UNCONFIRMED

Leicestershire Partnership NHS
NHS Trust

Trust Board

Minutes of the Meeting held in public on Thursday 28 April 2016, 9.30 am

Guthlaxton Committee Room, County Hall

A

Present: Mrs C Ellis, Chair
Mr D Mell, Non Executive Director
Mr D Hickman, Non Executive Director
Mr C Burns, Non Executive Director
Mrs E Rowbotham, Non Executive Director
Professor J Lindesay, Non Executive Director
Dr P Miller, Chief Executive
Professor A Childs, Chief Nurse/Deputy Chief Executive
Dr P Cross, Director of Finance
Dr S Kumar, Medical Director

In Attendance:
Mr A Duffell, Director of Human Resources and Organisational Development
Ms R Bilsborough, Director, Community Health Services
Ms H Thompson, Director, Families, Young People and Children Services
Ms T Smith, Director, Adult Mental Health/Learning Disability Services
Dr N O'Kelly, Clinical Director (for item TB/16/095.2)
Mrs M Eden, Assistant Trust Secretary

ACTION

TB/16/088 Apologies and welcome

Apologies were received from;
Mr B Patel, Leicester Healthwatch (participating observer)
Mr C Faircliffe, Leicestershire Healthwatch (participating observer)
Mr F Lusk, Trust Secretary

The Chair welcomed; Kamy Basra (Head of Communications), Professor Susan Corr (Head of Research and Development), and Phil Jones (Grant Thornton).

Items 2, 3, 4, 5 and 7 were taken out of the order of the agenda due to technical issues with the patient story video.

TB/16/089 Declarations of interest

The register was updated. In relation to interest in respect of items on the agenda:

Mr Mell declared that he was the Chairman of the Board of the NHS Leicester, Leicestershire and Rutland Facilities Management Collaborative.

ACTION

TB/16/090 Minutes of the previous public meeting, 24 March 2016

Resolved: The minutes of the meeting held on Thursday 24 March 2016 were confirmed.

TB/16/091 Matters arising actions

091.1 Trust Board members reviewed the list of matters arising actions at Paper B, and this commentary would be included in an updated version at the next meeting. The actions highlighted in amber were work in progress and due dates were provided. The remaining actions were 'green' as they were either included on the board agenda or closed.

091.2 Matters arising 615 – review of suicides – Professor Childs noted that the paper from the Medical Director to the Board in March 2016, and the paper later on the agenda regarding Southern Health NHS Foundation Trust, provided the evidence to close this action.

091.3 Matters arising 619 – revisit debate regarding distributed or centralised investigators – Professor Childs confirmed this was part of the Southern Health NHS FT work and a paper would be taken to the Quality Assurance Committee in May 2016.

TB/16/092 Chief Executive's Environmental Scan

Dr Miller presented Paper C, and the following was noted:

- Nationally;
  - Five Year Forward View - Sustainability and Transformation Plans (STPs) were well advanced, referencing the Better Care Together plans already identified in LLR. Further work was required on local workforce actions, the 'prevention' agenda and pathways for integrated care. David Bell (Interim Associate Director of Strategic Planning) attended the appropriate 'planning' Boards to ensure LPT's plans were in line.
  - Industrial action – the Trust has around 90 Junior Doctors; 30 of whom attended work, and 60 went on strike. On behalf of the board, Dr Miller publicly thanked staff who had worked to cover the periods of the strike.
- Regionally;
  - Funding reductions for nurses, and nursing bursaries removed. This would have an impact on flexible funding which supported people undertaking higher qualifications.
- Local Stakeholders;
  - Interserve staff were transferring into UHL.
  - There was a great deal of activity to complete the contracting round. The Heads of Agreement had been signed.
  - NHS England had arranged a panel to review the Pre Consultation Business Case. The consultation was planned for June/July 2016 subject to NHSE feedback.
- Organisational development;
  - Dr Miller thanked Mrs Basra and her team for the very successful

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'Celebrating Excellence' staff awards evening. It showcased much of the excellent work taking place across the Trust.
  - 46 staff were undertaking the 10 Peaks challenge, with a view to raising £5,000 for the Trust's charitable funds.
- Research/Innovation;
  - Dr Miller congratulated the Research Team on their 'outstanding partner contribution' award in the East Midlands.
  - The HR Team, for Centralised Staffing Solutions in partnership with HCL, had been shortlisted for a Health Service Journal value award.
- Service focus;
  - Within Families, Young People and Children's Services (FYPC), there had been further progress to reduce waiting times for Child and Adult Mental Health Services (CAMHS), and more awards and work on Future in Mind.
  - Community Health Services (CHS) had successfully rolled out Intensive Community Support (ICS). This was a huge undertaking and he asked Ms Bilsborough to pass on his thanks to her team.
  - Adult Mental Health/Learning Disability Services (AMH/LD) were moving towards a smoke free inpatient environment which was an important initiative for improving health inequalities for people with mental health problems. The 'My Care My Voice' project in the Learning Disability Service was an inspirational group of people who had received an award at the Celebrating Excellence awards.

Resolved: The Trust Board considered the Chief Executive's report and environmental scan.

TB/16/093 Patient Voice

The board watched a film of Anne talking about her mother's use of the podiatry service. Anne, who suffers from Myalgic Encephalopathy (ME), was the primary carer for her mother, who although suffering with dementia was living in her own home with support from Anne. Anne talked about ways she felt her mother could have been helped as a user of the podiatry service; such as regular appointments for podiatry so it was easier for her to remember, and avoided the lengthy delays of getting an appointment on the telephone. She also described the frustrating delays and difficulties experienced in obtaining orthotics.

Ms Bilsborough acknowledged the unfortunate experiences described by Anne, which had been filmed over a year ago. Since then the service had transformed the way orthotics were produced, largely through the capital purchase of a CAD CAM (computer-aided design and computer-aided manufacturing) which enabled far faster production than the previously handmade orthotics.

Ms Bilsborough referred to the length of time to get through to the service because the telephony was not fit for purpose. The service had now switched to a different phone service which had improved answering times. There was also now more flexibility with their booking system so that in special circumstances people could be offered rapid

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follow up, although this had to be balanced with patient need.

Mrs Rowbotham asked about those who could be offered routine appointments, as it was difficult for patients with dementia to remember they needed a follow up. Ms Bilsborough advised that it would be based on clinical need. There was not functionality on the appointment system previously to do this, but now there was a recall list which under a set of circumstances could be booked in routinely.

Professor Lindesay commented that this demonstrated the importance of having dementia friendly services.

Mr Mell noted that integration of services needed to be a continuous focus. In terms of the services for the lady's mother, he asked where the responsibility for enabling integration lay. Ms Bilsborough advised that for this particular lady, post diagnosis and treatment, her follow up care would be in the community so from a dementia perspective it would be back to the GP until she needed secondary intervention. Progress in this area would be defined within the Sustainability and Transformation Plan (STP).

TB/16/094 Chair's report

The Chair reported on the following:

- Two board visits; to the night nursing team and Hospice at Home. Both were managed by Jo Beeching who had deservedly won the 'exceptional achievement' award at the Celebrating Excellence ceremony. She had demonstrated very impressive compassion and care, not only with the patients but also with the families, and had made a lasting impression on the Chair.
- She had attended meetings in relation to; Better Care Together new models of care which must be submitted in the STP, in June. A launch of 'Future in Mind' where the keynote speaker had been Professor Chris Ham of the Kings' Fund, and there had been a presentation from Ms Thompson's team.
- The staff Celebrating Excellence awards had been a very uplifting experience.
- She had completed the Chief Executive's appraisal, and three of the Non Executive Directors. She would be continuing the round of appraisals, which would also include the Mental Health Act Managers.
- The Chair asked all to note the date of the Trust's Annual General Meeting of Thursday 8 September 2016. The Communications Team would be leading the arrangements for the event.

Mr Burns mentioned that he too had visited the Hospice at Home service and queried the arrangements of the Board Walk programme in relation to resources across the Trust and was concerned about the potential for duplication. The Chair confirmed that it was a personal visit for her and not part of the Board Walk programme.

Strategy

TB/16/095 Better Care Together (BCT)

095.1 Update for Partner Boards

Paper D provided an update for partner boards from the BCT Programme Office. Dr Miller reported that the consultation document was with NHS England. He and several colleagues had participated in a panel meeting to respond to various aspects, and feedback was awaited.

Mr Mell asked how the work around vanguards integrated with the BCT work, and how the place based initiatives and integration came together. Dr Miller reminded the board that vanguards were pilots of new ways of working. In LLR there was only one vanguard and this was around urgent care pathways. There was an upcoming meeting to see how federations could work more closely together and learn from others around the country. The STP, as a more comprehensive wider scoped document, would be the overarching description.

Professor Lindesay queried whether local authority colleagues were fully subscribing to the new models of care. Dr Miller confirmed that there was a commitment within social care locally to work with health on integration, but acknowledged that there was more to do, particularly to understand how far local authority colleagues were prepared to go with integration.

Mr Duffell asked, given the strategic impact of BCT, whether more comprehensive information would be issued for partner boards in future. Dr Miller responded that there would be more information flowing once the consultation commenced. The Partnership Board met in public so there were other ways to obtain further information.

Resolved: The Trust Board reviewed the progress of the BCT programme.

095.2 Workstream – End of Life

Dr O'Kelly gave a presentation to provide an overview of the workstream on end of life care. He provided the national context which was set against the Liverpool Care Pathway, an enquiry by Baroness Neuberger, and a number of national documents including "One Chance to Get it Right" with 5 priorities, and NICE guidance on end of life care in adults.

Dr O'Kelly outlined the main principles from the guidance which centred around holistic, patient centric care, sensitive communication between staff and the dying person, and with the needs of families being respected as far as possible. It was important to consider the patient's quality of life and death, their physical emotional and practical needs,

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provide care that was responsive and timely, and have honest discussions and planning. The NICE document provided guidance on recognising that someone was dying and responding appropriately, prioritising hydration, and emphasising individualised prescribing to avoid undue sedation.

Dr O'Kelly reported on progress to address these principles, and the following was noted:

- He represented LPT on the BCT End of Life workstream and learning lessons to improve health with Dr Kumar. In the last two years within LLR there had been a lot of progress in recognising patients in the last year of life, formation of a unified DNA/CPR approach, care planning, anticipatory medication and education on understanding the 5 priorities for end of life care. The focus in the BCT workstream in 2016/17 would be unified Care Planning involving patients, and provision of appropriately co-ordinated 24/7 care for people at the end of life and those who were important to them.
- Work was being developed on 24 hour access to specialist palliative care. They were working closely with colleagues in LOROS.
- With regard to the ongoing work of the LLR End of Life Board; the Health Needs assessment review was in progress, a unified end of life strategy should be in place in June 2016, and there was work on the summary care record for the Electronic Palliative Care Co-ordination Systems (EPaCCS).
- Dr O'Kelly chaired the Trust's End of Life Group with membership from all directorates. The group focussed on addressing concerns from the CQC review, training and education, the Trust's alignment with the LLR end of life strategy, and oversight of the action plan.
- He outlined in the presentation the progress being made within the services. In Community Health Services (CHS) more than 500 clinicians had been trained on the documentation related to Last days of life and DNA-CPR. This needed more traction so champions would be used across all directorates to cascade this training. A great deal of work was being undertaken on hospice at home care plans, and on website documentation. The mortality and morbidity reviews were discussed at the senior team meetings. Clinical supervision arrangements had been improved. They were working closely with LOROS to develop new ways to work together.
- In Families, Young People and Children's Services (FYPC) the Diana Service was an important resource for providing palliative care for children which was well aligned to the Rainbows hospice. The service provided annual training sessions for staff.
- Within AMH most end of life care was supported by the CHS palliative care service when required. They were looking to extend the mortality and morbidity process across the board.

Professor Lindesay asked whether this work extended into care homes. Dr O'Kelly advised that the hospice at home staff would visit care homes so they were very much involved. There was also the outreach care homes project in MHSOP. The mortality and morbidity process

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would also eventually be extended to other care sites. Dr Kumar added that person centred end of life care plans were fundamental to this.

Mr Mell noted that often a patient moved between care and his experience was that each time, it was a different GP depending on the locality of the care. This involved a repetition of the details each time so people moving and care plans being accessible was very important. Dr O'Kelly agreed that key to making sure this information was available to all was the work in the LLR End of Life board on the EPaCCS process.

Dr Miller congratulated Dr O'Kelly on the progress made and asked what his key priority was to make a difference over the next 6 months. Dr O'Kelly responded that he wanted to see progress on care planning and application of the EPaCCS process. He was frustrated about the lack of progress on the latter, when other areas had been successful in implementing it.

The Chair thanked Dr O'Kelly for his comprehensive presentation, and he left the meeting.

Resolved: The Trust Board noted the progress being made as part of Better Care Together.

TB/16/096 Five Year Forward View for Mental Health

Dr Kumar presented Paper E which was a summary of the five year strategy for mental health based on the Five Year Forward View. There were two related publications; the Royal College of Psychiatrists' independent report on acute adult psychiatric care "old problems, new solutions", and a Kings Fund document on physical and mental health care integration.

Dr Kumar advised that by summer guidance was expected to be published on how this was governed nationally, how services would be held accountable, and how it would be monitored. There would also be the appointment of a national equality champion.

Dr Kumar highlighted that the full report contained 58 recommendations and these were clustered into 6 themes; commissioning for prevention and quality care, care over 7 days a week (6 of those within that broad title), innovation and research, transparency and data revolution, changes in the payment system for mental health funding, regulations and inspections and how the CQC will change how it inspects the NHS.

Dr Kumar reported that he had received helpful input from the three operational services and Paper J provided a snapshot of some of those developments. They were included to stimulate thoughts and discussions. In terms of the recommendations Dr Kumar highlighted three areas;

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- The STP was expected to play an important part in how this strategy was taken forward. The acute mental health pathway was identified as a priority and when developing the STP it was important that this emphasis was reflected.
- Mapping of service areas to identify what was currently available, what was being developed, and what was required to fit the strategy.
- The broader questions about innovation around integration of physical and mental health care, and keeping integration as a focus when looking at any service changes/developments.

The Chair commented that it would be helpful for the board to spend more time in the future to brain storm Dr Kumar's final point, particularly when the STP was more defined. **SK**

Professor Lindesay noted that there had been many mental health strategies which often failed due to funding. He asked whether there were elements of this strategy that could be achieved locally that may not require financial input. Dr Kumar advised there were a number of strands, collectively using the STP and BCT, to take action forward. There was also the broader work on prevention. Working with the three service directorates and the STP he anticipated improved pace of action on integrated physical and mental health care. Dr Miller added that acute care colleagues needed to be encouraged in this endeavour.

Dr Miller commented that the detail within the report needed to be cross referenced to LPT's strategies to ensure alignment. There was a section about health and wellbeing and staff, and the Trust could contribute to the prevention of mental health problems by being a great employer.

Mr Burns asked if it would be helpful to draw together all the plans associated with the local and national initiatives into one plan for LPT. Dr Miller advised that by discussing them at the board, it ensured an awareness of the cross referencing of the plans. Dr Kumar noted that the annual plan contained a number of these themes and it was important to keep them within the framework of the strategy to monitor their progress and delivery.

Resolved: The Trust Board considered this strategy in the context of the NHS Five Year Forward View and the emerging new organisational forms to explore opportunities for prevention as well as integration of mental and physical health care.

TB/16/097 Quality strategy review update

Professor Childs presented Paper F, which updated the board on the current position with regard to the revision of the Trust Quality Strategy 2013-2016 which had been approved in October 2013.

Professor Childs reported that a Listening into Action (LiA) style event had been held. Those attending had reviewed the current LPT quality

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pillars against those of the CQC. The consensus was that staff wanted to keep the Trust pillars but with slight changes. They felt 'regulation' should be removed as it underpinned everything else, not just the CQC but also the Mental Health Act, Mental Capacity Act, and Deprivation of Liberty. So when looking at safe and effective care, it should consider all of these issues, and rather than 'patient experience' it would be 'patient centred care'.

Professor Childs advised that the reviewed quality pillars would be used to define the strategy as a Quality Improvement Strategy. The document would also be aligned to the Quality Account, 5 year plan and annual plan. It was due to be presented to the Quality Assurance Committee in June 2016.

Dr Miller asked if the strategy captured the Trust's commitment to quality improvement. Professor Childs responded that the content would reflect the revised title of Quality Improvement Strategy

Ms Bilsborough highlighted the importance of communicating to staff and raising awareness about the strategy. Professor Childs agreed, and advised that once approved at QAC, advice would be sought from the Communications Team about how to raise the profile of the strategy both internally and externally.

The Chair noted that when looking at the LPT pillars compared to the CQC 5 domains she could see that they matched across, with the exception of well led and she asked for this to be taken into account. **AC**

Resolved: The Trust Board received assurance on the work being undertaken to develop a meaningful quality framework and note that this would be presented to the Quality Assurance Group in June 2016.

TB/16/098 Dementia ward environment improvements fund raising campaign – Evington Centre

When presenting Paper G, Ms Bilsborough asked the board to watch a short film which gave a virtual tour of the ward environments at the Evington Centre and highlighted the issues caused by the current design and an outline of improvements.

Ms Bilsborough assured the board that the wards met statutory requirements but there were significant improvements that could be made for the benefit of the people cared for there with advanced dementia. The intention was to start a major fund raising campaign.

Ms Bilsborough advised the board that a bid for charitable funds had been approved some time ago to make some environmental improvements but it became clear that there were many other elements that needed to be included so it was difficult to spend the money on the original plans. She was seeking support to spend a component

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(£50,000) of the original commitment on developing a fund raising case and brochure to launch a major fund raising campaign. The detail of this was within the paper circulated in the board information pack.

The Chair confirmed that this had been debated at the Charitable Funds Committee where it had been agreed that it would be supportive of a major campaign. The Standing Financial Instructions required board approval to expenditure of £50,000 and above.

Mr Burns queried what happened if charitable funds were granted but not spent, and how long the money was earmarked for specific schemes if it was not spent. Dr Cross advised that the money remained within charitable funds until it was spent. The Charitable Funds Committee received regular update reports on expenditure against schemes, and payment was made against invoices. There was no definitive expiry dates for schemes, but through the progress reports the committee was able to understand the reasons if money had not been spent. Ms Bilsborough confirmed that a pause period had been requested for the scheme when it was originally identified that it would be difficult to spend the money on the original plans.

Mr Burns asked whether £50,000 was appropriate, what would happen to the remainder of the original component of the fund, and what the target was for the fund raising campaign. Ms Bilsborough advised that in a paper to the Charitable Funds Committee, included in the board information pack, there was a recommendation that upon launching the campaign the team would go back to the committee to request the use of the outstanding amount as a contribution towards the fund raising. In terms of a target, this would be clearer once the architects had developed the fund raising case. Estates colleagues had worked with the team to secure bids to carry out this work and the cost was identified as £50,000.

Professor Childs stated that he was very supportive of this work which he believed was the future of dementia care. Whilst not explicit in the rationale, some clinical practice challenges could be addressed through this project.

Mr Hickman sought assurance that appropriate guidelines were being followed, and also asked whether the campaign needed to raise all the funds before work could commence. Ms Bilsborough advised that the case would be constructed in phases so that it was possible to see improvements along the way. The architects had experience of running projects alongside fund raising. The Chair confirmed that this was the first major campaign in the Trust. The Charity Commission had established guidelines for fund raising and these would be complied with.

Resolved: The Trust Board approved the use of a component (£50,000) of the 'Lighting up our lives – a place to be ourselves' charitable funds allocation to pay for an architectural design

ACTION

study.

Performance and assurance reports

TB/16/099 Highlight report from Quality Assurance Committee (QAC)

Professor Lindesay reported on issues raised in the QAC meeting on 19 April 2016 which he had chaired in Mrs Rowbotham's absence.

- Following the progress made on actions to reduce cancellations and DNA rates in AMH outpatient clinics, QAC had agreed to de-escalate reporting, but with a request to see learning from this across the services.
- QAC had received the report on mortality governance and Southern Health NHS FT.
- The committee had reviewed a number of risks and requested some further work.

Mr Mell felt that the wording in the highlight report relating to the embeddedness of learning from SIs did not accurately reflect the action agreed. Professor Childs confirmed that his understanding was that he would explore this further for the committee and return with action to be taken in the future.

Mr Burns sought clarification on the timetable for the Quality Accounts to be approved. Professor Childs advised that a draft was included on the confidential agenda, and the intention was to review progress at the Extraordinary Trust Board meeting on 27 May.

Mr Burns queried whether QAC should consider self-regulation as a standing agenda item. Mrs Rowbotham confirmed that she had updated the board last month that QAC had considered the roll out in some detail in March and the first report was due back at the end of the first quarter.

Resolved: The Trust Board received assurance on the issues raised in the Quality Assurance Committee of 19 April 2016.

TB/16/100 Quality Monitoring Report – Serious Incidents (SIs)

Professor Childs presented Paper I, which provided a summary of the Trust's performance against key targets for the reporting and management of SIs. A thematic analysis was provided, with the key lessons learnt and action taken in response to mitigate risk. Statistical Process Control Charts (SPC) in the report were used to depict incident trends. He highlighted the following:

- There was a reduction in the number of SIs in March to 4. However this was set against an increase in the number of internal investigations into incidents that would have been reported previously.
- Reporting targets had been achieved over the month.

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- Preliminary data on the number of incidents placed the Trust in the top quartile, as compared to 2013 when the Trust was in the bottom quartile.

Mrs Rowbotham noted that QAC had requested detail to be included in the report on the rationale for investigation reports not signed off by commissioners, to identify if there were any trends. Professor Childs confirmed that this work was being undertaken but was not yet complete to enable the information to be included in this month's report.

Resolved: The Trust Board received assurance that the Trust had robust systems and processes in place to learn from adverse events and ensure that serious incidents were being managed effectively and in accordance with both the Trust and Commissioner incident reporting policies.

TB/16/101 Research and Development strategy quarterly update

Dr Kumar highlighted changes in the structure of the quarterly update report at Paper J which took into account feedback received. Evidence and examples were given as a marker of progress against each of the four goals; high quality research, building research capacity, embedding a research culture, and building a reputation of excellence.

Dr Miller referred to goal one and successful grants, and asked if there was an ambition attached to the number of bid submissions. Dr Kumar responded that the emphasis was on submitting as many applications as possible, particularly as the number of clinical academics was small. Rather than have a target, he suggested it would be better to create as many opportunities as possible to bid and then learn lessons about why they were not successful.

The Chair noted that charitable funds had been granted to support R&D activity. Professor Corr confirmed that interviews were being held shortly, and she would report back to the Charitable Funds Committee.

Resolved: The Trust Board received assurance on the progress against the R&D strategy goals and objectives for the period January to March 2016.

TB/16/102 Southern Health NHS Foundation Trust update, incorporating review and proposals for a mortality governance framework

Professor Childs reminded board members of a previous paper in January 2016 summarising the main findings of the Mazar's report into Southern Health FT, and comparing existing processes within LPT. It had been agreed that the board would be provided with further information about how some of the issues in the SHFT report could be addressed and around the work on suicide prevention being conducted by Dr Kumar.

ACTION

Professor Childs advised that the main issues in the Mazar's report related to mortality data capture, incident data, serious incidents, and board oversight and leadership. Paper K drew together an action plan and identified a mortality governance framework for the organisation to address some of the recommendations. Mortality reviews were already evident within CHS and the plan was to roll out this model across the organisation. Dr Kumar would chair a Mortality Surveillance Group which would report to the board. This was the first mortality governance framework for a combined mental health and community health organisation, and would therefore develop over time.

The aim was to report every death of someone who had used the Trust's services through the SI process. However, there were concerns locally and nationally around how an organisation could capture all deaths, and particularly how they would be appropriately investigated if the patient had been using other services. This was being discussed with commissioners.

Mrs Rowbotham asked when the board and QAC would start to see reports back from the Mortality Surveillance Group. Professor Childs advised that the group was unlikely to meet more than 4 times a year and due to the availability of data the first report was likely to be for the end of quarter 3 and subsequently reported on a 6 monthly basis. **AC**

Mr Hickman noted that one of recommendations was that the Trust Board should be sighted on numbers. He asked if it would be possible to receive the data before the timescale of the report. Professor Childs advised that at this point it was not possible to identify the deaths of everyone receiving services from LPT. The mechanism for establishing this process needed to be actioned first and this would be the focus in quarter 1. Mr Mell observed that there were external agencies which would have access to information about the deceased.

Dr Kumar advised that he had been signposted by the Trust Development Authority to other organisations who were dealing with the same issues as LPT. He had also communicated with colleagues in other mental health and community Trusts to try and make progress.

Ms Thompson highlighted that one of the processes in the Trust's mortality governance framework was to use the Child Death Overview Panels (CDOP) for every child's death under the age of 18.

Resolved: The Trust Board supported the action plan and the proposals for a mortality governance framework.

TB/16/103 Finance and Performance Committee (FPC) highlight report

The Chair presented Paper L from the FPC held on 19 April 2016. Dr Cross would expand on the year end position and contract in the next agenda item.

ACTION

The Chair highlighted that from month 1 onwards FPC would be receiving reports on the financial position from each of the service directors to identify issues and mitigations.

Resolved: The Trust Board received assurance on the issues raised in the Finance and Performance Committee of 19 April 2016.

TB/16/104 Finance Monthly Report

Dr Cross introduced Paper M which was in a different format due to the year-end process with tight timescales to adhere to, and provided a summary of the draft financial accounts. The previous position had been reported to FPC but there had been some movements. There had also been the opportunity for Audit and Assurance Committee members to review the detail.

Key points to note were:

- The Trust had achieved all statutory financial duties. This was a positive message and staff across the Trust should be credited for delivering this outcome in very challenging circumstances.
- A provisional surplus of £1.36m had been achieved. Whilst the NHS Improvement stretch target had not been reached, LPT was one of the best financially performing Trusts across the country. The detail of the year-end pressures and benefits would be reported to the board in the confidential meeting.
- The closing cash position was lower than plan at £7.2m.
- Capital expenditure was within the Capital Resource Limit agreed with the TDA.
- The Trust achieved 2 of the 4 Better Payment Practice Code targets which were secondary targets.

Dr Miller congratulated everyone for meeting the statutory duties and original financial plan. He noted that the closing cash balance was worsening each year. Dr Cross advised that part of the reason was due to investment in the capital programme. He agreed that cash reduction year on year would become increasingly challenging.

The Chair thanked Dr Cross and his team for achieving the year end deadlines for the accounts.

Resolved: The Trust Board reviewed the summary of draft financial accounts.

TB/16/105 Delivering our Strategic Initiatives 2015/16, quarter 4

Dr Cross presented Paper N which provided the outturn against the strategic plan, and showed how the Trust was performing against key milestones. Of the 18 strategic initiatives, 87% of the work had been achieved and the paper explored the reasons for shortfalls. It was

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acknowledged that there were some areas where action should have been more timely. There were those that did not align well to the annual plan and Mr Bell (Associate Director of Strategic Planning) would be reviewing these.

Mrs Rowbotham asked about the financial penalties for non achievement of CQUINS. Professor Childs advised that whilst there had been a provision in the accounts for this, the final position was not yet known and would be communicated once confirmed. **AC**

Resolved: The Trust Board received assurance on the outturn against plan, any reasons for not being able to complete certain actions by the end of the year, and any associated risk.

TB/16/106 Integrated Quality and Performance monthly report

Paper O provided an integrated quality and performance dashboard showing levels of compliance with the Monitor Risk Assessment Framework and Care Quality Commission registration. It also provided exception reports on areas requiring escalation, and dashboard analyses on specific areas of quality and performance, including financial and workforce information. The report format had received further refinement to align the KPIs against the Trust governance groups and the Corporate Risk Register with greater clarity. The quality, financial and performance aspects had been discussed at QAC and FPC and identified in their highlight reports.

Professor Childs highlighted the following points:

- Delayed Transfers of Care (DToC) for mental health patients was at 8.1%. This was a system issue and each case had now been validated. One case, which was still being reviewed, was in excess of 100 days which explained the current high figure.
- Data quality issues attributing to the challenges with the Mental Health Delayed Transfers of Care (DToC) in the Minimum Data Set were now understood and were being addressed. This should show improvements from June.
- The number of Clostridium Difficile (C Diff) cases for 2015/16 was 12 against a year-end target set by the commissioners of 7. Action plans had been reviewed at QAC and were also being scrutinised externally.
- QAC agreed to de-escalate reporting on CPA 7 day follow-up and 12 month reviews, as targets were now being consistently achieved.

The Chair highlighted that the FPC agenda included a focus on all waiting times. There was a great deal of work on data validation that various teams were running. Additional columns were included against the figures in the IQPR around information governance assurance which was part of the DQIP work and each area was RAG rated to indicate progress. She noted that there were some 52 week waiters appearing. Continuous data cleansing was required.

ACTION

The Chair congratulated those staff who had worked hard to deliver a turn around in performance for mandatory training and appraisals.

Dr Miller complimented staff on the stepped change in some areas of performance. The work on waiting time compliance needed to continue with commissioners, particularly in those areas outwith the Trust's control.

Resolved: The Trust Board;

- **Received assurance that the integrity of the data included in the report was being reviewed as part of the Trust-wide Data Quality Improvement Plan (DQIP);**
- **Received assurance with regard to areas of quality and performance where performance improvement action was being undertaken.**

Compliance reports

TB/16/107 Safer staffing – monthly report

Professor Childs presented the monthly report at Paper P to provide assurance to the board on the Trust's response to the National Quality Board (NQB) safer staffing guidance. This report confirmed the board's responsibilities and provided a summary analysis of the March 2016 Safer Staffing data. It detailed recruitment work plans and mitigations where there were staffing issues.

Professor Childs highlighted the hot spots as follows:

- Community Health Services (CHS) – the staffing situation at Rutland Hospital was steadier. St Luke's wards 1 and 3 were hot spot areas.
- Families, Young People and Children (FYPC) – Langley Ward had met the requirements but through the use of temporary staffing. Ward 3 at Coalville was still using temporary staff but vacancy levels had improved. There remained some temporary staffing in the event that a pod at the Agnes Unit was required.
- Adult Mental Health – staffing across all the wards at the Bradgate Unit remained a challenge. Safer staffing requirements were being met but through use of temporary staff. The Head of Nursing was undertaking a review with the team to look at skill and professional mix and new ways of working.

