services, the slight deterioration in the BPPC and the additional agency costs during the month, including those for non-clinical agency. The Committee received an update on the 2019/20 Financial Turnaround Plan since the last meeting. Key points to note were; • Enhanced vacancy controls were now in place. • All requests for recruitment (except for band 5 nurses) needed to be submitted to the Finance Team to ensure there was a budget associated with it and then was presented to the Financial Turnaround Group for approval. • A task and finish group had been set up to review agency costs. • Communications about the financial position were being sent to the wider Trust. • A task and finish group had been set up around corporate benchmarking. • QIA was being highlighted for new schemes as required. The Committee requested a completion column was added to the QIA performance dashboard. A number of new potential cost pressures were highlighted to the Committee. The Committee was not assured due to the worsening financial position at month 6 and ongoing gap in the recovery plan.	
Efficiency and Productivity Strategy		FPC acknowledged the Trust needed to take a more strategic approach to delivering financial sustainability to avoid the short term fixes that had been utilised previously, focusing on in year delivery, sometimes at the expense of long term sustainability. By introducing a more strategic approach to CIP identification and delivery, capital funding and delivering value in healthcare by sharing good practice, the Trust would stabilise its cost base and ensure it was in a much stronger position to respond to both national long term plan and LLR STP priorities. The Committee approved the Trust's three year efficiency and productivity plan and agreed updates would be received within the report on the financial plan for 2020/21.	
Estates and Facilities Management Update		An update on progress was presented, key issues were; • The Estates Strategy and Inpatient Strategic Outline Case were approved by Trust Board on 1 October. The SOC was now progressing to Outline Business Case. • Detailed work on dormitory accommodation had commenced, visits to AMH inpatient areas had been carried out to establish costs and timelines for potential alterations. Visits to MHSOP inpatient areas would be undertaken shortly. The planned action was on schedule	4529 / 4560

Report	Assurance level*	Committee escalation	ORR / Risk Reference
 FM Shared Service Review 		to support recommendation in December. • Work on the CAMHS build was on schedule and on budget. • In terms of cleaning and concerns raised at the last meeting around the KPIs, confirmation was received that only a small number of issues raised by NHSI related to actual cleaning standards and had now been resolved. The cleaning scores were accurate and reflected a good standard generally. • The Internal Audit Estates Maintenance Review had received limited assurance opinion which had been expected. The review and proposals would be reported through FPC. In view of LPT's deteriorating level of performance through the present contract with UHL the Committee was updated on the five options for future service provision being considered. These were; stay with existing partnership agreement with UHL; formal tender to a third party likely to be private sector; partner / collaborate for management resilience with NHFT; outsource to another non-acute trust; and to bring LPT's FM service full management provision back in-house. The recommendation for the preferred option was noted. The Committee agreed the recommendation to Trust Board for FM services would include the next steps, costs, timeline and risks so that a decision could be made by March 2020. FPC requested that the risks during this interim period were appropriatly documented with mitigations. The Committee was not assured due to the present performance and the requirment for a full risk assessment for the interim period.	
Waiting Times Summary 		FPC received an update detailing Trust performance against local and national waiting time targets, confirmed progress in relation to the seven priority services and work to address over 52 week waiters as at 31 August 2019. **52 week waits;** • No patients were waiting more than 52 weeks for a first appointment or from referral to treatment in consultant led services. • In non-consultant led services, there were 384 patients waiting over 52 weeks from referral to second appointment / treatment. This was a reduction of 38 on the position as at the end of July External resource had been secured to support services in developing performance improvement plans focusing on long waiters over target but under 52 weeks. The work was expected to be completed in November and an update on proposals to be received at FPC in December.	5265

Report	Assurance level*	Committee escalation	ORR / Risk Reference
		National targets; • National standards for consultant-led services (Adult ADHD and ASD) were not met in one of two indicators. • National standards were met for PIER and paediatric audiology. • Children's eating disorder access targets were due to be met by March 2020. The Trust was not meeting these targets currently but funding and a trajectory had recently been agreed with the CCG. **Priority Services** Concern was raised by the Committee that there was little evidence of sustainable improvement shown by the SPC analysis. FPC asked for a verbal update on the Harms Policy implementation plan which was reported by SE as on schedule. The Committee recognised the ongoing improvements in CAMH's and providing more appropriate reporting of the key waiting times through the dashboard. It was not assured that the same clarity was yet evident in improving outcomes. It was agreed a discussion would take place with executive leads for the key waiting time targets to update the committee on their proposed actions.	
IQPR and Performance Management 		The IQPR end of September 2019 position was presented for information. It was noted that the key concerns were presently being addressed within the body of the Committees agenda. Ongoing challenges around 7 day CPA were noted and it was reported being addressed by QAC DC reported that due to present concerns around meeting timelines for the new performance report, external resource had now been commissioned to help the Trust to develop a new style IQPR. The Committee received and noted the revised plan of action and additional resources in place to support performance management; • Funding to provide performance management expertise had been agreed by NHSE/I. A Performance Management Framework was expected to be delivered in November. • NHSE/I expertise had also been agreed to review existing PMO arrangements and recommend improvements. Based on the revised position proposed concerning the timeline for introduction of the new performance report, the Committee revised its position to not assured.	

Report	Assurance level*	Committee escalation	ORR / Risk Reference
NHS Oversight Framework 2019/20 		The NHS Oversight Framework for 2019/20 outlined the joint approach NHSE and NHSI would take to oversee organisational performance and identify where commissioners and providers may need support. The framework had replaced both the provider Single Oversight Framework 2018/19 and the CCG Improvement and Assessment Framework.	
Brexit Update 		FPC received assurance on plans in place around EU exit Daily sit rep reporting would restart week commencing 21 October Monday to Friday. No new risks for LPT had been identified. The only amber rated area had been around food as UHL could not predict what food shortages they would need to manage but this had now been resolved and UHL was satisfied they were RAG rated green. LPT would change its rating to green in response to UHL's amended RAG rating. A letter had been received from the City Mayor requesting an urgent meeting to discuss NHS and local authority Brexit preparedness.	4261
FPC Governance 		A proposal was received on the revised governance structure for FPC. It was based on the three levels of assurance principles. It was recognised it would address the concerns outlined in the CQC report in respect of clearer lines of reporting and improve alignment with the QAC. The Chairs and Executive leads for FPC and QAC had now scheduled regular meetings to ensure alignment of the approach, sharing of good practice and identify any areas of shared focus. The Committee agreed the next steps would include updating of the terms of reference for FPC which would be presented to the November meeting and terms of reference for the committees reporting into FPC for approval would be completed by December 2019.	
Any Other Business / New Risks		Additional risk emerging around facilities management review and change of provider was highlighted.	

Chair	Geoff Rowbotham, Non-Executive Director

Leicestershire Partnership NHS Trust

Meeting Name and date	**Trust Board, 1st November 2019**
Paper number	**N**

Name of Report: **Finance Report M6**

For approval		For assurance	X	For information	X

Presented by	Danielle Cecchini, Director of Finance	Author (s)	Chris Poyser, Head of Corporate Finance

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

Report previously reviewed by	
Committee / Group	Date
Finance & Performance Committee	**15/10/2019**

Assurance : What assurance does this report provide in respect of the Organisational Risk Register?	Links to ORR risk numbers
Provides assurance that the Trust financial position is closely monitored and managed, with any perceived adverse impact immediately and clearly highlighted to senior management	**All FPC finance risks**

Recommendations of the report
The Trust Board is recommended to accept the reported financial position, and to support any further actions designed to improve the year end forecast as agreed / discussed during the meeting.

Leicestershire Partnership NHS
NHS Trust

Finance Report for the period ended **30 September 2019**

For presentation at the **Trust Board** **1 November 2019**

Contents

Executive Summary and overall performance against targets

Introduction

1. This report presents the financial position for the period ended 30 September 2019 (month 6). The report shows a £696k surplus, which is in line with plan.

2. Operational budgets are currently overspending by £2,572k. The run-rate overspend for month 6 was £495k. Central reserves are still able to offset the operational overspend in order to deliver the year to date planned surplus. However, as has been forecast for several months, next month (month 7) is likely to be the month where central reserves will no longer be sufficient to offset the operational deficit if it continues at the same rate. This is illustrated in the table on page 6.

3. Adult Mental Health Services budgets show the highest level of overspend (£1,192k) followed by Estates services (£772k), FYPC Services (£326k) and Community Health Services (£276k). Enabling is the only operational directorate which is reporting an underspend (£137k).

4. Closing cash for September stood at £9.3m. This equates to 12.7 days' operating costs, and is above the planned cash level of £6.2m for September.

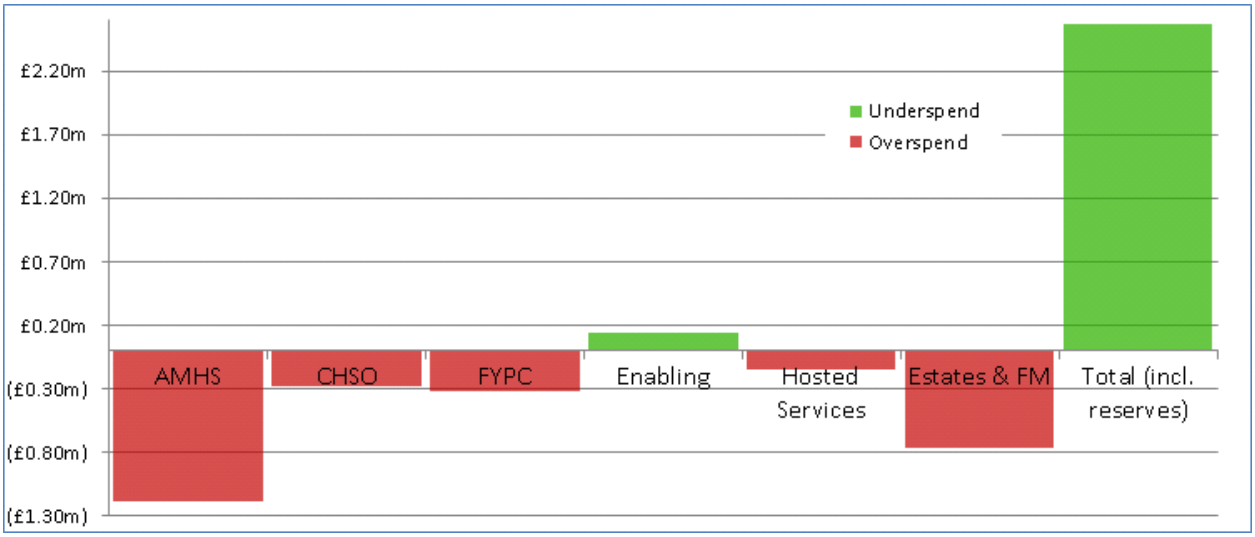
NHS Trust Statutory Duties	Year to date	Year end f'cast	Comments
1. Income and Expenditure break-even.	G	A	The Trust is reporting a surplus of £696k at the end of September 2019. This is in line with the Trust plan. The worsening run-rate increases the risk to delivery of a year end break-even **[see 'Service I&E position' and *Appendix A*]**.
2. Remain within Capital Resource Limit (CRL).	G	G	The capital spend for September is £3,324k, 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 £9.3m 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).	R	G	The target is to pay 95% of invoices within 30 days. Cumulatively the Trust achieved 3 of the 4 BPPC targets in September.
6. Achieve Cost Improvement Programme (CIP) targets.	G	R	CIP schemes are currently under delivering, showing £1,345k achieved compared to a £1,666k year to date target (equating to 80.7% delivery) at the end of month. **[See 'Efficiency Savings Programme' + *Appendix B*].** The year end forecast (for operational schemes) currently shows 69% achievement by the end of the year.
7. Deliver financial plan surplus	G	R	(Also see target 1 above). A surplus of £696k has been reported in month 6, in line with plan. The Trust plan for the year assumes a £0.5m LPT generated surplus, plus £2.1m PSF funding dependant on delivery of the NHSI breakeven control total. Delivery of the stretch target surplus by the year end is dependent on delivery of the Financial Turnaround Plan.
Internal targets	**Year to date**	**Year end f'cast**	**Comments**
8. Achieve a Financial & Use of Resources metric score of 2 (or better)	G	G	The Trust is currently scoring 2 for year-to-date performance. Despite the potential risks to the year end I&E surplus stretch target, the strong cash position means that a score of 2 overall for the year is still likely.
9. Achieve retained cash balances in line with plan	G	G	A cash balance of £9.3m was achieved at the end of September 2019. Delivery of the year end cash forecast is expected to exceed target due to notification (after plan submission) of the 2018/19 incentive PSF. **[See 'cash and working capital']**
10. Deliver capital investment in line with plan (within +/- 15% YTD planned spend levels)	G	G	Capital expenditure totals £3,324k at the end of month 6; £300k below plan. **[See 'Capital Programme 2019/20']**

Income and Expenditure position

The month 6 position includes a significant operational overspend that is currently offset by the release of all central reserves.

The chart below shows the year-to-date I&E variance against budget/plan and the individual service surplus/deficits contributing towards this overall position.



Income and expenditure forecast

The month 6 operational overspend of £2,572k represents a negative movement of £495k compared to month 5 (£2,077k). The month 6 position is worse than expected, this is primarily due to pressures within AMH (the AMH overspend alone worsened by a further £355k during the month)

Appendix F (risks, pressures and mitigations) provides details of the risk-adjusted year end forecast. Directorate year end forecasts have largely stayed the same as last month. However, during the month, the level of confidence regarding the receipt of the Mill Lodge VAT reclaim of £730k has reduced. This is following HMRC's review of our appeal. The next stage would be to pursue the claim via a Tax Tribunal. To reflect the reduced level of confidence, and assuming that the matter has not been resolved by the end of the financial year, it is likely that a 50:50 provision will be included in the Trust accounts, pending the final outcome. This is reflected in the risks and pressures analysis as a reduced benefit.

An additional potential financial mitigation is currently being pursued. This involves the adoption of an alternative approach to valuing our assets, which would result in a significant reduction in our capital charges. It has not yet been determined how much the Trust could benefit by adopting this new approach. Similar Trust's have seen cost reductions of c.£1m. At this stage, a £0.5m estimate has been reflected in the risks and pressures forecast, which mitigates the reduced Mill Lodge expectation.

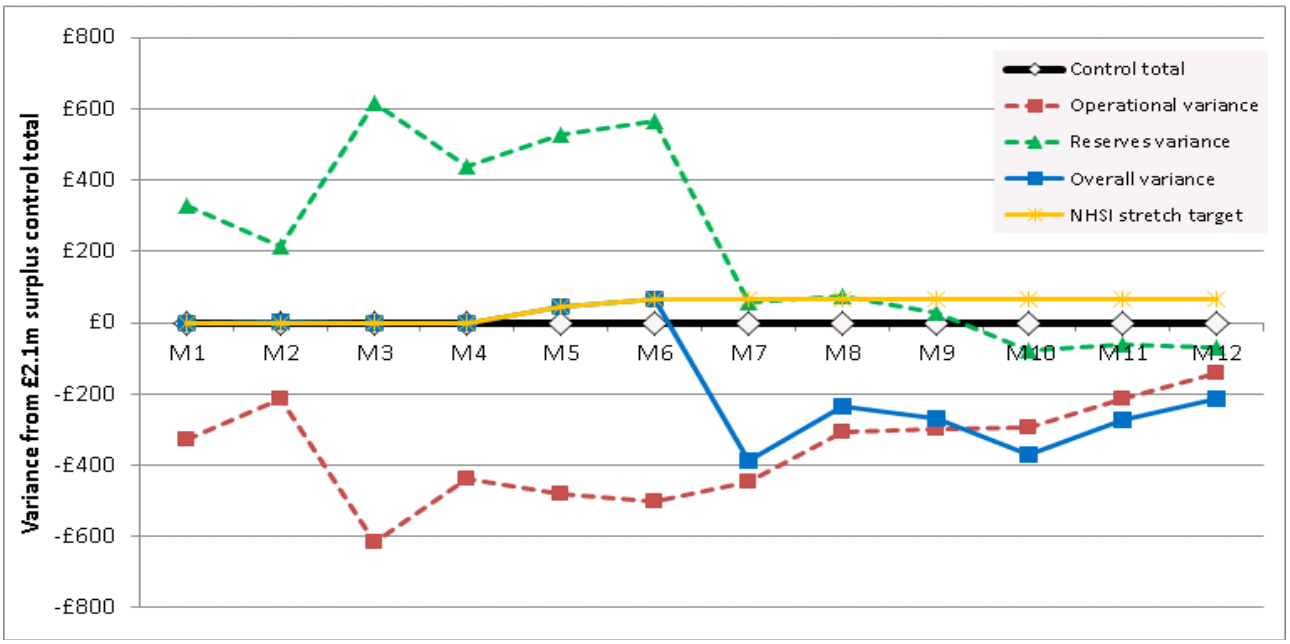
Run-rate variances – position excluding financial recovery savings

The graph below shows the monthly run-rate variance position, based on current forecasts (and excluding any financial recovery actions).

The Trust's control total surplus is the 'baseline' (i.e the black line '£0' position on the graph). The NHSI plan including the £500k stretch target is therefore shown as a variance to the control total (the yellow line), phased into the position from month 5. The operational variance is reflected as the red dotted line, with the reserves variance represented by the green dotted line. The blue line is the combined overall operational / reserves variance.

The reserves variance (underspend) fully offsets the operational variance up to month 6. However, from month 7, the availability of additional reserves benefit reduces rapidly to the extent that reserves underspends can no longer offset the expected operational overspends. At this point the blue overall variance line diverges from the yellow plan line – showing that the Trust will then go off plan. The cumulative under-performance from month 7 (before financial recovery actions are reflected) is a £1.4m shortfall against the £2.1m control total and a £1.9m shortfall against the £2.6m planned surplus

Run-rate variances

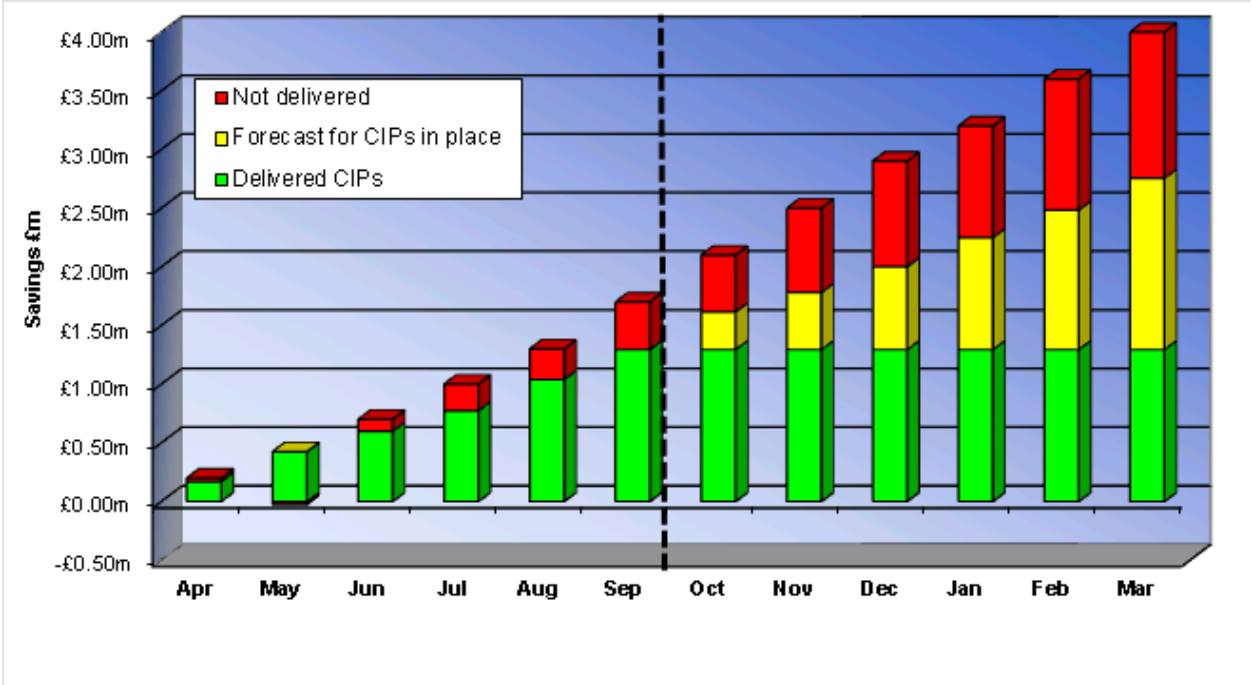


The risk adjusted forecast (shown at ***Appendix F***) assumes that £1.9m recovery actions can be delivered, thus achieving the planned surplus including the £0.5m stretch target (£2.6m). The phasing of recovery actions is yet to be confirmed by the turnaround operational leads, but the aim would be to ensure that these can be delivered in such a way that the Trust can still, as a minimum, achieve the control total each month, thus securing the PSF funding.

Delivery of this level of financial recovery plan must be recognised as a significant challenge, and the revised forecast reflects a move towards a 'best case' scenario.

Directorate Efficiency Savings Programme

CIP performance (directorate schemes) as at month 6



	Apr £000	May £000	Jun £000	Jul £000	Aug £000	Sep £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	Mar £000
Monthly plan total:	**212**	**427**	**672**	**967**	**1,307**	**1,666**	**2,061**	**2,456**	**2,852**	**3,249**	**3,648**	**4,047**
Actual performance to date												
Achieved	169	474	648	824	1,089	1,345	1,345	1,345	1,345	1,345	1,345	1,345
Forecast achieved	*0*	*0*	*0*	*0*	*0*	*0*	*322*	*487*	*706*	*954*	*1,189*	*1,461*
Total savings:	**169**	**474**	**648**	**824**	**1,089**	**1,345**	**1,666**	**1,832**	**2,051**	**2,299**	**2,533**	**2,806**
Variance:	**(43)**	**47**	**(24)**	**(143)**	**(217)**	**(321)**	**(394)**	**(624)**	**(801)**	**(950)**	**(1,114)**	**(1,241)**

At the end of September, CIP delivery amounted to £1,345k, against an overall year to date target of £1,666k. This equates to 80.7% delivery.

The year end forecast predicts performance significantly lower than plan by the end of March 2020 (69% delivery). The expected worsening performance is due to unidentified CIPs, the savings for which are phased in later in the year. This unidentified element includes the additional £500k CIP required to deliver the higher surplus target set for the Trust by NHS Improvement.