Professor Childs reported that a staffing review had been undertaken by the lead nurses in FYPC. This was being considered and he also expected a similar review from AMH by the end of May. These reviews took a similar form to those undertaken in CHS which the board had considered previously.

A new Executive Director of Nursing had been appointed to NHS Improvement and Professor Childs believed that she was discussing the possibility of safer staffing levels being determined at local level.

ACTION

However this was unlikely to remove commissioners or NHSI scrutiny.

Professor Childs advised that one of the board's matters arising actions was to include trend analysis in the report. This was complex and was not yet at a point that was meaningful.

Professor Childs reminded the board that he had previously outlined a new methodology which involved the collection of contact care hours per patient. This would go live in June, for May data, but only for acute Trusts. However, this would be helpful to replicate in LPT in order to support a national benchmark of how many care hours a patient receives, as this information was not currently available. This may mean that the safer staffing report would change.

Ms Bilsborough highlighted that in relation to the work that CHS had undertaken on safer staffing, which had previously been reported to the board, they had secured £1.6m of the £2.6m requested. This would support staffing levels on the stroke units and MHSOP but there remained a residual concern for the physical health wards.

Mr Mell noted Professor Childs' comments about including trend information. Without this information it was difficult to see whether the situation had improved or deteriorated. Professor Childs advised that some areas had improved, for example in CHS where there had been successful recruitment, although St Luke's was always difficult to recruit to. Across the Bradgate Unit wards it was worse. This was likely to be due to seasonal issues linked to when potential candidates graduated and was a national challenge.

In response to Mr Mell's query about which forum would be considering what next steps to take, Professor Childs advised that there were several strands of work. There was the new roles group, and AMH were reviewing skill/professional mix. This would be taken to the Strategic Workforce Group. Mr Duffell confirmed that there was an ongoing list of actions and work, this included a big recruitment event on 10 May.

Resolved: The Trust Board;

- **Received this report on the current Trust position with regard to the National Quality Board Safer Staffing requirements.**
- **Received assurance that all efforts were being employed to ensure the highest level of data quality possible, with detailed internal oversight and scrutiny in place over both completion and performance.**

TB/16/108 Care Quality Commission (CQC) action plan update

Professor Childs advised that Paper Q had been discussed at QAC and the Compliance Assurance (CompAss) task and finish group. This month there had also been oversight meetings with NHS Improvement and the commissioners, and last week with the Care Quality

ACTION

Commission. There had been progress and positive movement on the action plan with one red action remaining. This referred to the DNA CPR policy which was rated red as having missed the target date, and this was due to QAC.

Mrs Rowbotham had attended the last CompAss meeting and commented that there was rigour in ensuring evidence was available before upgrading any RAG rated actions.

Resolved: The Trust Board received the update.

TB/16/109 Review of Risk

Dr Miller confirmed that the risks had been discussed at the Executive Team earlier in the week and there were some changes to the items on Paper R. The discussions at board reflected the risks identified.

Mr Hickman commented that the summary showed high risks associated with finance, and yet Dr Cross had reported upon a favourable outturn. The board had discussed a number of workforce risks, and these were fragmented around the risk register. He asked if these should be consolidated into a summary workforce risk in the same way as the finance risks, and be of similar standing.

Dr Miller advised that the Executive Team had discussed a similar theme.

Mr Mell commented that if the workforce risks were aggregated, as with finance, there would be equal top risks which may not help in their resolution. It was agreed that this would return to the Executive Team to take a view on whether the risks should be combined. **AC**

Mr Burns noted that there were changes to some of the top risks and asked what these were. Dr Cross advised that BAF/2/640, related to market share, had increased as there was a significant tender in the pipeline for 0-19 services. Mr Duffell explained that the risk of being unable to recruit adequate staff, at BAF/4/1036, had increased as despite actions there was no evidence that there had been a reduction in vacancies, and in addition there were additional staff to recruit as a result of ICS and BCT.

Resolved: The Trust Board reviewed the summary Corporate Risk Register/Board Assurance Framework and top 5 risks.

TB/16/110 Receipt of documents for information

Resolved: The Trust Board confirmed receipt of;

- **Dementia ward environment improvements fund raising campaign – additional detail for Paper G**
- **Documents signed under seal, quarter 4**

ACTION

TB/16/111 Any other Business

None.

TB/16/112 Public questions on agenda items

112.1 Mrs McCarthy commented that Dr O'Kelly's presentation regarding end of life care had been very helpful, particularly in relation to her role as Interim Head of Department of Spiritual and Pastoral Care/Volunteer Service and the part these staff could play in patient's last days.

TB/16/113 Date of next meeting

The next public meeting would be held at 10.30 am on Friday 27 May 2016, in the Framland Committee Room at County Hall, Glenfield.

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Leicestershire Partnership NHS
NHS Trust

B

TRUST BOARD –27 MAY 2016

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)
617	January TB/16/022	Safer Staffing report – include trends	Adrian Childs	Ongoing	Head of Information is reviewing appropriateness of trend analysis against the data that is submitted to the national portal. April TB/16/107 "This was complex and was not yet at a point that was meaningful."
619	January TB/16/024	Add an action to revisit debate around distributed or centralised investigators	Adrian Childs	June 2016	For QAC agenda June 2016
629	February TB/16/041	Report to the board on the Care Quality Commission Safeguarding visit to the city	Adrian Childs	July 2016	Not yet received Deferred to July agenda
649	April TB/16/096	5YFV for mental health – developmental time on brain storming about how to be innovative around integration of physical and mental health care	Satheesh Kumar	Ongoing	Added to Board Development programme
651	April TB/16/102	Mortality Surveillance Group reports - first report likely to be for end of Q3 and subsequently reported on a	Adrian Childs	January 2017	(no Trust Board in December)

Action No	Meeting month and minute ref	Action/issue	Lead Officer	Due date	Outcome/evidence (actions are not considered complete without evidence)
		6 monthly basis.			
652	April TB/16/105	Confirm final outcome with regard to achievement of CQUINs	Adrian Childs	July 2016	Not yet confirmed by commissioners, however the anticipated outcome is that three have not been fully achieved (CAMHS standards, dementia and CHC)
653	April TB/16/109	Discuss in Executive Team whether top workforce risks should be aggregated (as with finance risks)	Adrian Childs	June 2016	To be discussed at Executive Team
650	April TB/16/097	Quality pillars – ensure the CQC 'well led' pillar is mapped into LPT quality pillars	Adrian Childs	June 2016	Quality strategy to go to QAC in June, mapping has taken place and will be highlighted in the strategy

May 2016 ENVIRONMENTAL SCAN

C

National

- Five Year Future View - sustainability and transformation plans – June 2016 – link to workforce
- Agency pay cap extended – focus on delivery
- 'Learning from mistakes' league published – LPT 'good' – 97/230
- Industrial action for junior doctors – new negotiations
- Carter review – re-energised

Board – Board of Directors

- Board development – focus on development of well led framework

Regional

- Quality Surveillance Group – enhanced rating – CQC/staffing
- Local Education and Training Board – focus on quality of training experience, governance development, 16/17 workforce plans. Implications of funding reductions
- LETC – developing our workforce locally to meet BCT challenge – implementation phase of workforce strategy – development of LETC into LWAB (workforce action board) to support STP.
- Meeting of EM CEOs 20/5/16

Organisational Development

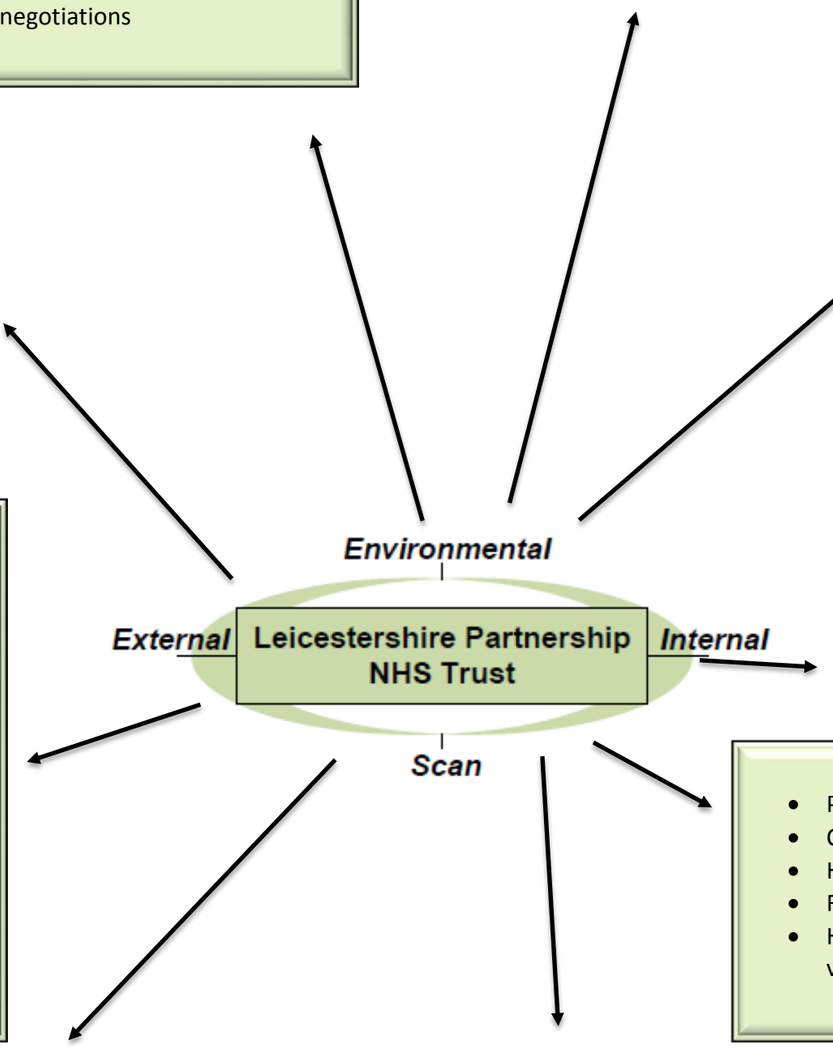
- Organisational response to CQC report – prep for new visit
- LiA – wave 5 teams moving forward – big conversations happening.
- Valued star awards - Chris Knight – primary care coordinator at Glenfield
- 2015 staff survey – improved results – more to do
- Leading together group 12/5/16 – 'Change' led by the 2 Helens, Thompson and Bevan
- 10 peaks challenge completed - £5000+ raised –
- global corporate challenge – 25 may – 92 teams of 7 registered – health and wellbeing.
- Leading differently programme launched
- Celebration of international nurses day

Local Stakeholders

- Chief Officers meeting – focus on Better Care Together, Urgent Care,
- System resilience, focus of treatment times, access to mental health, urgent care
- Better Care Together Board development – place based systems of care
- Urgent care delivery board – continued pressure on volumes of emergency admission – focus on quality and ambulance handovers
- Contract negotiations finalised
- Mobilisation of Interserve handover
- NHS England panel reviews BCT programme – 18/4/16
    - More work on capacity, sustainability

Divisional Focus: FYPC

- Care Navigation LiA Event – 18/05/16
- CAMHS Access Team business case finalised
- 0-19 tender preparation progressing
- CAMHS EPR (SystmOne) went live on 4th May



Divisional Focus: CHS

- Phase 2 ICS roll out complete (additional 130 home based beds)
- Community Therapy Patient Tracking List (PTL) process commenced in May
- Health and wellbeing centre at Hood park, Ashby opens
- Flexible CHS bed management plan being negotiated with CCGs
- Healthwatch release positive report on Coalville Community Hospital following visit

EM Research/Innovation

- CRN partnership group – CEO chairs – focus on recruiting to time and target – industry research
- National Institute for Health research Advisory Board - NIHR@10 – 18/5/16
- LPT research team, shortlisted for research team of the year

Divisional Focus: AMH/LD

- CQC follow up visit to HMP Leicester final report received, very positive feedback and the 2 requirement notices issued in Oct 15 have been lifted.
- First cohort of Leading Differently Programme commenced – early feedback very positive
- Relocation of LD services from Mansion House – aim is to transfer by the end of May
- Second RUOK partnership event on May 21st with activity at two sites: Leicester clock tower and the Haymarket shopping centre
- Celebration event for the My Care, My Voice project on 25th May
- Currently experiencing a surge in demand on the AMH Acute Care Pathway

Dr Peter Miller
Chief Executive

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'It's about our life, our health, our care, our family and our community'

Better care together

Leicester, Leicestershire & Rutland health and social care

D

Update for Partner Boards

Status Report

May 2016

Rutland County Council

Leicester City Council

Leicestershire County Council

NHS

Better care together
Leicester, Leicestershire & Rutland health and social care

Progress Report

Delivery plans 2016 – 18: All work-streams have submitted delivery plans for 2016 – 2018 and these are presently undergoing a "review and challenge" process to ensure they are clear and ambitious as well as remaining in line with the BCT and LLR system strategic objectives agreed in 2014. A number of work-streams can demonstrate they have achieved the plans outlined in the Strategic Outline Case, while others will need to increase their contribution to the delivery of BCT as a whole. In order to support a drive for delivery in 2016 – 2018 the delivery board Terms of Reference have been updated and it will focus on holding the system and work-streams to account for delivering against agreed plans.

Preparation for Public Consultation: An NHS England reconfiguration assurance panel took place in April and for the majority of the Department of Health's and best practice tests the programme was found to have nearly passed the test with a few outstanding documents that the panel require submitted. The areas of describing capacity changes and reaching financial balance need a little more work and are the focus activity for May. These activities are also required as part of the development of the Sustainability and Transformation Plan (STP)

Clinical Leadership: In line with its Terms of Reference the Clinical Leadership Group (CLG) has appointed a new chair. The group felt that to support system leadership thinking a joint chair should be created and the role will be shared between Satheesh Kumar of LPT and Mayur Lakhani of West Leicestershire CCG.

LLR New Models of Care event. The New Models of Care event in April was very well attended and actions will be taken forward partly bye the CLG and partly by Chief Officers.

PPI Chair: The BCT patient and public group has recruited a new chair, Evan Rees. Evan has both CCG and Healthwatch experience that will be valuable in the coming months

Communications Concordat: NHS England have suggested that the system would be advised to have a communications concordat in place during public consultation. Chief officers have agreed in principle and the detail is being developed by the communications group.

Better care together
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Supporting information

Top Two Risks and Issues

Risk or Issue	Update	Status (pre-action)
Demand Risk: There is a risk that changes to models of care and/or population changes create an increase in demand for services and the target shift of services can not be achieved	System capacity plans and the consequential financial impact are being revise d for a discussion with Chief Officers on the 25th of May. This will indicate the degree of shift and the financial challenge if any	Red
Reputational Risk: Engagement. There is a risk that staff, patients and the public fail to be consistently engaged with the programme and understand its vision and value	Engagement via work-streams continues. The programme overall is developing a number of "Information Packs" to may key messages and information more accessible to stakeholders and the public. Consultation document will be updated in line with governing body feedback	Amber

Key Programme Milestones

Milestone	Target Date	RAG
Financial position updated following issue of planning assumptions in mid January	End Jan 2016	Red Expected May 2016
NHSE assurance of final PCBC	Mid-April 2016	Green
Respond to NHS E assurance remaining queries	May – June 2016	Green
Submit Sustainability and Transformation Plan	June 2016	Green
Complete 2016-18 plan "review and challenge " process and finalise plan	June 2016	Green
NHSE and NHSI agreement to proceed to consultation	Summer 2016	Not started
Formal consultation	Summer 2016	Not started

Rutland County Council · Leicester City Council · Leicestershire County Council · NHS

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Leicestershire Partnership NHS
NHS Trust

REPORT TO THE TRUST BOARD - 27 MAY 2016		E
Title	People Strategy (Draft Version 3.3)	

Executive summary

The People Strategy exists to help improve the quality of care delivered to patients by ensuring that our workforce has the right numbers, skills, values, roles and behaviours to meet the needs of tomorrow.

Recognising this, the key workforce priorities facing the Trust are currently in relation to recruitment/vacancies, staff engagement/satisfaction (linked to the National Staff Survey), compliance with essential skills, increased use and cost of agency use and effective leadership. All of these areas are reflected within the existing BAF risks.

In addition to the priorities highlighted above, it is important to incorporate the wider national drivers, which can be summarised as:

- Workforce supply & demand
- Effective leadership
- Cost effective and appropriate use of agency staff
- Productivity improvements
- Staff engagement, involvement & satisfaction
- New roles with a focus on the apprentice role
- Culture of openness
- Impact of an ageing workforce

Taking into consideration national drivers alongside the Trust strategic objectives and other internal factors, such as the national staff survey, the 5 strategic aims of this strategy are described as follows:

- ❖ Provide a workforce that is flexible, efficient and at the right capacity, to meet the changing needs of the organisation
- ❖ Ensure the Trust has a diverse, skilled and capable workforce
- ❖ Develop a culture where the workforce is engaged, committed and supported
- ❖ Ensure the application of high quality management & leadership practices and behaviours
- ❖ Create a culture & environment that empowers & enables staff to improve the services we provide

To achieved these aims, it is intended that the high level objectives will fall into one or more of 5 key themes of work; ***Attraction & Retention***, ***Growth & Development***, ***Leadership***, ***Empowerment & Openness*** and ***Productivity***. In focusing on these areas, in CQC terms, this could be viewed as a focus on the *Effective*, *Responsive* & *Well Led* domains, whereas the previous HR & OD strategy could be viewed as a focus on the *Safe* and *Effective* domains.

A number of high level objectives have been outlined to support the delivery of this strategy and each will require more detailed project and/or business plans. It is also important to recognise that the delivery of this strategy would not sit wholly within the HR & OD directorate, as it will require wider corporate and organisational engagement to achieve.
Recommendation
The Trust Board is recommended to: • Support the overall direction of travel for the People Strategy • Support the strategic aims within the strategy • Support the central work themes within the strategy

Related Trust objectives	*Staff* – Staff will be proud to work here and we will attract and retain the best people
Risk and assurance	• BAF 1036 - Without recruiting adequate staff we may be unable to run safe and efficient services as our services transform. • BAF 1037 - Without effectively engaging and supporting our staff we may be unable to deliver high quality services and support transformational change. • BAF 366 - If we do not meet mandatory training compliance rates there may be an adverse impact on care delivery. • BAF 1038 - Inability to create high quality management and leadership capabilities may impact on the delivery of efficient and effective services.
Legal implications/ regulatory requirements	N/A
Presenting Director	Alan Duffell – Director of HR & OD
Author(s)	Alan Duffell – Director of HR & OD
*Disclaimer: This report is submitted to the Trust Board for amendment or approval as appropriate. It should not be regarded or published as Trust Policy until it is formally agreed at the Board meeting, which the press and public are entitled to attend.	

Leicestershire Partnership NHS Trust

People Strategy (Draft)

2016/17 – 2018/19

May 2016

1. Executive Summary

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2. Introduction/Background

The previous HR & OD Strategy was established to run from 2013/14 to 2015/16 and focused around 6 key work streams:

1. Leadership

2. Staff Engagement
3. Learning & Development
4. Employment & Recruitment
5. Health & Wellbeing
6. Technology

Although there was a developmental aspect within this strategy, the underlining focus was a need to address a number of operational/process issues alongside this. Some of these included:

- E-rostering
- Improved recruitment processes
- E-pay
- Consistent & coordinated operational HR processes
- Electronic appraisal and Learning Management System
- Mandatory training
- Equalities
- Improved leadership offer
- Policy changes
- Workforce planning, reporting and metrics

As we move into 2016/17, there is a need to develop a revised strategy to focus on the new workforce challenges faced by the Trust, as well as incorporate a more people/organisational development approach. However, it is still recognised that some of the areas within the previous strategy will still require further work to enhance/improve those areas and as such may be incorporated within the high level objectives and/or underpin the delivery of this People Strategy. In CQC terms, these underpinning foundations could be viewed as being *Safe and Effective*.

3. Why Have a Strategy?

The People Strategy is exists to help improve the quality of care delivered to patients by ensuring that our workforce has the right numbers, skills, values, roles and behaviours to meet the needs of tomorrow.

When considering the question as to *why* we require a People Strategy, it is also important to recognise that our staff are not only the largest single cost within the organisation, but of greater importance is to recognise that it is people within the organisation that will enable us to deliver high quality care and achieve the Trust vision and strategic objectives. Given this, in developing the strategy it is also important to acknowledge three key principles:

- Our staff are the single most determinant factor in relation to the quality of care we provide
- Our staff can be the most effective early warning system to safety and poor quality of care
- To perform at their best, our staff need support and the right environment

In accepting this, it is important to have in a place a strategy that focuses on the wider aspects of our workforce and describe the key areas of focus for the Trust.

4. Purpose

The purpose of this strategy is to outline the direction of travel and areas focus, in relation to workforce, for both the HR & OD directorate and the wider organisation, in order to contribute to achieving the Trust vision and strategic objectives.

5. National Context

Over recent years there have been a significant number of national drivers/initiatives which have had a workforce focus. Some of these key drivers are outlined within this section and it will be important for this strategy and the wider workforce agenda to address these challenges.

5.1 HEE Workforce Investment Plan

Health Education England (HEE) forecasts of future supply show suggest that nationally we are training more people to enter the system than those leaving the system in every profession. This includes people leaving NHS employment to work in the independent and care sectors. There is a forecast for an increase in available supply by 2020 with an additional 80,000 that staff could be available to be employed in the NHS. However, the plan does highlight the importance of the system acting to improve staff retention alongside efforts to improve course attrition and employment.

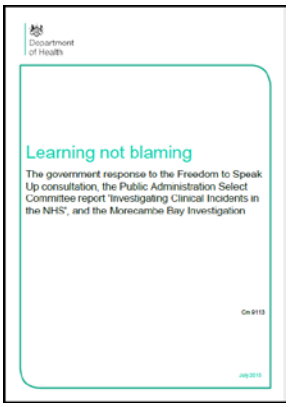
Despite the projected improved position, provider organisations must still address the increasing demand, potential increase in turnover and competition which is likely to remain until at least 2020.

5.2 Francis Review

Sir Robert Francis published his report on the 'Freedom to Speak Up' review in February 2015 and this was followed up more recently with 'Learning not Blaming' in July 2015.

The review recommended a wide-ranging reform of culture in healthcare, to ensure that healthcare staff feel safe to raise concerns over patient care and treatment without fear of reprisal. Sir Robert's stated priority is that "above all, behaviour by anyone which is designed to bully staff into silence, or to subject them to retribution by speaking up, must not be tolerated."

The Review emphasises the requirement for NHS bodies to encourage openness and transparency in handling concerns. There is a real emphasis on the continued need for cultural change, with a focus on leadership, training & the proper management of complaints and NHS bodies are encouraged to embrace this new culture.

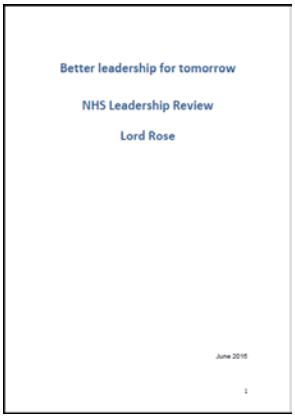


The review contains practical advice on how such cases should be handled, addressing issues such as the potential need for independent investigators and the need for practical support for staff who have raised concerns. The recommendations and guidance in the report, although not legally binding, will have a

significant impact on whistleblowing in the NHS and how NHS employers investigate concerns. A key aspect of these reviews is the use of a Guardian role within Provider Trusts to support staff in raising concerns.

5.3 Rose Review

The NHS Leadership Review, conducted by Lord Rose, published in June 2015, focused on what might be done to attract and develop talent from inside and outside the health sector into leading positions in the NHS; and to recommend how strong leadership in hospital Trusts might help transform the way things get done.



The report highlighted that everyone should know what great leadership looks like; and even though not every job will require leadership qualities, some parts of every job will. We should not try to prescribe from any particular discipline. We should aim to develop, recognise and reward appropriately leadership qualities across the whole NHS workforce.

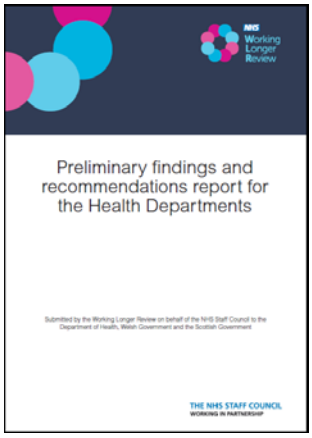
The report suggests few simple things would make a huge difference: some centralised effort on training; or helping middle managers keep their confidence and focus; or knowing that the top leaders of tomorrow may be doctors, nurses or administrators. At the start of their NHS career, everyone should have adequate training; in mid-career they should have adequate support and clear pathways to progression as managers; and top leaders should have the appropriate support and experience to enable them to make correct decisions.

The level and pace of change in the NHS remains unsustainably high: this places significant, often competing demands on all levels of its leadership and management. The administrative, bureaucratic and regulatory burden is fast becoming insupportable. The three areas of particular concern that are highlighted are:

- Vision: There is a lack of One NHS Vision and of a common ethos.
- People: The NHS has committed to a vast range of changes however; there is insufficient management and leadership capability to deal effectively with the scale of challenges associated with these.
- Performance: There is a need for proper overall direction of careers in management across the medical, administrative and nursing cadres.

5.4 Working Longer Review

There is no doubt that of the many challenges facing the NHS, employers and staff, is the impact of caring for an ageing society whilst concurrently supporting an ageing workforce is one of the greatest. The WLR was established to address the potential impact of working longer in the NHS

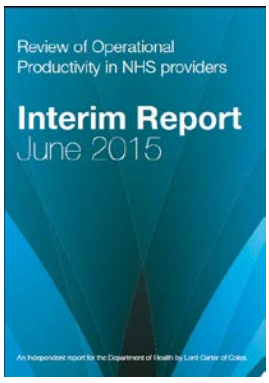


The review sought to identify recommendations which, if acted upon, will support employers and staff in meeting this challenge now and in the future. It is important to note that of the 1.3 million staff currently employed in the NHS, 70% of them will have an increased pension age and be

required to work longer to receive a full pension as a result of the Public Service Pensions Act 2013. NHS Demographics show that the average age of NHS employees is currently 43.7 years (in 2011, UK) and it is projected to rise to 47 years by 2023.

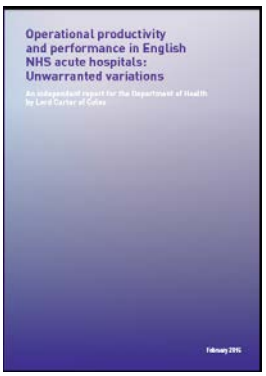
The report points out that whilst the impact of working longer could be a challenge for the service, it also provides an opportunity to think and act differently in the way we support staff to work longer. Looking after the health, safety and well-being of staff, from an early age, is one of the fundamental challenges the service must address. Having a diverse workforce of all ages is something we should rightly celebrate. However, doing nothing about the challenges which working longer could bring to employers, staff and patient care is not an option.

5.5 Carter Review



In 2015, the Department of Health has published an interim report outlining the work that has been carried out by Lord Carter of Coles to review the productivity of NHS hospitals. The report suggests that the NHS could save up to £5bn every year by 2020 by focusing efforts on major areas of spend:

- Workforce
- Hospital Pharmacy and Medicines
- Optimisation
- Estates Management
- Procurement



With respect to workforce, the interim Carter report recommended the use of e-rostering and other management tools to better deploy permanent nursing staff, as well as a focus on provider expenditure with agencies.

The follow up review looked at productivity and efficiency in English non-specialist acute hospitals, which account for half of the total health budget, using a series of metrics and benchmarks to enable comparison. It concluded that there is significant unwarranted variation across all of the main resource areas and from a workforce perspective it highlighted sickness absence as one of the areas with significant variation.

5.6 From Bursaries to Loans

The 2015 Spending Review confirmed that bursary for student nurses will be replaced with student loans and caps on student nursing numbers will be abolished. The current grant system means that there is a cap on student nurse numbers so over half of all applicants to nursing courses are turned away. This would mean that universities have the potential to be able to provide up to 10,000 additional nursing and other healthcare professionals.

From 2017/18, new students on nursing, midwifery and AHP pre-registration courses (which lead on to qualification with one of the health professional regulators) in England will take out maintenance and tuition loans like other students rather than getting an NHS grant.

Although this should be seen as a positive initiative , there is a risk that the loss of the bursary may put off some students taking up professional health care roles and/or that some universities may choose not to deliver some of the more specialist training programmes.

5.7 Apprentice Levy

As part of the Comprehensive Spending Review (CSR), government has published its response to the apprenticeships levy consultation. The levy will come into effect in April 2017, and will be payable by employers at 0.5 per cent of their pay bill. The introduction of the levy is to put investment into apprenticeships on a long-term, sustainable footing. It will be collected through the pay as you earn (PAYE) system and HMRC will work closely with employers to minimise the impact of implementing these changes. In addition to this, it is anticipated that NHS Trusts will be allocated a target for the number of apprentices it must take on each year and it is expected to be circa 2.3% of the total Trust WTE. For LPT this would be approximately 110 per year. To achieve this it would be necessary to remodel the workforce profile to fully integrate the apprentice role into the workforce structure.

5.8 Agency Use

There has been a significant national drive to make savings through a reduction in agency use/costs. In October 2015, plans were announced by the Department of Health which has seen the hourly rate the NHS can pay agency staff capped at 55% above the pay levels of permanent staff. This cap was phased in and was initially double the pay level of permanent staff, however, this has been gradually reduced to the 55% figure as at April 2016. In addition to this, NHS Trusts have been given control targets to meet, which is set at £7.7m in 2016/17 for LPT.

5.9 NHS Constitution

Although the NHS Constitution has now been in place for some time, it was based on the national research which indicated 4 themes of key importance to NHS staff, which still hold true:

- The resources to deliver high quality care
- The support needed to do a good job
- A worthwhile job with the chance to develop
- The opportunity to improve the ways of working

The results of this work were then incorporated into a number of initiatives, including the establishment of the NHS Constitution in January 2009 and later revised in March 2012.