Statement of Financial Position (SoFP)

PERIOD: September 2020	2018/19 31/03/19 Audited £'000's	2019/20 30/09/19 September £'000's
NON CURRENT ASSETS		
Property, Plant and Equipment	200,260	199,911
Intangible assets	1,909	1,764
Trade and other receivables	653	652
Total Non Current Assets	**202,822**	**202,327**
CURRENT ASSETS		
Inventories	319	412
Trade and other receivables	13,802	17,485
Cash and Cash Equivalents	8,357	9,332
Total Current Assets	**22,478**	**27,229**
Non current assets held for sale	**0**	**0**
TOTAL ASSETS	**225,300**	**229,556**
CURRENT LIABILITIES		
Trade and other payables	(14,856)	(16,968)
Borrowings	(220)	(220)
Capital Investment Loan - Current	(190)	(190)
Provisions	(1,202)	(1,144)
Total Current Liabilities	**(16,468)**	**(18,522)**
NET CURRENT ASSETS (LIABILITIES)	**6,010**	**8,707**
NON CURRENT LIABILITIES		
Borrowings	(8,025)	(8,024)
Capital Investment Loan - Non Current	(3,510)	(3,429)
Provisions	(1,129)	(1,129)
Total Non Current Liabilities	**(12,664)**	**(12,582)**
TOTAL ASSETS EMPLOYED	**196,168**	**198,453**
TAXPAYERS' EQUITY		
Public Dividend Capital	83,675	85,263
Retained Earnings	48,288	48,984
Revaluation reserve	64,205	64,205
TOTAL TAXPAYERS EQUITY	**196,168**	**198,453**

Non-current assets

- Property, plant and equipment (PPE) amounts to £199.9m. For the first six months of the year depreciation charges have exceeded capital spend, resulting in a reduced PPE balance.

Current assets

- Current assets of £27.2m include cash of £9.3m and receivables of £17.5m.

Current Liabilities

- Current liabilities amount to £18.5m and mainly relate to payables of £17m
- Net current assets / (liabilities) show net assets of £8.7m.

Working capital

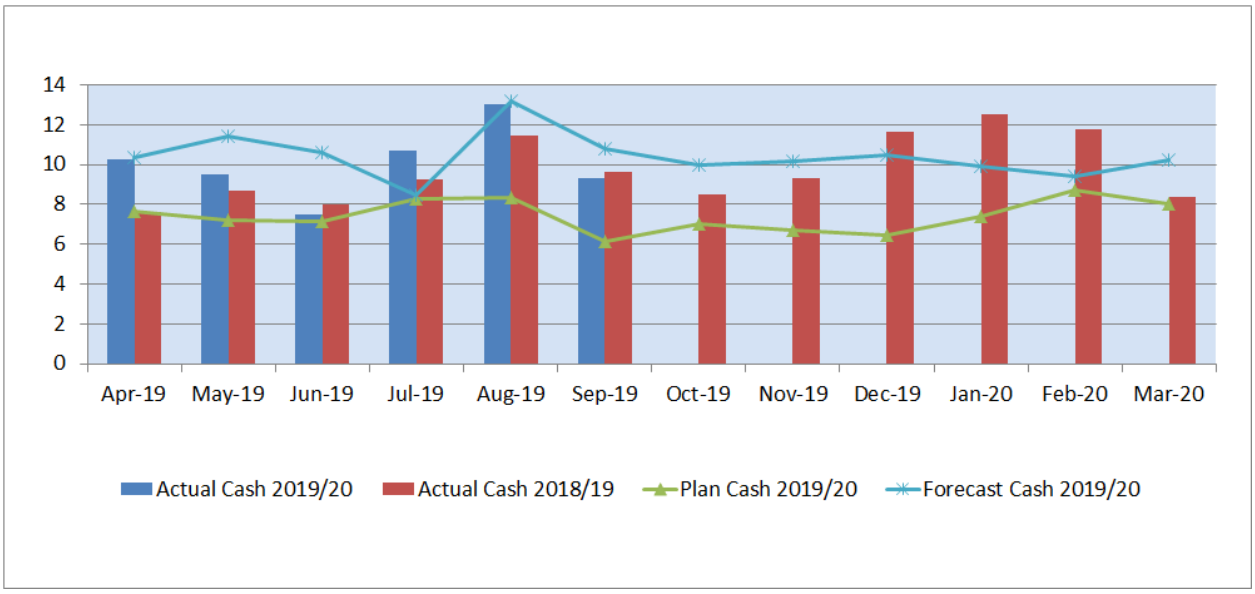
- Cash and changes in working capital are reviewed on the following pages.

Taxpayers' Equity

- September's year to date surplus of £696k is reflected within retained earnings.

Cash and Working Capital

12 Months Cash Analysis Apr 18 to Mar 19



Cash – Key Points

September's closing cash balance is £9.3m and equates to 12.7 days' operating expenses - this is £3.2m above the planned cash balance of £6.2m.

Internal cash forecasts are updated each month. The receipt of £3m relating to last year's PSF funding was received earlier than expected and is responsible for the cash over-achievement against plan (planned PSF is phased equally over 12 months).

The cash position has reduced by £3.7m during the month.The first PDC instalment of £2.8m to the Department of Health was paid in September. In additional to this, payroll and non pay expenditure has increased compared with previous months.

The year end cash forecast of £10.24m as at 31st March 2020 is £2.2m above the planned year end cash balance of £8m. This is due to NHSI notification in April of the incentive PSF funding awarded to the Trust for achieving its 2018/19 financial duties (£2.2m). The revised forecast of £10.24m is reliant on the delivery of the planned I&E outturn and the receipt of full 2019/20 PSF funding.

A detailed cashflow forecast is included at ***Appendix E.***

Receivables

Current receivables (debtors) total £17.5m. It should be noted that financial instruments such as accruals are also included in this calculation.

Receivables	Current Month (September 2019)					
	NHS	Non NHS	Emp's	Total	% Total	% Sales Ledger
	£'000	£'000	£'000	£'000		
Sales Ledger						
30 days or less	1,492	1,233	7	**2,732**	**15.3%**	**31.8%**
31 - 60 days	982	200	2	**1,184**	**6.6%**	**13.8%**
61 - 90 days	1,088	146	9	**1,243**	**7.0%**	**14.5%**
Over 90 days	2,630	635	165	**3,430**	**19.2%**	**39.9%**
	6,192	2,214	183	**8,589**	**48.1%**	**100.0%**
Non sales ledger	5,939	2,957	0	**8,896**	**49.9%**	
Total receivables current	**12,131**	**5,171**	**183**	**17,485**	**98.0%**	
Total receivables non current		360		360	**2.0%**	
Total	**12,131**	**5,531**	**183**	**17,845**	**100.0%**	**0.0%**

Debt greater than 90 days amounts to £3.4m, an increase of £282k since last month. Receivables over 90 days should not account for more than 5% of the overall total receivables balance. The proportion at Month 6 is 19.2% (last month: 18.3%).

Aged debts > 90 days

Based on the RAG ratings below (see key), 45 invoices totalling £564k are deemed to be red, a reduction of £1k since last month. The Accounts Receivable team focus on the green and amber debts, whilst the red debts are passed to Service areas once all general debt recovery processes have been exhausted. The majority of 'red' invoices relate to disputed AMH out-of-area recharges. Work continues to resolve these debts.

RAG	M4		M5		M6		Diff	
	£000	No	£000	No	£000	No	£000	No
Green	1,521	364	1,489	341	1,733	325	244	(16)
Amber	1,066	97	1,095	100	1,134	105	39	5
Red	571	46	565	45	564	45	(1)	0
Total	**3,158**	**507**	**3,149**	**486**	**3,431**	**475**	**282**	**(11)**

Key:

Green – invoice is in early stages of being chased / no queries or issues
Amber – invoice query raised / has been passed to requester to help resolve any disputes
Red * – invoice query raised which AR team cannot resolve / chased twice with requester

* If debts are red rated, this does not imply that they need to be written-off, just that more work is required to get disputes or queries resolved. There has not been any movement in the general bad debt provision of £374k since the start of the financial year.

Payables

The current payables position in Month 6 is £17m, a reduction of £4.8m during the month. The reduction relates to the six-monthly PDC payment of £2.8m plus resolution and payment of previously disputed invoices, including this year's NHS Property Services recharges. The over 90 days NHS supplier debt of £1,775k continues to relate to two suppliers: UHL (£483k) and old year NHS Property Services disputed invoices (£1.3m). Work is ongoing to resolve specific invoice disputes.

Payables	Current Month September 2019				
	NHS	Non NHS	Total	% Total	% Purchase Ledger
	£'000	£'000	£'000		
Purchase Ledger					
30 days or less	1,026	2,062	**3,088**	**18.2%**	**55.2%**
31 - 60 days	12	25	**37**	**0.2%**	**0.7%**
61 - 90 days	690	6	**696**	**4.1%**	**12.4%**
Over 90 days	1,758	17	**1,775**	**10.5%**	**31.7%**
	3,486	2,110	**5,596**	**33.0%**	**100.0%**
Non purchase ledger	2,163	9,209	**11,372**	**67.0%**	
Total Payables Current	**5,649**	**11,319**	**16,968**	**100.0%**	
Total Payables Non Current	0	0	**0**		
Total	5,649	11,319	16,968	**100.0%**	

Better Payment Practice Code (BPPC)

The specific target is to pay 95% of invoices within 30 days. Cumulatively the Trust achieved 3 of the 4 BPPC targets in September, with only two targets being met during the month, relating to the value of Non-NHS and NHS invoices.

Due to a Pharmacy system processing issue in September, a total of 208 invoices (203 Non-NHS and 5 NHS invoices) were not processed for payment on time. The Trust would have achieved all of its in-month and cumulative targets if this issue had not arisen. Additional monthly process checks are now in place to ensure this does not happen again.

The Finance team will continue to meet with any non-complying departments to help maintain this position and support achievement of all four targets at the end of the financial year.

Further details are shown in ***Appendix C***.

Capital Programme 2019/20

Capital expenditure totals £3.32m at the end of month 6, £300k below plan. Spend continues to increase due to payment of Interserve invoices for the construction of the CAMHS unit, Bradgate ward refurbishments and the Riverside office relocation.

Following last month's confirmation from NHSI to spend to original plan, the Capital Management Group has reviewed the progress of all schemes and identified expenditure slippage of c£1m. New and changes to existing schemes to be funded from this slippage include:

	£000
Increase in Electronic Patient Record system	88
Increase in Agile working (Estates)	126
Loughborough boilers	400
	614
Switchgear at Loughborough	tbc
Fixed installation and PAT testing	tbc
Backlog survey programme (3-year)	tbc
Computer aided FM system	tbc
Water risk assessments	tbc
Ward refurbishment furniture	tbc
Medical devices - disinfectors, sterilisers	tbc
Medical devices - bath replacements	tbc
Medical devices - syringe drivers	tbc

Work has started on 2020/21 capital planning; the Estates and IM&T strategy groups are reviewing capital requirements for next year and will be reporting back to the Capital Management Group in November.

	Annual Plan	Sep YTD Plan	Sep YTD Actual	Sep YTD Variance	Year End Forecast	Revision to Plan
Sources of Funds	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Depreciation	7,179	2,667	2,366	(301)	7,179	0
PDC capital for CAMHS	5,102	958	958	0	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**	**3,625**	**3,324**	**(301)**	**13,957**	**0**
Application of Funds	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Estates & Innovation						
Service Improvements	(7,138)	(1,929)	(1,870)	59	(7,578)	(440)
Estates & Equipment	(2,911)	(799)	(250)	549	(2,233)	678
Sub-total:	**(10,049)**	**(2,728)**	**(2,120)**	**608**	**(9,811)**	**238**
IT Programme	**(3,908)**	**(897)**	**(1,204)**	**(307)**	**(4,146)**	**(238)**
Total Capital Expenditure	**(13,957)**	**(3,625)**	**(3,324)**	**301**	**(13,957)**	**0**
(Over)/underspend against resource available	**0**	**0**	**0**	**0**	**0**	**0**

APPENDIX A - Statement of Comprehensive Income (SoCI)

Statement of Comprehensive Income for the period ended 30th September 2019	YTD Actual M6 £000	YTD Plan M6 £000	YTD Var. M6 £000	Year end forecast £000
Revenue				
Total income	141,884	139,358	2,526	278,567
Operating expenses	(137,631)	(135,106)	(2,525)	(268,805)
Operating surplus (deficit)	**4,253**	**4,252**	**1**	**9,762**
Investment revenue	18	18	(0)	36
Other gains and (losses)	0	0	0	0
Finance costs	(498)	(498)	0	(996)
Surplus/(deficit) for the period	**3,772**	**3,772**	**0**	**8,802**
Public dividend capital dividends payable	(3,076)	(3,076)	(0)	(6,154)
I&E surplus/(deficit) for the period (before tech. adjs)	**696**	**696**	**0**	**2,648**
IFRIC 12 adjustments	0	0	0	0
Donated/government grant asset reserve adj	0	0	0	0
Technical adjustment for impairments	0	0	0	0
NHSI I&E control total surplus	**696**	**696**	**0**	**2,648**
Other comprehensive income (Exc. Technical Adjs)				
Impairments and reversals	0	0	0	0
Gains on revaluations	0	0	0	0
Total comprehensive income for the period:	**696**	**696**	**0**	**2,648**
Trust EBITDA £000	**8,039**	**8,038**	**1**	**17,336**
Trust EBITDA margin %	**5.7%**	**5.8%**	**-0.1%**	**6.2%**

APPENDIX B – Monthly Operational CIP performance by Service

CIP performance by Directorate		2019/20 Financial Year													
		1 Apr £'000	2 May £'000	3 June £'000	4 July £'000	5 Aug £'000	6 Sept £'000	7 Oct £'000	8 Nov £'000	9 Dec £'000	10 Jan £'000	11 Feb £'000	12 March £'000	19/20 YTD £'000	19/20 yr/end plan £'000
AMH & LD	Plan	25	25	56	61	61	61	63	63	63	64	65	65	290	674
	Actual / Forecast	0	141	10	12	48	18	51	-69	15	45	31	65	228	367
	Variance	-25	116	-47	-49	-13	-43	-12	-132	-49	-19	-34	0	-62	-308
	Cumulative Variance	-25	91	44	-5	-18	-62	-74	-206	-254	-273	-308	-308		
	Cuml. % delivered	0%	280%	141%	97%	92%	79%	79%	51%	47%	50%	49%	54%	79%	54%
FYPC	Plan	49	49	49	49	49	49	49	49	49	49	49	49	293	586
	Actual / Forecast	49	49	49	49	49	49	49	49	49	49	49	49	293	586
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Cumulative Variance	0	0	0	0	0	0	0	0	0	0	0	0		
	Cuml. % delivered	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Community H/S	Plan	73	73	73	73	73	73	73	73	73	73	73	73	435	870
	Actual / Forecast	73	73	73	73	73	73	73	73	73	73	73	73	435	870
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Cumulative Variance	0	0	0	0	0	0	0	0	0	0	0	0		
	Cuml. % delivered	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Enabling	Plan	46	46	46	46	46	46	46	46	46	46	46	46	278	555
	Actual / Forecast	45	38	38	38	46	46	46	45	45	44	44	46	251	521
	Variance	-1	-8	-8	-8	0	0	0	-1	-1	-2	-2	0	-26	-34
	Cumulative Variance	-1	-9	-17	-26	-26	-26	-26	-28	-29	-31	-33	-34		
	Cuml. % delivered	98%	90%	87%	86%	89%	91%	92%	93%	93%	93%	93%	94%	91%	94%
Estates Services	Plan	19	22	22	66	66	66	99	100	100	100	101	102	261	862
	Actual / Forecast	2	5	5	5	5	5	38	38	38	38	38	40	27	257
	Variance	-17	-17	-17	-61	-61	-61	-61	-62	-62	-62	-63	-62	-234	-605
	Cumulative Variance	-17	-34	-51	-112	-173	-234	-294	-356	-418	-480	-543	-605		
	Cuml. % delivered	0%	0%	0%	13%	11%	10%	18%	22%	25%	27%	29%	30%	10%	30%
Trust-wide savings	Plan	0	0	0	0	45	65	65	65	65	65	65	65	110	500
	Actual / Forecast	0	0	0	0	45	65	65	30	0	0	0	0	110	205
	Variance	0	0	0	0	0	0	0	-35	-65	-65	-65	-65	0	-295
	Cumulative Variance	0	0	0	0	0	0	0	-35	-100	-165	-230	-295		
	Cuml. % delivered	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	100%	41%
Total	Plan	212	215	246	295	340	360	394	396	396	397	399	400	1,666	4,047
	Actual / Forecast	169	305	174	176	265	255	322	165	219	248	234	273	1,345	2,806
	Variance	-43	91	-72	-118	-74	-104	-73	-230	-177	-149	-164	-127	-321	-1,241
	Cumulative Variance	-43	47	-24	-143	-217	-321	-394	-624	-801	-950	-1,114	-1,241		
														81%	69%
Cumulative Delivered		80%	111%	96%	85%	83%	81%	81%	75%	72%	71%	69%	69%		

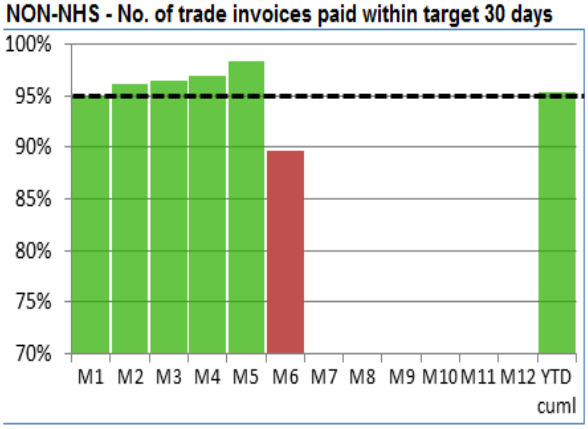
APPENDIX C – BPPC performance

Trust performance – current month (cumulative) v previous

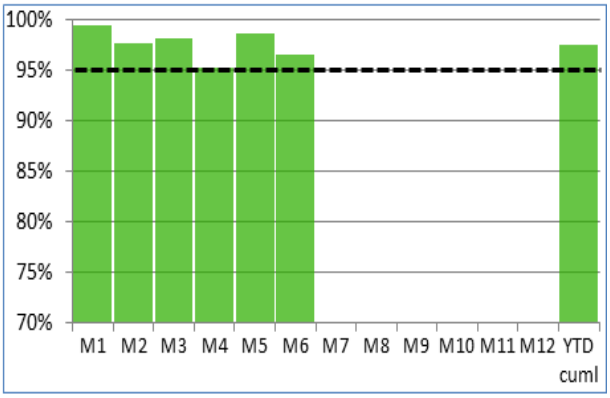
Better Payment Practice Code	September (Cumulative)		August (Cumulative)	
	Number	£000's	Number	£000's
Total Non-NHS trade invoices paid in the year	14,124	50,626	11,275	40,755
Total Non-NHS trade invoices paid within target	13,468	49,372	10,911	39,846
% of Non-NHS trade invoices paid within target	**95.4%**	**97.5%**	**96.8%**	**97.8%**
Total NHS trade invoices paid in the year	406	25,781	309	20,452
Total NHS trade invoices paid within target	385	25,578	297	20,436
% of NHS trade invoices paid within target	**94.8%**	**99.2%**	**96.1%**	**99.9%**
Grand total trade invoices paid in the year	14,530	76,407	11,584	61,207
Grand total trade invoices paid within target	13,853	74,950	11,208	60,282
% of total trade invoices paid within target	**95.3%**	**98.1%**	**96.8%**	**98.5%**

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

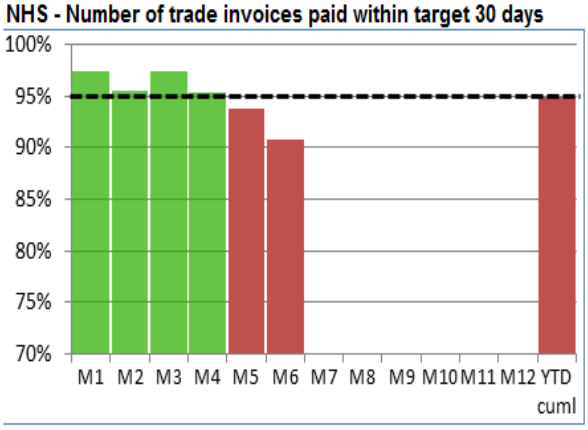
NON-NHS - No. of trade invoices paid within target 30 days



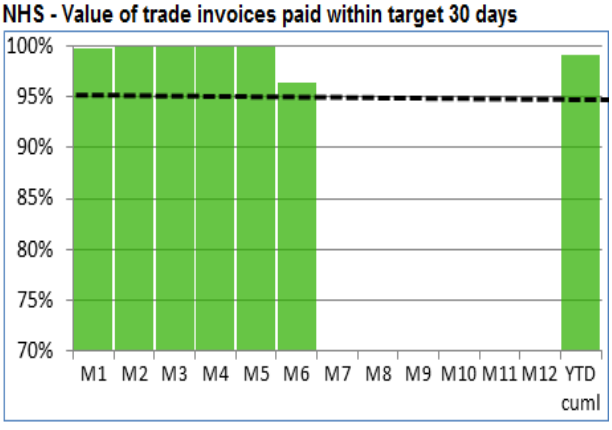
NON-NHS - Value of trade invoices paid within target 30 days



NHS - Number of trade invoices paid within target 30 days



NHS - Value of trade invoices paid within target 30 days



APPENDIX D – Agency staff expenditure

2019/20 Agency Expenditure (includes prior yr comparators)	2018/19 Outturn £000s Actual	2018/19 Avg. £000s Actual	2019/20 M1 £000s Actual	2019/20 M2 £000s Actual	2019/20 M3 £000s Actual	2019/20 M4 £000s Actual	2019/20 M5 £000s Actual	2019/20 M6 £000s Actual	2019/20 M7 £000s FCast	2019/20 M8 £000s FCast	2019/20 M9 £000s FCast	2019/20 M10 £000s FCast	2019/20 M11 £000s FCast	2019/20 M12 £000s FCast	19/20 YTD £000s Actual	19/20 Year End £000s Fcast
AMH/LD																
Agency Consultant Costs	-609	-51	-60	-64	-94	-59	-75	-86	-75	-75	-65	-65	-45	-45	-438	-808
Agency Nursing	-1,528	-127	-122	-142	-158	-173	-157	-214	-165	-155	-155	-150	-140	-135	-965	-1,865
Agency Scient, Therap. & Tech	-232	-19	-33	-18	-21	-26	-23	-12	-25	-25	-25	-25	-25	-25	-134	-284
Agency Non clinical staff costs	-409	-34	-48	-43	-31	-14	-25	-38	-25	-20	-20	-20	-20	-10	-200	-315
Sub-total	**-2,778**	**-231**	**-264**	**-267**	**-303**	**-273**	**-280**	**-350**	**-290**	**-275**	**-265**	**-260**	**-230**	**-215**	-1,737	**-3,272**
CHS																
Agency Consultant Costs	-182	-15	-15	-15	-12	-13	-11	-15	-15	-15	-15	-7	-7	-7	-81	-145
Agency Nursing	-3,579	-298	-306	-243	-305	-332	-302	-279	-290	-290	-320	-290	-270	-270	-1,768	-3,498
Agency Scient, Therap. & Tech	-644	-54	-54	-41	-47	-53	-49	-39	-50	-50	-50	-50	-50	-50	-284	-584
Agency Non clinical staff costs	-43	-4	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sub-total	**-4,447**	**-371**	**-375**	**-299**	**-365**	**-398**	**-362**	**-333**	**-355**	**-355**	**-385**	**-347**	**-327**	**-327**	-2,132	**-4,227**
FYPC																
Agency Consultant Costs	-429	-36	-42	-12	-29	-30	-41	-28	-30	-30	-30	-30	-30	-30	-182	-362
Agency Nursing	-521	-43	-118	-160	-163	-94	-96	-160	-70	-50	-30	-30	-20	-20	-791	-1,011
Agency Scient, Therap. & Tech	-26	-2	-4	-7	-11	-16	-5	-9	-5	-5	-5	-5	0	0	-52	-72
Agency Non clinical staff costs	-32	-3	-8	-15	-15	-28	-3	-8	0	0	0	0	0	0	-77	-77
Sub-total	**-1,007**	**-84**	**-172**	**-194**	**-218**	**-168**	**-145**	**-205**	**-105**	**-85**	**-65**	**-65**	**-50**	**-50**	-1,103	**-1,523**
Enabling, Hosted & reserves																
Agency Consultant Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Agency Nursing	-49	-4	0	29	0	0	0	0	0	0	0	0	0	0	29	29
Agency Scient, Therap. & Tech	-42	-4	-7	-4	-8	-10	-8	-5	-9	-9	-9	-9	-9	-9	-42	-96
Agency Non clinical staff costs	-623	-52	-22	-31	-24	-27	-19	-33	-30	-30	-30	-25	-25	-25	-155	-320
Sub-total	**-714**	**-60**	**-28**	**-6**	**-32**	**-38**	**-27**	**-38**	**-39**	**-39**	**-39**	**-34**	**-34**	**-34**	-168	**-387**
TOTAL TRUST															0	
Agency Consultant Costs	-1,220	-102	-117	-90	-136	-103	-126	-130	-120	-120	-110	-102	-82	-82	-701	-1,316
Agency Nursing	-5,676	-473	-546	-516	-626	-599	-556	-653	-525	-495	-505	-470	-430	-425	-3,495	-6,345
Agency Scient, Therap. & Tech	-944	-79	-99	-71	-87	-105	-85	-65	-89	-89	-89	-89	-84	-84	-511	-1,035
Agency Non clinical staff costs	-1,107	-92	-78	-89	-70	-70	-47	-79	-55	-50	-50	-45	-45	-35	-433	-713
Total	**-8,946**	**-746**	**-839**	**-766**	**-918**	**-877**	**-814**	**-926**	**-789**	**-754**	**-754**	**-706**	**-641**	**-626**	-5,140	**-9,409**
Agency ceiling (£8,122k)			-675	-677	-677	-677	-677	-677	-677	-677	-677	-677	-677	-677	-4,060	-8,122
Variance (+better/-worse)			**-164**	**-89**	**-241**	**-200**	**-137**	**-249**	**-112**	**-77**	**-77**	**-29**	**36**	**51**	-1,080	**-1,287**
Trust financial plan			-710	-681	-680	-678	-677	-675	-674	-670	-673	-675	-673	-656	-4,101	-8,122
Variance (+better/-worse)			**-129**	**-85**	**-238**	**-199**	**-137**	**-251**	**-115**	**-84**	**-81**	**-31**	**32**	**30**	-1,039	**-1,287**

At month 6, total Trust agency costs were £5,140k. This is higher than year-to-date planned spend of £4,101k, and also higher than the year-to-date agency spend ceiling of £4,060k set by NHS Improvement.

The year end plan was initially set to deliver the NHSI agency spend ceiling of £8,122k. However, since the plan was set, agency projections have increased significantly, mainly as a result of much higher spend within FYPC, due to the work to reduce CAMHS waiting lists.

After month 6, the revised forecast for the year is £9.4m against the plan / NHSI ceiling of £8.1m. This does not factor in the planned Financial Turnaround plan agency costs reduction

APPENDIX E – Cash flow forecast

APPENDIX E: 2019/20 CASH-FLOW FORECAST	SEP	SEP	SEP	OCT	NOV	DEC	JAN	FEB	MAR	YTD	19/20
	FORECAST	ACTUAL	VARIANCE	FORECAST	FORECAST	FORECAST	FORECAST	FORECAST	FORECAST	ACTUAL	FORECAST
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
OPENING BALANCE	**13,012**	**13,012**	**0**	**9,332**	**9,997**	**10,164**	**10,500**	**9,915**	**9,390**	**8,356**	**8,356**
INCOME											
CCG Block Contracts	17,951	17,951	**0**	18,172	18,172	18,172	18,172	18,172	18,172	107,706	216,738
NHS England Specialist Commissioning Contracts	623	620	**(3)**	626	623	623	623	623	623	3,963	7,704
Health Education England Medical Training Contracts	697	697	**0**	976	710	716	710	708	715	4,440	8,975
Local Authorities	1,437	1,437	**0**	1,437	1,437	1,437	1,437	1,437	2,157	7,297	16,639
UHL Contracts	587	0	**(587)**	787	200	200	200	200	400	413	2,400
Non Contract Activity (NCA) re service provision for Non- Leicester patients	325	217	**(108)**	325	325	311	325	325	574	1,281	3,466
Health Informatics Service (HIS)	943	427	**(516)**	1,027	916	850	740	850	1,049	968	6,400
360 Assurance Audit Services	381	202	**(179)**	521	342	242	242	242	323	757	2,669
Property income for rents and service charges	756	0	**(756)**	882	126	126	126	126	126	0	1,512
STP Funding 19/20	352	322	**(30)**	322	0	430	0	0	644	322	1,718
STP Funding 18/19 - Q4 plus incentive and bonus allocation	0	0	**0**	0	0	0	0	0	0	3,180	3,180
HMRC Mill Lodge VAT refund for construction works	0	0	**0**	0	0	0	0	0	0	0	0
HMRC VAT reclaims	344	344	**0**	266	259	259	259	259	259	1,688	3,249
Property disposals	0	0	**0**	0	0	0	0	0	0	0	0
Capital Loan	0	0	**0**	0	0	0	0	0	0	0	0
Other income receipts and recharges (including PDC)	1,271	882	**(389)**	1,118	1,335	620	620	1,334	1,459	3,582	10,066
PDC capital funding support	1,589	1,589	**0**	0	0	1,476	0	0	2,037	1,589	5,102
Income receipts relating to previous year	400	121	**(279)**	150	412	200	200	197	0	5,354	6,513
Total Receipts	**27,656**	**24,809**	**(2,847)**	**26,609**	**24,857**	**25,662**	**23,654**	**24,473**	**28,538**	**142,540**	**296,331**
PAYMENTS											
Payroll	16,940	16,988	**48**	16,940	16,940	16,940	16,940	16,940	16,940	102,473	204,113
Capital	1,745	552	**(1,193)**	1,614	1,497	1,801	1,166	1,326	479	2,574	10,457
Non pay general expenditure	4,578	4,825	**247**	4,685	4,200	4,653	4,200	4,700	5,125	23,507	51,070
UHL - Estates & FM Services	827	827	**0**	827	827	827	827	827	827	4,135	9,097
UHL - Other contracts	528	528	**0**	176	176	176	176	176	176	1,060	2,116
Rents and Service Charges (NHS Properties & Community Health Partnership)	1,594	671	**(923)**	1,252	329	329	329	329	330	1,051	3,949
HCL Agency Nursing Costs	400	550	**150**	250	400	400	400	500	531	2,274	4,755
Out of Area (OOA) costs for patients placed in private hospitals	449	750	**301**	200	200	200	200	200	200	1,573	2,773
Public dividend capital payment (PDC)	2,798	2,798	**0**	0	0	0	0	0	3,077	2,798	5,875
Other finance costs (inc loan interest and principal repayments)	0	0	**0**	0	120	0	0	0	0	119	239
Total Payments	**29,859**	**28,489**	**(1,370)**	**25,944**	**24,689**	**25,326**	**24,238**	**24,998**	**27,685**	**141,564**	**294,444**
CLOSING CASH BOOK BALANCE	**10,809**	**9,332**	**(1,477)**	**9,997**	**10,164**	**10,500**	**9,915**	**9,390**	**10,243**	**9,332**	**10,243**
Plan	**6,158**	**6,158**	**0**	**7,014**	**6,681**	**6,436**	**7,383**	**8,711**	**8,000**	**7,216**	**8,000**
Variance to plan	**4,651**	**3,174**	**(1,477)**	**2,983**	**3,483**	**4,064**	**2,532**	**679**	**2,243**	**2,116**	**2,243**

APPENDIX F – Risks, Pressures and Mitigations

Risk adjusted estimated year end position as at month 6

Likely Scenario					Scenario Analysis		
Description	Risk £000	Pressure £000	Mitigation £000	Net Total £000	Best £000	Likely £000	Worst £000
Opening 2018/19 budgets - break-even assumption	-	-	-	**0**	**0**	**0**	**0**
Operational positions							
Adult Mental Health & LD	(388)	(1,694)	388	**(1,694)**	(1,034)	(1,694)	(2,094)
Community Health Services	(1,050)	0	600	**(450)**	100	(450)	(950)
Families, Young People and Childrens Services	0	(1,790)	1,200	**(590)**	(450)	(590)	(990)
Enabling Services	0	(254)	554	**300**	350	300	200
Estates	0	(1,649)	36	**(1,613)**	(1,513)	(1,613)	(1,816)
Hosted Services	0	(1,000)	775	**(225)**	(150)	(225)	(450)
Service Delivery - total	**(1,438)**	**(6,387)**	**3,553**	**(4,272)**	**(2,697)**	**(4,272)**	**(6,100)**
Trustwide/Corporate							
Reserves contingency release (includes release of unused 18/19 provisions and further 19/20 VAT reclaims)	**0**	0	1,593	**1,593**	1,250	1,593	1,000
Risk of loss of income due to 'fixed' 19/20 cost based contract with Commissioners. Mitigation is early identification of issues and witholding of budget where funding is not forthcoming	(250)	0	250	**0**	0	0	(125)
Opening contract value risk. £0.9m is within LPT position and is covered by additional CIP (albeit CIPs are unidentified). Remaining £2.0m rests with CCGs - the mitigation for this is that it will only be reflected in the contract if definite QIPP/cost reduction can be agreed by both parties.	(2,000)		2,000	**0**	0	0	(892)
Additional £500k CIP linked to the increased NHSI surplus expectation (stretch target). Potential mitigation will be allocation/identification of additional CIP target (tbc)		(500)	0	**(500)**	0	(500)	(500)
Capital charges: £270k in-year pressure identified against budget. Opportunity to adopt new valuation method could realise additional savings - £500k estimate included pending further work		(270)	500	**230**	730	230	(270)
Risk that previous IT software VAT reclaims will be rescinded due to a change in HMRC approach. Mitigation is further unrelated VAT reclaims not yet reported.	(240)		240	**0**	167	0	(240)
Potential Recovery Actions							
Mill Lodge VAT reclaim - following HMRC review, VAT reclaim has not been agreed. Tax tribunal route to be considered. Likely case assumes case not settled at year end, and 50:50 provision included in accounts.			365	**365**	730	365	0
Freeze Invest to Save reserve in 2019/20			550	**550**	550	550	0
Cap 2019/20 redundancy costs at £200k			100	**100**	100	100	0
Additional financial recovery options - tbc			1,934	**1,934**	1,934	1,934	0
Trustwide/Corporate total:	**(2,490)**	**(770)**	**7,532**	**4,272**	**5,461**	**4,272**	**(1,027)**
Budget variance after net risks, pressures and mitigations	**(3,928)**	**(7,157)**	**11,085**	**0**	**2,764**	**0**	**(7,127)**
Trust plan surplus (includes additional £500k NHSI target)				**2,648**	**2,648**	**2,648**	**2,648**
Net I&E performance				**2,648**	**5,412**	**2,648**	**(4,479)**

Summary, including PSF forecast	Trust plan	PSF	Total
Trust control total	0	2,148	**2,148**
NHSI plan (includes £500k 'stretch' target)	500	2,148	**2,648**
Current forecast surplus/(deficit)	500	2,148	**2,648**
Forecast variance against £2.6m planned surplus	**0**	**0**	**0**

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board – 1 November 2019
Paper number	Paper Oi

Name of Report Integrated Quality and Performance Report

For approval		For assurance	X	For information	

Presented by	Dani Cecchini – Director of Finance, Business and Estates	Author (s)	Laura Hughes – Head of Information

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

Report previously reviewed by	
Committee / Group	Date
Not reviewed	Not reviewed

Assurance : What assurance does this report provide in respect of the Organisational Risk Register?	Links to ORR risk numbers
TBC	TBC

Recommendations of the report
The Trust Board is recommended to: • Receive assurance with regard to areas of quality and performance where performance improvement action is being undertaken; • Receive the NHSI compliance segment rating of three.

1 Introduction/ Background

1.1 The Integrated Quality and Performance Report (IQPR) summarises the Trust's performance against key NHS Improvement (NHSI), Commissioner and other targets; and provides analysis and commentary on those areas which require additional actions to ensure that we achieve our targets and objectives.

1.2 The strategic objective measures aligned to the Trust's 'STEP up to GREAT' priorities will be reviewed during 2019/20 and included in a future iteration of this report.

1.3 The report format is continually evolving to ensure it is aligned to the:
a) key performance indicators (KPIs)
b) Trust governance groups
c) corporate risk register (CRR) and board assurance framework (BAF)
d) Trust priorities

1.4 It should be noted that from May 2019, the following NHSI compliance is demonstrated in the report:

Segment Rating	3 - Providers receiving mandated support for significant concerns

2 Aim

2.1 The aim of this report is to provide the Trust Board with an integrated quality and performance report showing levels of compliance with the NHS Improvement's (NHSI) Single Oversight Framework and Care Quality Commission (CQC) registration, together with detailed analysis for those areas requiring additional action to ensure achievement of targets.

3 Discussion

3.1 The next three chapters highlight the key quality and performance indicators for each of the committees:
i. Quality Assurance Committee (QAC)
ii. Finance and Performance Committee (FPC)
iii. Strategic Workforce Assurance Group (SWAG)

3.2 Each chapter is separated into two themes:
i. NHS Improvement (NHSI) Single Oversight Framework (SOF)
ii. Trust identified quality of care/ performance/ organisational health indicators

3.3 The full integrated quality and performance review (IQPR) dashboard is available in Annex A and is referred to throughout the paper. Annex A provides monthly trends and supporting exception reports to support discussions.

4 Quality Assurance Committee (QAC)

NHS Improvement (NHSI) quality of care indicators

4.1 There is one identified NHSI trigger(s) in 2019/20 quarter four relating to the care programme approach seven day (CPA seven day) indicator.

4.2 Trust performance against the CPA seven day follow up standard is reported as two separate measures to account for:

i. only those patients discharged from a general psychiatric unit on a CPA;
ii. all patients discharged from a general psychiatric unit on CPA and on non-CPA.

4.3 Performance for patients discharged on CPA during August 2019 is 94.1% against a national lower limit target of 95% (reported one month in arrears).

4.4 The performance for all patients discharged on CPA and on non-CPA during August 2019 is 92.6% against a national lower limit target of 95% (reported one month in arrears). Based on the SPC chart, there is special cause improvement of CPA 7 Day rates since July 2018; however the Trust will inconsistently meet the target of >=95% unless further improvements are made.

4.5 In August 2019, there were eight patients recorded who breached the CPA seven day standard – of which, four were not contacted with attempts made; one not contacted with no attempt made; three data quality issues identified classifying it as breaches in the month. A record of year to date data quality errors affecting this indicator are retained to support the audit for this Quality Account indicator.

4.6 The 2019/20 trajectory for clostridium difficile (C. Diff) has been set by the Leicester, Leicestershire and Rutland (LLR) clinical commissioning groups (CCGs) as an upper limit of twelve cases per annum. There has been one (1) case of C. Diff in the month of September 2019, at Fielding Palmer Hospital. The year to date total occurrences of C.Diff is three (3). If this level of quality is sustained, the Trust can receive assurance of meeting this year-end target. Based on the SPC chart, there is no significant change to the number of reported cases since April 2018; and the Trust will consistently meet the trajectory. (See Annex A - detailed exception report – clostridium difficile (C Diff) cases).

Trust quality of care indicators

4.7 The CPA 12 month standard performance as at September 2019 is 89.0% against a lower limit threshold of 95%. The performance continues to improve following the implementation of patient level reporting and reminders to care co-ordinator. As per the new process, the circumstances leading to patients not receiving their 12 month review in a timely manner will be investigated following escalation to the appropriate manager(s). Based on the SPC chart, there is special cause improvement of CPA 12 month rates since December 2018; however the Trust will consistently fail the target of >=95% unless further improvements are made. (See Annex A - detailed exception report – CPA 12 month review).

5 Finance and Performance Committee (FPC)

NHS Improvement (NHSI) use of resources indicators

5.1 The NHSI single oversight framework (SOF) uses financial metrics to assess financial performance. Providers are scored from one to four against each metric and an aggregate overall score is derived (see Appendix One for details).

5.2 As at 2019/20 month 06, the year to date financial assessment is scored at two (2). The 2019/20 forecast outturn score is also two (2).

NHS Improvement (NHSI) operational performance indicators

5.3 There are no identified NHSI trigger(s) in September 2019.

5.4 The Trust continues to meet its national access targets for 18 week referral to treatment (RTT) services (incomplete pathways >=92% target), six week diagnostic services and two week early intervention in psychosis services. The Trust has no patients waiting more than 52 weeks for treatment on RTT pathways (see Annex A – detailed exception report – national access standards).

5.5 Inappropriate adult mental health out of area (OOA) bed days have shown an overall reduction since April 2018 as the Trust works to reduce mental health OOA bed days to zero by 2020/21. Over the last 12 months, the Trust has seen a sustained decline in OOA bed days from 1673 in 2018/19 quarter one to 1364 in 2019/20 quarter one. Quarter two bed days are showing as 2711.

5.6 It should be noted that OAP bed days are slightly inflated due to the source data held on RiO being incorrect. Actions are being taken to reduce the occurrence of data quality errors made at source and to ensure errors are rectified at source in a timely manner. This issue is technical in nature and is specific to data held on RiO. It is expected the ongoing issues will be mitigated as part of the planned migration from RiO to SystmOne in 2020/21. NHS Digital have been informed of this data quality issue which has inflated the 2018/19 bed days by approximately 300 days and the 2019/20 bed days by approximately 60 days.

5.7 In May 2019, the Trust, in partnership with Leicester, Leicestershire and Rutland (LLR) commissioners, provided access to ‘progress beds’ for patients nearing the end of their acute mental health inpatient spell. This ‘progress bed’ initiative aims to increase availability of AMH acute beds for patients presenting with acute needs so enabling prompt admission to a local bed.

5.8 This arrangement is anticipated to be an interim arrangement pending the commissioning of enhanced crisis and early discharge provision later in 2019/20. The qualitative and quantitative impact of progress beds will be formally reviewed every two months with findings reported via contract monitoring and internal governance routes. As progress beds are provided by Cygnet Healthcare in a range of units located outside of LLR, it is anticipated that there will be an increase in the total number of out of area placements in the first instance; however as acute OOA placements are repatriated the expectation is that overall OOA numbers will either remain static or potentially reduce.

5.9 The Trust's data quality maturity index (DQMI) score is now published nationally one month in arrears by NHS Digital. NHSI have specifically identified the mental health services data set (MHSDS) as an area for provider scrutiny. Nationally, NHS Digital are supporting NHS regulatory bodies to access and use this submitted data to develop tools such as the model hospital and more recently the STP mental health dashboards.

5.10 The DQMI MHSDS criteria expanded during 2019/20 and the Trust anticipated a drop in compliance to approximately 80% when the new criteria were implemented. . The Trust has agreed to a data quality improvement plan (DQIP) as part of the 2019/20 contract with the CCG commissioners to focus on improving performance against the new DQMI standards.

5.11 To support these improvements, three specific work streams have been implemented:

i. recording of patient demographics - in May 2019, a pilot data collection form was introduced in mental health outpatient services. A review of success is arranged for August 2019;
i. clinical coding - a review is underway to understand processes relating to the recording of primary diagnosis codes;
ii. technical submission process – a review is underway to understand processes relating to the development and validation of submission files.

5.12 The June 2019 DQMI MHSDS compliance rate has increased to 90.6% from 84.6% the previous month. Targeted actions are in place to identify the cause of the decline with a view to see improvements during 2019/20 quarter two (See Annex A – detailed exception report – data quality maturity index (DQMI)).

5.13 The percentage of patients admitted to inpatient services who are given access to Crisis Resolution/ Home Treatment teams ('gate keeping') in line with best practice standards returned to national submissions for 2019/20 quarter one. Following recommendation from the Executive Team, the Trust Board agreed to remove 'gate keeping' from national reporting for 2018/19 quarter three and four.

5.14 2019/20 quarter two gate keeping performance is achieved 99.1% against a lower limit threshold of 95%. It should be noted; the monthly performance breakdown for this quarter is 100%, 100% and 97.5% for July, August and September 2019 respectively, which suggests the improvements made over the period following the implementation and embedding of the new gatekeeping protocol from April 2019 had the desired impact. This indicator will continue to be closely monitored in the directorate to maintain the level of improvements.

5.15 The Trust has submitted the gatekeeping rate as 84.5% for the period April 2019 to June 2019 to NHS Digital, with no identified data quality issues.

Trust operational performance indicators

5.16 The management of patients experiencing a delayed transfer of care (DToC) remains high on the Trust agenda. As at September 2019, the Trust is above the 3.5% upper limit threshold at 4.1%. It should be noted the Leicester, Leicestershire and Rutland (LLR) DToC rate, which incorporates delays in the acute trust and LLR patients delayed in non-LLR hospitals is within the target threshold.

6 Strategic Workforce Assurance Group (SWAG)

NHS Improvement (NHSI) organisational health indicators

6.1 There are zero (0) identified NHSI trigger in September 2019.

6.2 Staff sickness absence remains above target at 4.9% in August 2019 (reported one month in arrears) – of which, 4.9% 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.