The Constitution applies to all staff, doing clinical or non-clinical NHS work, and their employers. It focuses on the **Staff Rights**, embodied in general employment and discrimination law. The constitution also outlines the **Legal Duties** for staff. In addition to legal rights and duties, there are a number of **Staff Pledges** which the NHS is committed to achieve that go above and beyond legal rights and although they are not legally binding, they represent a commitment by the NHS to provide high quality working environments for staff. The constitution also

includes **Expectations** that reflect how staff should play their part in ensuring the success of the NHS.

5.10 National Context Summary

When reviewing the different aspects of the national context and the key drivers for this strategy, they can be summarised as falling under the following key themes:

- Workforce supply & demand
- Effective leadership (including leadership development & attraction)
- Cost effective and appropriate use of agency staff
- Productivity improvements
- Staff engagement, involvement & satisfaction
- New roles with a focus on the apprentice role
- Culture of openness
- Impact of an ageing workforce

It will be important to incorporate these key drivers as part of the implementation of this strategy.

6. Organisational/Local Context

6.1 Vision, Values & Strategic Objectives

In 2014 the Trust reviewed its vision as follows:

To improve the health and wellbeing of the people of Leicester, Leicestershire and Rutland by providing high quality, integrated physical and mental health care pathways.

At the same time it also amended the strategic objectives shown below with a renewed the commitment to retain a workforce related objective:

- *Quality* – Deliver safe, effective, patient centred care in the top 20% of our peers
- *Partnerships* – Partner with others to deliver the right care in the right place at the right time
- *Staff* – Staff will be proud to work here and we will attract and retain the best people
- *Sustainability* – Ensure sustainability

Further to this, in 2014 the Trust also established a set of values, voted on by staff, that should remain core to all that we do and these are outlined below:

- Compassion
- Trust
- Respect
- Integrity

6.2 Profile

To assist in setting the organisational context, the trust profile is outlined within some of the key workforce indicators, shown within the table below:

WTE staff employed as at Apr 2016	4818
Head count as at Apr 2016	5522
Vacancy rate for 2015/16	7.8%
Pay bill as a % of total trust income for 2015/16	75%
Average number of WTE staff leaving the trust per year	500
Normalised staffing turnover as at Apr 2016	8.5%
Sickness absence for 2015/16	5.1%
Agency spend for 2015/16	£12.3m

6.3 Staff Survey 2015

The national NHS staff survey was conducted between October and December 2015 and for the first year the Trust has a new comparator group (Trusts with combined mental health, learning disability and community trusts in England), whereas previously our comparator Trusts were Mental Health. Over a 5 year period we have continued to see steady and solid improvement to a position where in 2011 we had 16 Key Findings (KFs) in the bottom 20% of Trusts to a position now where we have none. However, we still remain below average with a number of KFs and must continue to see this as a key area for the Trust to improve. The diagram below outlines our top performing areas, along with our most improved and worst performing areas.

Following on from 2014, effective team working and the support staff receive from their immediate manager continue to be a key area of challenge for the Trust.

6.4 Better Care Together – Workforce Strategy

At a high-level, the workforce impacts and areas of focus with the Better Care Together programme have been summarised as:

- **The shift of activity – acute > community > primary > social** – and the resultant need to change the capacity significantly across the system, increasing the capacity within primary, social and community care before capacity can be released in acute settings. There is a need to move staff around the system to provide care in different settings, and some staff may change employer to undertake new roles.

- **Change of location** – community hospitals, primary care hubs, home – staff will deliver care in different locations, with more care being provided in the patient's own home or in their locality. This may entail greater levels of autonomy and staff working with different levels of support and supervision, as well as a change in work location.

- **Roles and skills mix** – There is an opportunity to look at skills mix as the pathways are redesigned, and thereby potentially mitigate some of the existing recruitment challenges. Shifting care from secondary to community settings will require a review of both generalist and specialist skill balance. There will likely be the introduction of new emerging roles (such as Physician Associates) as well as joint roles for example across health and social care.

- **Re-skilling** - there will be significant levels of re-skilling of the current workforce required to support the roles and skills mix that is defined.

- **Culture - Working across boundaries** – levels of cross organisation working are already increasing and will continue to do so. There is a need for continuing development of the system, its leadership and culture (over and above organisational approaches) to successfully deliver BCT.

If LPT & BCT is to address quality and efficiency issues then we need to develop a more integrated workforce, capable of working across physical and mental healthcare, but also across the divide of social care and healthcare and working collaboratively with the voluntary and charitable sectors.

6.5 Workforce Supply & Attraction

The ability to supply/attract staff to fill critical posts (primarily clinical roles) is the single greatest workforce risk at present for the Trust. Although the overall vacancy rate of 7.8% is comparable or better than many NHS Trusts, when looking at specific clinical roles or services, it may be significantly higher. The result of not being able to recruit appropriately can impact upon; effective service delivery, increased use of bank/agency, as well as the overall morale and health & wellbeing of our staff. As such this will continue to be a significant area of focus within this strategy.

7. Strategic Aims

Clearly the People Strategy must support the achievement of the organisational strategic objectives, as well as address both the national and local challenges, outlined previously and support the delivery of other associated Trust strategies. In achieving this, the key focus for the workforce agenda will be on 5 strategic aims, as shown below:

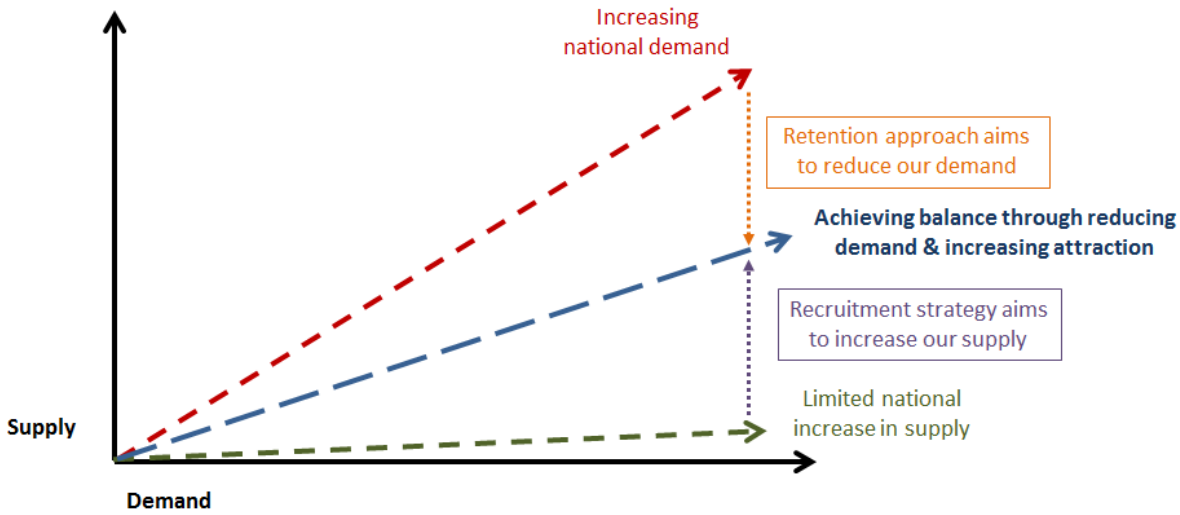
8. Work Themes

In order to achieve the 5 strategic aims, the intention is to focus on five central work themes over the next three years, as outlined within the model below. However, it will be important to recognise that these themes cannot stand in isolation as they must still be supported by the fundamentals of HR & OD, as well as align to wider corporate/organisational initiatives.

In CQC terminology these areas could be viewed as a focus on the *Effective*, *Responsive* and *Well Led* domains.

8.1 Attraction & Retention

Nationally there is an increasing demand for clinical skills, particularly qualified nurses and AHPs and this is likely to be the situation until at least 2020. In order to meet the needs of the Trust, the diagram below illustrates the need to both improve retention of staff and improve recruitment.

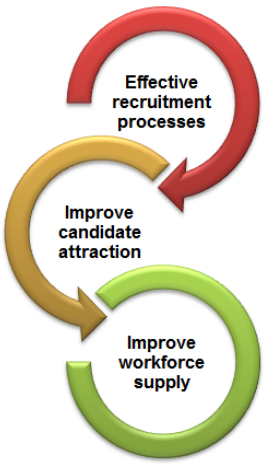


To address the aspect of recruitment, at the start of 2015/16 the three year Recruitment Strategy (Version 1.5a) was developed and implemented to help address both the short and longer term recruitment challenges facing the trust.

The guiding principles of the Recruitment Strategy are outlined as follows:

- Ensure we have a flow of suitable candidates to meet the workforce demands of the Trust
- Raise the profile of LPT in the market place as an organisation to come and work for
- Deliver the strategy in a way that is both affordable and meets the workforce needs of the Trust
- Continually explore options to attract and develop staff whilst identifying alternative sources, to meet the workforce demand.

In order to deliver this these principles, the Recruitment Strategy has a focus is on three key strands of work, outlined below:



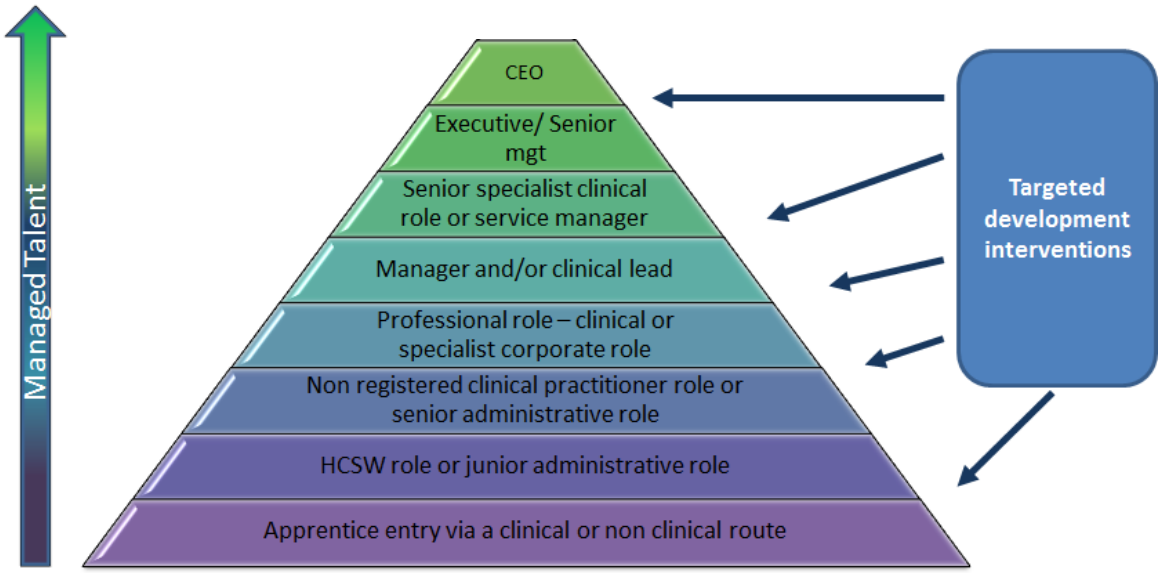
Improving the workforce supply should not only look at our external supply but also how we best support our existing staff in relation to their *health and wellbeing*, in order to improve attendance, productivity and motivation.

However, the vast majority of this strategy was focused upon recruiting new staff into the organisation and as such it did not emphasise the need to also retain existing staff, as such a Retention Approach was developed as an addendum to the Recruitment Strategy.

To improve on staff retention, the focus is on the key areas, outlined in the model below, which are generally viewed as best practice for supporting staff retention.

8.2 Growing & Developing our Staff

With recognition that there is increasing demand for a limited supply of staff, along with the national drivers in relation to apprentices and the move away from paid bursaries, there is an increasing need to describe a model of growing and developing our current staff. Not only will this help to address the supply gap, it will contribute to staff attraction and retention through enhancing the overall employment proposition. The model below outlines how the Trust could and should support staff to reach their potential and at the same time support succession planning throughout the organisation, as part of a career pathway.



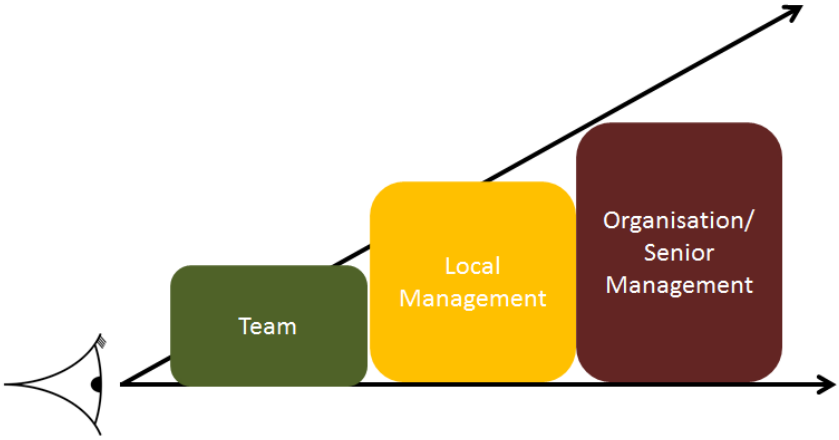
As part of the development of a career pathway, there is also a need to both raise awareness and emphasise across the Trust that "*every role counts*" in ensuring we provide the best possible care as an organisation and achieve the organisational objectives.

In conjunction with developing our staff, there is a further requirement to develop roles and to support this need, the Trust has recently established a Role Development Steering (RDS) Group. One of the functions is to improve consistency and standardisation of roles to provide greater flexibility. With the onset of the apprentice levy, the higher apprentice post and the national Nurse Associate role, it will be vital to develop a new apprentice model which is integrated into the overall workforce model for LPT going forward.

8.3 Leadership

The previous 2 years have seen a significant increase in the provision and support for leadership development, both through formal programmes such as Covey and Leading for Change, as well as the more open approach with the Leading Together Group. However, there is still further work required in relation to establishing solid values based leadership at all levels of the organisation, as well as a greater focus on talent management and succession planning. The aim is to both have a more integrated and coordinated approach to the leadership offer, as well as establish a tiered style approach, which would range from having a clear understanding of what as a Trust we expect from leaders, core/foundation management training to the more bespoke/targeted offers, as outlined in the model below:

In order to identify where the focus is needed, it is important to consider the *Leadership Line of Sight*. The model below depicts, from an individual perspective for most staff, the focus of influence will be primarily at a team level and secondly at a local management perspective, with the organisational level being a clear third.



Recognising this, there is an increasing need for a greater focus on effective teams and effective local line management, as these two areas will have the greatest impact on Trust and the services we provide. These are also identified as areas that require improvement from our 2015 National Staff Survey.

8.4.1 Empower and Engage our Staff

Over recent years the Trust has embarked upon a number of initiatives to help both empower and engage our staff, with Listening into Action (LiA) being one of the core aspects of this approach. Research has shown that autonomy and the ability have some control over their role/service is a strong factor when staff consider LPT as a great place to work. However, in many cases the ability to make changes is hampered by the need to understand and apply local policy, a task made more difficult given LPT operates 183 policies (as at Dec 2015). It will always be necessary for any NHS Trust to have appropriate policies in place, although there is also a need to simplify our organisational approach to make it easier for staff to make simple local changes happen.

LiA within the Trust has only 4 simple criteria to make change happen:

- Work within financial limitations
- Don't have a negative impact on Trust reputation
- Maintain or improve quality/ safety
- Ensure a positive or neutral impact on other teams/ services

Mercedes/Petronas F1, have seen significant improvements in both empowerment, reliability and quality with the implementation of their simple *See It*, *Say It*, *Fix It* initiative.

- See It – taking personal responsibility for actively recognising problems/issues
- Say It – personal responsibility for raising/escalating problems/issues
- Fix It – where it is within the individual's gift they take action to rectify the problem and where it is not in their gift they ensure that it is rectified.

Consideration will be given to the establishing an approach by combining elements both the LiA criteria and the Mercedes approach, in order to empower staff to make quick local quality improvements. This could further support the Trust change methodology, #*We-Improve* and also #*WeCreate*.

In addition to making it simpler for staff to make changes, there is also a need to simplify for staff what they can expect of the Trust and what is expected of them, along with the organisational values that all staff should display. There is the potential to develop an organisational charter/pledge approach (potentially #*WePledge*), to achieve this.

In order to gain the maximum value and input from or staff, as well as promote engagement, it will be important to focus on approaches that more easily encourage and support staff to contribute (moving from compliance to a contribution ethos) towards improved service delivery and the achievement of organisational initiatives and objectives. This would be further supported through the current #*WeConnect* approach.

8.4.2 Openness

Through the establishment of a culture of openness and transparency, we have the potential to have in place 5,500 CQC inspectors and early warning mechanisms through all of our staff. This approach has clear alignment to the *see it*, *say it* aspects of the Mercedes approach. As an organisation we have implemented the appropriate actions from the Freedom to Speak Up report and will shortly have in place a Freedom to Speak Up Guardian, directly accountable to the CEO. With the establishment of that post, it will be vital to review how we enable our staff to raise concerns/whistle blow, as well as develop an ethos and mechanisms where staff are able to do this in a safe and supported way.

8.5 Productivity

From a workforce perspective, productivity may be viewed as; having less staff, paying staff less and making more effective use of the staffing resource we have. Given the current level of vacancies within LPT and the increasing demand for services, there is

limited scope to reduce the workforce. Equally, given pay, terms and conditions are predominantly determined nationally, again there is limited scope with respect to improved productivity.

As such, the focus of this section will be to consider areas where as a Trust we are not always gaining the maximum benefit from our workforce, which is in essence a scarce resource.

The 5 primary areas of focus in order to strive for improved workforce productivity are:

- Reduction in sickness absence
- More effective rostering
- More balanced approach to the use of annual leave
- Reduction in agency use/costs
- Greater consistency & standardisation of roles to improve flexibility

These areas of productivity could be considered as "*hard*" aspects of productivity, however equally important to progress are the "*soft*" areas of productivity.

Focusing areas such as on empowerment and recognition to make staff feel appreciated has been shown to have an enormous impact on employee engagement, productivity and employee retention. Saying 'thank you' goes a long way in making employees feel happy and valued in their work and a recent study by the University of Warwick showed that happier employees are more productive. The benefits of showing appreciation cannot be underestimated and as such, the drive to improved productivity will also have its roots in leadership and empowerment & engagement.

9. Workforce Risks

As at April 2016, the 4 workforce related risks within the Board Assurance Framework (BAF) are based on; ability to recruit & retain staff, engaging with our staff/staff satisfaction, compliance with mandatory skills and effective leadership, as outlined below:

- BAF/4/1036 - Without recruiting adequate staff we may be unable to run safe and efficient services as our services transform.

- BAF/4/1037 - Without effectively engaging and supporting our staff we may be unable to deliver high quality services and support transformational change.

- BAF/4/366 - If we do not meet mandatory training compliance rates there may be an adverse impact on care delivery.

- BAF/1/1038 - Inability to create high quality management and leadership capabilities may impact on the delivery of efficient and effective services.

It is anticipated that although these may require in year revisions, these 4 areas of risk are likely to remain in force for the duration of this strategy.

10. High Level Objectives

The following high level of objectives have been identified to support the five work themes, to achieve the strategic aims.

5 Key Work Themes				
Attraction & Retention	Growth & Development	Leadership	Empowerment & Openness	Productivity

		Work Themes				
Ref	**High Level Objectives**	A & R	G & D	L	E & O	P
1	Develop mechanisms to support cross system working	✓				
2	Develop and implement a career development pathway	✓	✓	✓		✓
3	Enhance the current leadership framework to provide a more integrated approach leadership development, incorporating a talent management approach			✓		
4	Empower staff to make local improvements			✓	✓	
5	Embed and extend effective e-rostering mechanism across the Trust					✓
6	Articulate a longer term integrated approach to address Health & Wellbeing	✓				✓
7	Reduce sickness absence	✓				✓
8	Increase the LPT focus on the workforce profile through role development and an "*Every Role Counts*" ethos.	✓	✓		✓	✓
9	Reduce cost of, and reliance on, agency staffing	✓				✓
10	Explore options for enhancing a more flexible employment & educational model/offer across the Trust	✓	✓		✓	
11	Consolidate and enhance initiatives for attracting young people into NHS employment & establish a revised apprentice model	✓	✓			
12	Improve candidate attraction into LPT	✓				
13	Expand and extend the potential recruitment pool	✓	✓			
14	Enhance, promote and embed a culture of raising concerns				✓	

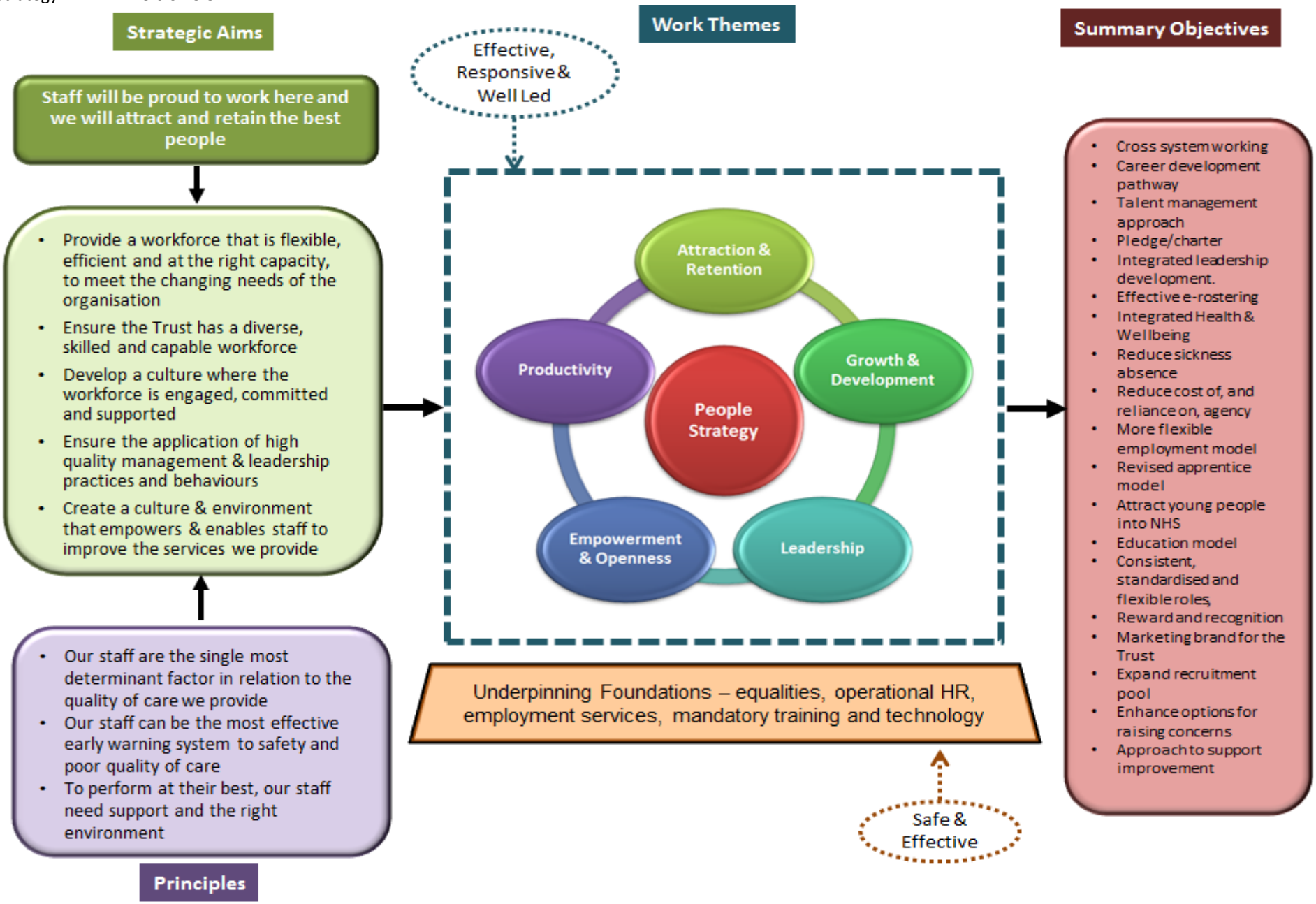
Each of these objectives will require more detailed project plans and/or business plans and over the period of this 3 year strategy, it is expected that further objectives will be developed under the 5 work themes, in order to achieve the strategic aims.

11. Conclusion

The People Strategy builds upon the previous HR & OD strategy and has a greater developmental focus, with respect to the wider workforce agenda. In doing so it sets out the direction of travel through the five strategic aims, which are addressed through 5 work themes. In doing so, the strategy will help improve the quality of care delivered to patients by ensuring that our workforce has the right numbers, skills, values and behaviours to meet their needs today and tomorrow. Although developmental in focus, it will still require to be underpinned by safe and effective operational HR/employment practices.

It is also important to recognise that the delivery of this strategy would not sit wholly within the HR & OD directorate, as it will require wider corporate and organisational engagement to achieve.

People Strategy on a Page



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Leicestershire Partnership NHS
NHS Trust

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REPORT TO THE TRUST BOARD - 27 MAY 2016	
Title	Communications Strategy 2016-18

Executive summary

Over the last year, the culture of the organisation has begun to shift to one where morale is improving, where staff want to come together, to improve services and be innovative, and the NHS leadership model is taking force. Staff engagement levels are improving. However, this shift has some way to go yet if we are to build a truly engaged workforce, with a common culture and unified brand.

Having a strong communications strategy is essential to building this vision, as we continue to develop during an ever challenging time, responding to significant transformational and organisational national and local priorities, with stretched finances and recruitment shortages.

The vision for this communications strategy:
Our communications will be values-based, always putting people at the heart of what we do to build well-informed and well-engaged, empowered communities.

Four key communications objectives will focus our priorities:

- Defining our brand and improving our reputation
- Improving internal communications to affect culture change and morale
- Championing effective digital communication and innovation
- Being insightful – for continuous improvement

Our key principles will focus on ensuring:

- **Service users will be partners in their care**: they will feel fully informed of their choices and confident in the care they receive from LPT (connecting to our clinical strategy), feel able to self-care where appropriate, and empowered in shaping the future of our services.
- **Staff will be partners in delivering our organisational objectives**: they will feel like one team, fully informed and supported; engaged with and contributing to shaping future service improvements (connecting to our HR&OD strategy); and be connected to the wider health and social care provider community as active community health champions for LPT.
- **Partners will connect with our vision and play an active part in the solutions**: they will hold us in high regard, value the mutual benefits of working together, and be champions of our services.

The key aims of the communications strategy are aligned with our organisational vision, values and objectives. The identified objectives will be central to helping us narrow the gap from where we are now to where we want to be.

Engagement
Over 1000 staff and 200 service users, from a cross section of protected

characteristics, backgrounds and roles, have provided direct input into the direction of travel outlined in this Communications Strategy.

This is a two-year strategy, which will require annual plans and defined resources to be successful.

Key steps to implementation will be:

1. **Co-design the tactical plans for the communications strategy with our audiences for each communications objective -** to ensure they are inclusive, accessible and responsive to the diverse needs of our audiences.
2. **Establish evaluation mechanisms and metrics** to continue annual tracking.
3. **Agree resources** required including completion of the **communications team** management of change, which proposes to introduce dedicated capacity to ramp up transformational impact on internal communications and digital communications.

Next steps

- Implementation plans will be finalised by July 2016
- Restructured communications team is proposed to begin from September 2016

Recommendation

The Trust Board is recommended to:

- Provide feedback, and endorse this direction of travel.
- Receive updates every 6 months.

Related Trust objectives	• Deliver safe, effective, patient-centred care in the top 20% of our peers. • Staff will be proud to work here, and we will attract and retain the best people. • Partner with others to deliver the right care, in the right place, at the right time. • Ensure sustainability.
Risk and assurance	Having a well-engaged workforce Workforce Governance will be through Executive Team
Legal implications/ regulatory requirements	None
Presenting Director	Dr Peter Miller, Chief Executive
Author(s)	Kamy Basra, Head of Communications

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

Leicestershire Partnership NHS
NHS Trust

Communications Strategy

2016 – 2018

Kamy Basra
Head of Communications
May 2016

1. Executive summary

Leicestershire Partnership NHS Trust (LPT), as we know it today, is a fairly new provider organisation, having come together around 5 years ago. During this time, we have worked towards creating a unified culture, having previously been three different providers. Our application to become a Foundation Trust was withdrawn following various CQC inspections, and the recent organisational-wide CQC inspection has highlighted that we must improve if we are to move to a 'good' and 'outstanding' trust in comparison to our peers.

Over the last year, the culture of the organisation has begun to shift to one where morale is improving, where staff want to come together, to improve services and be innovative, and the NHS leadership model is taking force. Staff engagement levels are improving. However, this shift has some way to go yet if we are to build a truly engaged workforce, with a common culture and unified brand. Having a strong communications strategy is essential to building this vision, as we continue to develop during an ever challenging time, responding to significant transformational and organisational national and local priorities, with stretched finances and recruitment shortages.

1.1 The vision for this communications strategy:

Our communications will be values-based, always putting people at the heart of what we do to build well-informed and well-engaged, empowered communities.

1.2 Four key communications objectives will focus our priorities:

- Defining our brand and improving our reputation
- Improving internal communications to affect culture change and morale
- Championing effective digital communication and innovation
- Being insightful – for continuous improvement

1.3 Our key principles will focus on ensuring:

- **Service users will be partners in their care**: they will feel fully informed about their choices and confident in the care they receive from LPT (connecting to our clinical strategy), feel able to self-care where appropriate, and empowered in shaping the future of our services.

- **Staff will be partners in delivering our organisational objectives**: they will feel like one team, fully informed and supported; engaged with and contributing to shaping future service improvements (connecting to our HR&OD strategy); and be connected to the wider health and social care provider community as active community health champions for LPT.

- **Partners will connect with our vision and play an active part in the solutions**: they will hold us in high regard, value the mutual benefits of working together and be champions of our services.

2. Introduction

Effective communication is central to helping us deliver our organisational objectives, pivotal in narrowing the gap from where we are now to where we want to be.

2.1 Target audiences

At a high level, **our main target audiences** for this communications strategy, all of which can be split into **current and potential**, are:

- staff
- service users
- carers
- unions
- volunteers
- members
- partner organisations
- commissioners
- regulatory bodies
- media
- wider stakeholders (eg. Councillors, MPs, general public, other bodies, etc).