6.3 Based on the SPC chart, there is no significant change in the rate of staff sickness since February 2018; and the Trust will inconsistently meet the Trust target of <=4.5%. (See Annex A – detailed exception report - % staff sickness).

6.4 Staff turnover (normalised) was 8.7% for September 2019, which meets the Trust threshold of performing at less than 10% for a rolling twelve month period.

Trust human resources – workforce performance indicators

6.5 The Trust vacancy rate in September 2019 remains at 9.6%, which is above the upper limit threshold of 7%.

6.6 Cumulative year-to-date Trust agency costs were £5,140K as at 30 September 2019 (month 6). This is above the planned spend of £4,101k for the same period. The September year-to-date NHSI agency ceiling target is £4,060k. This Trust is exceeding this limit by £1,080k.

7 Conclusion

7.1 This report demonstrates that whilst there are a significant number of targets being achieved, along with some notable areas of improvement, there remain a number of targets which are not currently being achieved and where attention is now being directed to ensure continued improvement in the coming months.

8 Recommendations

1 The 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.

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

9 Appendices

Appendix one – description of NHSI segmentation

Segmentation helps NHSI determine the level of support required. It does not give a performance assessment in its own right, nor is it intended to predict the ratings given by CQC. It also does not determine the specifics of the support package needed − this is tailored by teams working with the provider in question. NHSI are segmenting the sector into four, depending on the extent of support needs identified through the oversight process.

1 - Providers with maximum autonomy − no potential support needs identified across our five themes – lowest level of oversight and expectation that provider will support providers in other segments.

2 - Providers offered targeted support − potential support needed in one or more of the five themes, but not in breach of licence (or equivalent for NHS trusts) and/ or formal action is not needed.

3 - Providers receiving mandated support for significant concerns – the provider is in actual/ suspected breach of the licence (or equivalent for NHS trusts).

4 - Special measures − the provider is in actual/ suspected breach of its licence (or equivalent for NHS trusts) with very serious/ complex issues that mean that they are in special measures.

Leicestershire Partnership NHS Trust

Paper Oi

Integrated Quality and Performance Report

Advancing health and well-being

End of September 2019 Position

Data to 30 September 2019 unless otherwise stated

Previous month's data refreshed where available

Leicestershire Partnership NHS Trust

Contents

NHS Improvement Themes of the Single Oversight Framework

Themes		Measures	Q1 Self Assessed Concerns	Q2 Forecasted Concerns
Quality of Care	Care Quality Commission (CQC) judgements on the Quality of Care provided by the Trust; safe, effective, caring and responsive	CQC 'inadequate' or 'requires improvement' assessment in one or more of:- 'safe', 'effective', 'caring', 'responsive' -CQC warning notices -Any other material concerns identified through, or relevant to, CQC's monitoring process, e.g. civil or criminal cases raised, whistleblower information, etc. -Concerns arising from trends in our quality indicators (Appendix 2) -Delivering against an agreed trajectory for the four priority standards for 7-day hospital	Yes current CQC rating of 'requires improvement'	Yes
Finance & Use of Resources	Strengthening financial performance and accountability by overseeing financial efficiency and financial control total	-Poor levels of overall financial performance (average score of 3 or 4) -Very poor performance (score of 4) in any individual metric -Potential value for money concerns	No	No
Operational Performance	Improve and sustain performance against NHS Constitution standards	For providers with Sustainability and Transformation Fund (STF) trajectories in any metric: failure to meet the trajectory for this metric in more than two consecutive months (quarterly for quarterly metrics) For providers without STF trajectories: failure to meet any standard in more than two consecutive months	No	No
Strategic Change	Delivering strategic changes set out in the Five Year Forward View focussing on sustainability and transformation plans (STP)	Material concerns with a provider's delivery against the transformation agenda, including new care models and devolution	Governance arrangements of STP under review. Consultation and implementation yet to be confirmed	Governance arrangements of STP under review. Consultation and implementation yet to be confirmed
Leadership & Improvement Capability	Good governance and leadership	-Material concerns -CQC 'inadequate' or 'requires improvement' assessment against 'well-led'.	Yes current CQC rating of 'inadequate'	Yes

Segment Rating: 3

The five themes above are used by NHS Improvement to support providers to improve to attain and/or maintain a CQC 'good' or 'outstanding' rating.

Segmentation:
NHS Improvement (NHSI) use information from data monitoring processes and insights gathered though work with providers, to identify where providers have a potential support need under one or more of the five themes. NHSI will also use judgement, based on consistent principles, to determine whether or not providers are in breach of licence – or the equivalent for NHS trusts – and to determine, as part of that judgement, if providers should go into special measures (segment 4).

Rated **GREEN** No issues identified or Universal or Targeted support is agreed with NHSI **RED** where mandated support is issued by NHSI. Where the trust identifies a concern, a written description stating the issue and any associated actions to address those concerns will be accompanied and is locally rated as **Amber**.

Leicestershire Partnership NHS Trust

NHS Improvement Quality of Care Metrics

	NHSI Sector	Indicator	NHSI Monitoring Frequency	Monthly Performance: Reporting Period (rolling three months) Jul-19	Aug-19	Sep-19	Sparkline YTD	Quarterly Performance: 2018/19 Q4	2019/20 Q1	Q2	Q3	Q4	Annual Performance: 2018/19 Year End Total	2019/20 Year to Date Total	Trigger (two consecutive monthly breaches)	Current month directorate performance: Adult Mental Health/ Learning Disabilities	Community Health	Families, Young People & Children	Enabling Services	Comments
SAFE	All	**Occurrence of any Never Event**	Monthly *(six month rolling)*	**0**	**0**	**0**		**0**	**0**	**0**			**1**	**0**	0	**0**	**0**	**0**	**0**	Methodology: count of 'never events' in rolling six- month period
	All	**NHS England/NHS Improvement Patient Safety Alerts not completed by deadline**	Monthly	**0**	**0**	**0**		**0**	**0**	**0**			**0**	**0**	0	**0**	**0**	**0**	**0**	Methodology: number of NHS England or NHS Improvement patient safety alerts outstanding in most recent monthly snapshot
	Acute	**VTE Risk Assessment**	Monthly	**246**	**238**	**261**		**793**	**737**	**745**			**3249**	**1482**	0		**261**			
	Acute	**Clostridium Difficile Occurrence (against contractual year to date target of 12)**	Monthly	**0**	**1**	**1**		**2**	**1**	**2**			**5**	**3**	1	**0**	**1**	**0**		
	Acute	**Clostridium Difficile - infection rate (per 100,000 bed days)**	Monthly	**0**	**39.93**	**38.20**		**26.74**	**13.06**	**26.32**			**13.06**	**19.66**	0	**0**	**37.92**	**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**			**1**	**0**	0	**0**	**0**	**0**		Methodology: number of children and young persons under 16 who are admitted to adult wards
EFFECTIVE	Mental Health	**Care Programme Approach (CPA) follow up - proportion of discharges from hospital followed up within 7 days**	Monthly	**91.3%**	**92.6%**			**94.6%**	**93.1%**	*Not due*					1					Methodology: proportion of discharges from general psych wards followed up within 7 days (including MHSOP)
	Mental Health	**% clients in employment (two months in arrears)**	Monthly	*Not due*	*Not due*	*Not due*		**0.0%**	**2.0%**	*Not due*					0	**3.0%**				Methodology: percentage of people aged 18 to 69 period in contact with mental health services in employment Latest data is for June 2019 Low performance is linked to a technical submission issue and is not reflective of practice. Work continues with NHS Digital to resolve the reported performance
	Mental Health	**% clients in settled accommodation (two months in arrears)**	Monthly	*Not due*	*Not due*	*Not due*		**37.0%**	**36.0%**	*Not due*					0	**37.0%**				Methodology: percentage of people aged 18 to 69 in contact with mental health services in settled accommodation Latest data is for June 2019
CARING	All	**Written complaints - rate**	Quarterly	**76.2%**	**56.0%**	**72.2%**		**68.2%**	**70.2%**	**67.2%**			**70.2%**	**68.9%**	0	**62.5%**	**85.7%**	**50.0%**		Methodology: count of written complaints/ count of total complaints
	Acute	**Mixed sex accommodation breaches (sleep breaches only)** *National methodology aligned to NHS England guidance*	Monthly	**0**	**0**	**0**		**0**	**0**	**0**			**0**	**0**	0	**0**	**0**	**0**		Methodology: The number of breaches of mixed-sex accommodation (MSA) sleeping accommodation
	All	**Staff Friends and Family Test % recommended - care**	Quarterly												0					
	Acute	**Inpatient scores from Friends & Family Test - % positive**	Monthly	**96.1%**	**95.9%**	**94.2%**									0	**88.5%**	**94.6%**	**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	**97.4%**	**96.5%**	**96.2%**									0	-	**95.2%**	**99.4%**		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	**96.9%**	**94.0%**	**91.2%**									0	**87.9%**	**92.6%**	**92.6%**		Methodology: count of those categorised as extremely likely or likely to recommend/ count of all responders

Identified Triggers	2

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 M6)

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	1	0.2	2	0.4
				2.5		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
				11.3		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
				0.49%		0.77%					
Financial controls	0.2	Distance from financial plan	Year-to-date actual I&E margin (surplus/deficit) in comparison to year-to-date plan I&E margin (surplus/deficit) on a control basis	>=0%	(1)-0%	(2) - (1%)	<=(2)%	1	0.2	2	0.4
				0.00%		-0.20%					
	0.2	Agency spend	Distance from provider's cap	<=0%	0% - 25%	25 - 50%	>50%	3	0.6	2	0.4
				26.6%		15.0%					

	YTD		F/OT
FINANCE SCORE:	**2**		**2**

Comments:
Under the Single Oversight Framework (SOF), NHS Improvement use these financial metrics to assess financial performance by:
• scoring providers 1 (best) to 4 against each metric
• averaging individual providers' scores across all the metrics to derive a use of resources score for the provider.

Note: Where providers have a score of 4 or 3 in the 'financial and use of resources' theme, it will identify a potential support need, as will providers scoring a 4 (i.e. significant under performance) against any of the individual metrics. Providers in financial special measures will score a 4 on this theme.

TRUST BOARD | QUALITY AND ASSURANCE | FINANCE AND PERFORMANCE | STRATEGIC WORKFORCE ASSURANCE | EXCEPTION REPORTS

NHS Improvement Operational Performance

	NHSI Sector	Indicator	Target	NHSI Monitoring Frequency	Monthly Performance: Reporting Period (rolling three months) Jul-19	Aug-19	Sep-19	Sparkline YTD	Quarterly Performance: 2018/19 Q4	2019/20 Q1	Q2	Q3	Q4	Annual Performance: 2018/19 Year End Total	2019/20 Year to Date Total	Trigger (two consecutive monthly breaches)	Current month directorate performance: Adult Mental Health/ Learning Disabilities	Community Health	Families, Young People & Children	Comments
OPERATIONAL PERFORMANCE METRICS	Acute & Specialist	**Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway**	>=92%	Monthly	**94.3%**	**92.4%**	**92.6%**		**96.5%**	**96.8%**	**93.1%**			**96.8%**	**95.0%**	0	**92.6%**			Methodology: count of the number of patients whose clock period is less than 18 weeks during the calendar months of the return/ count of number of patients whose clock has not stopped during the calendar months of the return
	Acute & Specialist	**Maximum 6-week wait for diagnostic procedures - patients on an incomplete pathway**	>=99%	Monthly	**100.0%**	**100.0%**	**100.0%**		**100.0%**	**100.0%**	**100.0%**			**100.0%**	**100.0%**	0			**100.0%**	Methodology: proportion of patients referred for diagnostic tests who have been waiting for less than six weeks
	Mental Health	**People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral (SDCS and MHSDS) - patients on a completed pathway**	>=53%	Quarterly *(three month rolling)*	**81.8%**	**81.3%**	**65.2%**		**76.5%**	**83.3%**	**75.4%**			**83.3%**	**78.9%**	0			**65.2%**	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				Methodology: the number of patients in the defined audit sample who have both: - a completed assessment for each of the cardio-metabolic parameters with results documented in the patient's electronic care record held by the secondary care provider. - a record of interventions offered where indicated, for patients who are identified as at risk as per the red zone of the Lester Tool. a) Internal mental health provider sample submitted to national audit provider for the CQUIN b) Early intervention: Internal mental health provider sample submitted to the Royal College of Psychiatrists CCQI EIP Network c) Mental health: Internal mental health provider sample submitted to national audit provider for the CQUIN
		b) Early Intervention in Psychosis Services	>=90%	Annually												0				
		c) Community Mental Health Services (people on CPA)	>=65%	Annually												0				
	Mental Health	**Inappropriate adult mental health out of area placements (OAPs)**	0 by March 2020	Monthly	**727**	**1248**	**736**		**538**	**1364**	**2711**			**3462**	**4075**	0				Methodology: Total number of bed days patients have spent out of area in period This measure should show a demonstrable reduction in total number of bed days patients have spent inappropriately out of area against rolling annual baseline, working towards elimination of inappropriate out of area placements by 2020/21
	Mental Health	**Data quality maturity index (DQMI) score (mental Health services only)**	>=95%	Quarterly	See DQMI exception report for details				*not yet available*							0				Methodology: MHSDS quarterly score in DQMI (ethnic category, general medical practice code (patient registration), NHS number, organisation code (code of commissioner), person stated gender code, postcode of usual address)

Identified Triggers	0

Leicestershire Partnership NHS Trust

NHS Improvement Organisational Health

	NHSI Sector	Indicator	NHSI Monitoring Frequency	Monthly Performance: Reporting Period (rolling three months) Jul-19	Aug-19	Sep-19	Current Year to Date Total	Quarterly Performance: 2018/19 Q4	2019/20 Q1	Q2	Q3	Q4	Annual Performance: 2018/19 Year End Total	2019/20 Year to Date Total	Trigger (two consecutive monthly breaches)	Current month directorate performance: Adult Mental Health/ Learning Disabilities	Community Health	Families, Young People & Children	Enabling Services	Comments
ORGANISATIONAL HEALTH	All	**Staff Sickness (month in arrears)**	Monthly	**4.7%**	**4.9%**			**4.3%**	**4.5%**				**4.9%**	**not due**	0	**6.3%**	**5.2%**	**4.5%**	**2.6%**	Methodology: number of days sickness reporting within the month/ number of days available within the month
	All	**Staff Turnover**	Monthly	**8.7%**	**8.5%**	**8.7%**			*not applicable to quarterly reporting*				**9.6%**		0	**9.4%**	**8.8%**	**9.1%**	**6.6%**	Methodology: number of leavers reported within the period / average of number of total employees at end of the month and total employees at end of the month for previous 12 month period
	All	**NHS Staff Survey** Key Finding 2. Staff satisfaction with the quality of work and care they are able to deliver	Annual	**3.69**					*not applicable to quarterly reporting*						0					2018 staff survey results Methodology: staff recommendation of the organisation as a place to work or receive treatment
	All	**Proportion of Temporary Staff**	Monthly	**12.3%**	**12.2%**	**13.3%**		**12.2%**	**12.7%**	**13.3%**					0					Methodology: agency staff costs (as defined in measuring performance against the provider's cap) as a proportion of total staff costs. Calculated by dividing total agency spend over total pay bill.
	Acute	**CQC Inpatient/MH and Community Survey: Community**	Annual	**6.1**					*not applicable to quarterly reporting*						0					Survey results for 2018. Rating of Overall Experience out of 10.0, where 10.0 is the highest rating.
	Mental Health	**CQC Inpatient/MH and Community Survey: Mental Health**	Annual	**6.6**					*not applicable to quarterly reporting*						0					Survey results for 2018. Rating of Overall views of care and services out of 10.0, where 10.0 is the highest rating.

Identified Triggers	0

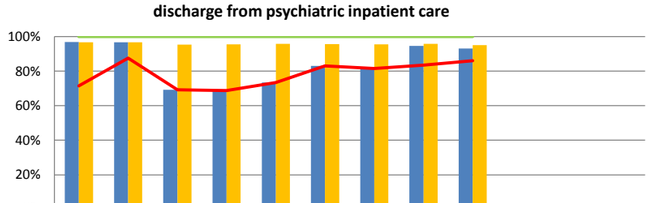
NB: The NHSI Single Oversight Framework has no specified target for the Quality of Care Monitoring Metrics.

Leicestershire Partnership NHS Trust

LPT Benchmarking Information

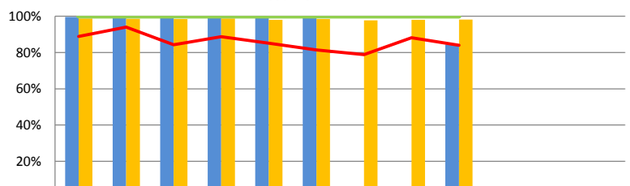
Description	Benchmarking comparisons are taken from NHS England's official statistics publications. Each graph show the Leicestershire Partnership NHS Trust performance against the highest and lowest performing trusts in that period **IMPORTANT**: National data conforms to strict data quality requirements and is a reflection of performance at specific points in time. For this reason, the nationally reported performance may differ slightly from the Trust's locally reported performance. The aim is to reduce these differences by improving timely and accurate data entry onto the Trust's clinical systems.

Proportion of patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care



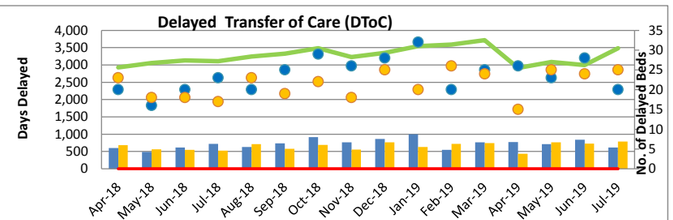
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	2017/18				2018/19				2019/20			
LPT	96.9%	96.7%	69.2%	68.8%	73.4%	83.0%	81.6%	94.6%	93.1%			
England	96.7%	96.7%	95.4%	95.5%	95.8%	95.7%	95.5%	95.8%	95.1%			
Highest	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			
Lowest	71.4%	87.5%	69.2%	68.8%	73.4%	83.0%	81.6%	83.5%	86.1%			

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



	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	2017/18				2018/19				2019/20			
LPT	99.6%	99.2%	100.0%	99.5%	99.6%	100.0%	0.0%	0.0%	84.5%			
England	98.7%	98.6%	98.5%	98.7%	98.1%	98.4%	97.8%	98.1%	98.2%			
Highest	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			
Lowest	88.9%	94.0%	84.3%	88.7%	85.1%	81.4%	78.8%	88.2%	84.0%			

Delayed Transfer of Care (DToC)



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
LPT Days Delayed	600	490	613	719	631	737	912	767	862	994	548	762	775	709	840	618
UHL Days Delayed	682	563	544	527	711	574	689	554	768	632	717	739	435	768	730	784
Highest Days Delayed	2927	3059	3130	3106	3244	3326	3480	3231	3345	3542	3588	3718	2915	3087	2996	3480
Lowest Days Delayed	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
LPT DToC Beds	20	16	20	23	20	25	29	26	28	32	20	25	26	23	28	20
UHL DToC Beds	23	18	18	17	23	19	22	18	25	20	26	24	15	25	24	25

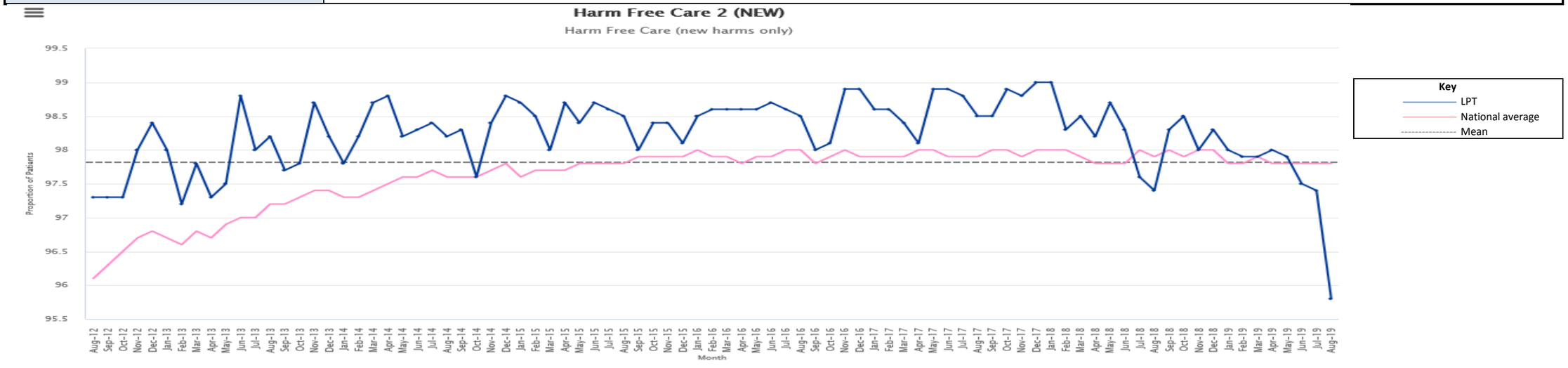
Comments:

Gatekeeping: The LPT national gatekeeping figures for 2017/18 Q2 reflects the inclusion of one elective patient; and 2017/18 Q2 reflects one excluded A&E patient. NHS Digital have advised they are not accepting amendments to national data for this financial year. The Trust is not reporting national gatekeeping data for 2018/19 Q3 and Q4

CPA 7 Day: As a result of data quality work undertaken in 2018/19 quarter one and quarter three, we are awaiting confirmation from NHS Digital to allow us to resubmit the national CPA seven day 2018/19 information, which will reflect in increased performance for the period

LPT Safety Thermometer

Description	The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing 'harm free' care. The data shown relates to prevelance of harm (VTEs, falls, pressure ulcers, UTIs), collected on a specific day; and is not directly comparable to the NRLS harm free rates, which is representative of all harms. Safety Thermometer data is not intended for benchmarking against other organisations.



Comments:

Trust Quality of Care

		Trust Performance													Current month directorate performance					
		Source	Reporting Frequency	Quality Indicator	Reporting Period (rolling three months) Jul-19	Aug-19	Sep-19	Sparkline YTD	2018/19 Q4	2019/20 Q1	Q2	Q3	Q4	Year to Date Position	Year End Target	Adult Mental Health/ Learning Disabilities	Community Health	Families, Young People & Children	Enabling Services	3rd party/ External	Comments
SAFE	Total incidents reported (including near misses) taken from Safeguard	TRUST	Monthly		1759	1571	1471		4316	4579	4907			9380		571	629	134	13	124	
	- of which Total Serious Incidents (SIs)	COM	Monthly		15	2	26		14	30	42			73		3	21	1	0	1	
	STEIS - SI action plans implemented within timescales	COM	Monthly	=100%	100.0%	90.9%	100.0%		96.3%	100.0%	93.7%			94.8%	=100%	100.0%	-	100.0%			
	Total patient safety incidents reported (including near misses) (NRLS)	TRUST	Monthly		1150	969	927		2753	2750	3053			5796		437	393	90	7		
	MRSA Bacteraemia cases - Community	COM	Monthly		0	0	0		0	0	0			0	0	0	0	0			
	Clostridium Difficile (C Diff) Occurrence	COM	Monthly	<=12 (per annum)	0	1	1		2	1	2			3	12	0	1	0			
	NHSE/ NHSI Patient Safety Alerts Outstanding	NHSI	Monthly	=0	0	0	0		0	0	0			0	0	0	0	0			
CARING	Total compliments received	TRUST	Monthly		123	99	50		243	298	272			570		12	27	9	2		
	Total complaints received	TRUST	Monthly		21	25	18		107	84	64			148		8	7	2	1		
	Complaints acknowledged within 3 working days	TRUST	Monthly	=100%	100.0%	100.0%	100.0%		100.0%	98.8%	100.0%			99.3%	=100%	100.0%	100.0%	100.0%			
EFFECTIVE	Meeting commitment to serve new psychosis cases by early intervention teams: % newly diagnosed cases against commissioner contract	COM	Monthly	>=95%	190.9%	136.4%	181.8%		145.5%	136.4%	169.7%			153.0%	>=95%			181.8%			
	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%	97.6%	94.1%			96.8%	95.6%				95.7%	>=95%	92.4%	100.0%	100.0%			
	- All patients discharged from a psychiatric inpatient unit *(national methodology aligned to Quality Account)*	TRUST	Monthly	>=95%	91.3%	92.6%			94.6%	93.1%				92.6%	>=95%	91.4%	96.0%	100.0%			
	Care programme approach (CPA) patients: % having formal review within 12 months	TRUST	Monthly	>=95%	91.9%	90.8%	89.0%							89.0%	>=95%	89.9%	95.1%	71.6%			
	Access to Healthcare for All		Monthly	=4	4	4	4		4	4	4			4	4						

Comments and Actions:

The pressure ulcer indicator has been removed from the IQPR due to a change in National guidance from NHSE around ceasing to describe as Avoidable and Unavoidable. The Trusts intends to reinstate a pressure ulcer measure following recommendation at the Trust Patient Safety Improvement Group of a new indicator definition.

Incident Reporting: The approach taken by LPT in monitoring incident related KPIs is to encourage a reporting culture in line with the National Patient Safety Agency (NPSA) and the National Reporting and Learning System (NRLS) reports into incident reporting rates.

Total Serious Incidents (SIs): Previous months' figures have been updated and amended after a review to reflect accurate position.

STEIS - SI action plans implemented within timescales: Previous months' figures have been updated and amended after a review to reflect accurate position.

Total patient safety incidents reported (including near misses): Previous month's figures have been updated to reflect accurate position.

MRSA Bacteraemia - Community: Cases are not validated until 15th of each month following lock down on the national system MESS. This process could result in current month figures changing. Year end target of zero (0) is based on the Commissioner target.

Clostridium Difficile (C Diff) Occurrence: The trajectory for 2019-20 for Clostridium difficile is twelve (12). There has been 1 reported case for Clostridium difficile during the month of September 2019 at Fielding Palmer Hospital.

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.
181.8% for the month of September 2019 is the result of 20 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. The reported position for August 2019 contains three data quality errors.

Care programme approach (CPA) patients: % having formal review within 12 months: Please refer to CPA 12 Month exception report for further details.

National CQUINS 2018-19

CQUIN No	Description	Services	Funding Available	Q1 Target	Current month	Q1	Q2	Q3	Q4	Comment on Red & Amber Ratings
1a	Introduction of health & wellbeing of NHS staff		£182,801						0.0%	
1b	Healthy food for NHS staff, visitors and patients		£182,801						100.0%	
1c	Improving the uptake of flu vaccinations for frontline clinical staff		£182,801						25.0%	
3a	Improving Physical healthcare - SMI		£438,722			100.0%			100.0%	
3b	Improving Physical healthcare collaboration with GPs		£109,680			100.0%	100.0%	100.0%	100.0%	
4	Improving services for people with MH at A&E		£346,359			100.0%	100.0%	100.0%	100.0%	
5	Transitions out of Children and Young People's MHS		£346,359			100.0%	27.5%		32.5%	Partial payments achieved for discharge readiness (12.5%) and post transition goal (15%). 0% achieved for planning for transition
9 a-e	Preventing ill health by risky behaviours - Smoking & Alcohol		£548,402			30.0%	67.0%	75.0%	90.0%	Q1 - 30% partial payment achieved Q2 - 67% achieved Q3 - Achieved 100% for 9a,b,c,d, and no payment for 9e
10	Improving the assessment of wounds		£346,359				100.0%		100.0%	
11	Personalised care and support planning		£346,359						100.0%	

Key: Blue = Forecast/unconfirmed; **Green** = Fully achieved; **Amber** = Partially achieved; **Red** = Not achieved

Commentary:
All payments for quarter 1 have been confirmed except for CQUINs 9a-e. Quarter 2 payments have been confirmed except for CQUINs 5 and 9a-e. Quarter 3 payments were confirmed except for CQUIN 9e.

Quarter 4 - Full payment was achieved for 6/10 CQUINs and partial payment for 3/10 CQUINS. The health and wellbeing of staff CQUIN (1a) was not achieved although there had been year on year improvement on all 3 indicators the comparison with 2016 did not meet the improvement thresholds.

National CCG CQUINS 2019-20

CQUIN No	Description	Min Threshold	Max Threshold		Q1	Q2	Q3	Q4	Commentary
CCG 2	Staff Flu Vaccinations	60%	80%				**50.0%**	**80.0%**	Forecast minimum threshold of 60%. By achieving the minimum threshold the payment will be £0
CCG 3a	Alcohol & Tobacco- Screening	40%	80%			**50.0%**	**80.0%**	**80.0%**	2019/20 Q1 requirements are to provide a position statement. New systems are in place to capture data and training is being provided.
CCG 3b	Tobacco Brief Advice	50%	90%			**50.0%**	**75.0%**	**90.0%**	
CCG 3c	Alcohol Brief Advice	50%	90%			**50.0%**	**75.0%**	**90.0%**	
CCG 4	72 Hour follow up post discharge	50%	80%				**71.0%**	**80.0%**	Not due to report until 2019/20 Q3. Early indications show LPT are meeting the minimum threshold.
CCG 7	Three high impact actions to prevent hospital falls	25%	80%			**30.0%**	**50.0%**	**80.0%**	2019/20 Q1 position statement required. Only applicable to community hospitals. Templates are being introduced to enable data capture.
CCG 9	Stroke 6 Months reviews	35%	55%		**55.0%**	**55.0%**	**55.0%**	**55.0%**	SSNAP is a new way of reporting in LPT. Service is embracing the new system and CQUIN; and are forecasting to achieve maximum thresholds.

NHSE CQUINS 2019-20

CQUIN No	Description	Min Threshold	Max Threshold		Q1	Q2	Q3	Q4	Commentary
PSS4	Health weight in adult secure MH services	N/A	N/A		**100.0%**	**100.0%**	**100.0%**	**100.0%**	The Phoenix Ward staff are establishing new programmes including physical activity and healthy eating to help inpatients to maintain a healthy weight. The level of staff involvement and engagement with the Clinical Reference Groups work streams support the likelihood of achieving the milestones for this NHSE CQUIN.
PSS5	Addressing CAMHS T4 staff training Needs	N/A	N/A		**100.0%**	**100.0%**	**100.0%**	**100.0%**	

Key: Blue = Forecast/unconfirmed; **Green** = Fully achieved; **Amber** = Partially achieved; **Red** = Not achieved

Commentary:
These forecasts are based on quality performance of the CQUINS, rather than achievement forecasts and payment calculations.

Leicestershire Partnership NHS Trust

Trust Operational Performance

	Trust Performance														Current month directorate performance		
	Source	Reporting Frequency	Monthly target	Reporting Period (rolling three months) Jul-19	Aug-19	Sep-19	Sparkline YTD	2018/19 Q4	2019/20 Q1	Q2	Q3	Q4	Year to Date Position	Year End Target	Adult Mental Health/ Learning Disabilities	Community Health	Families, Young People & Children
Occupancy Rate - Mental Health Beds	TRUST	Monthly	<=85%	89.5%	90.4%	86.9%		83.4%	87.7%	88.9%			88.3%	<=85%	89.9%	81.0%	76.2%
Occupancy Rate - Community	TRUST	Monthly	>=93%	84.9%	84.7%	88.3%		89.4%	87.8%	85.8%			86.8%	>=93%		88.3%	
% Delayed Transfer of Care (DTOC)	DOH	Monthly	<=3.5%	3.7%	4.6%	4.1%		4.7%	4.8%	4.1%			4.5%	<=3.5%	4.5%	4.1%	Reported only by exception
Patients admitted to inpatient services who are given access to Crisis Resolution/ Home Treatment teams in line with best practice standards - % patients gatekept *(national methodology aligned to Quality Account)*	TRUST	Monthly	>=95%	100.0%	100.0%	97.5%		*not available*	84.5%	99.1%			92.5%	>=95%	97.5%		
Total number of Home Treatment episodes carried out by Crisis Resolution team year to date	COM	Monthly	>=145	288	246	246		743	740	780			1520	1740	246		

Comments and Actions:

Mental Health Bed Occupancy Rate: The Trust figure does not consider that certain services have different targets, e.g., MHSOP has a 90% target; Specialist Services represents Eating Disorders with a 80% target and EXCLUDES patients on leave; CAMHS INCLUDES patients on leave; Adult represents Adult Acute only and LD represents the Agnes Unit with a target of 95% for the four new Intensive Support beds but 85% otherwise. There are no service targets set therefore they are based on the Trust target of 85%. The RAG ratings are:
Green: Actual > Target AND Actual < Target + 5%; Amber: Actual >= Target + 5% AND Actual <= Target + 10% OR Actual <= Target AND Actual >= Target - 5%; Red: Actual > Target + 10% OR Actual < Target - 5%

% Delayed Patients (DToC) - Please see 'DETAILED EXCEPTION REPORT - % Delayed Transfer of Care (DToC)' for detailed commentary.

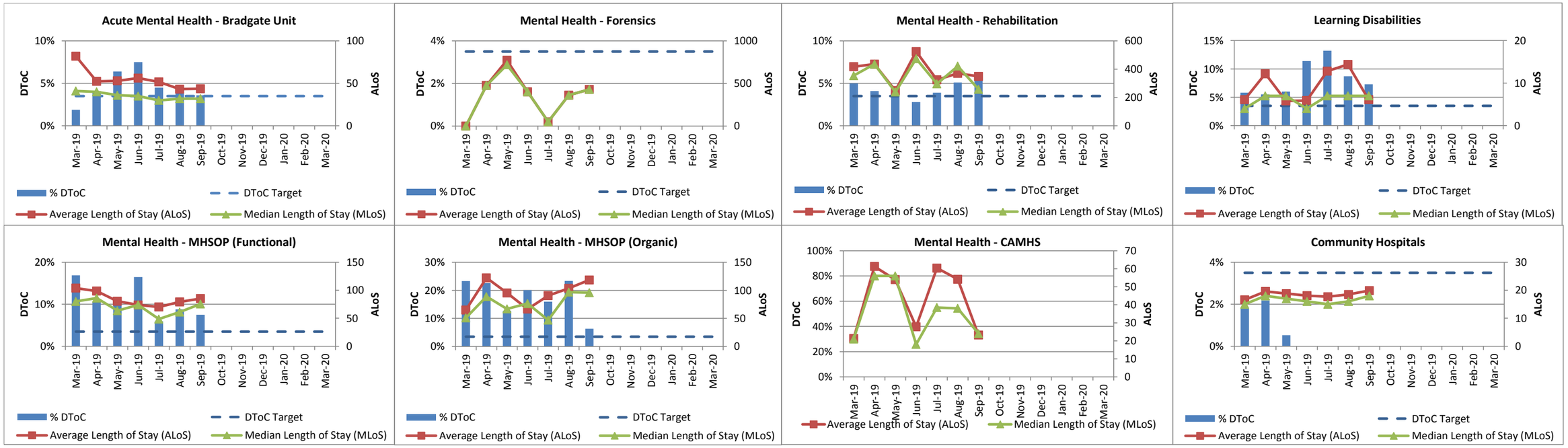
Patients admitted to inpatient services who are given access to Crisis Resolution/ Home Treatment teams in line with best practice standards: This item is no longer subject to significant data quality concerns and national report has recommenced from 1st April 2019. The reported position for September 2019 has one data quality error.

Total number of Home Treatment episodes carried out by Crisis Resolution team year to date: Year to date performance is currently 174.7% which equates to 1520 episodes against a pro-rata target of 870.

Leicestershire Partnership NHS
NHS Trust

Trust Inpatient Performance

The Better Care Fund (BCF) planning guidance requires cross system organisations to work together to achieve the local, agreed ambition for delayed transfer of care (DTOC) to not equate to more than 3.5% of hospital beds. DTOC rates are aligned to national Unify submissions.



Comments and Actions

Delayed Transfer of Care (DToC)

The calculation methodology for DToC is*:

Numerator: the number of non-acute patients (aged 18 and over on admission) per day under consultant and non-consultant-led care whose transfer of care was delayed. For example, one patient delayed for five days counts as five.

Denominator: the total number of occupied bed days (consultant-led and non-consultant-led).

Delayed transfers of care attributable to social are included.

Actions to improve DToC across the Leicester, Leicestershire and Rutland system include:

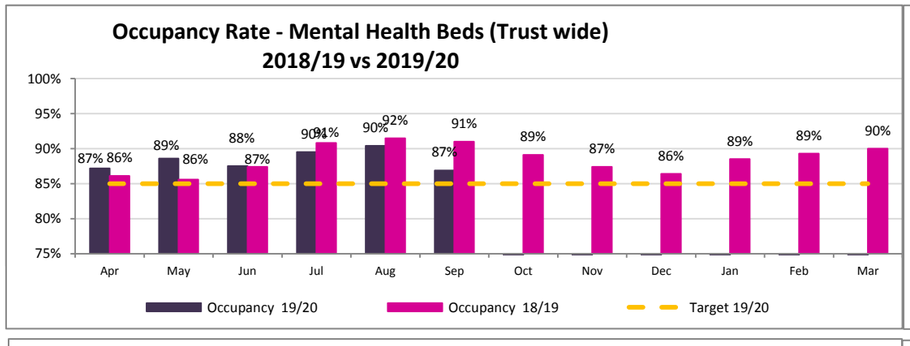
- implementing an integrated discharge team and trusted assessor model which will be extended to community hospitals and mental health wards during 2017/18 following a pilot at the acute trust;
- improvements in pathways into community hospitals - for which an audit of step down beds will be used for clinical engagement;
- improvements to patient/ family choice policies and information across hospital sites, this includes clear policies around 'choice' with an agreed training and communications plan.

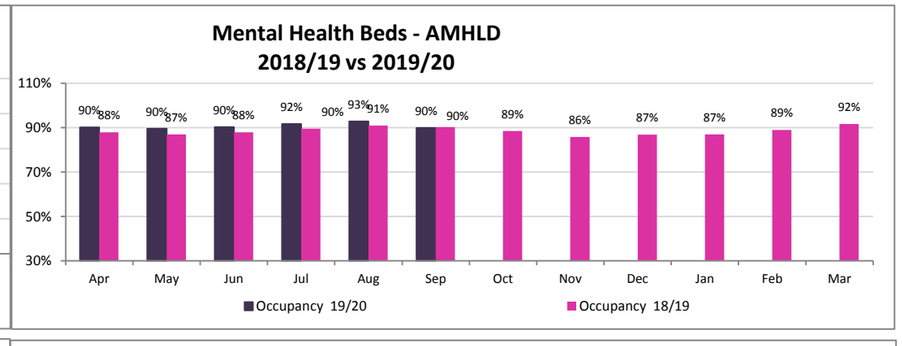
Length of Stay (LoS)

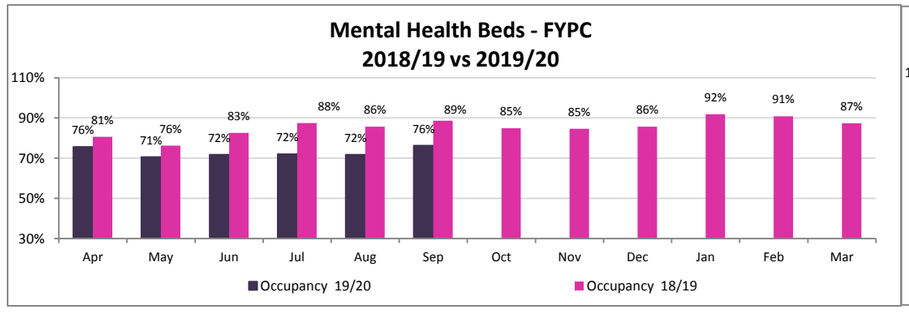
The length of stay displayed is the national operating framework definition, which takes data from Hospital Episode Statistics (HES) and includes ALL services and lengths. LoS is measured from admission to discharge, therefore a ward with no discharges in the period will not have a LoS calculated. All previous month's figures are updated each month to allow for late entry of data.

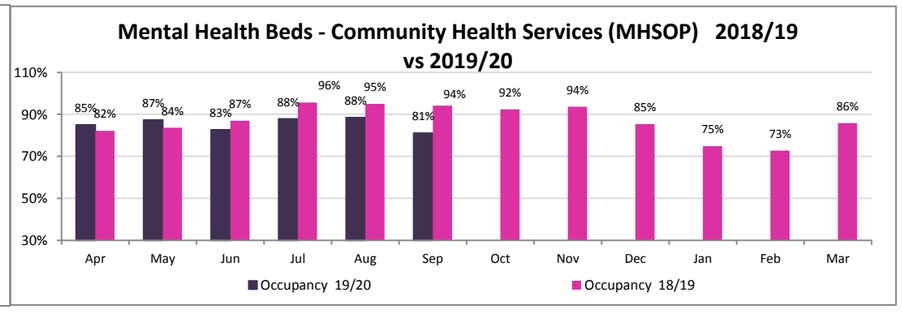
IMPORTANT: There are no patients excluded from this calculation and this KPI is not comparable with the LoS CQUIN or national benchmarking which is calculated using different exclusion parameters.

Mental Health Bed Occupancy Rate (%)









Responsible Lead: Directors of Services
Indicator Source: COM/DOH Operating Framework

Comments and Actions:

CAMHS (FYPC) - On leave beds counted as admitted

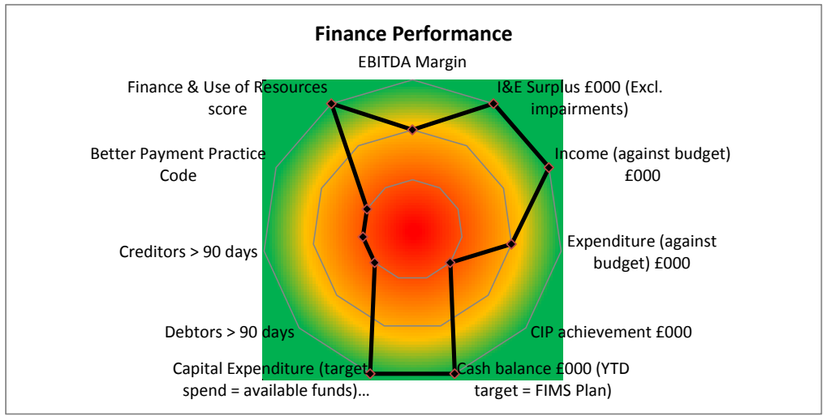
LD - On leave beds counted as admitted
This may result in occupancy rates above 100%

Leicestershire Partnership NHS Trust

Performance - Finance September 2019 (Month 6)

Comments and Actions:

- **Position:** As at 2019/20 month 6, the Trust is achieving the planned year to date surplus of £696k. A year end surplus of £2.6m is forecast based on the receipt of Sustainability and Transformation funding of £2.1m.
- **EBITDA:** The EBITDA margin as at 2019/20 month 6 is 5.7%. 81% of the 2019/20 year to date CIP target was achieved this month.
- **Cash Balance:** The cash balance at the end of 2019/20 month 6 is £9.3m. Planned cash for the month end was £6.2m. Debtors over 90 days are 19.2%. Creditors over 90 days are 10.5%.