Any communications plan need to be break these down further for targeting and segmentation purposes, to ensure inclusivity, accessibility, and appropriate engagement based on level of interest and influence (see LPT Stakeholder Strategy).

2.2 Key aims of this communications strategy

1. **Align communications priorities with our corporate objectives, to help reinforce our vision, values and purpose**.
    - **To define our brand and improve our reputation** - improving clarity, awareness, understanding, engagement, confidence and trust for our services and organisation [*Deliver safe, effective, patient-centred care in the top 20% of our peers*].

    - **Improve our internal communications to facilitate culture change and morale** to one of feeling informed, engaged and actively participating, because you feel valued, have a sense of belonging, and feel empowerment [*Staff will be proud to work here, and we will attract and retain the best people*].

    - **Champion effective digital communication and innovation**, connecting people to aid continuous improvement, and supporting system-wide transformation to diversify our offer [*Partner with others to deliver the right care, in the right place, at the right time*].

    - **Being insightful for continuous improvement**: Listen, engage, involve, and co-design to continually research our audience's needs and evaluate to improve experience with our brand and to build impactful, accessible communications that make the most of our resources [*Ensure sustainability*].

2. **Ensure delivery through a communications service fit for the future by**
    - Being **innovative** and forward-thinking, embracing and championing effective digital technologies to enhance our multi-media communications
    - A **creative team with the right capacity, skills and passion** to make a difference and be the best
    - **Efficiency** in our use of resources, and resourceful in creating effective impact and reach
    - Providing communications **leadership** to enable staff to own their communications activity with confidence and improve communications across and within our services.

3. **Co-design the tactics and implementation - that meets the needs of the LPT and its audiences**.
    - A programme of **creative involvement with our main target audiences** (staff, service users, carers, volunteers, members, partners, and wider stakeholders) has taken place to test the communications' vision and define
        - a benchmark for where we are at,
        - the tactics and channels to create workplans for each of the communications priorities (point 1 above).
    - Co-designing the improvement of communications channels will be ongoing – to ensure they are inclusive, accessible and responsive to the diverse needs and preferences of our key target audiences.
    - Establish **metrics to monitor and track reputation and stakeholder perceptions**, and evaluation mechanisms to continuously improve the effectiveness of corporate communications.

3. Organisational context

3.1 LPT's vision

To improve the health and wellbeing of the people of Leicester, Leicestershire and Rutland by providing high quality, integrated physical and mental health care pathways.

To support this, our communications strategy will aim to:

- Put the patient/service user is at the heart of what we do - our communications plans must be inclusive and responsive to their needs and preferences.
- Support the health and wellbeing needs of service users, inspire self-management of health and wellbeing, and champion prevention through behaviour change communications.
- Support our clinicians to improve the quality of the services we provide by sharing key learnings, celebrating good practice, and effectively communicate with patients/service users
- Support our clinicians to improve the quality of the services we provide by sharing key learnings, celebrating good practice, and communicating effectively with patients/service users/carers

3.2 LPT Values

Respect, Compassion, Trust, Integrity

Our communications strategy is values-based.

Our values must be translated into everything the communication team does in our communications messages and plans: in our language, tone, brand, and positioning – resonating in a meaningful way in our content, approaches, accessibility and engagement with our audiences.

We must always seek to be open, honest and inclusive in our communications, championing our equal opportunities policy and seeking to co-design communications activities with our target audiences. The communications team have pledged team values of '**putting people at the heart of everything we do**'.

3.3 Key organisational priorities

Without effectively engaging and supporting our staff we may be unable to deliver high quality services and support transformational change. The lack of an effective communications strategy is therefore a key risk for the organisation.

LPT has identified specific improvements around quality, safety, estate, workforce and sustainability. Transformation priorities include developing our digital offer, place-based and asset-based health and social care, and all-age liaison psychiatry. Our key communications activity needs to be prioritised particularly around supporting the delivery of these key organisational priorities, influential for the future ambitions of LPT.

Internal drivers

1. **CQC report** – communications activity needs to facilitate the spread of good practice where we are getting the basics right and to help mobilise the workforce to move forward from 'requires improvement' to 'good' and 'outstanding'. Communications will focus on recognition, celebration, spread of learning and collaborative leadership.
2. **Better Care Together** – communications support for the system left shift and recruitment, engagement and compelling narrative around hospital closures backed by consultation, using co-design to motivate culture change around attitudes and behaviours, and contributing to multi-agency communications plans and platforms.
3. **Budgetary constraints and sustainability** – considering our stretched financial targets and stretched resources, we need to champion a culture to remain competitive and sustainable through efficiency, innovation and creativity; and linking to our corporate social responsibility priorities including volunteering and fundraising.
4. **Recruitment and retention** – position LPT as an employer of choice, with employees as ambassadors of LPT as a great place to work.
5. **Supporting our Clinical Strategy** – with communications activity reinforcing integration of our services and strengthening our communities, spreading knowledge and skill across the workforce, introducing and sharing new and alternative technologies, and spreading lessons learnt and best practice in clinical delivery.
6. **Improving staff morale and creating a shared culture across LPT** – this is not a problem solely related to LPT (with lessons learnt from Mid Staffs, Francis and

Keogh). We will focus on mobilising pride in 'We Are LPT' to create internal engagement and buy-in for our **continuous quality improvement** agenda, shared purpose and a sense of community that is recognised, valued and listened to.

7. **Five year business plan** – getting the basics right. We must ensure that our standard communications is effective, accessible and meets the needs of our staff, service users and patients as well as looking at new and different ways to reach them.

External drivers

1. **NHS Five Year Forward View** (NHS England 2015) - sets out how the health service needs to change to remain relevant, effective and sustainable. Improving our communications will be a key to "a more engaged relationship with patients, carers and citizens so that we can promote wellbeing and prevent ill-health".
2. **Digital dominance and consumerism** – the UK is now a 'smartphone society' - two-thirds of people own a smartphone, using it for nearly two hours every day to browse the internet, access social media, bank and shop online (Communications Market 2015 (August), Ofcom). Expectations have also changed, to the need for faster responses and quicker and easier transactions. Our communications must be at the forefront of online and digital technologies, maximising use of social media, apps, our websites and other digital tools to improve the quality and accessibility of our services, and the experience of our staff and service users. We also need to take account of the recent NHS digital roadmap and ensure we are truly multi-media. However, we must still ensure we get the basics right, to reach those that still find digital communication inaccessible or difficult to engage with.
3. **Demography and demand** – we serve a diverse population, with demand for our services from older people and from children and young people set to rise over the next few years. Our communications needs to be targeted appropriately to both age groups. There is a larger South Asian, and increasingly Eastern European population in Leicester city, for whom we need to ensure our communications are inclusive, accessible, and appropriate. Equally, there are many rural areas, with older age profiles and families. Demographics must be considered as part of our communications and engagement plans, and we must ensure we facilitate the Accessible Information Standard. People are never 'hard to reach', we are just failing to engage them properly.
4. **Mental health parity of esteem** – as a provider of mental health services we want to champion the importance of mental and physical health as a holistic health and wellbeing service. We also want to challenge the social stigma that still exists around mental health. Our campaigns will be mindful and challenging in championing this.

3.4 What would excellent communications look like for our staff?

Between January to May 2016, the communications team have engaged around 1000 staff across LPT in developing our key communications priorities for improvement. The engagement followed a Listening into Action methodology, supplemented by online surveys, roadshows and team meetings. These were the top 10 headlines from the feedback.

1. **The most popular mechanisms for keeping staff informed are emails, e-newsletter, and team meetings**. However, in an ideal world, this is how they want to be communicated with…

2. **Everyone wants a more searchable, modern and responsive website and intranet**. The current speed is too slow and staff felt that it was difficult to find the information they require. Especially important areas noted: policies, training opportunities, staff directory, and service directory. Patient opinion and useful links also noted as important for external website, and wide support for a patient portal.

3. **Email overload around communication** that isn't relevant to is a big bugbear. The majority of staff want relevant, targeted information and newsfeeds they can access on areas of interest – to make it as meaningful as possible to them.

4. **Short, snappy headlines – in a weekly enewsletter.** The weekly LPT newsletter is widely read, if not skim read, and most staff find it useful. Ideally staff want bite-sized chunks, with headline contents highlighted at the beginning, and pointed to further info elsewhere. A new enews will be introduced that is more interactive, have the functionality to do all this, and have an instant poll facility – one of the top ways staff said they like to provide feedback, alongside surveys. Built in analytics will help us to measure improvement in impact.

5. **Staff want us to help promote more two way communications** – enabling staff to share their news with each other and to provide feedback to the top. Communication is currently considered to be too top down. Staff would like more opportunities for user generated and staff generated content.

6. **Staff understand, and relate to, our values** more than our vision and objectives. They are more intrinsic in all communications and feel meaningful. Patients, service users and staff need to be at the heart of our communications messages to show how they are relevant to all, and reflective of our common values. Our vision and objectives need to feel more meaningful to staff if they are to engage with them and own them as they do the values.

   "I have no idea about the Trust's visions. Decisions are made with no thought of including what those who work for the Trust feel need to part of the vision"

7. **We need to do more to raise our profile and market ourselves better**. Staff want to continue being supported to identify and share good news stories so that people understand who we are and what we stand for. Overwhelming, staff said our brand should be based on our values, and that we care, about our staff and service users. They also feel many don't understand who we are as an organisation – we need to do more to define this. Some staff still do not even relate themselves to LPT.

   Staff would welcome a communications toolkit to offer more self-service communications support. In particular, you wanted templates and learning opportunities, and support around social media, as part of our service offer. Many

people offered good feedback about the values team break as a model for teams to use.

8. Popular offline communications channels included: cascading k**ey messages via managers through team briefs**, and use these as a mechanism to provide feedback; regular notice board updates, and making **People Matters an LPT magazine** for staff, service users and members.

9. **Having the right equipment would help such as smartphones and VPN** is important. You would welcome **text messaging** on key messages, and apps for work, to save time or access in your own time. Lack of PCs in wards is particularly problematic in gaining information.

10. **Our brand should emanate our values**. It should make staff feel valued and proud to work here, and our patients and service users should feel that we care about them and what they say; that we are accessible, safe, and trustworthy.

3.5 What would excellent communications look like for our service users, patients, carers, volunteers and members?

Around 180 service users, carers, volunteers and members have been engaged to develop this strategic direction of travel. This has been through a range of existing groups and networks, use of the voluntary sector and healthwatch organisations, and through our online survey and social media.

Top 5 headlines were:

1. **Preferred method of communication** for finding out about our services is overwhelmingly our website (85%), followed by posters and leaflets (41%).

2. **The preferred method of providing feedback** on our services is through the Friends and Families Test survey (59%), email (55%) and the LPT website (44%). There currently isn't a secure way to provide this via email and the LPT website doesn't easily offer this possibility. A correspondence app may fill this gap. Those that do provide feedback don't always receive a response as to how this has been taken up.

3. **People would prefer to receive more support and information** to improve their health and wellbeing through the LPT website, whereas this is currently through NHS Choices and 111 in the main. Demand for mobile apps was also evident.

4. The majority find our website useful, however complained about the slow speed and unclear navigation structure. It was described as dated in design and unengaging. At least 13 service users have volunteered to help **co-design a future website**.

5. **People Matters** was fairly familiar to many of the respondents, the majority of whom were supportive of a move to an **online magazine with limited printed copies**.

In conclusion, service user feedback so far has shown a clear preference for improved online communications and an improved website, in addition to the valuable face-to-face communications methods.

4. Communications Priorities

Our communications will be values-based, always putting people at the heart of what we do to build well-informed and well-engaged, empowered communities.

As outlined earlier, our communications priorities for the next 2 years will focus on the following areas, in order to achieve communications objectives that support our key organisational priorities and transformational vision. Each objective will have a detailed action plan for implementation, which is targeted as and where it is required.

- **Defining our brand and improving our reputation**
- **Improving internal communications to affect culture change and morale**
- **Championing digital communication and innovation**
- **Being insightful – for continuous improvement**

Here we outline the key tactics to help deliver each communications objective.

4.1 To define our brand and improve our reputation - improving clarity, awareness, understanding, engagement, confidence and trust for our services and organisation [*Deliver safe, effective, patient-centred care in the top 20% of our peers*].

1. ***Rebrand and reposition the Trust as a good to excellent performing Trust***.
    a. Undertake a reputational audit with key stakeholders to establish a benchmark.
    b. Engage staff to create a meaningful vision reflective of our values, of what we want to be known for and where we want to be, supporting our mission to deliver patient centred, safe, high quality care.
    c. Position our brand reflective of our ambitions to be innovative, place-based and person-centred with key stakeholders.
    d. Create a marketing plan for our recruitment strategy, positioning us a family brand that cares about its staff.
    e. Create a content strategy to reinforce our messaging and aspired brand personality – greater use of storytelling and building compelling narrative
    f. Strengthen our internal communications strategy using 'We Are LPT' (see 4.2a) to support the creation of a working culture reflective of our brand values, instilling pride in our staff and motivating them to act as brand ambassadors.

2. ***Strengthen our reputation management to be reflective of our brand values***
    a. Shout about the good stuff – celebrate and showcase through a multi-media approach, that isn't just about the traditional press releases and newsletters:
        i. Create opportunities for dialogue through social media for example, more face to face engagement through experiential community events and bumping spaces;
        ii. Seek to influence and be thought leaders, including targeting of key influencers and seek speaking opportunities;
        iii. Create advocates through social movement campaigns to build on this good work; and

iv. Gain official accreditation and recognition by supporting our clinical staff to apply for awards and subsequently publicising this.

b. Manage the reputational challenges – using our values of trust, respect, integrity and compassion to reframe all our responses around the benefits for the patient's health and wellbeing, and building stronger communities. See our communications team principles below (section 6)
c. Partnerships and relationships – tracking changing sentiment to achieve fair accurate coverage. This includes active informed relationships with key media and selling in of regular proactive media releases.

3. ***Not just a mental health trust*** – challenge misconceptions and increase awareness and understanding of who our organisation is and what we do.
    a. This is closely linked to (a) above, however it is about increasing our profile as a Trust and our services.
    b. Profile parity of esteem between physical and mental health services

4. Build our reputation as an employer of choice
    a. Implement an innovative marketing strategy and recruitment brand that better showcases our unique selling point/employee value proposition (product), why come to work here (place), how we invest in our staff (people), and the benefits and incentives on offer (price).
    b. Integrate our marketing strategy appropriately into all our communications channels.

5. Raise the profile of our corporate social responsibility agenda
    a. Showcase our activity for building stronger communities and CSR themes to create a more well-rounded picture of our brand personality and values

6. Raise the profile of our charity
    a. Produce a communications strategy for our charitable funds that positions our brand as going the extra mile in innovative ways despite funding constraints. Our communications focus will be on encouraging support from potential donors, showing how the money is being spent and making a difference

4.2 Improve our internal communications to facilitate culture change and morale to one of feeling informed, engaged and actively participating, because you feel valued, have a sense of belonging, and feel empowerment [*Staff will be proud to work here, and we will attract and retain the best people*].

7. ***Create a strong internal communications strategy*** - not only to inform and gain feedback, but to strengthen engagement, involvement and co-design around continuous quality improvement, our values and objectives.

    a. **Introduce a range of effective internal communications channels** following the comprehensive staff engagement between January to May 2016.
        i. Create a refreshed communications offer including a team with more capacity to deliver internal communications and digital communications (two new communications officer posts are proposed in the current management of change).
        ii. Introduce a more diverse range of communications channels that offer two-way communications to reach staff. Particular focus is needed on community workers, shift workers and ward staff, who have less time to

look at emails. This will include team briefs for team meetings and interactive notice boards.

iii. New intranet and interactive enewsletter software – as detailed below, to improve staff engagement and two-way communication.
iv. Introduce a communications volunteer role to keep notice boards and receptions up to date, and a network of communications champions.
v. Strengthen support to web administrators to facilitate off-line communications.
vi. Introduce a communications toolkit to enable staff to feel more empowered to undertake basic communications activities, using the communications team for more specialist support.

b. **We will use values-based communications** - ensuring all internal communications messages reflect our brand values and key messages.

c. **Create powerful narrative around our vision**, key organisational objectives and priorities that start with the benefits for patient/service user, staff and stronger communities (as appropriate).
   i. Relevant, targeted and timely methods and messages customized for staff groups.
   ii. Incorporate nudge communications – behaviour change mechanisms to influence attitudes and behaviours such as changing physical environments.

d. Instil pride in our workforce through
   i. sharing of and celebrating good news through multi-channels,
   ii. regular and multiple mechanisms for recognition
   iii. opportunities to co-design and front PR and campaigns
   iv. always show how staff are valued through thanks and stories
   v. integrate opportunities for staff to provide views and news

e. Ensure staff feel like active partners in LPT's future
   i. Honest communication about changes as soon as possible
   ii. Champion opportunities to shape and contribute to future
   iii. Create multi-platform forums for networking to complement the Listening into Action programme (virtual, online and physical events, web chats, internal social media platforms, etc)

f. Create a spirit of community across LPT - #WeAreLPT
   1. **We Are LPT** - The Trust is buzzing with staff trying to bring about a positive change, to connect our workforce, and to inspire continual improvement. Embodying our values, mobilising teams, and creating a way we do things at LPT, are common goals.

      At the same time, #WeAreLPT has grown as an online social movement from our staff. Many staff who currently use this hashtag, do so out of a sense of pride and promotion.

      By building on the WeAreLPT brand, and the pride associated with it, we can mobilise this sense of belonging and common purpose. Ultimately it is about shifting mindset to greater collaboration, greater empowerment and supporting each other; a new LPT mindset. This can only be good for our future vision, for improving our services and ultimately for the care of our service users and patients.

WeAreLPT will help us to develop a compelling narrative, to engage and inform, to motivate and mobilise our staff. Expanding the WeAreLPT into a family of sub-brands will provide an opportunity to create connectivity, communities of practice, and an LPT community of staff.

2. **The formation of WeConnect** – an LPT online tool to enable easy professional networking to make connections, have conversations, search for skills and interests, and have secure clinical conversations.

3. **The formation of WeCreate** – an online innovation crowd-sourcing application enabling staff to share fab ideas and further their ideas by creating interested parties and finding the right resources to progress them. This is backed by a WeCreate ethos – encouraging an innovative workforce for our future that champions and empowers staff to have ideas.

4. **Enterprise social networks (ESN)** will form a key part of the objective for WeCreate and WeConnect, facilitating communities of common interest to develop and feel empowered together, through the use of an internal social media app.

8. **New staff intranet** –a new customizable staff intranet, allowing users to choose news feeds, and other apps, including those above, that they want to help them in their day. It offers choice over how and when they receive their information over mobile and desk top technology, with improved search facilities and saved searches for policies, key documents, services and staff

9. **Improve staff newsletter** – this weekly newsletter is a popular way for staff to find out top news messages. However, it is considered too long and not easy to navigate. There are also no metrics currently behind the newsletter to help measure its reach and impact. New interactive e-newsletter software will be implemented to analyse instant statistics, to improve targeting and relevant messaging, and enable instant polls and other engagement and sharing functions.

10. **Embrace new technology** – as above, this is key to diversifying the way we reach over 5000 staff across over 100 sites. Linking with the IT strategy, and agile working ambitions, we must explore staff apps, webcasts, internal social media and other such technology to facilitate reach.

11. ***Creation of a communications portal and toolkit*** - empowering staff with the right tools and resources
    a. The power of self-service: staff can become more familiar with good communications practice through a range of communications tools they can try out such as event calendars, communications plan templates, event in a box templates, photo library, writing style guides, etc.
    b. A visible communications team: accessible to all staff when needed, supported by a toolkit they can use to enable staff and manage demand and capacity.
    c. Interactive learning forums set up by the communications team to facilitate dissemination and use of best practice communications and innovative channels such as apps and social media – those that already exist and our own.

12. ***Asset based community building and social movements*** – to engage and mobilise staff through major transformational projects and reinforce a culture of continuous quality

improvement, empowerment and building better relationships and understanding – through values, innovation and leadership.

a. Reinforce use of WeConnect and WeCreate to help staff to identify their strengths and skills which could be offered for the 'bigger cause'
b. Creation of WeCitizen – an app encouraging staff to be volunteer their time, act sustainable and fundraise, as part of our corporate social responsibility.
c. Champion fun staff initiatives to improve their health and wellbeing
d. Use the principles of social movement theory to back major engagement and behaviour change programmes i.e. leadership, public narrative, framing communications, mobilising to continuously energise, organising communities, and supporting change platforms.

13. Creative use of spaces

a. Branded 'bumping spaces' to inspire innovation and sense of community – dedicated branded areas to influence and change behaviour
b. Review use of physical spaces for communications such notice boards, staff rooms, and agile working areas.
c. Pop up spaces for campaigns, roadshows and creative thinking.
d. Photo galleries of staff/achievement walls in receptions

4.3 Champion effective digital communication and innovation, connecting people to aid continuous improvement, and supporting system-wide transformation to diversify our offer [*Partner with others to deliver the right care, in the right place, at the right time*].

14. We will **champion creativity and innovation**, actively seeking new and different ways of promoting the objectives of the Trust to improve patient experience of our services and perceptions of our brand (NHS 5YFV: *"we need to raise our game on health technology – radically improving patients' experience of interacting with the NHS").*

15. **Create an e-communications strategy** that creates a seamless customer journey and experience with our offline communications and services, improving our **online digital roadmap.**

a. **Create a mobile responsive website** that offers our service users and partners
   i. routes for engagement and self-service,
   ii. clear navigation to information and contact details
   iii. customization to receive news and updates
   iv. a patient portal to access their health records
   v. web chats with specialists
   vi. leave patient opinion
   vii. patient experience blogs and vlogs
   viii. interactive content using films and images
   ix. integrate with our app store (see point iv below)
   x. integrate with a new fundraising website

b. **create a new staff intranet** (see Internal Communications 2a below)

c. **Step up a gear on social media**
   i. Expand use of Twitter and Facebook to seek and enter into more dialogue and influence
   ii. Target key influencers on social media as ambassadors
   iii. Create more social media campaigns; aim to go viral

iv. Use analytics to be more strategic about its use in terms of timings, audiences, monitoring interest in conversations.
v. Expand portfolio to Instagram – we have the basics right now on Twitter and Facebook, let's try the next big one.

d. **Expand our 'app store' portfolio of mobile apps**.
   i. Creation of a health and wellbeing account for users – like a google account for health (part of innovation strategy)
   ii. Host our library of apps on the wellbeing account
   iii. Support the organisation to create meaningful apps that fill a gap in the market and complement our service offer
   iv. Actively facilitate the development of apps that improve staff communication and engagement such as the newsletter app and intranet apps (see Internal Communications)
   v. Expand use of free apps to help create innovative communications.

16. ***Champion codesign and coproduction*** in our engagement and communications approaches with relevant stakeholders (staff, service users, carers, members, volunteers, partners, commissioners) to ensure rich ownership and better chance of impact in our aim to build stronger communities. (NHS constitution: "of the people, by the people and for the people)

17. ***Create partnerships to deliver communications*** – seek to make connections to enhance our communications plans by linking staff across LPT and making links with our partners and potential partners for system-wide improvements.

18. ***Expand our audiences*** – to further our objectives, we must always consider capturing the awareness and understanding of potential audiences, whether they be potential service users, potential staff, potential partners, members or volunteers for example. How can we track how many more 'converts' have joined a particular cause or campaign? How many more followers we have? (see below)

4.4 **Being insightful for continuous improvement**: Listen, engage, involve, and co-design to continually research our audience's needs and evaluate to improve experience with our brand and to build impactful, accessible communications that make the most of our resources [*Ensure sustainability*].

19. ***Introduce regular research and evaluation mechanisms***
   a. We must be continually insight driven to build on our successes, do the basics well, capture feedback and build in evaluation frameworks into our work.
   b. Learn from our industry and look for ways to be ahead of the curve and share our outcomes.
   c. Increase use of analytics, through available technology, to track engagement and reach, such as that available on social media and on our forthcoming enewsletter software. How many people have actually read something? What are their interests? When is the best time to send information? What is and isn't working?

20. Conduct an annual reputation and communications audit and report
   a. A baseline has been established with staff and service users. This needs to be measured every year to check progress and continually improve our approach.

b. Conduct a stakeholder reputation audit to establish a baseline for future improvement (linked to our stakeholder strategy).

21. **Build an innovative, forward-thinking, *efficient and effective communications team*** with the right skills and passion to make a difference and be the best.

22. Use of **free CMS system** to explore CMS systems tracking stakeholder journeys and levels of interaction with our communications

23. ***Make the most of our resources***:
    a. seeking sponsorship and other funding opportunities for our communications campaigns where appropriate
    b. look at income generation opportunities from our communication products to enhance business opportunities for LPT

24. ***Define and track the 'customer' journey*** – segment and target our messages appropriately for each target audience, based on their level of interest and knowledge using communications tools, meeting the Accessible Information Standards and equality impact assessments. Always bear in mind where the next level of engagement with them. For example, move this journey from inform to engagement, to consultation, to advocacy, and then to active involvement as and where necessary. For patients and service users this could also mean moving them from being supported to self-care, to supporting others (such as from volunteering or peer support), or from carer to member to donor. Mapping patient journeys for touchpoints to evaluate improvement opportunities will support this.

5. Our key messages

5.1 A key overaching message for all our target audiences:

- We put patients and service users at the heart of everything we do, using compassion, integrity, trust and respect.

5.2 For service users, patients and carers

- We are improving the quality and safety of our services and striving for excellence
- We seek to provide innovative ways to deliver care around patients' needs
- Your views matters – we want to learn and improve through them.

5.3 For staff

- We are proud of the commitment and passion of our staff
- We value our staff and are committed to their health, wellbeing and development
- We are committed to continually improving our services
- We celebrate success and innovation, and share our learning
- Your views matters – we want to learn and improve through them.

5,4 For wider stakeholders

- We are improving the quality and safety of our services and striving for excellence

- We seek to provide innovative ways to deliver care around patients' needs
- Your views matters – partnership matters to delivering the best care.

6. Communications Team principles

- **Strategic**: Always highlight benefits to patients, plan and be proactive
- **Transparency**: Communicate with honesty, trust, respect and integrity
- **Audience:** be relevant, targeted, timely, appropriate, and inclusive
- **Enable and empower:** enhancing the culture and values of LPT
- **Innovative:** always seek to be creative and innovative in gaining reach and impact
- **Partnerships:** create, connect and celebrate partnerships within and outside the organisation for the benefit of the best communications outcomes
- **Evidence based:** evaluate what we do, learn from mistakes, constantly seek to improve on benchmarks, and celebrate and share our successes

7. Implementation

This is a two-year strategy, which will require annual plans and defined resources to be successful.

Key steps to implementation will be as follows:

a. **Co-design the tactical plans for the communications strategy with our audiences (with annual implementation plans) for each communications objective.**
   i. Defining our brand and improving our reputation
   ii. Improving internal communications to affect culture change and morale
   iii. Championing effective digital communication and innovation
   iv. Being insightful – for continuous improvement (see point b)

b. **Connect with key interfaces to finalise tactical plans:** customer services, patient experience, IT strategy, membership strategy and partnership strategy.

c. **Establish evaluation mechanisms and metrics** to continue annual tracking:
   i. Reputation audit with stakeholders
   ii. Measureable targets in an action plan that will be reviewed and evaluated each year and presented in an annual communications report.
   iii. Monthly communications activity evaluation report

d. **Agree resources** required including completion of the **communications team** management of change, which will introduce dedicated capacity to ramp up transformational impact on internal communications and digital communications.

Let's make this happen

- Implementation plans will be finalised by July 2016
- Restructured communications team will begin from September 2016

- Trust Board are requested to endorse this direction of travel
- Receive updates every 6 months.

Author: Kamy Basra, Head of Communications, May 2016

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Leicestershire Partnership NHS
NHS Trust

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TRUST BOARD – 27th May 2016

QUALITY ASSURANCE COMMITTEE – 17th May 2016

OVERVIEW REPORT TO BOARD

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

Assurance level	Colour to use in 'Assurance level*' column below
Not assured	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans If red, commentary is needed in "Next Actions" to indicate what will move the matter to "full assurance"
Partially assured	Amber - there are gaps in assurance but we are assured appropriate action plans are in place to address these
Assured	Green – there are no gaps in assurance

Key issue	Assurance level*	Committee update	Next action	Timescale
Commissioners SI policy		Received early May 2016 and circulated to Committee for information. LPT policy has been re-drafted in line with this and is now out for consultation.	QAC expects to be in a position to adopt a revised LPT SI policy in June 2016	June 2016
Safer Staffing requirements for Langley Ward (Adult Eating Disorders) and Ward 3 CAMHS, in FYPC-paper received.		Comprehensive report on nurse staffing establishment across inpatient wards within FYPC. QAC assured that systems and processes are in place to review staffing and manage the associated risks. Review of skill-mix across both areas is underway.	Progress and review of nursing establishments to be reported every six months to Trust Board.	July 2016
Infection Prevention and Control Committee highlight report. Integrated Quality Performance Report.		Concerns about high number of "amber" rated issues and position re Clostridium Difficile in relation to 2015/16. 0 Clostridium Difficile reported in 2016/17.	Detailed report to be provided for further assurance.	June 2016
Draft LPT Quality Account 2015-16		KPMG data testing has highlighted a potential data quality issue with the CRISIS gatekeeping indicator. The issue relates to record keeping and may be linked to the RiO transition.	Stakeholder feedback expected in next two weeks. KPMG report due to be received 27th May 2016. Final Draft to be considered at Trust Board on 27th May 2016.	