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	5.8%	5.7%	6.0%	6.0%												
I&E Surplus £000 (Excl. impairments)	696	696	2,648	2,648												
Income (against budget) £000	140,806	141,884	278,567	278,567												
Expenditure (against budget) £000	140,110	141,188	275,919	275,919												
CIP achievement £000	1,666	1,345	4,047	2,806	290	228	435	435	293	293	278	251	110	110	261	27
Cash balance £000 (YTD target = FIMS Plan)	6,158	9,332	8,000	8,000												
Capital Expenditure (target spend = available funds) £000	3,324	3,324	13,957	13,957												
Debtors > 90 days	5.0%	19.2%	5.0%	5.0%												
Creditors > 90 days	5.0%	10.5%	5.0%	5.0%												
Better Payment Practice Code	95.0%	89.8%	95.0%	95.0%	95.0%	97.2%	95.0%	99.4%	95.0%	99.0%	95.0%	80.6%	100.0%	100.0%	95.0%	99.0%

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%

Trust Human Resources - Workforce Performance

		Trust Performance													Current month directorate performance				
		Source	Reporting Frequency	Monthly target	Reporting Period (rolling three months)			Sparkline YTD	2019/20				Year to Date Position	Year End Target	Adult Mental Health/ Learning Disabilities	Community Health	Enabling Services	Families, Young People & Children	Hosted Services
					Jul-19	Aug-19	Sep-19		Q1	Q2	Q3	Q4							
Workforce Profile	Number of WTE Employed	TRUST	Monthly		4652.71	4642.35	4601.26		4638.03	4601.26					1154.4	1714.1	460.4	1047.4	225.0
	Substantive Staff Headcount	TRUST	Monthly		5352	5338	5291		5331	5291					1287	1991	510	1267	236
	Bank Only Headcount	TRUST	Monthly		1007	1009	1016		1047	1016									
	% Vacancy Rate	TRUST	Monthly	G: <=7% R: >10%	8.6%	8.9%	9.6%		8.1%	9.6%				G: <=7% R: >10%	14.0%	9.5%	8.2%	6.8%	0%
	% Staff From a BME Background	TRUST	Quarterly	>=20%	22.1%	22.3%	22.6%		22.1%	22.6%				>=20%					
	% of Males Employed	TRUST	Quarterly		17.0%	17.1%	17.3%		17.0%	17.3%									
	% Staff Aged 16-29 Years	TRUST	Quarterly	>=12%	12.5%	12.5%	12.3%		12.5%	12.3%				>=12%					
Sickness Absence (one month in arrears)	% of Sickness Absence (1 month in arrears)	TRUST	Monthly	G: <=4.5% R: >=4.75%	4.7%	4.9%			4.5%	4.8%				G: <=4.5% R: >=4.75%	6.3%	5.2%	2.6%	4.5%	2.0%
	WTE Days Lost to Sickness (1 month in arrears)	TRUST	Monthly		6693	7015			18850	19126			32559		2263	2786	373	1459	135
	% Short Term Sickness (1 month in arrears)	TRUST	Monthly		1.8%	2.0%			1.9%	2.0%					2.3%	2.3%	0.9%	1.8%	0.9%
	% Long Term Sickness (1 month in arrears)	TRUST	Monthly		2.9%	4.9%			2.8%	2.8%					4.0%	2.9%	1.7%	2.7%	1.1%
	Cost of Sickness (£) (1 month in arrears)	TRUST	Monthly		£ 584,645	£ 639,636			£ 1,678,549	£ 1,224,281			£ 2,902,830		£204,148	£243,152	£38,585	£134,198	£19,552
Turnover	% Normalised Workforce Turnover (Rolling previous 12 months)	TRUST	Monthly	G: <=10% R: >12%	8.7%	8.5%	8.7%		9.0%	8.7%				G: <=10% R: >12%	9.4%	8.8%	6.6%	9.1%	6.1%
	% Total Workforce Turnover (Rolling previous 12 months)	TRUST	Monthly	G: <=10% R: >12%	9.2%	9.0%	9.3%		9.3%	9.3%				G: <=10% R: >12%	9.4%	9.9%	6.8%	9.4%	7.4%
	Executive Team Turnover	TRUST	Monthly		26.4%	26.4%	26.4%		13.2%	26.4%									
	Starters minus Leavers (headcount)	TRUST	Monthly		26	20	4		14	17			93		-3	10	2	-9	4
	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%	90.7%	91.3%	90.6%		90.7%	90.9%				G: >90% R: <85%	88.4%	91.5%	89.9%	91.5%	90.0%
Temporary Staffing	Bank Costs	TRUST	Monthly		£ 1,319,959	£ 1,322,613	£ 1,401,294		£ 3,813,641	£ 4,043,866			£ 7,857,507						
	Agency Costs (NHSI National 2017/18 Target)	TRUST	Monthly	<=£7.7m (p/a)	£ 876,966	£ 813,941	£ 926,375		£ 2,523,307	£ 2,617,282			£ 5,140,589	<=£7.7m					
	Agency Costs (LPT Internal Target)	TRUST	Monthly	<=£9.5m	£ 876,966	£ 813,941	£ 926,375		£ 2,523,307	£ 2,617,282			£ 5,140,589	<=£9m					
	Temporary Staffing Spend as a % of Total Paybill (Inc. bank, agency and additional hours worked)	TRUST	Monthly		12.3%	12.2%	13.3%		12.7%	13.3%									
	No of Off Framework Agency Usages	TRUST	Monthly		236	305	191		414	732			1146						
	No of Breaches to Agency Price Cap	TRUST	Monthly		553	683	629		1531	1865			3396						
	Agency volume (number of shifts filled by agency)	TRUST	Monthly		2761	2963	2621		7707	8345			16052						
	Roster approval period (weeks)	TRUST	Monthly	G: >6	5.80	5.50	5.66		5.20	5.65									
	% Split of Substantive to Bank to Agency Staff (Nurses band 2-6, inpatient areas only, taken from Safer Staffing portal)	TRUST	Monthly		66.1%, 28.7%, 5.2%	65.9%, 29.4%, 4.8%	68.1%, 27.7%, 4.2%												
	% Split of Qualified to Unqualified Staff (Nurses band 2-6, inpatient areas only, taken from Safer Staffing portal)	TRUST	Monthly		36.7%, 63.3%	36.4%, 63.6%	36.3%, 63.7%												
Organisational Change	Number of Staff Made Redundant	TRUST	Monthly		1	0	2		0	3			2		0	0	2	0	0
	Number of Staff on Pay Protection	TRUST	Monthly		28	29	25		28	27			25		7	11	4	3	0
Employee Relations	Number of open formal grievances	TRUST	Monthly		2	1	2		1	2					1	1	0	0	0
	Number of open bullying and harassment cases	TRUST	Monthly		2	3	6		1	4					1	5	0	0	0
	Number of open formal disciplinary cases	TRUST	Monthly		9	8	8		7	8					2	5	0	1	0
	Number of open employment tribunals	TRUST	Monthly		2	2	2		1	2					0	1	0	1	0
	Concerns raised to an external organisation	TRUST	Monthly		0	0	0		2	0			2		0	0	0	0	0
	Concerns raised in house	TRUST	Monthly		13	5	13		16	31			47		5	4	1	3	0
Employee Engagement	% Staff recommend LPT as a place to work	TRUST	Quarterly	G: >=57%	N/A	N/A	N/A		N/A	N/A				G: >=57%					
	% Staff happy with standard of care provided	TRUST	Quarterly	G: >=67%	N/A	N/A	N/A		N/A	N/A				G: >=67%					
	Pulse and Staff Survey Response Rate	TRUST	Quarterly	G: >=50%	N/A	N/A	N/A		N/A	N/A				G: >=50%					
Learning and Development Overview	% of Consultants with a completed annual appraisal	TRUST	Monthly	G: >=90% R: <75%	97.0%	96.0%	93.0%		96.3%	95.3%				G: >=90% R: <75%	95%	100%		87%	
	% of Staff with a Completed Annual Appraisal	TRUST	Monthly	>=80% R: <75%	92.9%	93.4%	93.1%		92.0%	93.1%				>=80% R: <75%	91.6%	94.2%	90.6%	93.5%	94.1%
	% All Mandatory Training Compliance for substantive staff	TRUST	Monthly	G: >=85% R: <75%	92.8%	92.1%	92.2%		92.8%	92.4%				G: >=85% R: <75%	90.0%	93.0%	90.4%	94.0%	91.9%
	% All Mandatory Training Compliance for bank-only nursing staff	TRUST	Monthly	G: >=75% R: <65%	83.0%	86.6%	82.2%		81.0%	83.9%				G: >=75% R: <65%					
	% of new starters who attended Trust Induction on their first day (excluding bank staff)	TRUST	Monthly	G: >=85% R: <75%	100.0%	100.0%	100.0%		100.0%	100.0%				G: >=85% R: <75%					
	% of staff who have undertaken clinical supervision within the last 3 months	TRUST	Monthly		81.5%	80.0%	84.5%		80.7%	84.5%					79.6%	89.1%	63.2%	82.3%	100.0%
Learning and Development (Detail for Substantive Staff)	% Core Mandatory Training Compliance	TRUST	Monthly	G: >=85% R: <75%	95.1%	95.1%	95.2%		95.4%	95.1%				G: >=85% R: <75%	93.9%	96.3%	93.2%	96.0%	91.9%
	% Fire Safety training compliance	TRUST	Monthly	G: >=85% R: <75%	88.8%	88.8%	89.0%		88.9%	88.9%				G: >=85% R: <75%	85.1%	90.9%	88.0%	91.1%	85.6%
	% of Information Governance training compliance	TRUST	Monthly	G: >=95% R: <75%	90.8%	91.2%	91.5%		90.9%	91.2%				G: >=95% R: <75%	88.2%	93.1%	87.3%	93.1%	94.5%
	% Clinical Mandatory training compliance	TRUST	Monthly	G: >=85% R: <75%	92.6%	92.1%	91.9%		92.8%	92.2%				G: >=85% R: <75%	89.5%	93.8%	70.9%	92.6%	100.0%
	% Mental Health Act training compliance	TRUST	Monthly	G: >=85% R: <75%	82.0%	82.3%	82.0%		80.9%	82.1%				G: >=85% R: <75%	81.5%	91.3%	23.1%	79.5%	
Declaration of Protected Characteristics	Declared Disability	TRUST	Monthly	G: >=85% R: <75%	78.2%	76.9%	76.1%		78.4%	77.1%				G: >=85% R: <75%					
	Declared Sexual Orientation	TRUST	Monthly	G: >=85% R: <75%	80.6%	80.8%	81.0%		80.4%	80.8%				G: >=85% R: <75%					
	Declared Religious Belief	TRUST	Monthly	G: >=85% R: <75%	79.3%	79.4%	79.6%		79.2%	79.5%				G: >=85% R: <75%					

Comments and Actions:

% Sickness Absence - see exception report

Agency Usage - see exception report

Leicestershire Partnership NHS Trust

DETAILED EXCEPTION REPORT - Clostridium Difficile (C Diff) Cases

Responsible Director	Anne Scott
Responsible Committee	QAC

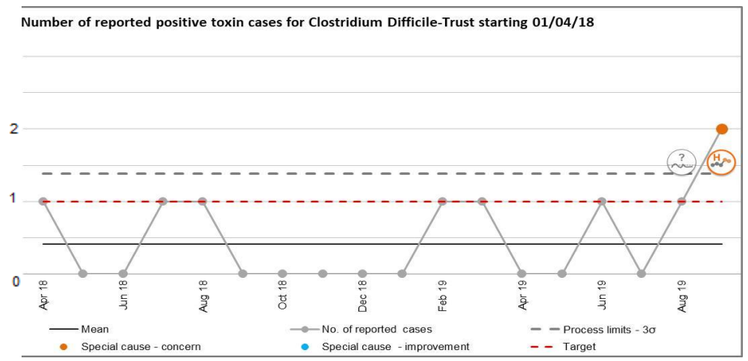
Responsible Services	All
KPI Reference ID	MSP.02

Risk Reference	
Risk Owner	

Risk Description:

Calculation Method	Count of the number of reported positive toxin cases for Clostridium Difficile each month

Clostridium Difficile (C Diff) Cases	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
2018/19	1	0	0	1	1	0	0	0	0	0	1	1	**5**
Wards	EC - Beechwood Ward	-	-	EC - Clarendon Ward	CV - Snibston Ward	-	-	-	-	-	BC - Langley Ward	H&B - North Ward	
2019/20	0	0	1	0	1	1							**3**
Wards	-	-	EC - Beechwood Ward	-	SL - Ward 3	FP - General Ward							



Key: CV - Coalville Hospital
FP - Feilding Palmer Hospital
H&B - Hinckley and Bosworth Hospital
SL - St Luke's Community Hospital
EC - Evington Centre
LGH - Loughborough General Hospital
MMH - Melton Mowbray Hospital
BC - Bennion Centre

Comments and Actions:

The trajectory for 2019-20 for Clostridium Difficile is twelve (12).

There has been 1 reported case for Clostridium difficile during the month of September 2019 at Fielding Palmer Hospital.

The total Clostridium Difficile cases for this year is three (3).

Based on the SPC chart, we can see there is no significant change to the number of reported cases since April 2018; and we will consistently meet our trajectory.

Leicestershire Partnership NHS Trust

DETAILED EXCEPTION REPORT - CPA 7 Day Follow-up

Responsible Director	Gordon King, Rachel Bilsborough
Responsible Committee	QAC

Responsible Services	AMH, CHS
KPI Reference ID	

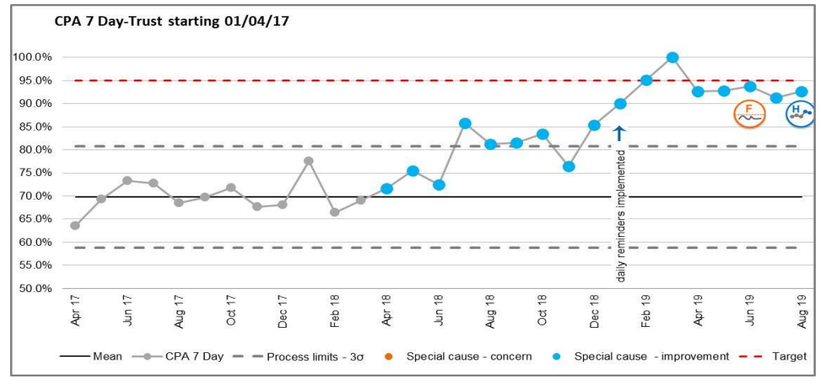
Risk Reference	
Risk Owner	

Risk Description:

Calculation Method	**Numerator:** The number of people under adult mental illness specialties who were followed up (either by face to face contact or by phone discussion) within 7 days of discharge from psychiatric in-patient care during the period **Denominator:** The total number of people under adult mental illness specialties discharged from psychiatric in-patient care during the period

Performance (%)	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20
Adult Mental Health Services	100.0%	91.0%	91.8%	91.5%	89.3%	91.4%						
Community Health Services	100.0%	100.0%	100.0%	100.0%	100.0%	96.0%						
Trust Total	100.0%	92.7%	92.8%	93.7%	91.3%	92.6%						

CPA 7 Day is reported one month in arrears



Comments and Actions:

To improve performance against the CPA seven day standard, the Adult Mental Health and Learning Disabilities directorate (AMH .LD) have redesigned the monitoring process for CPA seven day with an aim to undertake the CPA seven day follow -ups within 48 hours. Daily individualised proactive reports and reminders will be provided to wards to undertake reviews; and missed reviews will be escalated to the service manager. We ekly performance reports will be reviewed by the business team with escalations made to the business manager for relevant actio n.

Based on the SPC chart, we can see there is special cause improvement of CPA 7 Day rates since July 2018; however we will consistently fail our target of >=95% unless further improvements are made.

Leicestershire Partnership NHS Trust

DETAILED EXCEPTION REPORT - CPA 12 Month Review

Responsible Director	Gordon King, Rachel Bilsborough
Responsible Committee	QAC

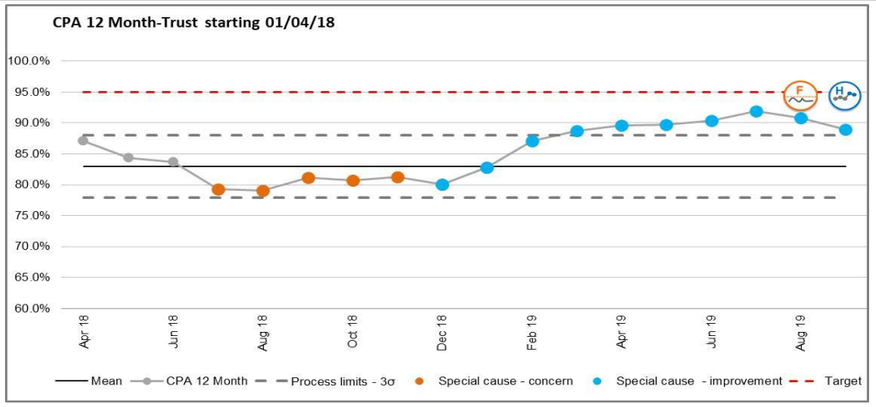
Responsible Services	AMH, CHS
KPI Reference ID	

Risk Reference	
Risk Owner	

Risk Description:

Calculation Method	**Numerator:** The number of patients on CPA (who have been on CPA for 12 months) **and** who have had a CPA review within the last 12 months **and** whose record has been authorised by a responsible clinical officer **Denominator:** The number of patients on CPA (who have been on CPA for 12 months)

Performance (%)	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Adult Mental Health Services	88.1%	89.5%	89.6%	90.8%	91.9%	91.7%	89.9%						
Community Health Services	96.4%	93.7%	96.3%	95.2%	100.0%	98.0%	95.1%						
Trust Total	88.7%	89.6%	89.7%	90.4%	91.9%	90.8%	89.0%						



Comments and Actions:

All care plans entered against a patient record must be authorised by a responsible clinical officer in order to count as a positive contact.

To improve performance against the CPA 12 month standard, the AMH.LD directorate have produced an action plan with an aim to increase operational team focus on out of date CPA 12 month reviews, with targeted support by the directorate business team. Individualised performance information is directed to care co-ordinators, detailing their out of date reviews and those that are upcoming within the next three months. Self-service performance reports are also available to support the management of CPA 12 month performance.
As anticipated, performance has improved in February 2019 where these actions have been implemented.

Based on the SPC chart, we can see there is special cause improvement of CPA 12 month rates since December 2018; however we will consistently fail our target of >=95% unless further improvements are made.

Leicestershire Partnership NHS Trust

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

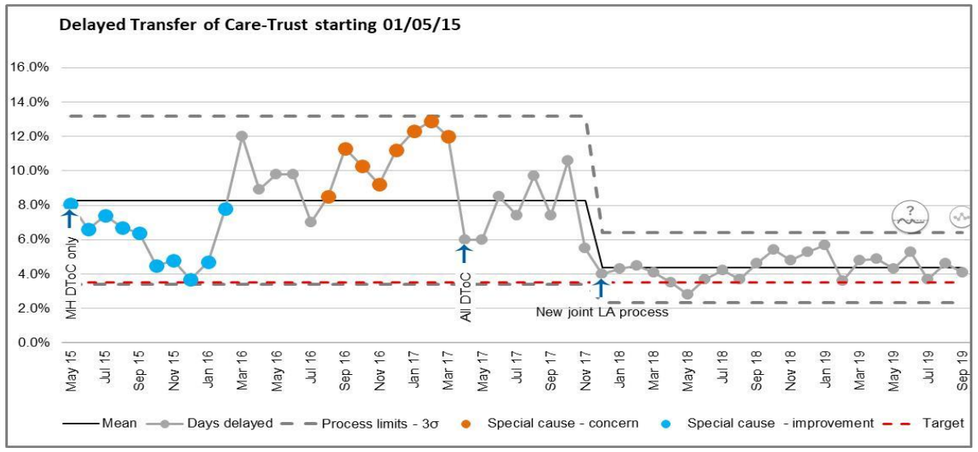
Responsible Director	Rachel Bilsborough, Gordon King
Responsible Committee	FPC

Responsible Services	AMH
KPI Reference ID	QEFS.06

Risk Reference	2403	**Risk Description:** Delayed Transfer of Care (DToC) is high in most of the inpatient areas in LPT reducing the bed flow within LPT and in the LLR system
Risk Owner	Sue Elcock	

Calculation Method	**Numerator:** the number of non-acute patients (aged 18 and over on admission) per day under consultant and non-consultant-led care whose transfer of care was delayed. For example, one patient delayed for five days counts as five. **Denominator:** the total number of occupied bed days (consultant-led and non-consultant-led). *Delayed transfers of care attributable to social are included.* *Delays are aligned to National Unify reporting.*

DTOC (%)	Target	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Acute Mental Health - Bradgate Unit	<=3.5%	1.9%	4.1%	6.4%	7.5%	4.5%	4.5%	3.6%						
Mental Health - Forensics	<=3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%						
Mental Health - Rehabilitation	<=3.5%	5.0%	4.1%	4.1%	2.8%	3.9%	5.1%	5.8%						
Learning Disabilities	<=3.5%	5.8%	5.5%	6.0%	11.4%	13.2%	8.7%	7.3%						
Mental Health - MHSOP (Functional)	<=3.5%	16.9%	10.5%	10.3%	16.5%	5.9%	8.8%	7.5%						
Mental Health - MHSOP (Organic)	<=3.5%	23.3%	22.6%	12.7%	20.1%	16.0%	23.4%	6.3%						
Community Hospitals	<=3.5%	1.8%	2.2%	0.5%	0.0%	0.0%	0.0%	0.0%						
TRUST TOTAL	<=3.5%	4.8%	4.9%	4.3%	5.3%	3.7%	4.6%	4.1%						



LLR System DTOC figures are reported nationally in arrears, they are shown below for illustrative purposes														
		Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
LLR SYSTEM TOTAL *(inc UHL, out of area patients etc.)*	<=3.5%	2.5%	2.1%	2.4%	2.7%	2.3%								

Comments and Actions:

% DToC - Mental Health: Patients delayed during discharge for the month of September 2019 are the result of the following top four categories: Housing (16.9%), Joint (15.3%), Social Services (12.3%), NHS (10.7%) and all other reasons (44.6%).

% DToC - Community: Delays for community hospital patients during the month of September 2019: There were 0 days delayed.

A clinical discharge meeting is chaired by the Clinical Director and covers all wards in mental health and forensic inpatient areas. The meeting is attended by all relevant multi agency partners to focus on manging DToCs as well as potential / emerging DToCs in the system. Similar arrangements are also in place in MHSOP, rehabilitation and learning disability services. DToCs in learning disability services are escalated to the Transforming Care Board; and complex clinical decisions are escalated to a clinical cabinet for resolution. Multi-agency issues that cannot be addressed by the group are escalated to the multi-agency DToC meeting chaired by the Medical Director and attended by the director/ senior management representation from all partner organisations.

A multi agency action plan is in progress to improve the DToC position (an update on actions since January 2018):
- The redesign of discharge pathway 2 (home with new support) and pathway 3 (complex transfers – unable to go straight home) led by Home First is due to take place. This will include agreeing and implementing an LLR-wide model for Discharge to Assess and reablement.
- The development of a trusted assessment between multi agency staff.
- Bring the Housing Enablement Team into the integrated discharge team (IDT) and increase in resources to support IDT presence at the front door.
- Review the discharge hub environment usage to ensure multi agencies can work together to pursue complex discharges.
- Explore opportunities for all adult social care staff facilitating discharges to have access to NHS systems to share information about patient needs.
- Combining the IDT with Red2Green to allow a wider resource to be focused on similar issues and responses.
- A review of the effectiveness of the continuing healthcare end to end process implemented within Community and Community Hospitals
- A phased implementation of the continuing healthcare end to end process for UHL with an assessor for MLCSU commencing in March 2018 to support the Complex Discharge Team

Based on the SPC chart, we can see there is no significant change in the rate of DToCs since December 2017; and we will inconsistently meet our Trust target of <=3.5%.