Key issue	Assurance level*	Committee update	Next action	Timescale
Integrated Corporate Risk Register and BAF risk report		QAC reviewed and provided an assurance opinion on 5 specific risks from the risk workplan.	Further work was requested for the following risks: 1238-achievement of KPIs (numerous actions out of date) 1133-uncertainty over future cost of the provision of Estates and Facilities services (discussion required at FPC) 1039-developing approach to change – delivery of Strategic Objectives (risk does not capture embeddedness of operational changes)	June 2016
		Consideration of a new corporate risk to capture effective care planning and documentation, outcomes from SIs and clinical audit.	Quality Team to consider further.	June 2016
		Consideration of timing of risk reviews by QAC in line with the current risk workplan and whether this is logical in terms of presentation/discussion at FPC.	Risk team to consider further and update as appropriate.	July 2016
CQC action plan update report		One red action relating to the formalization of DNACPR policy.	Work is underway to ensure that a suitable policy is in place within the month. It is anticipated that this will be adopted by QAC in June 2016.	June 2016
Internal audit reports under the remit of QAC to be presented to QAC as well as Audit and Assurance Committee.		QAC received Internal Audit reports for • Duty of Candour • Clinical Coding	Executive Lead and Committee administrator to produce a tracker to enable QAC to monitor progress of all reports.	June 2016
Caldicott Q4 2015-16 and Closure report.		QAC received and noted the report.	N/A	N/A

Recommendation	The Trust Board receives the issues raised in the highlight report from the Quality Assurance Committee held in May 2016.
Author	Professor Adrian Childs, Chief Nurse (Executive Lead)
Presented by (Chair of committee)	Liz Rowbotham (Chair)

Leicestershire Partnership NHS
NHS Trust

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TRUST BOARD – 27th May 2016

Quality Monitoring Report - Serious Incidents (SIs) April 2016

1.0 Introduction

1.1 A Serious Incident (SI) is defined as an incident that occurred in relation to NHS-funded services and care resulting in (or could have resulted in) one of the following:

- Unexpected or avoidable death to one or more patients, staff or members of the public.
- Serious and or permanent harm to one or more patients, staff or members of the public where the outcome requires life-saving intervention, major surgical/medical intervention or will shorten life expectancy or result in prolonged pain or psychological harm.
- The actions of staff providing NHS funded care that are likely to cause significant public concern i.e. serious instances of abuse (physical/sexual/mental).
- An event that prevents or significantly threatens the Trusts ability to deliver healthcare services.
- One of a core set of 'Never Events' as defined and updated annually.

1.2 This report provides a summary of the Trust's position against key targets for the reporting and management of serious incidents. A thematic analysis and identification of actions taken to reduce risk of recurrence is also included.

1.3 Statistical Process Control (SPC) Charts are used to depict incident data over time. SPCs are the application of statistical theory to quality control. The SPC charts in this report show SI data fall within 'normal variance'.

KEY;

- = Total SIs reported by month over a rolling 12 month period.

___ = Trend Line - this represents the arithmetic linear trend of the data over time.
___ = Upper Control Limits (UCL)
___ = Lower Control Limits (LCL)
UCL and LCL - all of the data points should fall within these limits, if a point falls outside of these limits then an investigation is warranted to find and eliminate the cause or causes.
___ = Upper Warning Limits (UWL)
___ = Lower Warning Limits (LWL)
UWL and LWL are two standard deviations either side of the average (trend line), which catch additional sequences that may indicate out-of-control situations e.g. five or more points, which are all increasing or decreasing (a trend) and which cross a warning limit.

2.0 AIM

2.1 This report is presented in the interests of 'Being Open' (Being Open Framework, National Patient Safety Agency (NPSA), 2009) and to provide assurance that the Trust has robust systems and processes in place to learn from adverse events to minimise or eliminate the risk of recurrence in the interests of patient safety.

3.0 RECOMMENDATIONS

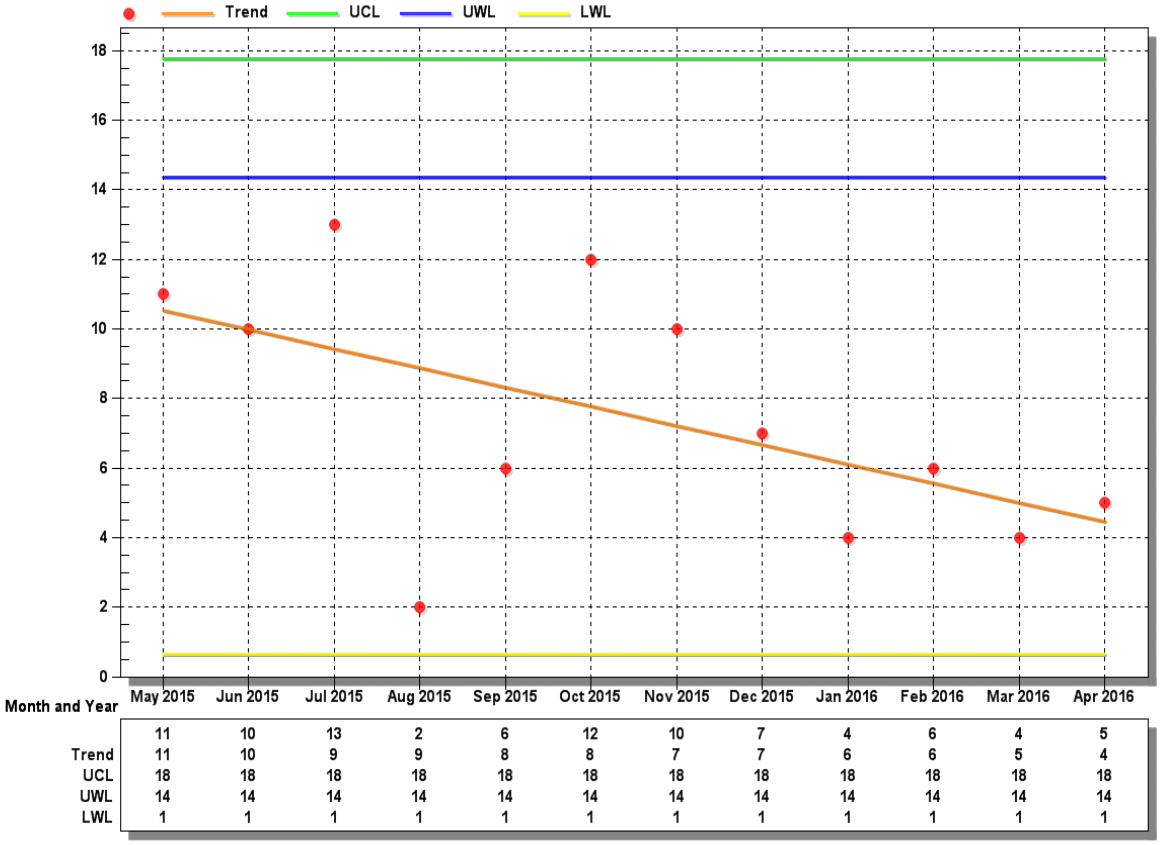
The Trust Board is asked to:

I. Receive assurance that the Trust has robust systems and processes in place to learn from adverse events and ensure that serious incidents are being managed effectively and in accordance with both the Trust and Commissioner Incident reporting policies.

4.0 SERIOUS INCIDENT REPORTING ACTIVITY

4.1 Monthly Incident trends

Fig 4.1 : Total Serious Incidents Reported



Month and Year	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016
	11	10	13	2	6	12	10	7	4	6	4	5
Trend	11	10	9	9	8	8	7	7	6	6	5	4
UCL	18	18	18	18	18	18	18	18	18	18	18	18
UWL	14	14	14	14	14	14	14	14	14	14	14	14
LWL	1	1	1	1	1	1	1	1	1	1	1	1

Figure 4.1 highlights the monthly trend with regard to numbers of serious incidents reported by Leicestershire Partnership Trust (LPT) since May 2015. The highest reported serious incident in April 2016 is suspected suicide (40%).

4.2 Suicides data Review

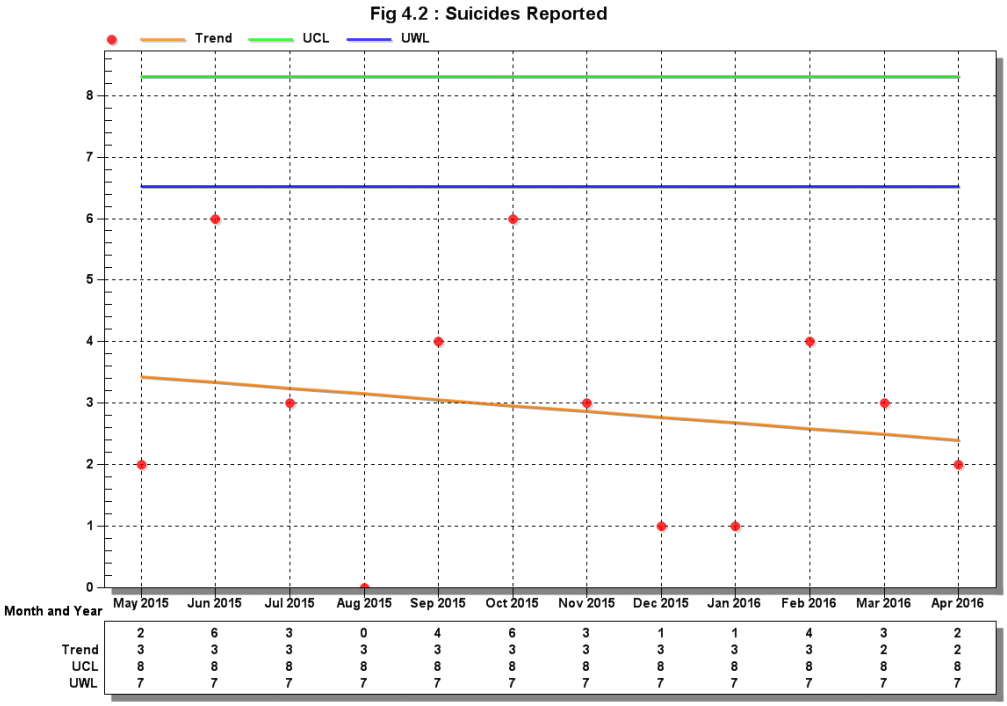


Figure 4.2 above shows the cumulative total of suicides over the last 12 months. There were 34 suspected suicides in the community and one inpatient suicide reported (to be confirmed by Coroner's inquest).

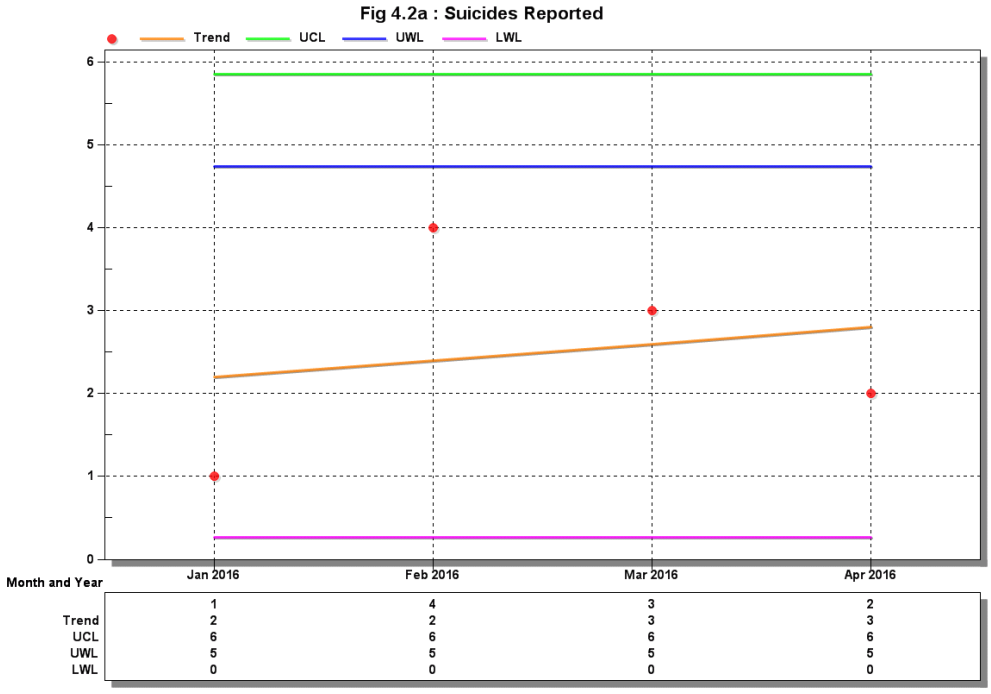


Figure 4.2a above shows there were 9 community suicides and 1 inpatient suicide reported to date in 2016.

Extrapolating data from the latest National Confidential Enquiry into suicide and homicide in people with mental illness results in an increased prevalence of 28 suicides within the Trusts patient population within a calendar year, based on historical data analysis. The Trust has developed a suicide prevention strategy. QAC will receive regular updates on progress of this strategy from the Medical Director.

4.3 Attempted Suicides Reported

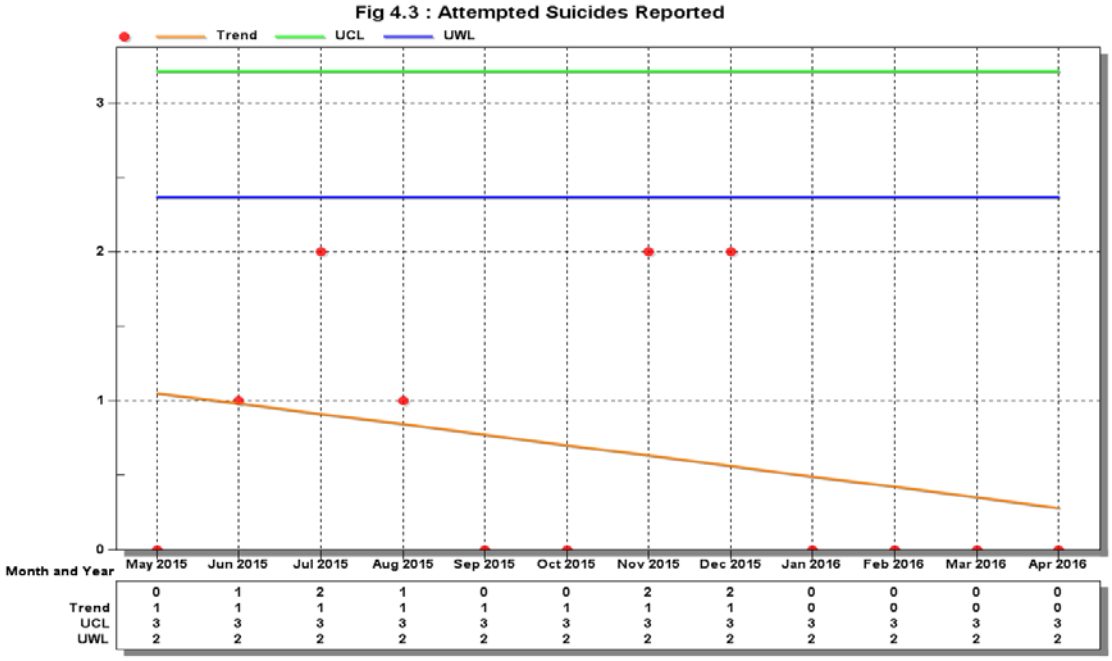


Figure 4.3 highlights the monthly trend with regard to attempted suicide numbers reported by LPT since 1st May 2015.

5.0 MONITORING COMPLIANCE WITH OUR POLICY

5.1 There were six reports which had due dates in April 2016 out of which five (83%) met their timescale. One CHS SI report missed due date due to delay with divisional sign off.

There are currently 16 SI investigations in progress (live).

Division	Number of live SIs
FYPC	5
CHS	3
AMHLD	5

Adult Mental Health and Learning Disabilities and Families Young People and Children Services have the highest number of live investigations.

Following a reported incident a 72 hour report is submitted to the patient safety team for review. 72 hour reports allow for review of a reported incident and in some circumstances are used to confirm whether a reported incident requires escalation in line with the SI policy.

5.2 Number of SIs logged onto STEIS within 48 hours of notification to Patient Safety Team

SI reported	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Green (within 48 hours)	**10**	**8**	**4**	**6**	**4**	**5**
Amber (breached ≤ 7 days)	**1**	**0**	**0**	**0**	**0**	**0**
Red (breached ≥ 8 days)	**0**	**0**	**0**	**0**	**0**	**0**

In the above six month period 38 SIs have been logged in total and of these one incident was not reported within timescale, this was due to late submission of the completed 72 hour report by the service. Please note that the total number of SIs logged may change following review of the RCA by our commissioners who can then make the decision to downgrade the SI.

6.0 APRIL 2016 POSITION

6.1 Serious Incidents reported

The Trust logged five new SIs in April 2016. The Trust now has 16 SIs open, all 16 investigations are progressing within the required deadlines.

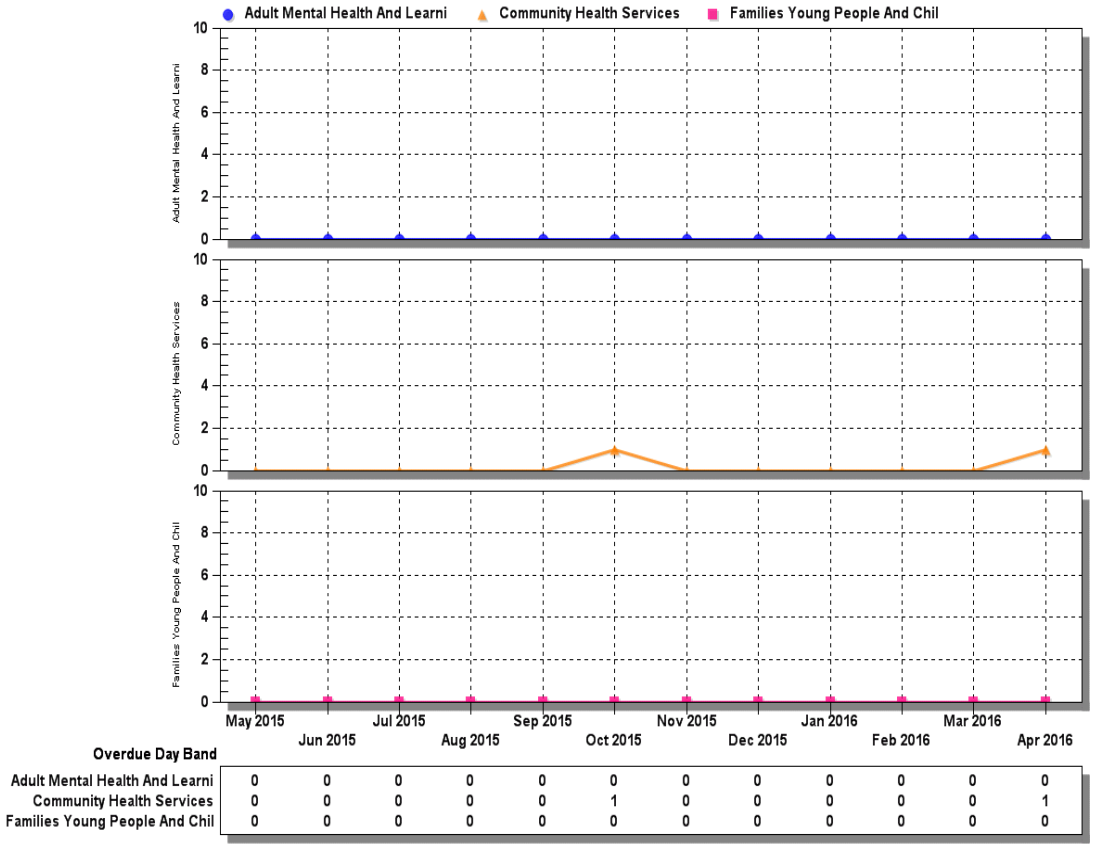
From 1st May 2015 – 30th April 2016 two SIs have been reported as Level 2 (comprehensive) all other SIs have been reported as Level 1 (concise) (see appendix 1).

Table 6.1 – STEIS Incidents reported during April 2016

	INCIDENT CATEGORY*	DEPARTMENT	Service
1	VTE meeting SI critieria	Heather Ward	AMH&LD
2	Apparent / actual / suspected self-inflicted harm (Suspected Suicide of community patient)	MHSOP South Leicestershire Community Mental Health Team	CHS
3	Pressure Ulcer meeting SI criteria	Uppingham Road Health Centre – District Nursing	CHS
4	Apparent / actual / suspected self-inflicted harm meeting SI criteria (Suspected Suicide of community patient)	Health Visiting – New Parks Sure Start	FYPC
5	Failure to obtain appropriate bed for child who needed it	CAMHS Ward 3	FYPC

*Incident categories may change post investigation

6.2 Total Number of Overdue Reports by Service (1st May 2015 – 30th April 2016)



Overdue Day Band												
Adult Mental Health And Learni	0	0	0	0	0	0	0	0	0	0	0	0
Community Health Services	0	0	0	0	0	1	0	0	0	0	0	1
Families Young People And Chil	0	0	0	0	0	0	0	0	0	0	0	0

6.3 SI reports closed by commissioners

There were 12 feedback forms received from our Commissioners in April 2016. Seven reports were closed without comment. Two reports were closed with comments and three reports were not closed.

The Corporate SI Oversight group reviews all SI feedback received from commissioners, which in turn informs our SI training and development programme, and the work of Divisional SI sign off groups.

A feedback form is a document that the Trust receives from our commissioners highlighting the comments raised following a review of our SI reports at their SI sign off meetings. The feedback also confirms whether the commissioners have agreed closure of the SI report or the report requires amendments and a re-submission before closure can be agreed.

Service Line	No. of feedback forms received	No. of SIs closed	No. of action plans changed
AMHLD	7	5	2
CHS	3	3	0
FYPC	2	1	0

7.0 Conclusion

There has been a reduction in numbers of SIs reported since May 2015 when the national criteria for SIs changed. Suicide remains the highest reported category.

Some of the incidents (such as fractures where no intervention was required) that were previously classified as SIs are now being investigated as internal SIs.

APPENDIX 1: Serious Incident process and level summary

All Incidents that are identified as meeting the criteria for external reporting are logged onto the National Strategic Executive Information System (STEIS) within two working days. Once an incident has been reported onto STEIS the Commissioner and LPT will agree the severity of the incident and it will be allocated a level; 1 (Concise internal investigation), 2 (Comprehensive internal investigation), 3 (Independent investigation) see table below.

Table 1 – Serious Incident Level

Level	Description
Level 1 **Concise internal investigation**	Incident suited to less complex incidents which can be managed by individuals or a small group at a local level. This level of incident will require a concise / compact investigation report which includes the essentials of a credible investigation.
Level 2 **Comprehensive internal investigation** (this includes those with an independent element or full independent investigations commissioned by the provider)	Incident suited to complex issues which should be managed by a multidisciplinary team involving experts and / or specialist investigators where applicable. This level of incident will require a comprehensive investigation report including all elements of a credible investigation.
Level 3 **Independent investigation**	This is required where the integrity of the investigation is likely to be challenged or where it will be difficult for an organisation to conduct an objective investigation internally due to the size of organisation or the capacity / capability of the available individuals and / or number of organisations involved. This level of incident will require a comprehensive investigation report including all elements of a credible investigation.

All SI's are subject to a thorough investigation which includes:

- Establishing the facts
- Highlighting any areas of good practice
- Identifying any service delivery problems, care delivery problems, contributory factors, root cause(s), any learning points and actions required to minimise the same type of incident happening again.

The NPSA Incident Decision Tree flowchart is used to enable investigators to determine if the incident is as a result of individual failings or system failures. This helps to identify if the actions that need to be taken to prevent recurrence should be localized or Trust wide and ensures appropriate use of human resource procedures.
On completion of the investigation, the report is submitted to the Divisional Director for review and approval prior to submission to the CCG for closure. Any recommendations made within the report are incorporated into an action plan, which is agreed with all identified leads. The action plan is then entered onto the

Safeguard Incident Data base and monitored by the Divisional Clinical Governance Groups.

On a quarterly basis a Serious Incident learning progress report is presented to Quality Assurance Committee.

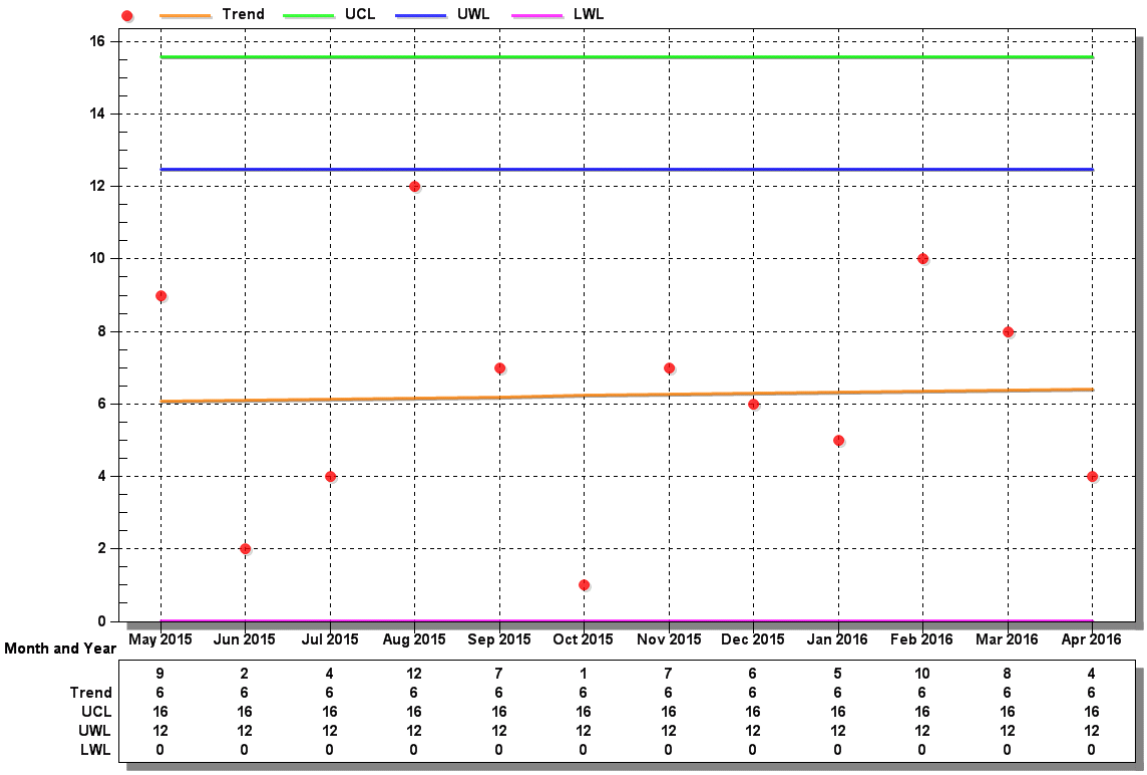
APPENDIX 2: Root Cause themes from SIs closed by our commissioners in April 2016.

SI Cause Type	Total no. of SIs closed	Root Cause Theme
Attempted Suicide	1	Patient X had a long standing mental illness and deterioration in his mental health occurred due to triggers at the time of the incident.
C.Diff Infection	1	The root cause of this incidence has been identified as a delay in source isolation in patients with type 5, 6 and 7 stool, and therefore evidence of poor adherence to policy and procedure for the management of patients with known or suspected infected diarrhoea.
Suspected suicide	2	1. The investigation has been unable to identify a root cause that is attributable to the care and treatment provided by Leicestershire Partnership NHS Trust. *2.* The investigation has been unable to identify a root cause that is attributable to the care and treatment provided by Leicestershire Partnership Trust.

APPENDIX 3 – INTERNAL INVESTIGATION REPORTING ACTIVITY – APRIL 2016

1. Monthly Incident trends

Fig. 1.1 : Internal Investigations logged



Month and Year	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016
	9	2	4	12	7	1	7	6	5	10	8	4
Trend	6	6	6	6	6	6	6	6	6	6	6	6
UCL	16	16	16	16	16	16	16	16	16	16	16	16
UWL	12	12	12	12	12	12	12	12	12	12	12	12
LWL	0	0	0	0	0	0	0	0	0	0	0	0

Figure 1.1 highlights the monthly trend with regard to numbers of internal investigations reported since 1st May 2015.

2. APRIL 2016 POSITION

2.1 Internal Investigations reported

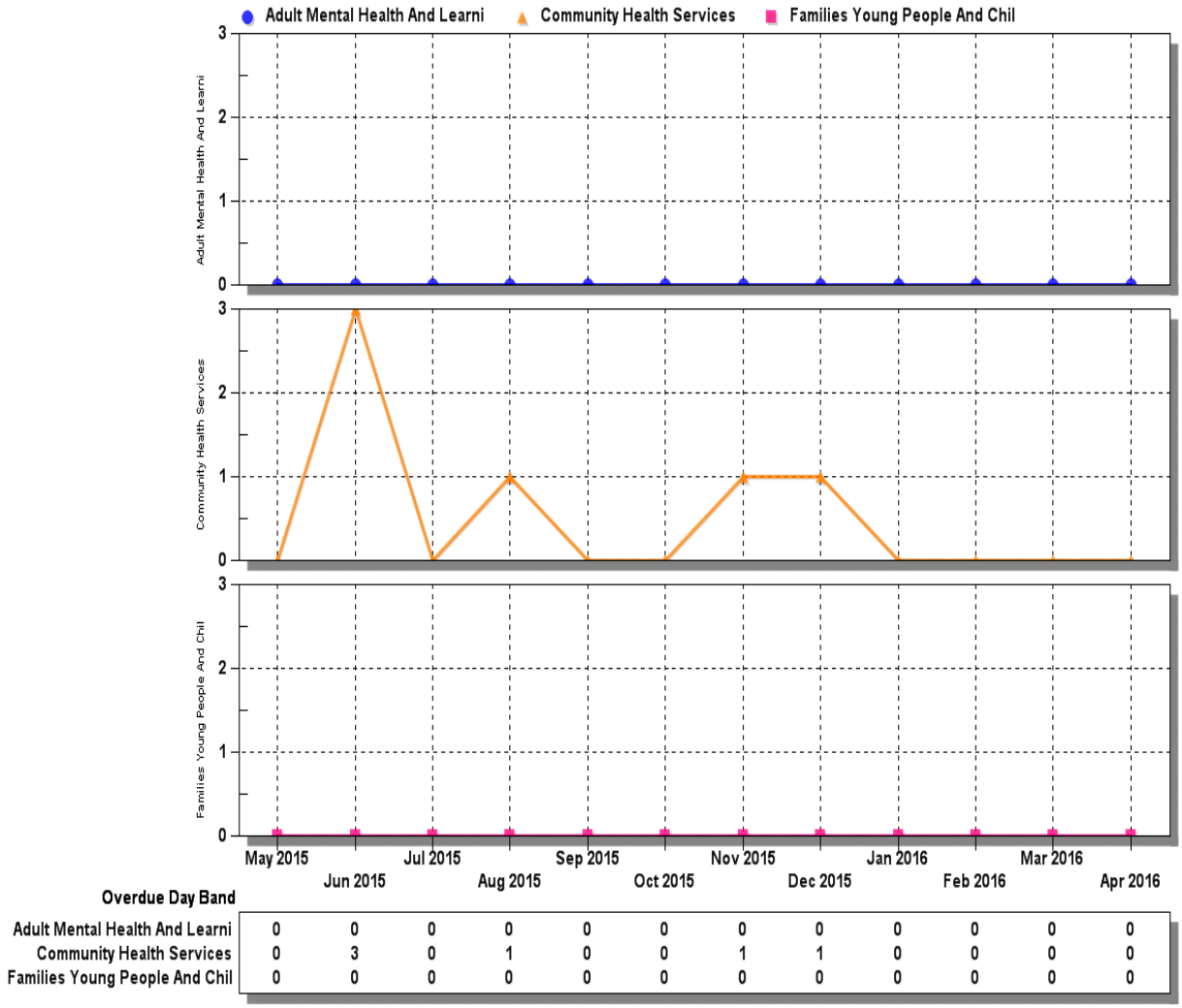
The Trust logged four new internal investigations in April 2016 (see Appendix 1 for definitions). The fall in SIs reported onto STEIS is as a direct result of the new SI framework and the emphasis on the harm outcome to the patient. The Trust however has continued to investigate what would previously have been STEIS SIs as internal SIs, which has led to an increase in internal investigations.