Risk Associated Actions:

- Implementation of Red Green approach in mental health to improve the inpatient pathway leading to timely identification of patients needs and addressing the needs
- Consistent approach to managing patient choice through development and implementation of a guidance appropriate to community hospitals and mental health
- Improve the engagement of nursing homes with trusted assessment to reduce the delays
- Operationalise move on housing for DToC from Bradgate unit and ensure robust process in place for maintaining the flow
- Improve the process for speedy resolution of AHP placements working with CCG
- Improving the process of CHC funding working with CCG and social care for Community Hospital patients
- Ensuring the sustainability of Red to Green approach across all areas within the community hospitals in a sustainable manner

Leicestershire Partnership NHS Trust

DETAILED EXCEPTION REPORT - National Access Standards

Responsible Director	Gordon King
Responsible Committee	FPC

Responsible Services	AMHLD/ FYPC
KPI Reference ID	18wkRTT; DM01

Risk Reference	n/a	**Risk Description:**
Risk Owner	n/a	

Description	NHS Improvement (NHSI) monitors the Trust against three access standards: % of service users on incomplete referral to treatment (RTT) pathways (yet to start treatment) waiting no more than 18 weeks from referral (92%) % of service users on incomplete referral to diagnostic pathways (yet to start treatment) waiting no more than six weeks from referral (99%) zero tolerance RTT waits over 52 weeks for incomplete pathways (0%) *Targets are taken from the NHSI Single Oversight Framework (SOF) 2017* *Referrals waiting and compliance are taken from the national monthly returns (18wkRTT and DM01) and may be reported in arrears due to the timings of national reports* *Reason for breaches are taken form service patient tracking list (PTL) meetings*

18 Week Referral to Treatment (Asperger's and ADHD Services)

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
STF RTT Trajectory - max no. of referrals breaching in month	6	6	6	9	9	6	6	6	9	9	6	6	6	6	6	9	9	6	6	6	9	9	6	6
Referrals waiting over 18 weeks	0	11	8	9	1	2	1	7	30	31	16	8	0	11	26	0	36	34	0	0	0	0	0	0
- of which patient choice	*4*	*11*	*8*	*9*	*1*	*2*	*1*	*7*	*30*	*31*	*16*	*8*	*11*	*11*	*26*	*0*	*14*	*14*	*0*	*0*	*0*	*0*	*0*	*0*
- of which Trust delays	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*22*	*20*	*0*	*0*	*0*	*0*	*0*	*0*
Incomplete waiting time compliance (%)	98.3%	96.7%	97.6%	97.4%	99.7%	99.4%	99.7%	98.5%	94.1%	94.0%	97.0%	98.5%	98.0%	97.7%	94.9%	94.3%	92.4%	92.6%						

Key: Forecast figures (may change)

6 Week Referral to Diagnostic Test (Children's Audiology Service)

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
STF RTT Trajectory - no. of referrals breaching in month	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
Referrals waiting over 6 weeks	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
- of which patient choice	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
- of which Trust delays	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Incomplete waiting time compliance (%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%						

Zero tolerance RTT waits over 52 weeks for incomplete pathways (0%)

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
No. of RTT referrals over 52 weeks	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	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 - Mental Health Inappropriate Out of Area (OOA) Bed Days

Responsible Director	Gordon King
Responsible Committee	QAC

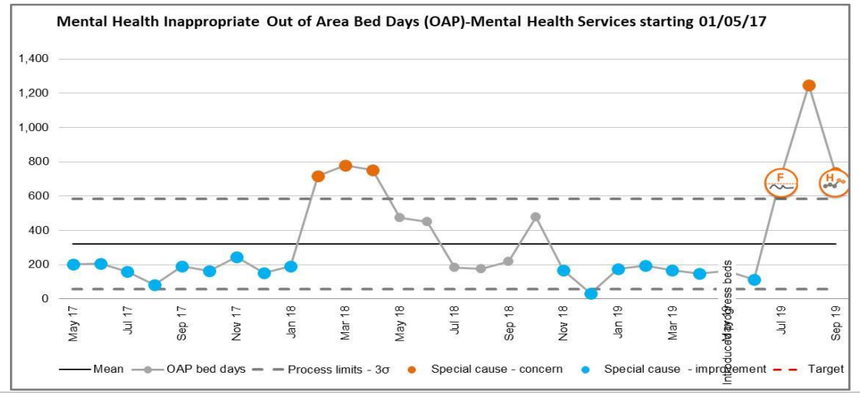
Responsible Services	AMH, CHS
KPI Reference ID	

Risk Reference	
Risk Owner	

Risk Description:

Calculation Method	**Numerator:** Total number of bed days patients have spent out of area in period **Denominator:** Total number of occupied bed days in period

Performance (%)	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Adult Mental Health Services	88.1%	89.5%	89.6%	90.8%	91.9%	91.7%	89.9%						



Comments and Actions:

Leicestershire Partnership NHS Trust

DETAILED EXCEPTION REPORT - Data Quality Maturity Index (DQMI)

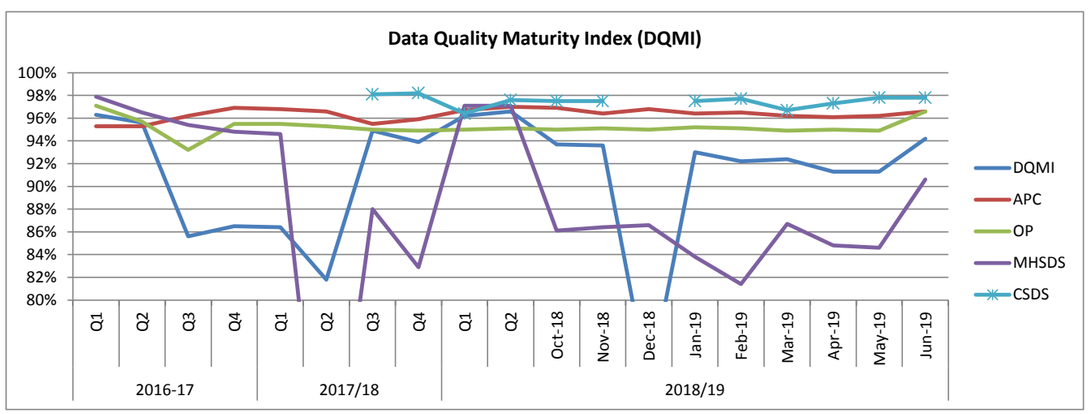
Responsible Director	Dani Cecchini
Responsible Committee	FPC

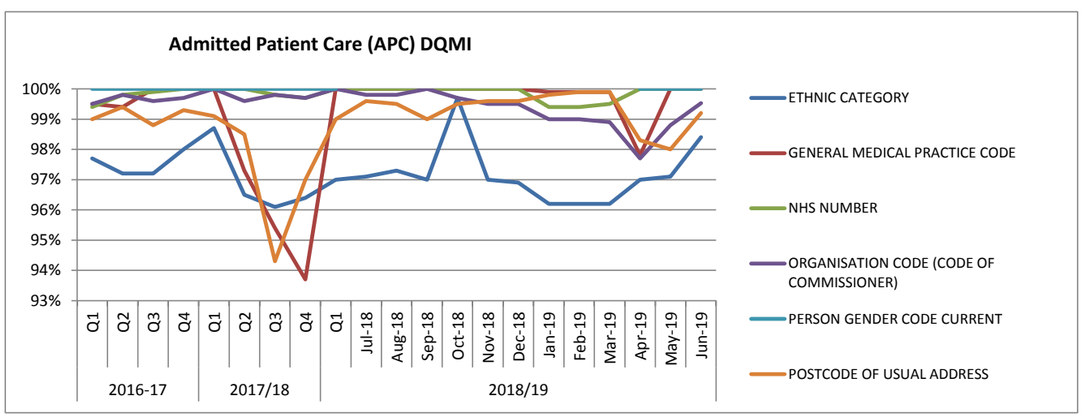
Responsible Services	AMH, CHS, FYPC
KPI Reference ID	

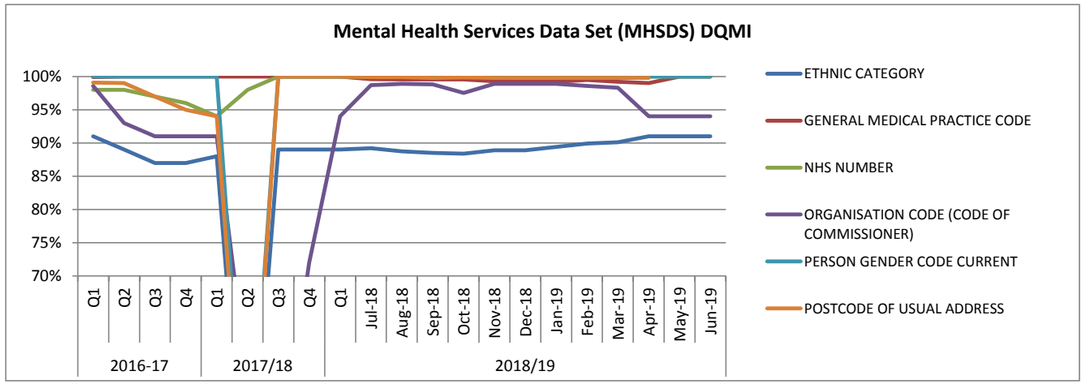
Risk Reference	1119
Risk Owner	Dani Cecchini

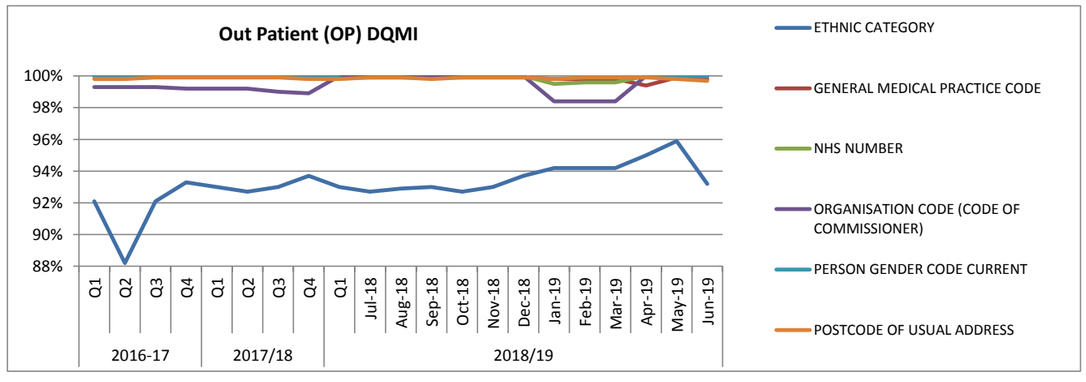
Risk Description: There is a risk we cannot assure ourselves of the accuracy and validity of all information we provide from our patient information systems; which could adversely affect patient outcomes where information is required to make decisions.

Calculation Method	Proportion valid and complete data items **Numerator:** ((Coverage)*(mean proportion valid and complete for each data item)*100))









Comments and Actions:

National dataset compliance is published six months in arrears. Local performance is shown monthly where available in lieu of nationally published performance.

Data Quality Maturity Index (DQMI)

The sudden decrease in compliance during 2017/18 Q2 is attributed to a technical error which is not linked to data quality.

Work to improve completeness and validity of DQMI in submissions was completed in May 2018. We expect to see a change in DQMI compliance for 2018/19 Q1 in line with the improved submission process.

The recording of ethnicity data is being managed through the clinical effectiveness group (CEG) from June 2018. We expect to see improvements to ethnicity recording from July 2018.

The spine matching processes across the Trust and primary care services is being reviewed for improvements. We expect to see incremental improvements to all indicators from July 2018 as actions are completed.

Leicestershire Partnership NHS
NHS Trust

DETAILED EXCEPTION REPORT - % Staff Sickness

Responsible Director	Sarah Willis
Responsible Committee	SWG

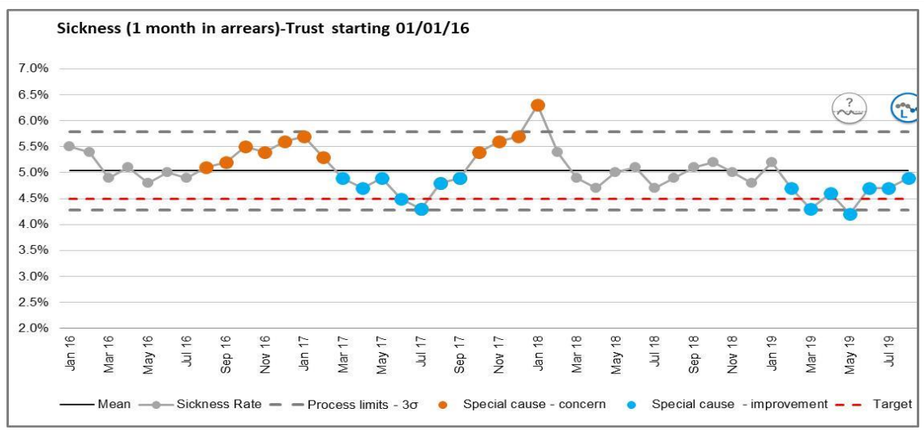
Responsible Services	AMH, CHS, FYPC, Enabling
KPI Reference ID	

Risk Reference	1833
Risk Owner	Kathryn Burt

Risk Description: Quality of service provided to our patients and service users will be affected by the high level of sickness absence within the Trust. There will also be an impact on the health and wellbeing linked to the increased reliance on use of temporary staffing.

Calculation Method	**Numerator:** the number of available calendar days lost to staff sickness in the period **Denominator:** the total number available calendar days in the month

Performance (%)	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Adult Mental Health Services	<=5.6%	5.4%	5.0%	6.0%	5.4%	6.3%							
Community Health Services	<=4.8%	5.0%	4.4%	5.0%	5.2%	5.2%							
Families, Children and Young People's Services	<=4.3%	4.7%	4.4%	4.4%	4.5%	4.5%							
Enabling Services	<=2.3%	2.6%	2.0%	2.5%	2.9%	2.6%							
Hosted Services	<=2.3%	2.1%	1.5%	1.9%	1.2%	2.0%							



Comments and Actions:

% Sickness Absence:

AMH.LD sickness is showing significant improvement from last year however has recently taken an upturn. The cumulative rate for 2018/19 was 5.4 % (below target of 5.6%). This is a 0.8% reduction from 2017/18 and builds on improvements made in 2016/17. Advice from Amica and Occupational Health is that the complexity of the client group supported in AMH.LD means that higher levels of sickness absence should be anticipated.
Actions in place:
- HR support to focus on supporting, training and coaching Managers.
- Target setting for staff who reach the Trust triggers and if breached formal action taken.
- Monthly teleconference for managers, HR and the Director to discuss actions being taken to tackle sickness absence.
- HR Team focusing on supporting staff with underlying health conditions using guidance from the Reasonable Adjustment Policy and Tailored Adjustment Agreements.

CHS Sickness absence remains high on the workforce agenda with community services receiving a daily situation report on all staffing and sickness concerns. They have also undertaken a review of sickness trends and patterns and HR have provided a number of bespoke training sessions. Across CHS a commitment has been made to identify and support all current line managers to undertake the four training courses designed to support with staff management. A focus on health and wellbeing has been initiated to support staff with expanding the health and wellbeing agenda within their own areas.

FYPC Sickness remained the same in August as the previous month and is showing Amber, and is an improvement on same time last year.. This is discussed in length at Workforce Meetings, FYPC SMT have also agreed to discuss this in more detail in the FYPC Operational Meetings on a monthly basis. Work will continue with Teams and Managers, including training, advice on target setting and continued monthly monitoring of staff sickness within teams. Information has been provided to SMT on staff who are line managers and have not attended Management of Ill Health Training and also to encourage Managers to attend half day refresher training. Stress Tools are discussed at Workforce Group and communicated to Managers through Comms and individual Team Meetings. The HR team will undertake further 1 x 1 work with Managers who have a 6% and over the target rate. Hot spots will be identified and fed back to SMT for discussion.

Enabling - sickness has seen a slight decrease in sickness absence but is still showing as red. All absence is being appropriately managed within the services with support from HR.

Based on the SPC chart, we can see there is no significant change in the rate of staff sickness since February 2018; and we will inconsistently meet our Trust target of <=4.5%.

Risk Associated Actions:

1. Managers to be reminded on an ongoing basis of the need to input sickness absence in a timely way.
2. HR staff to ensure that all sickness absence cases are recorded on case management system to aid reporting.
3. Management of Ill-Health Policy to be revised and agreed by staff side.
4. Programme of health and wellbeing interventions to be available for staff.

Leicestershire Partnership NHS Trust

DETAILED EXCEPTION REPORT - Agency Costs

Responsible Director	Anne Scott
Responsible Committee	FPC/ SWG

Responsible Services	All
KPI Reference ID	PW.35

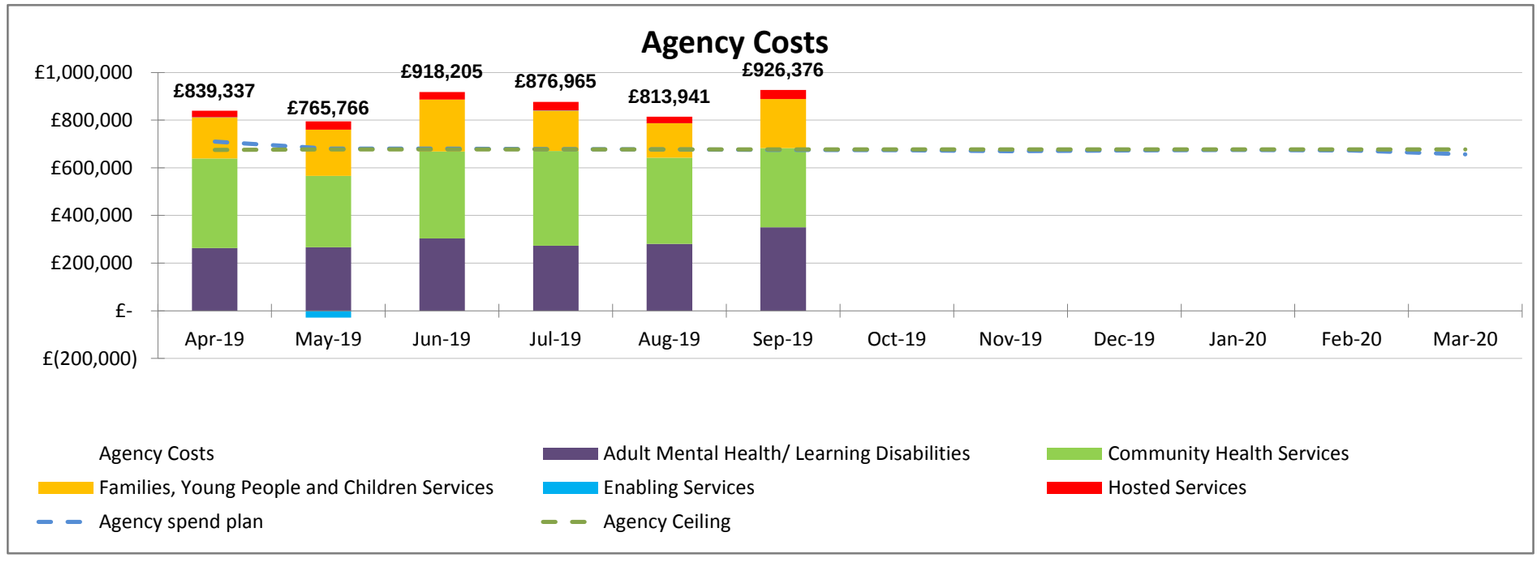
Risk Reference	1932	**Risk Description:** Inability to achieve sufficient workforce supply to deliver the workforce requirements set out within the Trust business plan and people strategy. . Links to risks 1037, 1038, 2515 and the safer staffing risk.
Risk Owner	Sarah Willis	

Risk Reference	1260	**Risk Description:** Substantive staffing on inpatient units is below the funded establishment and this could have an impact on patient care and the ability to deliver effective care on a consistent basis. Links to risk 1932.
Risk Owner	Anne Scott	

Calculation Method	Total cost of Trust agency pay bill

Split by Services

	Current Month	Previous Month
Adult Mental Health/ Learning Disabilities	£ 350,199	£ 280,616
Community Health Services	£ 332,942	£ 362,092
Families, Young People and Children Services	£ 205,424	£ 144,544
Enabling Services	£ -	£ 283
Hosted Services	£ 37,811	£ 26,406



Comments and Actions:

Cumulative year-to-date Trust agency costs were £5,140K as at 30 September 2019 (month 6). This is above the planned spend of £4,101k for the same period.

The September year-to-date NHSI agency ceiling target is £4,060k. This Trust is exceeding this limit by £1,080k

Risk Associated Actions:

Appendix 1: IQPR Change Log

Date	Indicator Code	Indicator Description	Requested by	Change
Apr-17		Quality Pages	QAC	All Quality indicators reviewed
Jul-17		Operational Performance	FPC	re-formatted layout in line with Quality pages
Oct-17		DToC for Community Health	ET	Community moved to national methodology
Sep-19		SPC graphs	Board	SPC graphs introduced into exception reporting where possible
Sep-19		Radar charts	FPC	Removed radar chart page as duplicated information
Oct-19		OOA Exception report	FPC	Exception report for OOA bed days included

Paper Oii

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	Jul-19	Aug-19	Sep-19	Referrals Trendline (Rolling 12 Months)	Jul-19	Aug-19	Sep-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	Jul-19	Aug-19	Sep-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	Jul-19	Aug-19	Sep-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	116	92	96		110	86	100		110	8	0	12	0	95%	95.1%	88.1%	93.2%		82	14	0	16	0	95%	83.9%	92.0%	85.4%						
MH02	Assertive Outreach	6 Weeks	Referral to Assessment	2	2	9		1	2	2		6	1	0	6	0	95%	100.0%	100.0%	85.7%		4	0	0	0	0	95%	N/A	N/A	100.0%						
MH06	Personality Disorders	13 Weeks	Referral to Assessment	117	73	82		26	56	40		290	399	1	43	58	95%	48.1%	43.3%	42.0%		11	26	0	39	0	95%	11.1%	25.0%	29.7%						
MH07	Dynamic Psychotherapy	13 Weeks	Referral to Assessment	21	23	29		25	8	4		51	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	95	100	83		96	79	91		40	10	0	13	0	95%	68.3%	68.6%	80.0%		72	12	0	11	0	95%	75.0%	85.6%	85.7%						
		2 Working Days		9	12	12		8	11	12		0	0	0	0	0	95%	N/A	N/A	N/A		11	1	0	0	0	95%	100.0%	100.0%	91.7%						
		4 Hours		0	0	0		0	0	0		0	0	0	0	0	95%	N/A	N/A	N/A		0	0	0	0	0	95%	N/A	N/A	N/A						
MH09	Psycho-oncology (Routine and Urgent)	4 Weeks	Referral to Assessment	18	16	26		26	24	16		29	49	0	26	0	95%	26.3%	17.5%	37.2%		4	16	0	25	0	95%	22.2%	23.5%	20.0%						
		48 Hours		9	10	4		4	5	3		9	4	0	11	0	95%	85.7%	81.8%	69.2%		0	2	0	6	0	95%	20.0%	0.0%	0.0%						
MH10	Liaison - Psychiatry	1 Working Day	Referral to Assessment	38	34	37		38	26	36		4	1	0	1	0	95%	100.0%	53.8%	80.0%		24	10	0	0	0	95%	94.3%	86.7%	70.6%						
		13 Weeks		16	8	9		24	56	26		13	2	0	36	0	95%	93.2%	87.5%	86.7%		17	2	0	45	0	95%	95.7%	94.7%	89.5%						
MH11	Cognitive Behavioural Therapy	13 Weeks	Referral to Assessment	64	53	51		26	26	27		103	1	0	13	0	95%	98.2%	97.5%	99.0%		36	2	0	16	0	95%	97.4%	100.0%	94.7%						
MH13	Forensic - Community and Out Patients	8 Weeks	Referral to Assessment	19	18	39		12	14	12		55	14	0	30	0	95%	75.0%	52.9%	79.7%		12	11	0	20	0	95%	50.0%	66.7%	52.2%						
MH18	Adult General Psychiatry - Community Mental Health Teams and Outpatients - Treatment	6 Weeks	Referral to Assessment	428	378	421		419	413	409		595	641	8	49	218	95%	47.3%	41.1%	47.8%		148	205	0	50	0	95%	56.5%	53.5%	41.9%						
		5 Days		18	14	12		15	12	10		5	5	0	4	0	95%	25.0%	18.2%	50.0%		7	3	0	7	0	95%	53.8%	72.7%	70.0%						
MH20	Mett Day Centre and Linnaeus Nursery	4 Weeks	Referral to Assessment	1	1	11		5	7	4		4	0	0	0	0	95%	N/A	100.0%	100.0%		8	0	0	0	0	95%	100.0%	N/A	100.0%						
MH21	Huntington's Disease	4 Weeks	Referral to Assessment	2	2	2		1	0	2		1	0	0	0	0	95%	0.0%	66.7%	100.0%		3	0	0	0	0	95%	66.7%	N/A	100.0%						
MH23	Adult ADHD Service Consultant-Led Service	National incomplete target 92%: 18 Weeks	Referral to Treatment	117	82	83		47	27	58		337	28	0	33	0	92%	95.8%	94.7%	92.3%		29	68	0	26	0	95%	90.5%	48.5%	29.9%						
MH24	Homeless Service	1 Week	Referral to Assessment	42	42	33		32	40	37		6	9	0	5	0	95%	29.4%	4.0%	40.0%		21	21	0	9	0	95%	67.4%	71.4%	50.0%						
MH25	Aspergers Assessment Consultant-Led Service	National incomplete target 92%: 18 Weeks	Referral to Treatment	61	35	43		23	40	31		81	6	0	26	0	92%	90.5%	82.6%	93.1%		35	14	0	31	0	95%	67.4%	93.7%	71.4%						
MH48	Crisis Intervention (Crisis Level 1 and 2)	4 Hours	Referral to Assessment	7	7	4		7	7	3		0	0	0	0	0	95%	100.0%	N/A	N/A		3	1	0	0	0	95%	66.7%	50.0%	75.0%						
		24 Hours		337	290	278		308	346	266		6	0	0	0	0	95%	100.0%	100.0%	100.0%		241	32	0	1	0	95%	80.1%	85.7%	88.3%						
MH49	Mental Health Triage Team	1 Hour	Referral to Assessment	406	368	369		385	324	349		0	0	0	0	0	95%	N/A	N/A	N/A		171	197	0	18	0	95%	46.3%	51.8%	46.5%						
		Emergency 2 Hours	Referral to Assessment	406	368	369		385	324	349		3	2	0	11	0	95%	36.4%	32.1%	60.0%		280	88	0	18	0	95%	70.4%	76.3%	76.1%						
		Crisis 4 Hours	Referral to Assessment	28	43	22		27	38	21		0	0	0	0	0	95%	0.0%	25.0%	N/A		19	3	0	0	0	95%	92.9%	95.2%	86.4%						
MH16	Adult General Psychiatry-Acute Recovery Team	3 Working Days																																		
		48 hours																																		
		7 days																																		

Comments and Actions:

MH49 - Mental Health Triage Team 1 hour
Emergency referral via the Leicester Royal Infirmary Emergency Department – As LPT are working towards the NHS England Liaison target 20/21 which states that no acute hospital is without an all age mental health service in an emergency department. Compliance against the 1 hour target will be measured as part of the service development planned in order for the mental health triage to deliver the Core24 standards. Achievement of the target is subject to ongoing review of capacity, performance and resource.

Methodologies

RTT Methodology:
The RTT methodology is correct as per the way that RiO electronic patient record functions. There are system level action dates that are needed to sequence the information for the calculation. This means that the front end processing of RTT needs to happen as it occurs and entered in to RiO. Therefore, any information entered into RiO that is back dated will take the

Incomplete:
Incomplete waiting list performance is based on the number of patient referrals on an active waiting list at month end; and the percentage of those within the target waiting times.

Complete:
Complete wait time performance is based on the number of patient referrals completed with or without treatment during the reporting period; and the percentage of those within the target waiting times.

WeAreC.B.I.T
Corporate Business Information Team

Waiting Times Compliance - Community Health Services

Leicestershire Partnership NHS
NHS Trust

Service Details				Patient Flow (referrals and discharges in month)								Incomplete Pathways (at end of month)										Complete Pathways (in month)										Information Assurance Framework				
				No. of New Referrals Received				No. of Discharges				No. of Referrals Waiting			Length of Wait		Waiting Time Compliance					No. of Referrals Seen			Length of wait		Waiting Time Compliance									
Service Spec	Service Name	Target Waiting Time *(all targets are locally agreed unless otherwise stated)*	Wait Time Measure	Jul-19	Aug-19	Sep-19	Referrals Trendline (Rolling 12 Months)	Jul-19	Aug-19	Sep-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	Jul-19	Aug-19	Sep-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	Jul-19	Aug-19	Sep-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	684	661	717		2005	893	805		644	1171	0	46	0	95%	30.0%	30.9%	35.5%																
		Level 1 Assessment																				42	122	0	46	0	95%	22.2%	13.1%	25.6%					
CHS04	Respiratory Specialist Service	Urgent	Referral to first clinically relevant face to face contact	10	6	5		8	7	6		1	0	0	0	0	90%	100.0%	100.0%	100.0%		5	0	0	0	0	90%	100.0%	83.3%	100.0%						
		Routine		203	149	164		140	135	140		121	16	0	13	0	90%	96.1%	91.5%	88.3%		140	23	0	10	0	90%	91.8%	83.3%	85.9%						
		Rapid Response																																		
CHS07	Heart Failure Service	Urgent	Referral to first clinically relevant face to face contact	26	10	8		6	6	15		0	0	0	0	0	90%	100.0%	N/A	N/A		8	0	0	0	0	90%	92.0%	91.7%	100.0%						
		Routine		178	173	175		77	122	113		119	9	0	16	0	90%	94.0%	91.7%	93.0%		167	21	0	15	0	90%	95.6%	92.3%	88.8%						
CHS10	Physiotherapy	Routine 4 Weeks	Referral to first clinically relevant contact	0	0	0		914	411	276		1	1	0	42	0	95%	0.0%	12.5%	50.0%		1	4	0	37	0	95%	7.4%	0.0%	20.0%						
		Urgent 5 Working Days		0	0	0		246	74	62		0	0	0	0	0	95%	N/A	N/A	N/A		0	0	0	0	0	95%	N/A	N/A	N/A						
		Non self Urgent RTT 5 Working Days	Referral to Treatment	24	22	19		43	28	23		8	1	0	4	0	92%	62.5%	63.6%	88.9%		18	9	0	4	0	95%	66.7%	61.1%	66.7%						
		Non self Routine RTT 30 Working Days		358	333	219		452	346	377		151	229	0	32	0	92%	34.3%	41.4%	39.7%		251	87	0	29	0	95%	48.1%	58.5%	74.3%						
		Self Referrals Urgent RTT 5 Working Days		453	427	320		197	297	276		156	122	0	6	0	92%	47.8%	44.8%	56.1%		197	213	0	5	0	95%	35.3%	40.4%	48.0%						
		Self Referrals Routine RTT 30 Working Days		1904	1770	1982		901	1196	1220		1143	68	0	24	0	92%	74.8%	78.0%	94.4%		1676	70	0	21	0	95%	92.6%	93.7%	96.0%						
CHS19	Podiatry	Routine 20 Working Days	Referral to first clinically relevant face to face contact	1472	1356	1277		1401	1246	1425		954	31	0	17	0	95%	97.0%	96.5%	96.9%		1272	109	0	9	0	95%	93.3%	93.1%	92.1%						
		Urgent 5 Working Days		40	34	22		14	14	11		4	1	0	3	0	95%	100.0%	75.0%	80.0%		14	1	0	1	0	95%	100.0%	100.0%	93.3%						
CHS22	Speech Therapy	Routine 4 Weeks	Referral to first clinically relevant face to face contact	312	326	309		353	283	252		225	32	0	13	0	95%	83.9%	88.2%	87.5%		252	74	0	23	0	95%	82.8%	77.4%	77.3%						
		Urgent 10 Working Days		50	40	47		42	36	51		16	0	0	0	0	95%	100.0%	94.1%	100.0%		44	1	0	2	0	95%	98.0%	96.9%	97.8%						
CHS69/70/80	Community Therapy	3 Working Days (P1)*	Referral to first clinically relevant contact	133	118	140		153	125	122		21	8	0	2	0	95%	90.9%	93.8%	72.4%		113	11	0	1	0	95%	86.4%	90.3%	91.1%						
		20 Working Days (P2)*		655	576	579		601	583	489		467	496	0	22	0	95%	47.3%	44.7%	48.5%		219	344	0	25	0	95%	43.1%	43.4%	38.9%						
		60 Working Days (P3)*		103	99	78		95	103	83		186	57	0	23	0	95%	79.8%	76.7%	76.5%		42	59	0	23	0	95%	41.5%	49.3%	41.6%						
CHS87	Stroke & Neuro	3 Working Days	Referral to first clinically relevant contact	8	5	8		1	6	12		0	0	0	0	0	95%	N/A	N/A	N/A		8	0	0	0	0	95%	100.0%	100.0%	100.0%						
		20 Working Days		229	214	202		245	183	234		149	80	0	13	0	95%	71.4%	63.9%	65.1%		118	103	0	14	0	95%	63.5%	52.0%	53.4%						
MH37	MHSOP Community Teams	High Priority 4 Weeks	Referral to first clinically relevant face to face contact	19	26	21		14	18	9		12	6	0	13	0	95%	73.7%	64.0%	66.7%		21	7	0	9	0	95%	80.0%	76.2%	75.0%						
		Routine 6 Weeks		104	93	119		88	80	82		96	23	0	12	0	95%	90.2%	80.9%	80.7%		83	19	0	15	0	95%	85.6%	83.3%	81.4%						
MH40	MHSOP - Memory Clinics	RTT 18 Weeks	Referral to Treatment	246	225	216		130	140	132		717	58	1	46	53	92%	94.4%	91.7%	92.4%		176	38	0	45	0	95%	83.5%	86.2%	82.2%						
		High Priority 4 Weeks	Referral to first clinically relevant face to face contact	0	0	0		0	0	0		0	0	0	0	0	95%	N/A	N/A	N/A		0	0	0	0	0	95%	N/A	N/A	N/A						
		Routine 6 Weeks		0	0	0		8	7	4		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	1	2	1		6	3	4		0	2	0	10	0	95%	100.0%	50.0%	0.0%		2	0	0	0	0	95%	100.0%	100.0%	100.0%						
		Routine 6 Weeks		130	128	132		144	106	109		151	18	0	15	0	95%	84.8%	81.7%	89.3%		103	25	0	13	0	95%	82.9%	76.4%	80.5%						
CHS05a	Planned End of Life Care Service (Hospice at Home)	2 Weeks	Referral to first clinically relevant face to face contact	2	1	0		2	1	0		0	0	0	0	0	95%	N/A	N/A	N/A		0	0	0	0	0	95%	100.0%	100.0%	N/A						
		24 Hours		75	62	61		75	61	63		0	0	0	0	0	95%	N/A	N/A	N/A		54	4	0	0	0	95%	95.9%	91.8%	93.1%						
		2 Hours		67	62	56		66	62	55		0	1	0	0	0	95%	N/A	N/A	0.0%		50	3	0	0	0	95%	92.4%	75.0%	94.3%						
MH55	Integrated Care – Mental Health	15 Working Days	Referral to first clinically relevant face to face contact	36	26	33		28	24	26		24	8	0	7	0	95%	76.7%	63.0%	75.0%		4	21	0	8	0	95%	50.0%	24.1%	16.0%						
CHS17	City Reablement Service	5 Working Days	Referral to first clinically relevant face to face contact	73	46	54		55	62	53		4	0	0	0	0	95%	81.8%	100.0%	100.0%		53	6	0	2	0	95%	89.6%	87.2%	89.8%						
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:

MH40 MHSOP Memory Clinic 52 Weeks Breach
The 53 week waiter for MHSOP Memory is genuine. To summarise, this was a YODAS patient who required additional input from the MHSOP Psychology service to aid the Memory diagnosis. There has also been a few DNA's and cancellations throughout the patient pathway. The YODAS referral was received on 8th October 2018. Initial assessment was completed on 26th November 2018 and an MRI brain scan was requested on 28th November 2018. The results of the san were received on 20th January 2019. Patient attended appointment on 25th February 2019. An internal referral to Psychology was made on 8th March 2019 and the patient has been seen five times. Follow up appointment with Memory service on 29th July 2019 was attended by the patient. The next Memory service appointment is scheduled for 21st October 2019 for the patient to receive a diagnosis following their attended appointment

Respiratory and Heart Failure Services, the Urgent waiting times target is 10 working days and the Routine waiting times target is 20 working days.
Respiratory and Heart Failure Service Targets have been updated to reflect the new service specfications and back dated from April-19 to Current Reporting Month this has been updated for patients on Complete and Incomplete Pathways.

CHS04 - Respiratory Specialist Service
The Rapid Response waiting times target is 1 working day and the element of this within the Respiratory Service will officially commence from 1st November 2019 once commissioners investment is paid to the service to support the 1 working day referrals. Therefore, it will be greyed out until then.

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	Jul-19	Aug-19	Sep-19	Referrals Trendline (Rolling 12 Months)	Jul-19	Aug-19	Sep-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	Jul-19	Aug-19	Sep-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	Jul-19	Aug-19	Sep-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	408	331	475		482	462	434		294	0	0	0	0	99%	100.0%	100.0%	100.0%		353	1	0	32	0	92%	99.8%	100.0%	99.7%						
CHS24	Childrens Occupational Therapy	18 Weeks	Referral to Treatment	38	26	36		29	32	25		80	2	0	24	0	92%	100.0%	99.0%	97.6%		41	0	0	0	0	92%	100.0%	96.9%	100.0%						
CHS25	Childrens Physiotherapy	18 Weeks	Referral to Treatment	23	10	11		35	12	15		48	2	0	19	0	92%	95.1%	96.7%	96.0%		15	2	0	20	0	92%	100.0%	83.3%	88.2%						
CHS27	Childrens Speech & Language Therapy	18 Weeks	Referral to Treatment	247	116	153		244	330	347		462	2	0	26	0	92%	97.8%	97.2%	99.6%		215	13	0	28	0	92%	97.5%	96.7%	94.3%						
CHS29	LNDS & HENS Domiciliary	4 Weeks	Referral to Assessment	129	116	120		118	118	132		88	32	0	19	0	95%	33.9%	55.1%	73.3%		57	74	0	11	0	92%	41.3%	53.5%	43.5%						
	LNDS & HENS Outpatients	18 Weeks	Referral to Assessment	478	422	464		262	275	343		1099	82	0	35	0	95%	89.3%	93.0%	93.1%		319	38	0	32	0	92%	91.2%	91.4%	89.4%						
CHS34	Community Paediatrics	18 Weeks	Referral to Treatment	148	67	77		80	59	57		234	5	0	32	0	92%	96.5%	96.5%	97.9%		62	9	0	26	0	92%	90.4%	92.2%	87.3%						
MH19	PIER - First Episode in Psychosis Service	National complete target 53%: 2 Weeks	Referral to Treatment	59	55	52		44	45	34		20	8	0	5	0	53%	52.6%	68.2%	71.4%		13	7	0	8	0	56%	81.0%	80.0%	65.0%						
MH30	CAMHS Young People's Team	13 weeks	Referral to Treatment	25	24	32		42	41	28		39	0	0	0	0	92%	97.1%	100.0%	100.0%		25	0	0	0	0	92%	100.0%	100.0%	100.0%						
MH31	CAMHS Learning Disabilities	18 weeks	Referral to Treatment	12	12	13		9	9	12		19	0	0	0	0	92%	100.0%	100.0%	100.0%		14	0	0	0	0	92%	100.0%	100.0%	100.0%						
MH33	CAMHS Paediatric Psychology	18 weeks	Referral to Treatment	30	19	30		25	37	30		70	6	0	19	0	60%	92.5%	96.2%	92.1%		20	5	0	28	0	60%	61.1%	71.1%	80.0%						
MH47	CAMHS - Eating Disorders	Routine 4 Weeks	Referral to face to face assessment	11	7	12		8	11	20		5	4	0	12	0	60%	66.7%	33.3%	55.6%		5	3	0	12	0	60%	80.0%	66.7%	62.5%						
		Urgent 1 Week	Referral to face to face assessment	5	1	3		0	1	2		0	0	0	0	0	60%	N/A	N/A	N/A		3	0	0	0	0	60%	40.0%	0.0%	100.0%						
MH47	CAMHS - Eating Disorders	Commissioner: Routine 6 Weeks	Referral to NICE Concordant Treatment	11	7	12		8	11	20		5	1	0	8	0	95%	63.6%	55.6%	83.3%		3	2	0	12	0	95%	66.7%	40.0%	60.0%						
		Commissioner: Urgent 4 Weeks		5	1	3		0	1	2		1	0	0	0	0	95%	N/A	N/A	100.0%		2	0	0	0	0	95%	100.0%	100.0%	100.0%						
MH47	CAMHS - Eating Disorders	National monitoring: no target Routine 4 Weeks	Referral to NICE Concordant Treatment	11	7	12		8	11	20		4	2	0	8	0	95%	36.4%	33.3%	66.7%		3	2	0	12	0	95%	33.3%	40.0%	60.0%						
		National monitoring: no target Urgent 1 Week		5	1	3		0	1	2		1	0	0	0	0	95%	N/A	N/A	100.0%		2	0	0	0	0	95%	60.0%	0.0%	100.0%						
MH50	CAMHS Access and Outpatients	4 weeks	Referral to first clinically relevant contact	55	26	52		67	19	33		32	0	0	0	0	92%	62.5%	94.7%	100.0%		35	0	0	0	0	92%	100.0%	81.3%	100.0%						
		13 weeks		159	134	151		193	79	134		115	0	0	0	0	95%	98.6%	98.1%	100.0%		106	2	0	15	0	92%	97.2%	97.3%	98.1%						
MH51	CAMHS Crisis and Home Treatment	24 Hours	Referral to first clinically relevant contact	47	43	92		65	27	67		2	0	0	0	0	92%	0.0%	N/A	100.0%		77	7	0	0	0	95%	80.0%	90.7%	91.7%						
CHS28a	CAfSS ;- Diana Community & Family Service	28 calender days	Referral to Assessment																																
CHS28b	DIANA CHILDRENS COMMUNITY NURSING	2 Working Days	% of acute referrals actioned within 2 working days																																
CHS29	LNDS & HENS Community Hospital Inpatients	Urgent 48 Hours																																	
		Routine 5 days																																	
CHS67	Childrens Respiratory Physiotherapy	Urgent 48 Hours																																	
		Routine 4 Weeks																																	
MH04	Eating Disorders Outpatients and Day Care	Urgent 10 Days																																	
		Routine 13 Weeks																																	

Comments and Actions:
Services working to national wait times definitions have targets aligned to national guidance.

Services working to Referral to Treatment methodologies have a 92% target

Services working to Referral to Assessment/ First relevant clinical Contact methodologies have a 95% target.

MH50 CAMHS Access and Outpatients
The 6 Patients that Appear on the CAMHS Access and Outpatients 4 weeks Waiting Time label over Target Completes, have been rectified to 4 Patients as 2 patients where incorrectly recorded on SystmOne.

Methodologies:

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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	o Green – SOPs in place and adhered too o Amber - SOPs in development/ rollouto o Red – SOPs not yet available
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 – 1 November 2019

AUDIT AND ASSURANCE COMMITTEE held 4 OCTOBER 2019

HIGHLIGHT REPORT

The key headlines/issues and levels of assurance are set out below, and are graded as follows:

Strength of Assurance	Colour to use in 'Strength of Assurance' column below
Low	Red - there are significant gaps in assurance and/or not properly assured as to the adequacy of action plans/controls
Medium	Amber - there is reasonable level of assurance but some issues identified to be addressed.
High	Green – there are no gaps in assurance and there are adequate action plans/controls

Report	Assurance level*	Committee escalation	ORR Risk Reference
Organisational Risk Register		Accepted that in development and much progress seen to processes. Next steps had been clarified and actions taken supported. Evidence for full assurance anticipated and moving with pace. Committee agreed that it should focus on gaining assurance on the successful implementation over the next few months, followed by being satisfied that properly embedded.	All
Internal Audit Progress Report		Adjustments to plan were noted. The poor rate of Internal Audit First Follow-up completion of management risk actions was discussed. Going forward these actions would be captured in the corporate Risk management processes.	1 18
External Auditors Progress report		A summary of KPMG's work since July 2019 was received, with positive progress was reported. The draft audit plan 2020/21 would now be brought earlier than scheduled to the December meeting which was agreed as helpful.	17
Counter Fraud Progress Report		Reports received and the change of strategic governance focus was supported.	12
Financial Waivers		Assurance received with minor queries raised over some items with clarification of criteria for waivers to be re-visited as part of a current SO/SFIs review.	17

Report	Assurance level*	Committee escalation	ORR Risk Reference
Losses and Special Payments		First report received by Committee (formerly Finance and Performance Committee) and no issues for concern.	12 17
Internal Audit Follow-Ups		The lack of delivery for First Follow-Up agreed management actions was discussed at length. A possible next step was to invite Executive Director leads to the Committee to help understand issues around progress rates.	1 18
Committee's Annual Plan Review		Adjustments had been made to reflect the governance structure review and the plan was "live" to further changes as needed.	1
Deep Dive		A consideration to an Assurance Matrix was given with facilitation by 360 Assurance. The applicability to the Annual Governance Statement and areas of risk assurance were agreed and would be followed-up by Head of Assurance and Trust Secretary. The Chair Deep offered his support on the Assurance mapping that 360 were doing in relation to Annual Governance Statement.	1 3 18 20

Chair	Darren Hickman