Table 2.1 provides a summary of the four internal investigations reported during April 2016.

Table 2.1 – Internal Investigations April 2016

	INCIDENT CATEGORY	DEPARTMENT	Service
1	Self harm – ligature	Crisis Resolution Team	AMH&LD
2	Fall	Beechwood Ward	CHS
3	Sudden / Unexpected Death	City Unscheduled – Neville Centre	CHS
4	Attempted Suicide	MHSOP City West Community Mental Health Team	CHS

3. Total Number of Overdue Internal Investigation Reports by Service April 2016



Overdue Day Band	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016
Adult Mental Health And Learni	0	0	0	0	0	0	0	0	0	0	0	0
Community Health Services	0	3	0	1	0	0	1	1	0	0	0	0
Families Young People And Chil	0	0	0	0	0	0	0	0	0	0	0	0

4. Root Cause themes from Internal Investigation Incidents closed in April 2016

Internal Investigation Cause Type	Total no. closed	Root Cause Theme
Child/Young person sustained non-accidental injury	1	The root cause cannot be determined as the perpetrator/s of baby's injuries has not been determined and the case remains an open Police investigation.
Fall	1	The investigation team have determined that there were no care or service delivery problems from LPT.
Physical – Disruptive Behaviour	1	There has been no identified root cause for this incident. The investigation has found that the incident could not have been predicted, however, has identified a number of learning points that will be taken from this investigation and used to improve practice within the services involved in the patient's care and more widely within the division.
Self- harm – medication	1	This investigation did not conclude definitive contributory or causal factors resulting in this incident that could be associated with the actions of Leicestershire Partnership Trust (LPT) services from initial contact by the patient until the ambulance was called on the same day.

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Leicestershire Partnership NHS
NHS Trust

TRUST BOARD – 27th May 2016

Learning from Serious Incidents Quarter 4 2015/16

1.0 Introduction

1.1 This report outlines performance and progress in relation to Serious Incidents (SIs). The information detailed in this report is examined quarterly within the Patient Safety Group (PSG) and learning and emerging themes are discussed, addressed and or escalated as required.

2.0 Recommendation

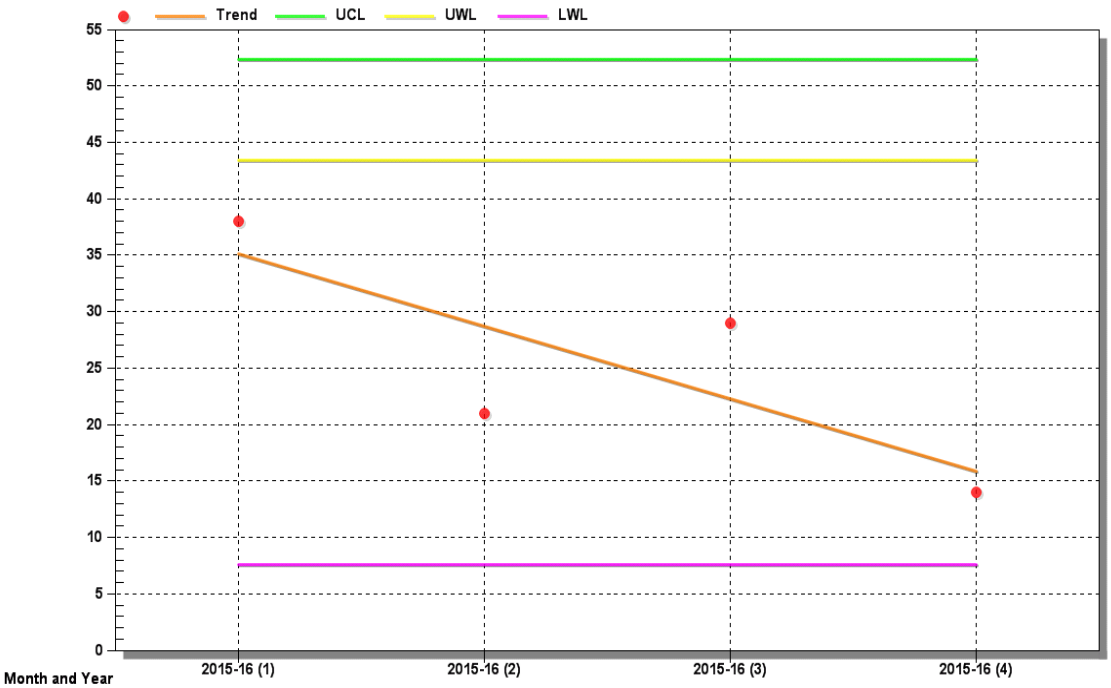
The Trust Board is recommended to receive assurance that the actions detailed are being addressed and changes made following lessons learnt from SIs.

3.0 SI data

3.1 In quarter 4 2015/16 there were 14 SIs that met the reporting criteria for escalating to the Clinical Commissioning Group (CCG).

There is a decrease from 29 SIs, which met the reporting criteria in quarter 3, 2015/16.

Fig 3a : serious incidents logged by quarter



Month and Year	2015-16 (1)	2015-16 (2)	2015-16 (3)	2015-16 (4)
Trend	38	21	29	14
UCL	35	29	22	16
UWL	52	52	52	52
LWL	43	43	43	43
	8	8	8	8

Figure 3a highlights the quarterly trend with regard to numbers of serious incidents reported by LPT since 1st April 2015.

4.0 Incident trends since April 2015

4.1 There has been a decrease in total SIs logged in quarter 4 2015/16 from 29 in quarter 3 2015/16 to 14 in quarter 4 2015/16.

The highest three types of incidents during quarter 4 2015/16 are:

a. Suspected Suicides (50%)
b. Slips / Trips / Falls (21%)
c. Safeguarding Vulnerable Child (14%)

SERVICE OVERVIEW

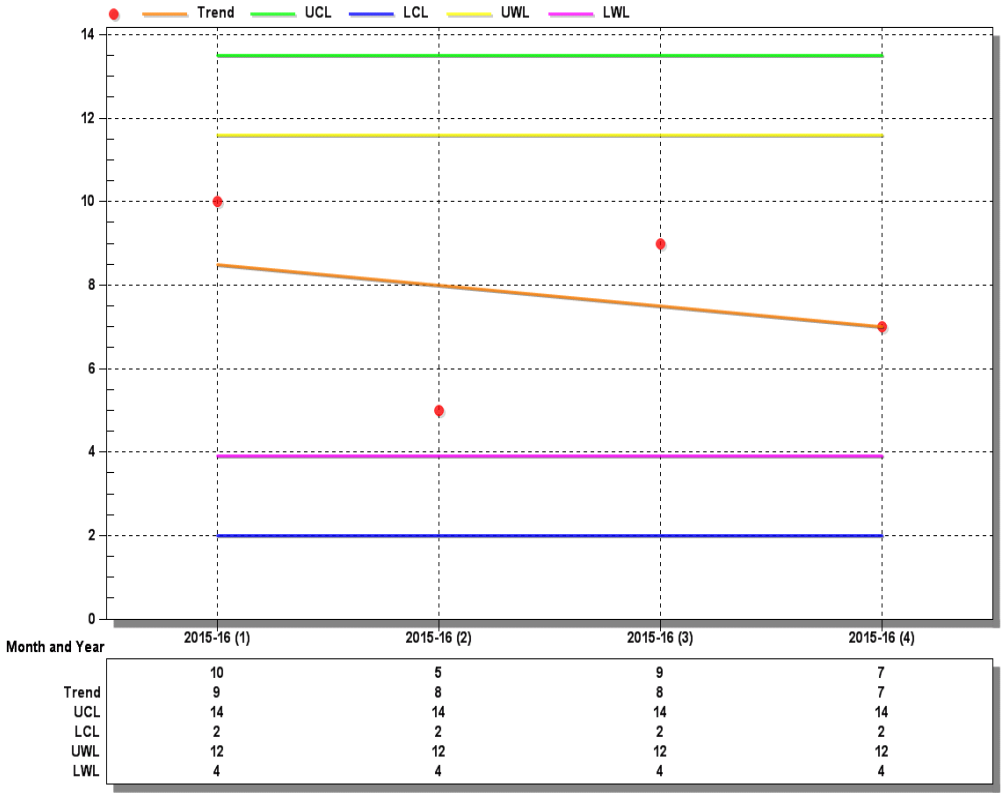
5.0 Adult Mental Health and Learning Disabilities

5.1 There has been a decrease in externally reportable SIs within Adult Mental Health and Learning Disabilities from 14 in quarter 3 2015/16 to eight in quarter 4 2015/16, which is due to a decrease in suspected suicides and attempted suicides.

The highest categories of incidents reported within Adult Mental Health Services for 1 January 2016 to 31st March 2016 are:

a. Suspected suicide in the community equating to 87.5%

Fig 5a : Suicides logged by quarter

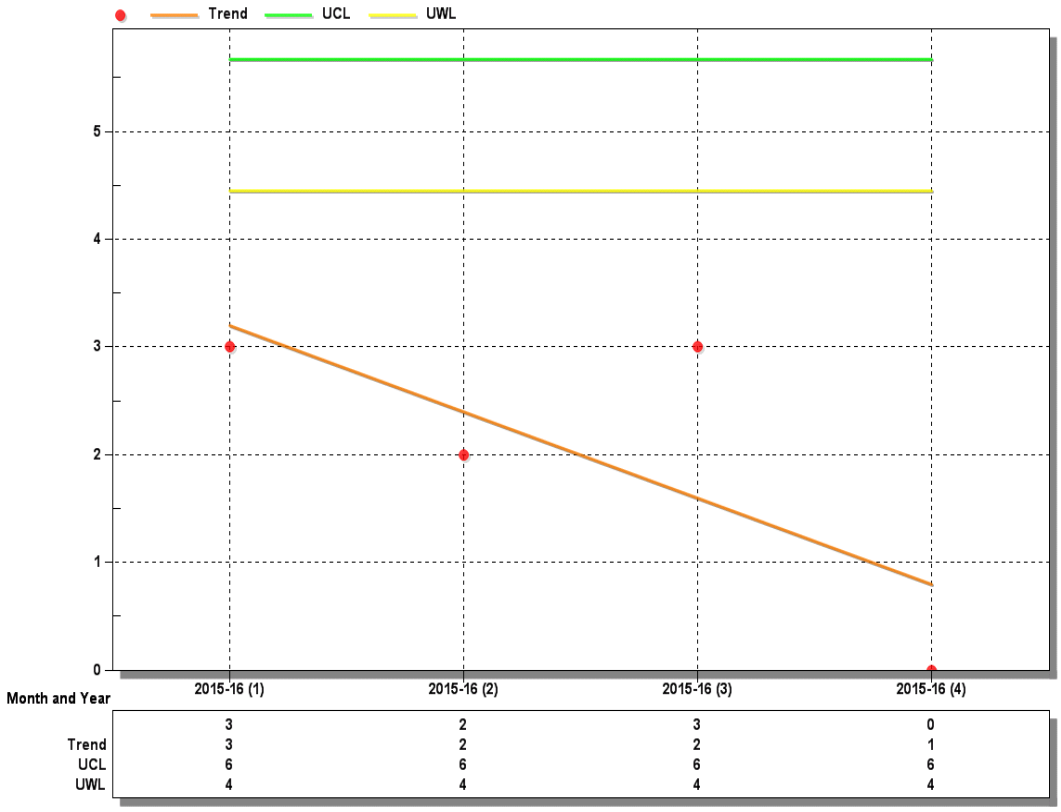


Month and Year	2015-16 (1)	2015-16 (2)	2015-16 (3)	2015-16 (4)
Trend	10	5	9	7
UCL	9	8	8	7
LCL	14	14	14	14
UWL	2	2	2	2
LWL	12	12	12	12
	4	4	4	4

5.2 There has been a decrease in the number of suspected suicides reported within Adult Mental Health from nine in quarter 3 2015/16 to seven in quarter 4 2015/16. Please note the above

figures may vary from quarter to quarter dependent upon the results of Coroners inquests conducted and closed during that time.

Fig 5b : Attempted Suicides logged by quarter



5.3 There has been a decrease in attempted suicide SIs within Adult Mental Health from three in quarter 3 2015/16 to zero in quarter 4 2015/16.

5.4 Learning implemented and actions taken as a result of SI investigations in AMH&LD services

Learning implemented and action taken as a result of SI investigations (AMH)	
Attempted Suicide	• Handover sheet in use at the Bradgate Mental Health Unit will be reviewed with a view to having annotated entries with the time and name of the staff making the entry and review the identification of current and historical risks separately. • Handover tool will be reviewed to consider that each risk of self-harm should be listed separately and should include a brief reference to the appropriate action agreed by the Multi-Disciplinary Team (MDT). • A review of the electronic risk assessment paperwork will be completed to ensure that there is an area for recording decisions about positive risk taking. This will then be cascaded to staff. • To ensure that formal supervision is taking place at the Bradgate Mental Health Unit in addition to informal discussions

	and peer group meetings. • A review of the availability of support and supervision provided to Consultants and other staff working with personality disorder.
Confidential Information Leak (Joint investigation with FYPC)	• Posters to be designed and displayed in all reception areas reminding patients to inform staff regarding any changes to their demographic details. • The Administration and Outpatient Services Manager will work with the administration teams to ensure that letter and care plan templates can be altered to suit addresses of varying lengths. Secretaries will be made aware that they can alter the templates and should know how to do this. This should facilitate using a window envelope for all clinical correspondence, as per current guidance. • Communication has been sent to Administration teams highlighting the importance of when it is not possible to use a window envelope, the name and address on the envelope should be cross-checked with the name and address on the correspondence being sent.
Suicide by Outpatient	• LPT guidelines for the provision of staff welfare and support following a distressing incident to be reviewed as it is recommended that in cases where multiple teams are involved a lead person is identified to ensure that all staff involved are contacted and informed of the incident and appropriate actions are taken. • A review will be completed within the AMH inpatient units to complete physical health assessments for patients. This will aim to seek assurances that these are being completed and the quality of them in addition to identify any trends and /or patterns on particular wards / areas. • Physical health nurses to highlight all new admissions to ensure a physical health check is carried out with the patient's consent. If refused to be encouraged regularly in line with the policy. • Initiatives to be explored around employing RGNs within the Bradgate Mental Health Unit to bolster the physical healthcare support to patients in the unit. • Report has been shared with University Hospitals of Leicester (Oncology) for learning specifying in particular how the oncology nurse specialists could have influenced psychological wellbeing. • Additional guidance for electronic patient records to be considered e.g. how to date and time records/what contacts to record, requirements for staff to document all contact in RiO progress notes in addition to requirements for all changes of address to be recorded in the 'address history' facility on RiO. • A review of the Community Mental Health Team Operational procedure will take place to include clear guidance on expected time frames for written correspondence on the outcome of

	assessments to be sent to the referrer. • Deliberate Self Harm and Open Mind Services to highlight the necessity for regularly scheduled and recorded formal one to one supervision (i.e. in addition to informal discussions, "catching up" sessions, peer group meetings etc.).

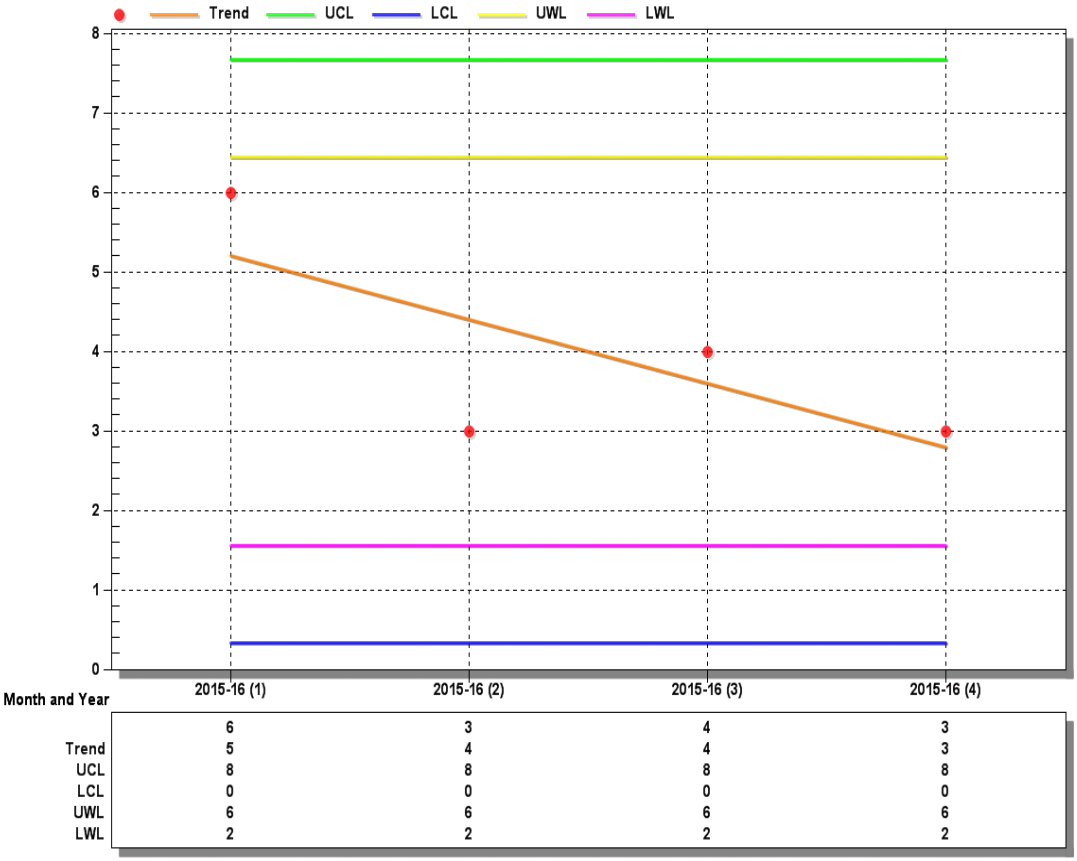
6.0 Community Health Services

6.1 There has been a continued decrease in externally reportable SIs within Community Health Services (CHS) in quarter 4 2015/16 from nine in quarter 3 2015/16 to four in quarter 4 2015/16.

6.2 The top category of incidents reported within CHS for 1 January 2016 to 31 March 2016 is slips, trips, falls equating to 75%.

All falls SI's are reviewed at the trust wide falls group, lessons learned are shared with falls champions from all areas for dissemination.

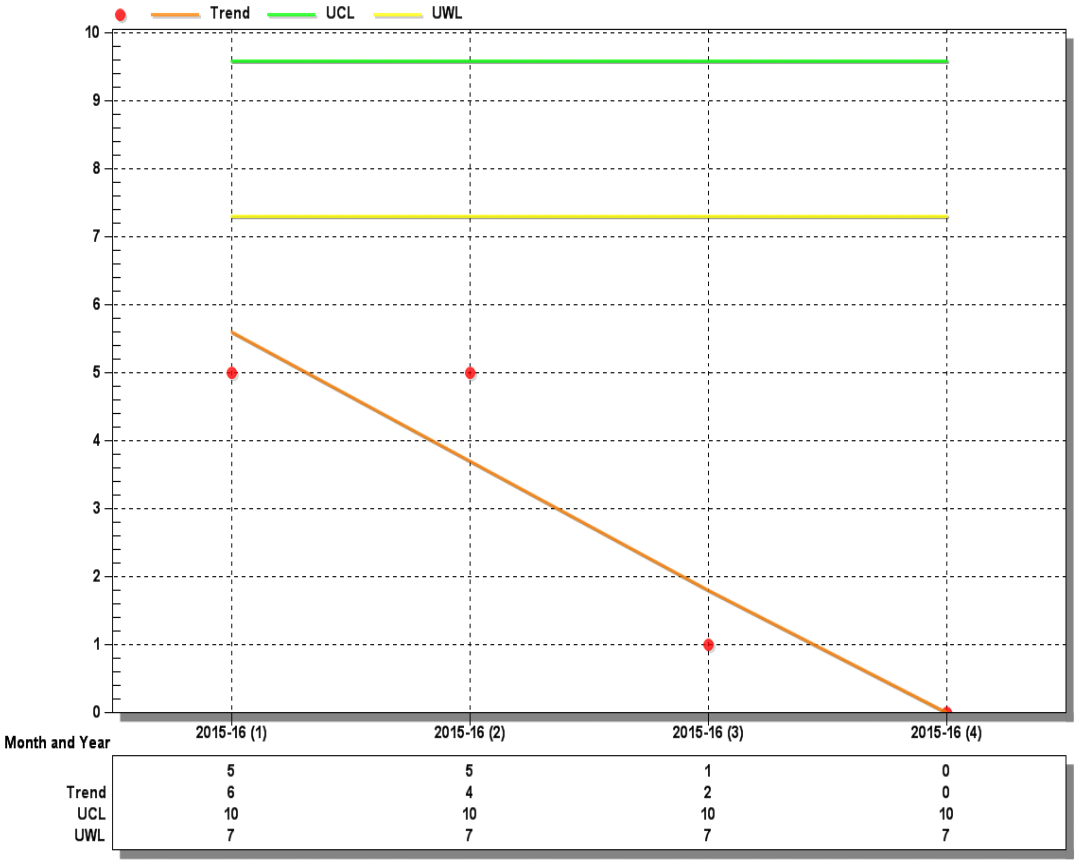
Fig 6.a : Slips / Trips / Falls



Month and Year	2015-16 (1)	2015-16 (2)	2015-16 (3)	2015-16 (4)
Trend	6	3	4	3
UCL	5	4	4	3
LCL	8	8	8	8
UWL	0	0	0	0
LWL	6	6	6	6
	2	2	2	2

6.3 There has been a decrease in the number of slips / trips / falls SIs reported within CHS from four in quarter 3 2015/16 to three in quarter 4 2015/16.

Fig 6b : Pressure Ulcers logged by quarter



6.4 Figure 6b above shows that there has been a continued decrease in pressure ulcer SIs reported within CHS from one in quarter 3 2015/16 to zero in quarter 4 2015/16.

6.5 Learning implemented and action taken as a result of SI investigations in CHS division.

Learning implemented and action taken as a result of SI investigations (CHS)	
Attempted Suicide	• To review the RiO records with clinical staff, Care Programme Approach (CPA) Practice Group and the RiO Exploitation Team in order to reduce the duplication and ensure that the information from core assessment, risk assessment, care planning and crisis/contingency planning flow. To review the Therapeutic Risk Taking Tool to identify its role and remit within the documentation. Identify the best way of implementing this.
C.Diff Infection	• All ward health care assistants (HCAs) to attend for clinical supervision regarding escalation of patient clinical changes outside 'normal' range. • All ward Registered Nurses (RNs) to attend for clinical supervision and reflection regarding appropriate delegation of tasks to health care assistants, requesting feedback and review of patient clinical parameters. • All ward RNs and HCAs to understand the importance of collecting stool samples and recording this in case notes

	• Any non-compliance in the infection control assurance folder should be followed through to ensure that actions are implemented and re-checked. Matron and ward sister to review at the end of each month. • Nurse in charge to inform cleaning staff directly which patients are in standard isolation precautions and rooms requiring terminal cleaning. • Review of clostridium difficile recovery plan January 2016 to include additional education and training. • New verbal handover form will be in use.
Confidential Information Leak	• A standardised operation procedure (SOP) to be created in relation to the transportation and destruction of patient identifiable information. A review of the Information Governance training to be completed. A bank/agency orientation process to be produced that includes expectation in this regard both prior to the introduction of a technological solution and afterwards. • Identify electronic solutions to support the maintenance of patient confidentiality and make a recommendation how to proceed.
Slip / Trip / Fall	• Ward sister to facilitate clinical supervision to highlight the importance of complete record keeping. Ward staff to attend clinical supervision session and record on ULearn.
Suspected Suicide	• Increased Psychology provision to ensure their professional opinion is reflected within the Multi-disciplinary team (MDT) reviews and to support and direct staff to develop holistic formulations and plans of care. • A meeting has been held with staff involved in the care of this patient to reflect on the quality of documentation and to develop a greater understanding about the difficulties in practice relating to non-completion of care plans and risk assessments to establish how this could be improved. • Bespoke risk assessment and management training is being commissioned around self-harm and suicide in Older Adults in line with NICE Guidance. This needs to be made available to staff working in Mental Health Services for Older Persons (MHSOP) inpatient areas and to monitor this through the MHSOP risk assurance group. • To review and consult current practice relating to the MDT records being integral to the contemporaneous records and not being stored in a separate electronic folder. • A review and recommendations on the current care planning

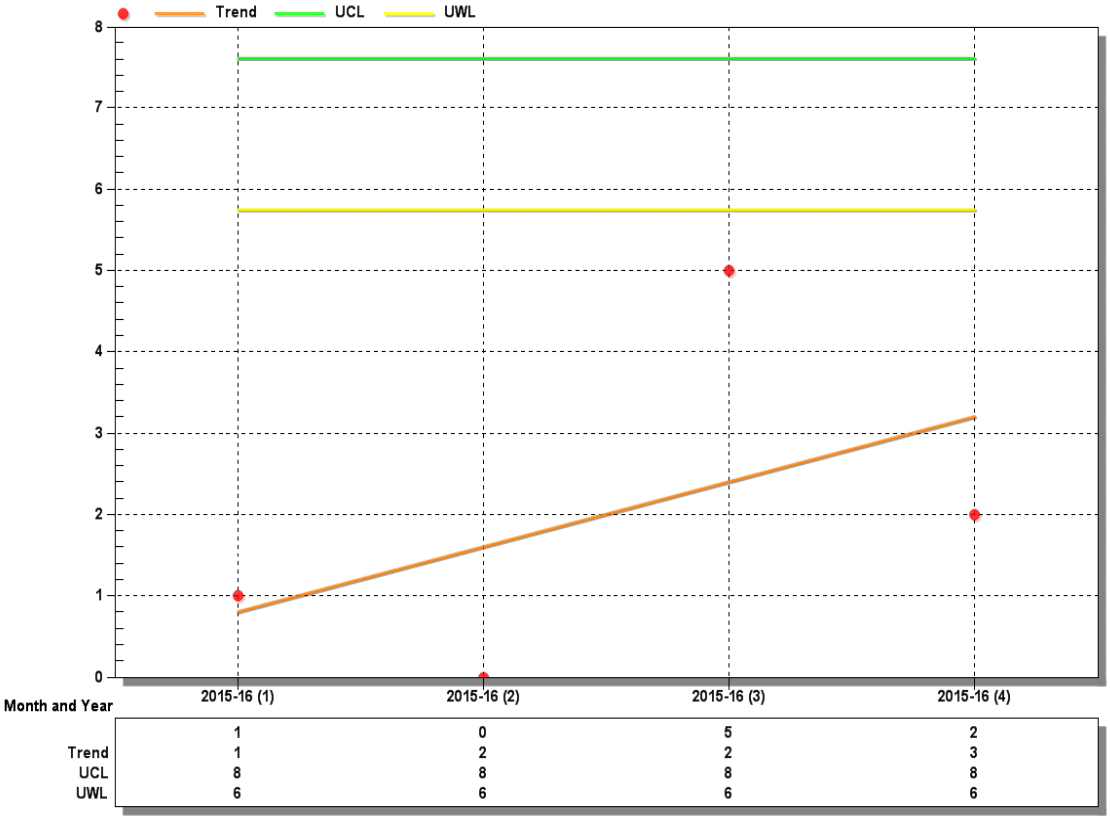
	audit process will be undertaken by Governance Colleagues as a result of discrepancy between the care planning audit outcomes and care plans in practice. • To undertake a review of the Trust Policy on leave from inpatient services in practice to ensure care plans reflect the agreed leave arrangement. To review whether a standard template would be beneficial to support leave planning and patient safety. • Patients' legal status to be reviewed during the MDT meeting- a section to be added to the MDT template to cover this.

7.0 Families, Young People and Children Services

7.1 There has been a decrease in externally reportable SIs within Families Young People and Children Services (FYPC) from six in quarter 3 2015/16 to two in quarter 4 2015/16; this is due to a reduction in Safeguarding Vulnerable Child SIs.

7.2 The top category of incidents reported within FYPC for 1 January 2016 to 31 March 2016 is Safeguarding Vulnerable Child equating to 100%:

Fig 7.2a : Safeguarding Vulnerable Child



7.3 Figure 7.2a above shows that there has been a decrease in safeguarding vulnerable child SIs reported within FYPC from five in quarter 3 2015/16 to two in quarter 4 2015/16.

7.4 Learning implemented/ actions taken as a result of SI investigations in FYPC

Learning implemented taken as a result of SI investigations (FYPC)	
Confidential Information Leak (Joint investigation with AMH/LD)	• Standard Operating Procedure has been updated to include guidance on retaining signed copies of clinical correspondence. • Posters to be designed and displayed in all reception areas reminding patients to inform staff of any changes to their address or telephone numbers. • The Administration and Outpatient Services Manager to work with the administration teams to ensure that letter and care plan templates can be altered to suit addresses of varying lengths. Secretaries to be made aware that they can alter templates and should know how to do this. This should facilitate using a window envelope for all clinical correspondence, as per current guidance. • Communication to be sent to Administration teams highlighting the importance of when it is not possible to use a window envelope, the name and address on the envelope should be cross-checked with the name and address on the correspondence being sent. • The outcomes of the investigation will be shared across the Division's administration teams.
Safeguarding Vulnerable Child	• A reflective discussion has taken place with Health Visitor about documenting marks on non-mobile babies. • Guidance to be developed to support the GP alignment and Health Visitor liaison arrangements in Leicester City. • The working practice of the two Health Visitors' clinics has been reviewed to ensure safe delivery including record keeping on SystmOne and appointment arrangements. • When carrying out assessments of children, Health Visitors are to review the child and maternal SystmOne record, to gain an understanding of the previous history. • Health Visitors to ensure that they are clear which SystmOne unit the practitioner accesses when they are transferring information electronically. • Health Visitors to complete an incident form if they are not invited to attend a pre-birth conference. • Leicester Recovery Partnership (LRP) manager to meet with the Social Work Team managers to share information regarding the LRP service, including treatment

	programmes and to address communication issues between social workers and the LRP service. • The LRP Standard Operating Procedures to be strengthened to include specific safeguarding practice guidance for LRP workers. • LRP worker concerned to have a reflective discussion with their safeguarding supervisor regarding the supervision required for this case.

8.0 Themes and learning from SI investigations in Q3 2015/16

All recommendations, lessons learnt, notable practice and actions from SI investigations are monitored through divisional governance systems. Divisional trends and themes are also monitored through these governance arrangements. The Patient safety team continues to review trends and themes and produce quarterly reports which include trends and actions taken.

Twenty seven investigation reports were signed off by commissioners in quarter 4 2015/16. All actions from those reports were completed within timescale or remain on target for completion by the due date.

8.1 Themes identified from serious incidents in this quarter were:

- The continued need for improved physical health care in mental health settings
- Staff access to clinical supervision
- Staff access to support following a serious incident
- Handover of care

8.2 Some of the key changes made as a result of SIs in quarter 4 (2015/16):

- Review of handover tools at the Bradgate Unit

- Physical health nurses to highlight all new admissions to ensure a physical health check is carried out with the patient's consent. If refused to be encouraged regularly in line with the policy.

- Posters to be designed and displayed in all reception areas reminding patients to inform staff regarding any changes to their demographic details.

- Review of clostridium difficile recovery plan January 2016 to include additional education and training.

- Patients' legal status to be reviewed during the MDT meeting- a section to be added to the MDT template to cover this.

- Leicester Recovery Partnership (LRP) manager to meet with the Social Work Team managers to share information regarding the LRP service, including treatment programmes and to address communication issues between social workers and the LRP service.

- The LRP Standard Operating Procedures to be strengthened to include specific safeguarding practice guidance for LRP workers.

9.0 Performance

Quality of Investigation Reports

	No. CCG feedback received	No. SIs closed without CCG feedback	No. SI action plans amended as a result of CCG feedback
Qtr 4 – 15/16	43	22 (51%)	3 (7%)
Qtr 3 – 15/16	29	16 (55%)	9 (31%)
Qtr 2 – 15/16	38	20 (53%)	7 (18%)
Qtr 1 – 15/16	48	25 (52%)	7 (14%)

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

Submission	Total no. of SIs reported	Q4 – 15/16	Q3 – 15/16	Q2 – 15/16	Q1 – 15/16
Green (within timeline)	*102	100%	96%	100%	100%
Amber (breached ≤ 7 days)	1	-	2%	-	-
Red (breached ≥ 8 days)	-	-	-	-	-

* The number of SIs reported onto STEIS during Q4 14/15 and Q1, Q2 and Q3 2015/16.

The delay in reporting onto STEIS in the previous quarter was due to the late submission of the completed 72 hour report by the service.

Final report submission (≤ 45 working days for grade 1 and ≤ 60 working days for grade 2)

A total of 23 incident investigations were concluded and 100% were submitted to the commissioners by the target date.

Submission	Q4 15/16	Number	Q3 15/16	Number	Q2 15/16	Number	Q1 15/16	Number
Green (within timeline)	100%	23	96%	21	100%	40	100%	29
Amber (breached ≤ 7	0	-	4%	1	-	0	-	2

days)								
Red (breached ≥ 8 days)	0	-	-	0	-	0	-	3

9.1 Open Incidents

As at 14 April 2016 there were 12 open incidents all of which were progressing within timescale.

9.2 Trends in incident reporting and investigations

On a quarterly basis trends from serious incidents are reviewed and checked to ensure that the Trust is taking action to address any identified issues.

9.3 Never Events

'Never events' as defined by the National Patient Safety Agency (NPSA) would always be reported as SI's and therefore immediately notified to the relevant Clinical Commissioning Group/Commissioner.

There were zero never events reported within quarter 4 (2015/16).

9.4 Investigation Training

Investigation training continues and there is now an extensive pool of investigators in each division. However further training dates are required to both maintain and increase the number of investigators. Further training dates are available throughout 2016.

9.5 National Reporting and Learning System (NRLS)

The latest NRLS report (April 2016) showed that LPT remains in the top 25% of reporters, being 9th of 56 Trusts. ,however there was an increase of 2.86 incidents per thousand bed days compared to the previous reporting period which is a 5% increase in incident reporting rate.

APPENDIX 1

10.0 INTERNAL INVESTIGATION REPORTING ACTIVITY

10.1 Quarter 4 2015/16 Position

In quarter 4 2015/16 there were 23 internal investigations reported, please see table 10.1a below.

Table 10.1a – Internal Investigations Quarter 4 2015/16

	INCIDENT CATEGORY	DEPARTMENT	SERVICE
1	Attempted Suicide	Assertive Outreach City	AMH&LD
2	Attempted Suicide	Beaumont Ward	AMH&LD
3	Missing Patient	Bosworth Ward	AMH&LD
4	Self Harm – Other	Crisis Resolution Team	AMH&LD
5	Breach of Patients Confidentiality	Dynamic Psychotherapy	AMH&LD
6	Clinical Condition	Heather Ward	AMH&LD
7	Physical / Disruptive Behaviour	Place of Safety	AMH&LD
8	Failure to return from authorised leave	Thornton Ward	AMH&LD
9	Failure of Security Equipment	Leicester Prison	AMH&LD
10	Fall	Beehwood Ward	CHS
11	Fall	Kirby Ward	CHS
12	Attempted Suicide	MHSOP City East	CHS
13	Self harm medication	MHSOP South Leicestershire	CHS
14	Treatment / procedure inappropriate / wrong	North Ward	CHS
15	Fall	Wakerley Ward	CHS
16	Sudden Unexpected Death	Wakerley Ward	CHS
17	Fall	Wakerley Ward	CHS
18	Fall	Wakerley Ward	CHS
19	Fall	Ward 1, St Lukes Hospital	CHS
20	Breach of Patient's Confidentiality	Children's Therapies	FYPC
21	Safeguarding Vulnerable Child	Health Visiting – Beaumont Leys Health Centre	FYPC
22	Safeguarding Vulnerabe Child	Health Visiting – Countesthorpe Health Centre	FYPC
23	Safeguarding Vulnerable Child	Health Visiting – Countesthorpe Health Centre	FYPC

10.2 Themes and learning from internal investigations in Quarter 4 2015/16

Seventeen internal investigations have been completed during quarter 4 2015/16 and some of the key themes/learning identified were:

- A robust induction programme for locum consultants
- To ensure the availability of patient appropriate Lithium information leaflets

- Clinical Education leads to focus training on the use of the Slips, trips and falls policy and the proactive management of falls risk

- A clinical risk group has been commenced in Mental Health Services for Older persons (MHSOP) to review processes and documentation in relation to clinical risk

- Refresher training for Health Visitors on non- accidental injury in non-mobile babies

- Patient information leaflets on pulmonary embolism/ deep vein thrombosis to be available on Adult Mental Health wards

Leicestershire Partnership NHS
NHS Trust

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Trust Board – 27 May 2016

Quarterly Complaints Report (1 January to 31 March 2016)

1. Introduction

1.1 A complaint is defined as 'a verbal or written expression of dissatisfaction requiring a response'. Complaints can be raised verbally or in writing. Statutory duties with regard to complaints are detailed in the NHS Complaints Regulations 2009 (No.309).

1.2 This report provides a summary of the Trust's position against the regulatory requirements for the management of complaints on a quarterly basis.

1.3 The detail behind the complaints is scrutinised at Service Governance level and this quarterly complaints review captures themes and trends as well as trust wide service changes instigated following learning from complaints.

1.4 Statistical Process Control (SPC) Charts are used to depict complaint trends. SPCs are the application of statistical theory to Quality Control. The SPC charts in this report show complaints data falls within 'normal variance'.

KEY;

- = Total complaints reported by month over a rolling 12 month period.

___ = Trend Line - this represents the arithmetic linear trend of the data over time.
___ = Upper Control Limits (UCL)
___ = Lower Control Limits (LCL)
UCL and LCL - all of the data points should fall within these limits, if a point falls outside of these limits then an investigation is warranted to find and eliminate the cause or causes.

___ = Upper Warning Limits (UWL)
___ = Lower Warning Limits (LWL)
UWL and LWL are two standard deviations either side of the average (trend line), which catch additional sequences that may indicate out-of-control situations e.g. five or more points, which are all increasing or decreasing (a trend) and which cross a warning limit.

1.5 Triangulation work is being undertaken on complaints received in quarter 4 (2015/16) with patient safety data received in the same period. This work will be presented in a separate, dedicated report to the Quality Assurance Committee (QAC).

2 Aim

2.1 This report aims to provide assurance that robust systems and processes are in place to manage and learn from complaints.

3. Recommendations

3.1 The Trust Board is asked to receive assurance that the Trust has robust systems and processes in place to ensure that complaints are being managed effectively in accordance with both the Trust and regulatory expectations.

4. Complaints received in quarter 4 (2015/16)

4.1 The total number of complaints received during quarter 4 2015/16 by each service is shown in figure 1.

Figure 1: Complaints by Service quarter 3 (2015/16)

Service	Total
Adult Mental Health And Learning Disabilities (AMH/LD)	38
Community Health Services (CHS)	35
Families Young People And Children (FYPC)	13
Corporate	1
Trust Total	**87**

4.2 At the time of reporting:-

- 51 complaints have been responded to; 28 in excess of 25 working days
- 11 complaints remain on-going within 25 working days
- 15 complaints remain on-going in excess of 25 working days
- 5 complaints are awaiting patient consent to investigate
- 5 complaints have been withdrawn.

4.3 Figure 2 indicates how many complaints the Trust considered well founded (upheld) versus the number of complaints it did not judge to be well founded and therefore did not uphold.

Figure 2: Number of 'upheld' and 'not upheld' complaints in quarter 3 (2015/16)

Month	Total number of complaints	Not Upheld	Upheld (including partially upheld)	Number of complaints ongoing	Number of complaints withdrawn
January 2016	30	7	17	1 (+ AC 1)	4
February 2016	27	7	12	8	0
March 2016	30	1	3	20 (+ AC 5)	1

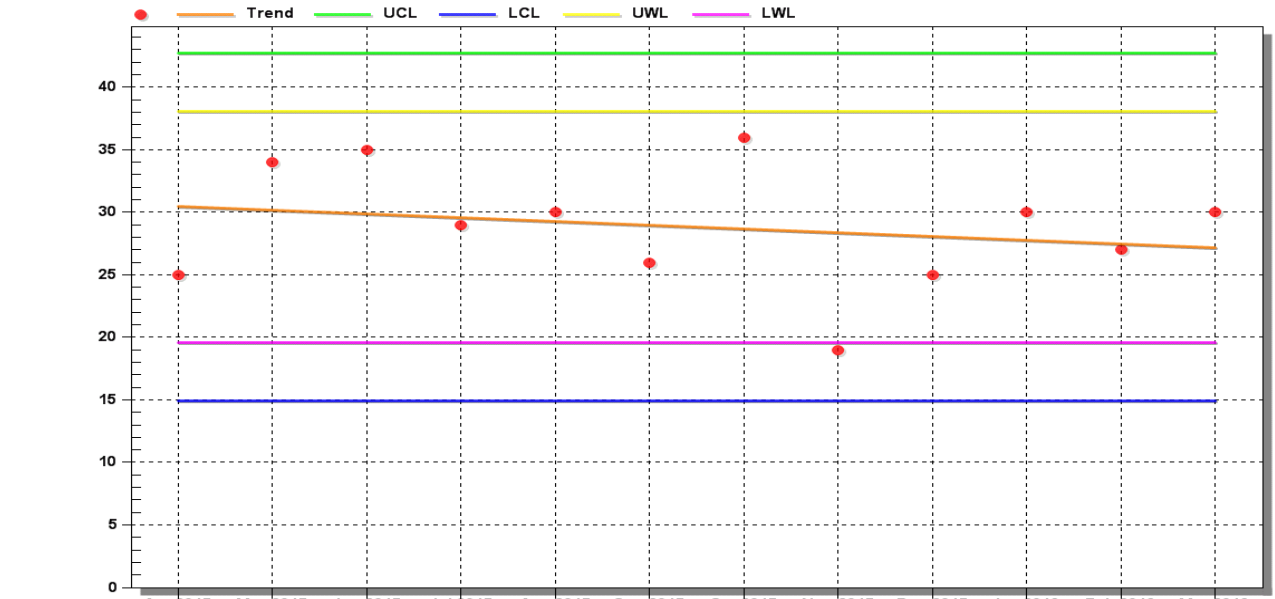
(AC = awaiting consent)

The Complaints Team currently decide whether to uphold a complaint or not. Appendix 2 contains the definitions used in deciding whether a complaint is upheld or not.

5. Trust Complaints Trends and Themes

5.1 The Trust received 11 less complaints in this quarter compared with the quarter 4 (2014/15). See figure 3 for the trend in number of complaints over the past 12 months.

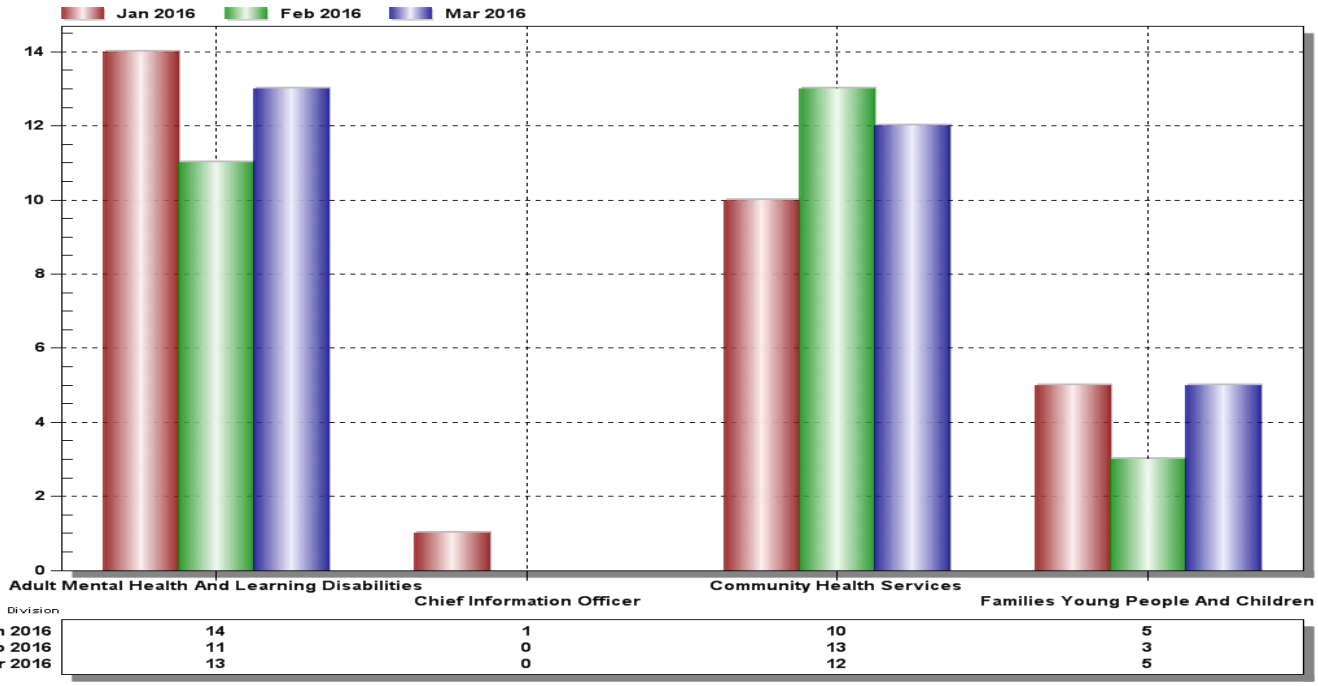
Figure 3: Complaints Trend over last 12 months



Month and Year	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016
	25	34	35	29	30	26	36	19	25	30	27	30
Trend	30	30	30	30	29	29	29	28	28	28	27	27
UCL	43	43	43	43	43	43	43	43	43	43	43	43
LCL	15	15	15	15	15	15	15	15	15	15	15	15
UWL	38	38	38	38	38	38	38	38	38	38	38	38
LWL	20	20	20	20	20	20	20	20	20	20	20	20

5.2 Figure 4 shows the month by month number of complaints received by each service during quarter 4 (2015/16).

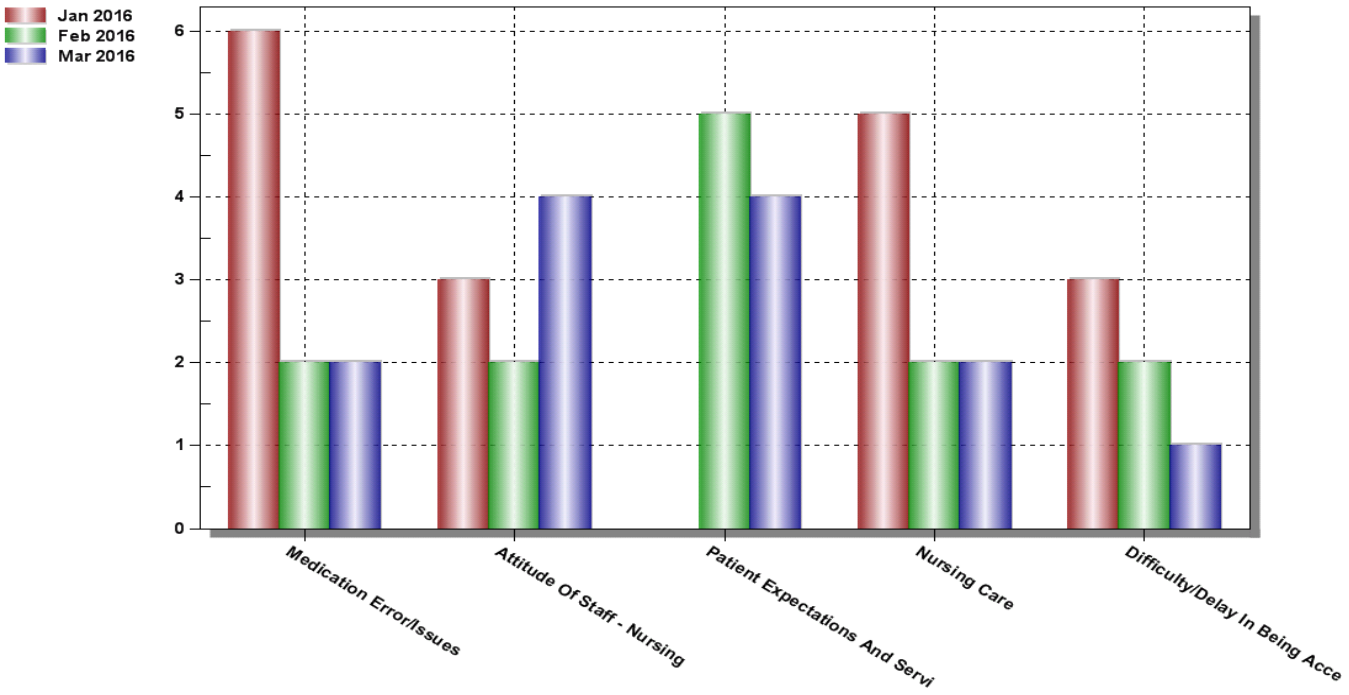
Figure 4: Complaint Trend by Service



Division	Adult Mental Health And Learning Disabilities	Chief Information Officer	Community Health Services	Families Young People And Children
Jan 2016	14	1	10	5
Feb 2016	11	0	13	3
Mar 2016	13	0	12	5

5.3 The Trust top five themes of complaints received in quarter 3 are shown in figure 5. The top category this quarter was 'Nursing Care', this theme has also featured in the top five for the past two quarters. 'Attitude of Staff – Medical' also features this quarter, but has reduced from first in Q2 to third in Q3. A full breakdown of complaint category by service is included in Appendix 1.

Figure 5: Top 5 Trust complaints themes January 16 – March 16



Category					
Jan 2016	6	3	0	5	3
Feb 2016	2	2	5	2	2
Mar 2016	2	4	4	2	1

6. Service changes following learning from complaints

6.1 AMH.LD received 38 complaints this quarter; this was an increase of three complaints compared to the previous quarter.

6.2 A recurrent theme in AMH.LD complaints, which is echoed in patient survey results, is the importance of medication information being explained. During Q4, two complaints identified the importance of clarifying the reasons for a change in medication and explaining the rationale behind any medication with the patient/carer including communicating the possible side effects/benefits. The lessons learnt from these complaints have been shared with clinicians for consideration.

6.3 The importance of communicating processes and procedures to new patients/carers will be raised with all clinicians as part of the business meeting

6.4 CHS received 35 complaints this quarter; this was an increase of ten complaints compared to the previous quarter.

6.5 Community Health Services has seen a rise in reporting of complaints during quarter 4. The Top 2 categories has remained as: Nursing care and staff attitude,

a 6 month review of these complaints is planned to identify any key themes and shared learning from these.

6.6 A trend was identified on one ward at Coalville Community Hospital who have had a number of complaints relating to staff attitude. Actions being taken include:

- Workshops being developed for staff to include valuing input from patients and relatives.
- Visiting times changed across all wards to offer more flexibility for patients and relatives.

6.7 Spot checks have been undertaken to ensure lessons learnt have been embedded from November / December complaints, with positive results as follows:

- Concerns over pressure ulcer care to heel, in regards to dressing and compression application. Lessons learnt have been embedded within the community with bespoke hub clinics, giving appropriate time for assessment, record keeping/documentation and review.
- Information given to the hospital on the patient's eating and drinking behaviour was dismissed. Lessons learnt – monthly audit of the notes is carried out using the compliance audit tool.
- Concerns raised over care due to missed medication – complaint was withdrawn however this was discussed with the team for learning to ensure better communication with carers regarding authorisations and administration of medicines within the community.

6.8 FYPC received 13 complaints this quarter; this was a decrease of eight complaints compared to the previous quarter.

6.9 Half of the complaints received in this quarter are regarding the CAMHS Service and key themes are:

- parents who feel that their son/daughter has been either inappropriately discharged from the Service, or have been discharged without sufficient alternative support
- the length of time young people have waited to be seen and assessed by CAMHS
- concerns from estranged parents where the young person has withdrawn consent for information regarding their care to be shared with that parent.

6.10 Other FYPC complaints in quarter 4 relate to concerns regarding the quantity/frequency of Speech and Language provision for young people in school, and errors relating to incorrect venues for arranged immunisation appointments.

6.11 Lessons learned by FYPC in this quarter have been:

- to ensure that estranged parents are informed when a young person withdraws consent for CAMHS to share information with them and that an assessment of their capacity to do so is filed on the record

- to manage child/family expectations by informing them that CAMHS support children and young people where there is a diagnosis of a mental health condition. Where behavioural problems are not caused by an underlying mental health condition, these young people are discharged from CAMHS Services and signposted to alternative services for support.

6.12 Corporate services received one complaint this quarter, regarding a suspected breach of confidentiality. This complaint is now resolved.

6.13 To help ensure the embeddedness of implementation of improvement actions the complaints team are in the process of adapting the Safeguard database to accept lessons learned and associated action plans. Once set up this system will ensure notifications are automatically generated to remind those responsible when actions are due and will monitor until completed. This will ensure a sustainable process for embedding implementation of improvement actions.

7. Improvements to the Complaint Service

7.1 The Trust has a CQUIN to improve the way the complaints are handled and responded to. The improvement work is based on the standards and complainant satisfaction survey developed by the Patients Association. .

7.2 During this quarter the actions required were achieved, these were to:-

a. Implement action plan – all implementation actions have been achieved for Q4.

b. Undertake case note peer reviews against patient association standards template – the third panel took place on 16 February 2016 and comprised of 14 members including clinical and non-clinical staff, lay people and voluntary sector representatives who reviewed 12 cases all closed in quarters 3 or 4. From the findings of the peer review we compared compliance against three sections of standard:
    i. Accessibility – significant improvement was found overall, and particularly with regards to levels of accessibility due to 'consistency of providing a key named worker or single point of contact' (from 87% to 96%) and 'giving an explanation of how the complaints process at the organisations works' (from 54% to 85%) when compared to the findings of the second panel in December 2015
    ii. Investigation – significant improvement in levels of practice were found during the investigation process in relation to 'the investigation report clearly and concisely summarises the investigation evidence and preliminary conclusions reached' (35% to 56%) compared to the findings of the second panel
    iii. Appreciating complainant – significant improvement was found in complainant appreciation with regards to 'consistent personalisation in correspondence and communication' (77% to 89%) and 'expressed in a style and language that was appropriate' (77% to 91%) compared to the findings of the second panel.

c. Redo complainant satisfaction survey – the complaint satisfaction survey was repeated during quarter 4. We sent the survey out to 53 complainants whose complaints closed in quarter 3. We received 12 responses which equated to a response rate of 22.5%. Examples of improvements were:

    i. The percentage of complainants who found the process of making a complaint very difficult fell by 5% (n2)
    ii. Complainants who stated they had been made aware of the facility of the Health Service Ombudsman rose by 15% (n5)

iii. Complainants confirming that the timescale was discussed with them at the beginning of the complaints process rose by 17% (n9)

d. Produce a final evaluation of the impact of the CQUIN and future sustainability – this is currently being undertaken. Results can be found in the CQUIN 6 Report for quarter 4.

8. Conclusion

8.1 This report highlights the Trust's performance in regards to complaints received during this quarter, including themes, trends, identified learning and changes being made across the Trust in response to issues identified by patients and their relatives.

8.2 This document concludes the reporting of complaints for the financial year 2015/16. It will be reported in the Complaints Annual Report for 2015/16, due in September 2016, that there were a total of 346 complaints across the year:

- Adult Mental Health and Learning Disabilities – 162
- Corporate Services – 4
- Community Health Services – 118
- Families, Young People and Children - 62

APPENDIX 1

Quarter 4 2015/16 Complaint numbers by Category and Service

Category	AMH/LD	CHS	FYPC	Corporate	Total
Medication Error/Issues	7	3			10
Attitude of Staff - Nursing	4	5			9
Nursing Care	1	8			9
Patient Expectations and Service Delivered	2	5	2		9
Difficulty/Delay in Being Accepted by a Service	3	1	2		6
Communication/Information to Carers	1	2	2		5
Discharge Arrangements	1	2	2		5
Issues Around Standard of Therapy or Care	2	2	1		5
Attitude of Staff - Allied Health Professionals		2	2		4
Patient Safety	4				4
Attitude of Staff - Medical	3				3
Confidentiality	1			1	2
Diagnosis Problems	1		1		2
Inadequate/Incomplete Assessment	2				2
Inadequate/Incomplete CHC Assessment		2			2
Admission Arrangements	1				1
Aids and Appliances		1			1
Appointment – Cancellation (OP)		1			1
Appointment - Delay (OP)			1		1
Attitude Of Staff - Admin	1				1
Clinical Advice/Treatment		1			1
Communication/Information to Patients	1				1
Difficulty Obtaining Results of Tests	1				1
Information	1				1
Loss of Personal Property	1				1

Appendix 2

Definitions used when deciding whether to uphold a complaint

Upheld	Not upheld	Partially upheld
If a complaint is received which relates to one specific issue, and substantive evidence is found to support the complaint, then the complaint should be recorded as **upheld**.	Where there is no evidence to support any aspects of a complaint made, the complaint should be recorded as **not upheld**.	If a complaint is made regarding more than one issue, and one or more of these issues (but not all) are upheld, the complaint should be recorded as **partially upheld**. **NB** This category was reinstated by the Health and Social Care Information Centre (HSCIC) in April 2015 prior to this complaints were either recorded as 'upheld' or 'not upheld'

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Leicestershire Partnership NHS Trust

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Trust Board 26th May 2016

Patient and Carer Experience and Involvement Quarterly Report (Quarter 4 2015/2016)

1. Introduction

1.1 Patients tell us that their experience of care can be as important to them as clinical effectiveness and safety. Throughout the last few years, patients and the people who care about them have told us that there are six areas of experience that matter most to them. They want to:

- feel welcomed
- be listened to and heard
- know that we make every effort to join things up for them
- know that we are there for them when they need us
- feel that they are involved as much as possible
- feel we are having a positive impact on their lives

1.2 The Government has been very clear that patient experience is really important in the provision of quality healthcare. This has been reinforced by the NHS Constitution, the Quality Outcomes Framework and the NICE Quality Standards for Experience and Mental Health Experience.

1.3 Recent high profile failings in healthcare management have also highlighted that the ongoing measurement and action in relation to patient experience is a crucial element of monitoring the effectiveness of healthcare services and that, if monitored in real time, such information can often help to pre-empt more serious issues that could lie ahead.

1.4 Leicestershire Partnership NHS Trust (LPT) has embraced this shift in focus on patient experience and has begun to really embed it within the strategic direction of the organisation through the LPT business plan.

2. Aim

2.1 This report highlights the work that is taking place across the organisation to involve and consult with patients and their carers and gather feedback on their experiences of our services.

3. Recommendations

3.1 The Trust Board is recommended to receive assurance on the work being undertaken to improve how the Trust hears the voices and improves the experience of those who use our services, and their carers.

Discussion

4. Organisational engagement with patients and their carers

4.1 Patient and Carer Experience and Involvement Strategy 2015-17

4.1.1 Progress made against the strategy work plan's key actions during this quarter:

- The Trust Development Authority (TDA) Patient Experience Self-Assessment framework has been used to carry out an organisational diagnosis to establish to what extent 'improving the patient experience' is embedded in LPT's culture and processes.
- A register of the variety of ways patients and carers can provide feedback has been formulated by services.

4.1.2 Planning for 2016/17:

- The patient experience team will commence the review of the current Patient and Carer Experience and Involvement Strategy early in 2016/17.
- The current work plan has been extended to include key actions during Q1 2016/17, with a commitment that during that period the reviewed Strategy and work plan for the remainder of 2016/17 will be developed.
- The actions for Q1 2016/17 will incorporate:-
    - Co-design of a patient involvement toolkit
    - Development of customer care training
    - Further development of patient experience data, including FFT and triangulation
    - Review of the 2015-17 Patient and Carer Experience and Involvement Strategy.

4.2 Patient Advice and Liaison Service (PALS)

4.2.1 During quarter 4 the PALS team received 707 contacts compared to 764 contacts in quarter three. These contacts have been categorised as:

- Compliments 323
- Concerns 299
- Enquiries 80
- Comments 5

4.2.2 The top three themes for concerns this quarter are shown in table 1

Table 1

Concerns	
Patient Expectations and Service delivered	46
Medication Errors/Issues	29
Appointment Delay (OP)	23

4.2.3 As a result of concerns raised actions have been taken in the following areas:

- Service processes fully explained regarding treatment eligibility and discharge criteria
- Staff reminded of process to follow during consultant's absence to ensure no prescribing delays
- Patients kept informed of any issues with cancelled or rescheduled appointments. Regular updates provided on waiting list status.

4.2.4 The PALS 'meet and greet' volunteer trial has been completed and the patient experience team are looking at the findings and will be suggesting some recommendations to services about how this can be taken forward.

4.2.5 Customer Services Web is a web-based system to allow staff to enter feedback from patients directly into the Safeguard database. Easy to use short forms can be accessed through the same system as the electronic Incident Reporting Form (eIRF). During this quarter all three services have entered compliments, concerns and prison concerns (AMH.LD) which are included in the figures above. Training has been disseminated throughout services via a train the trainer approach and the system is embedding well.

4.3 Commissioning for Quality and Innovation (CQUIN) 2015-16

4.3.1 There are two patient experience CQUIN's this year. These are:-

- Carer Support - to develop the way we communicate with and involve carers using the Triangle of Care self-assessment tool in inpatient areas; Mental Health Services for Older People (MHSOP), Complex Care and Learning Disabilities.
- Complaints Handling - to improve the way we handle and respond to complaints to improve the service user experience, by means of a complainant satisfaction survey and reviewing closed complaints using the Patients Association Peer Review Process.
- All requirements for this quarter have been achieved.

4.4 Progress Update on Board Walks

4.4.1 Board Walks is the name given for the restyled Trust Board members' visits to services and areas across the Trust with the aim of further developing two-way communication and relationships between Trust board members, frontline staff, patients and their carers. The new process began in April 2015.

4.4.2 During this quarter twenty one board walks have been carried out by board members across the organisation, nine within AMH/LD services, five within FYPC and seven within CHS.

4.4.3 Analysis of the completed feedback identified some recurrent themes. These were:

- Staffing – evidence of enthusiastic, positive, welcoming staff teams. Issues noted with staff sickness resulting in bank or agency cover, an issue around the relationship between University Hospitals of Leicester (UHL) staff and LPT staff and the communication between senior LPT staff and frontline staff. A suggestion was made around the balance of clinical/non-clinical workforce in one area.

- Property and environment – positive feedback about areas being clean, tidy, well organised and welcoming. There were some suggestions around flooring, lighting and making space for confidential discussions.
- Patient information – positive feedback around 'you said we did' boards highlighting improvements made. Some suggestions around how patient information could be displayed more effectively.
- Team working – evidence of person centred approaches and compassionate care.
- Patient/carer feedback – thank you cards and comments from patients saying that they feel listened to, supported and well cared for.

4.4.4 Actions taken as a result of feedback include:

- Increase staff awareness of the Trusts Ujala Translation services for when they are required to visit patients who may have difficulty with the English language.
- Recommended to look at closer working with similar groups (e.g. Homeless, Asylum Seekers) – for any potential shared approaches/ economies of scale.
- The development of a 'good mental health' space in the Urgent Care Centre is being considered in order to support patient experience and staff wellbeing.

4.4.5 The board walks process has been further developed to include 'top themes' relating to risk, safety, experience and audit which will be reviewed and updated each quarter. The feedback form has been edited to reflect these improvements and shortened as a result of feedback received. See appendix 1.

4.5 Patient Voice

4.5.1 This ongoing initiative to bring patient experience to the LPT Trust Board gives a regular opportunity for patients and carers to hear and be heard. Two stories were presented to the Trust Board this quarter, a patient talking about her experiences on the ward at St Lukes Community Hospital and a carer of a patient who has used LPT services for many years talking about their experiences of The Willows. The Patient Experience Team has a library of patient or carer stories which are being used widely across the Trust for staff training and induction, team meetings and service development sessions.

4.6 The LPT Chief Executive Officer (CEO) held a quarterly meeting with representatives from Healthwatch Leicester, Leicestershire and Rutland in February 2016. The Healthwatch representatives submitted a variety of questions submitted by their members and the answers were discussed in the meeting. The questions covered topics such as the Child and Adolescent Mental Health Service (CAMHS), the LPT complaints process, orthotics support for patients and changes in crisis care; the answers were discussed at the meeting.

5. Service Engagement with Patients and their Carers

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

5.1.1 Learning Disability Services carried out a 'coming together' event in January 2016 to review the findings and agree the priorities from the Experienced Based Co-Design project 'My Care, My Voice'.

5.1.2 The Willows in-patient survey results for quarter four show that 97% of patients who completed the survey feel welcomed by staff. 96% of patients say it's easy to find someone to talk about their worries or fears and 100% of patients surveyed say the ward appears clean. Lower scores have been noted in relation to food. 78% of patients reported that they either always or sometimes felt that the medication prescribed for them and its side effects, had been discussed with them.

5.1.3 A Community Outpatient Appointment Questionnaire has been completed during this quarter. The aim of the survey is to gain a patient perspective on potential changes to the booking and appointment reminder system which it's hoped will reduce the number of cancelled clinics. The service has received over 300 responses and the results will be included in the next quarterly report.

5.1.4 Analysis of Bradgate Unit and Herschel Prins Centre Inpatient Community ward forum feedback has highlighted that patients would like staff to eat with them and so staff are being encouraged to do this. Also as a result of patient feedback, new sofas have been ordered and a comments box has been introduced onto Heather Ward. The comments will be reviewed by the Ward Matron.

5.1.5 The Crisis Resolution Team (CRT) have introduced a service user satisfaction questionnaire. This quarter's results show that patients feel safe, treated with compassion and supported to develop a plan for managing a future crisis. However, the results highlighted that 69% of patients were not aware who their key worker was and some patients feel less able to deal with a future crisis.

5.1.6 Come and Share meetings at the Agnes Unit provide an opportunity for patients at the unit to give feedback about their experiences of the service, what they like, where improvements could be made and suggestions for activities. This quarter positive feedback has been received about the food and activity sessions and new staff have been recruited.

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

6.1 A redesign programme is currently underway within the Child and Adolescent Mental Health Service (CAMHS). The new model of service delivery will 'go live' in April 2016 and will prioritise early intervention and access into CAMHS specialist services, as well as promoting close working with children and families. CAMHS are using a co-design approach and working with staff, young service users, parents, carers and the Evolving Minds service user group to help shape and develop CAMHS services.

6.2 The Evolving Minds group are applying for funding to develop their branding and marketing in order to reach more children and young people across Leicester, Leicestershire and Rutland. The group are developing a virtual network so that young people can give their feedback. Hinckley and Bosworth District Council has agreed to fund an event to develop a local Hinckley group and further partnerships have been developed in Rutland and Loughborough for young people to attend and feedback on young people's mental health services.

6.3 The co-design team have been consulting with parents and carers with regard to the Health Visiting Service in the City, County and Rutland. The Co-design team have designed and disseminated questionnaires on Survey Monkey, via email and social media. To date over 200 responses have been received as well as speaking face to face with over 80 parents and carers in the City. Themes are

emerging and a full analysis and report will be completed when all neighbourhoods have been accessed.

6.4 The Big Mouth Forum is a children and young people's forum made up of young people from across Leicester City with additional needs. A training film has been developed by the co-design team with young people who have described their hopes and aspirations. The film will be used as a training aid for LPT's Health Visitors for children with additional needs.

7. Community Health Services (CHS)

7.1 A carer attended the Dementia Champion Group to talk about their experiences of caring for someone with dementia.

7.2 CHS have developed and piloted an app version of the Patient Experience Satisfaction questionnaire which includes the Friends and Family Test (FFT) question. The app includes an 'opt out' option for patients who don't wish to complete the survey providing data for that aspect of FFT for the first time. The pilot showed an increase in returns using the app so the service are rolling it out across all teams with the support of the Health Informatics Service (HIS).

7.3 Mental Health Services for Older People (MHSOP) have hosted a 'Food Focus Fortnight' in February 2016 in response to patient feedback about food. Patients, carers and visitors gave their feedback on the food and tasting sessions were carried out.

7.4 An inpatient on Ward 3 at St Lukes Community Hospital was filmed talking about her experiences on the ward. The video was shared at ward meeting and the following actions agreed: development of a 'Carer's Corner' with information on services within the community to support patients on discharge, improved in-reach from community staff to ensure seamless flow from inpatient to community and improved communication with patients regarding the call bell response.

7.5 A review of visiting times has been undertaken across the Community Hospitals involving patients, relatives and staff. Recommendations include – more open flexible visiting times, adoption of John's campaign which encourages open visiting for carer's of people with dementia, developing a visitor/carers charter and to review carer facilities across all sites.

8. The Friends and Family Test (FFT)

8.1 FFT is made available to patients across the Trust in a number of ways, dependent upon the service. Posters, cards and leaflets are displayed in clinics and on wards, welcome packs include leaflets and a card with a freepost envelope, there is a page on the Trust's website where FFT feedback can be entered and a 'Quick Response' code on the card that can be used with smart phones. A digital application has been trialled, with success, and will be rolled out to services through the use of interactive electronic tablets.

8.2 Adult Mental Health and Learning Disability Services have seen a steady increase in their inpatient FFT return rates and are continuing to improve visibility and availability of the FFT card through posters and other promotional material in inpatient areas. Bespoke questionnaires have been created that incorporate the FFT question with questions that were identified by the CQC visit. Community

Health Services, Families and Young People's services provide us with the most feedback and are highly recommended by all service users we are targeting to improve the return rate through the digital application on the electronic tablets.

8.3 Table 2 provides a Trust wide overview of FFT scores for quarter 4 plus the divisional breakdown with return rates.

Table 2 - Results of Friends and Family Test in Quarter 4

Trust-wide	**January**	**February**	**March**
No. of patients treated	51152	52751	52576
No. of returns	1121	964	1160
% Extremely Likely and Likely	97%	97%	97%

AMH.LD	**January**	**February**	**March**
No. of patients treated	6747	6766	6104
No. of returns	54	90	77
% Extremely Likely and Likely	88%	84%	83%
Return rates for Non-inpatients/inpatients	0.8%	1.3%	1.3%

CHS	**January**	**February**	**March**
No. of patients treated	25146	24880	25762
No. of returns	515	545	527
% Extremely Likely and Likely	98%	97%	99%
Return rates for Non-inpatients/inpatients	2%	2.2%	2%

FYPC	**January**	**February**	**March**
No. of patients treated	19259	21105	20710
No. of returns	552	329	556
% Extremely Likely and Likely	99%	100%	97%
Return rates for Non-inpatients/inpatients	2.9%	1.6%	2.7%

8.4 These results show that on average 97% of our patients are extremely likely or likely to recommend our service. This data is published nationally and used to compare similar Trusts for the same period. These reports can be found on NHS England's FFT website here: http://www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/

8.5 During this quarter, we received 2540 comments from patients who completed the FFT card compared to 3193 last quarter. This drop is mainly attributed to loss of the freepost license due to moving bases. Furthermore, three inpatient wards

have been closed for refurbishment. Of the comments, 82% were positive compliments, 7% were comments that required actions and approximately 9% had no comments. The suggestions that require actions are forwarded to the team leads for action. Some examples of patient comments and resulting actions are attached in appendix 2.

9. Conclusion

This report provides assurance that the foundations for gathering reports of patient experience and involvement activities and initiatives, in terms of systems and processes, are continually strengthened.

Appendix 1

Leicestershire Partnership NHS
NHS Trust

Board Walk Feedback Form

Visiting Director:-
Team Visited:-
Date:-

Describe your first impressions:-

Six top themes from last quarter's patient experience, risk, safety and audit results:

1. Staff Attitude:-
- Look for evidence of staff feeling rushed, feeling that the patient/carers are hostile towards them, burnt out staff. Do staff feel safe? Do staff feel that they can highlight any problems and to whom?
- How are the new ways of working progressing? (District Nurses only):-

2. Clinical Advice, care and treatment:-
- Are both physical and mental health needs being met? If a patient for a mental health problem; how are we meeting their physical health needs and vice versa? Evidence that patients are kept safe?

3. Continuation of Care:-
- How long has the patient been cared for by the service? Is there evidence of safe transfer of care? Look for evidence of effective discharge planning for patients in Community Hospitals.

4. Appointments:-
- What is in place to improve appointment delays, DNA rates and appointment cancellations? E.g. reminder phone calls to patients that have previously DNA'd

5. Communication:-
- How is patient information shared with patients, their families and carers? Is there evidence of effective communication around medication and side effects of medication
- Do staff know how to access and download information about medication and side effects for patients?
- Are carers information packs available?

6. Involvement:-
- Look for evidence of involvement with patients and carers either regarding decisions about their care and treatment or evidence of involvement in service design and or delivery.

Feedback from staff:

What is the one thing that would improve your experience at work and enable you to provide improved care to patients?

Do staff have anything they would like to highlight to the Trust Board?

Feedback from patients, families and carers:

Please describe any feedback from patients or carers:-

Feedback for patient experience team:

Are there any actions or items you would like to see escalated?

Appendix 2 – Friends and Family Test

Actions taken as a result of FFT comments

Service and area	Comment	Action taken
AMH/LD Stewart House	Quality of Food	A 'food focus' group will be set up to look into the issues in more detail.
CHS Coalville DN Ward 7	Poor response from Single Point of Access, waited too long to answer	Recruitment and upskilling campaign taking place and call handling times are improving
CHS - MSK Coalville	Would like to have got in quicker, long wait!	Staff have reduced non-clinical duties to help increase clinical time
Estates/CHS – The Coalville Medical Centre	Cold no reception. Treatment room rather 'shabby'.	In relation to the decor in the treatment room, this will be referred to the Support Service Manager.

Leicestershire Partnership NHS Trust

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TRUST BOARD – 27 May 2016

FINANCE AND PERFORMANCE COMMITTEE – 17 May 2016

OVERVIEW REPORT TO BOARD

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

Assurance level	Colour to use in 'Assurance level*' column below
Not assured	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans If red, commentary is needed in "Next Actions" to indicate what will move the matter to "full assurance"
Partially assured	Amber - there are gaps in assurance but we are assured appropriate action plans are in place to address these
Assured	Green – there are no gaps in assurance

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
Finance and Performance Risk Register		Feedback from Quality Assurance Committee received and scrutiny of all risks undertaken	Ensure all actions are up-to-date, risks reflect the new financial year and specific areas of focus are progressed	June 2016
Director of Finance's update		Update provided including in relation to the new Learning and Development Centre, contracting, estates and facilities management transfer and newly released Internal Audit reports.	Further progress report to be provided	June 2016
Major Incident Plan – annual review		The Major Incident Plan was approved subject to minor amendments		
360 Assurance quarterly review		Quarterly report received with focus on: • Hosting arrangements • Financial performance • Increase in number of Limited Assurance reports being issued – partly due to the risk-based approach of the Internal Audit Plan, each committee is overseeing actions		
IM&T Strategy Quarterly Update		Update report received and noted. The alignment	Process for aligning the DQIP and EPR work to	July 2016

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
including RiO End of Project Report		of the Data Quality Improvement Programme (DQIP) and the Electronic Patient Record (EPR) development was the key area of focus. The RiO End of Project Report was received and approved with the benefits and lessons learnt to be embedded in future projects.	be agreed and reported back to the Committee	
Accessible Information Standard		The project remains on track for delivery although a couple of key milestones had slipped	The impact of non-achievement of timelines to be confirmed particularly with the standard being a legal requirement	June 2016
Service Line Reporting (SLR)		Next steps for SLR agreed with increased service engagement and a baseline exercise to be undertaken. The future use of SLR as a business tool was also discussed.	Confirmation of timing of next steps to be agreed and monitored	August 2016
Cost Improvement Programme (CIP) Outcome Panel		The process and outcome for financially and quality assessing 2016/17 CIPs was presented with good assurance gained. The new role of the Service Transformation Group was also highlighted.	Monthly CIP monitoring to continue to be received at FPC Quarterly reports from CIP Outcome Panel to include quality and financial impact	June 2016 August 2016
Month 1 Finance Report		At Month 1, the Committee noted a small deficit of £58k in comparison to a planned deficit of £193k. Whilst it is early to forecast, the Trust remains on track to deliver a forecast position better than the £2.1m planned deficit with a break-even out-turn the revised target. Other points to note are: • Agency expenditure exceeding NHS Improvement cap • Cash forecast lower than the minimum expected cash-holding days	Forecast risks and pressures to be presented at Month 2 Board to consider how it gains assurance/ oversight on the agency staffing performance through sub-committees	June 2016 May 2016

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
Service Directorate Finance Summary Reports		Summary finance briefings were received from all three clinical service directorates with risks and mitigations discussed.	Continue monthly production of directorate reports	June 2016
Data Quality Improvement Plan (DQIP) progress		Progress continues to be noted with an area of focus being the pace of the programme - balanced against the available resources / capacity.	Clarity required on completion dates where identified as "TBC" Alignment of DQIP and EPR development work to be progressed	June 2016 July 2016
Integrated Quality and Performance Report (IQPR) and Waiting Times		The Committee focused on: • Length of Stay • Early Intervention in Psychosis • ADHD/Aspergers • Audiology • CQUINs • Agency usage Further focus in relation to waiting times; reasons for increase in waiting times, the expansion of Patient Tracking Lists (PTL's) and the accuracy of data.	Continue incremental development of IQPR 2016/17 CQUINs forecast to be included in IQPR with Quarter 4 out-turn for 2015/16	Ongoing June 2016

Recommendation	The Trust Board receives and notes the issues raised in the highlight report.
Author	Cathy Ellis – Trust Chair Pete Cross – Director of Finance, Business and Estates
Presented by (Chair of committee)	Cathy Ellis – Trust Chair

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Leicestershire Partnership NHS
NHS Trust

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REPORT TO THE TRUST BOARD – 27 May 2016	
Title	Summary Finance Report for the period ended 30 April 2016 (month 1) – **Public meeting**.

Executive summary
This report is brought to the Finance & Performance Committee to provide an update on the Trust's financial position as at the end of April 2016 (Month 1). The Trust is reporting an income and expenditure deficit of £46k against a planned deficit of £193k. This is a favourable year-to-date variance of £147k against the deficit plan, due to an improved offer in the final agreed 16/17 contract with local CCGs. It is early in the year to produce reliable detailed year end forecasts, however the improved contract offer now results in an I&E year end break-even forecast. This would be a £2.1m favourable variance against the £2.1m deficit plan filed with NHS Improvement. Assuming that the break-even forecast can be achieved, all annual statutory financial duties are expected to be delivered at the end of the year.
Recommendation
The Trust Board is recommended to review the finance report and accept the reported financial position for month 1.

Related Trust objectives	Ensure sustainability: continue to deliver a balanced financial plan
Risk and assurance	Relevant to all Corporate Finance risks
Legal implications/ regulatory requirements	NHS Statutory Financial Duties; Delivery of Trust Development Authority authorised financial plan and surplus.
Evidence for the Quality Governance Framework (eg paper evidences board engagement with staff (3C)	
Presenting Director	Dr Pete Cross, Director of Finance
Author(s)	Chris Poyser, Head of Corporate Finance Matt White, Financial Controller
*Disclaimer: This report is submitted to the Trust Board for amendment or approval as appropriate. It should not be regarded or published as Trust Policy until it is	

formally agreed at the Board meeting, which the press and public are entitled to attend.

Finance Report for the period ended
30 April 2016

For presentation at the
PUBLIC Trust Board
26 May 2016

Contents

Executive Summary and overall performance against targets

Introduction

1. This report presents the financial position for the Trust for the period ended 30th April 2016 (month 1)

2. The report shows a year to date defict financial position of £46k for the Trust as a whole. This is against a planned deficit for month 1 of £193k and therefore represents a positive variance of £147k.

3. The 2016/17 financial plan submitted to NHS Improvement (NHSI) showed a deficit of £2.1m for the year. Although it is too early in the year to produce a detailed forecast year end position, the outcome of final contract negotiations has improved the position compared to the original plan. This accounts for the favourable variance in month 1, and will also improve the position by the end of the year, so that a break even position is now forecast.

4. As the final contract negotiation outcome has resulted in a significant expected deviation from plan at such an early stage of the year, options to formally revise Trust budgets to reflect the break-even assumption will be explored during May. It is not yet clear whether a formal plan resubmission will be required by NHSI.

NHS Trust Statutory Duties	Year to date	Year end f'cast	Comments
1. Income and Expenditure break-even.	R	G	The Trust is reporting a net overall income and expenditure deficit of £47k as at 30 April 2016. This is a favourable variance of £146k against NHSI plan. Initial indications are that the Trust will achieve a break-even by the end of the year. **[see 'Service I&E position' and *Appendix A*]**.
2. Remain within Capital Resource Limit (CRL).	G	G	The capital spend is within the CRL at both the year-to-date position and in the year end forecast.
3. Achieve the Capital Cost Absorption Duty (Return on Capital Employed).	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% (noting potential exceptions in respect of TCS assets)
4. Remain within the External Financing Limit (EFL).	G	G	The EFL target will be achieved at the end of the financial year.

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. The Trust is compliant with 2 of the 4 BPPC targets in April. Current expectations are that all 4 targets will be achieved by the end of the financial year **[See 'Cash & Working Capital']**
6. Achieve Cost Improvement Programme (CIP) targets.	R	G	CIP schemes have delivered £641k of the £716k year to date target (89%) at the end of month 1. Current forecasts assume that all CIPs will be achieved by the end of the year **[See 'Efficiency Savings Programme' +*Appendix B*]**
7. Achieve positive monthly income and expenditure run rate (a surplus).	R	A	(also see target 1 above). A deficit of £47k has been reported in month 1. The likely year end forecast is to break even – some minor surpluses are anticipated in future months in order to achieve year end break even..
Internal targets	**Year to date**	**Year end f'cast**	**Comments**
8. Achieve a Financial Sustainability Risk Rating (FSRR) of at least 3.	R	G	With a deficit run-rate and reduced cash, the Trust is currently performing at a level that would indicate a FSRR of 2. Assuming a forecast year end break-even, the position would be expected to improve to '3' by the end of the year.
9. Achieve retained cash balances in line with plan, and >11 days operating costs.	R	A	A cash balance of £5.8m was achieved at the end of April 2016; this is £1.1m lower than plan. This equates to 7.9 days' operating costs. Year end cash is forecast to improve significantly over the original plan figure of £3.7m (due to the additional contract income now agreed). Further work is required to determine if this will be sufficient to meet the 11 day target. **[See 'Cash & Working Capital']**
10. Deliver capital investment in line with plan (within +/- 15% YTD planned spend levels)	A	G	Capital expenditure to date totals £98k, £108k less than planned spend for April of £206k. All of the planned £12.7m expenditure is expected to be incurred by the end of the year. **[See 'Capital Programme 2016/17']**

Overall Headline Message

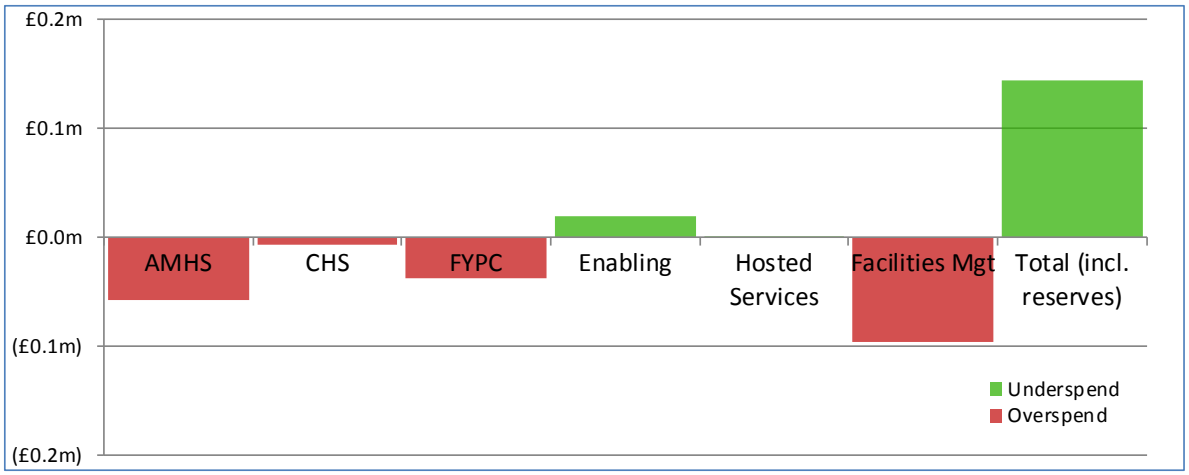
5. As at month 1, the Trust is reporting a year to date deficit of £46k against a NHSI plansurplus of £193k, producing a favourable variance of £147k.

6. The likely year end position is currently forecast as break-even, a £2.1m positive variance against the NHSI plan £2.1m deficit.

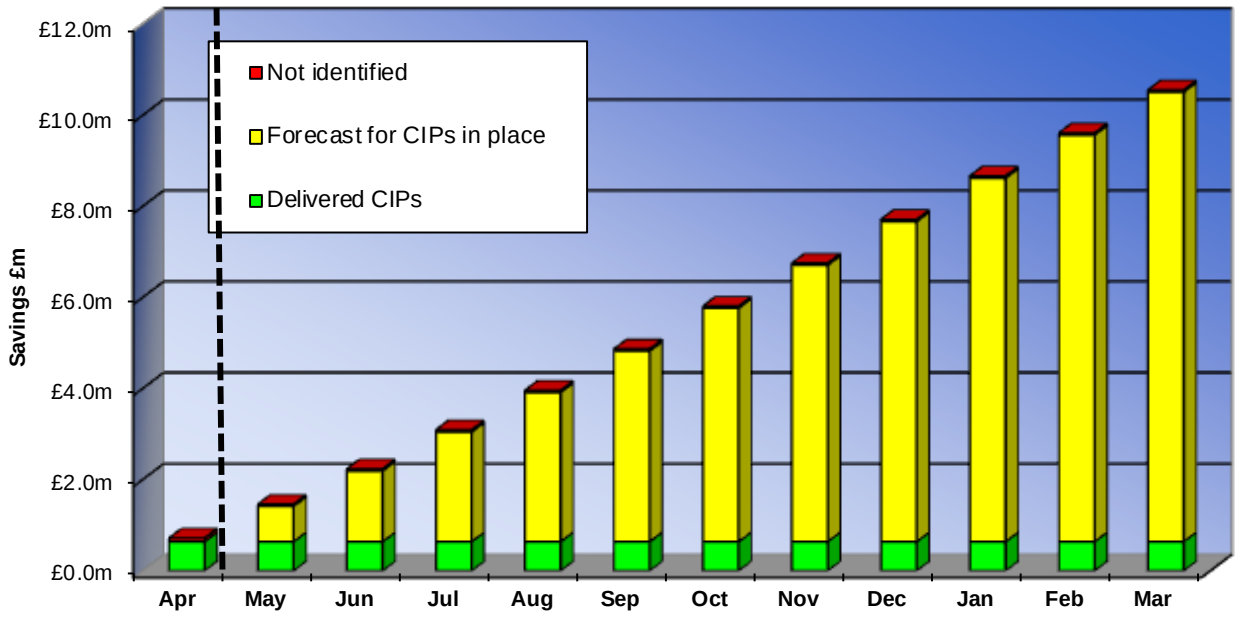
Service I&E position and variance analysis

The table below shows the operational I&E variance against budget/plan and the individual service surplus/deficits contributing towards this overall position.

Month 1 year to date operational income and expenditure budget variances by service



Efficiency Savings Programme



	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:	**716**	**1,461**	**2,238**	**3,094**	**3,961**	**4,868**	**5,811**	**6,755**	**7,714**	**8,669**	**9,616**	**10,557**
Actual performance to date												
Achieved	641	641	641	641	641	641	641	641	641	641	641	641
Forecast	0	778	1,556	2,411	3,278	4,186	5,129	6,073	7,032	7,987	8,934	9,875
Total savings:	**641**	**1,419**	**2,196**	**3,052**	**3,919**	**4,826**	**5,769**	**6,713**	**7,672**	**8,627**	**9,574**	**10,515**
Variance:	**(76)**	**(42)**	**(42)**	**(42)**	**(42)**	**(42)**	**(42)**	**(42)**	**(42)**	**(42)**	**(42)**	**(42)**

At the end of April, delivery against CIP targets amounted to £641k against an overall year to date target of £716k. This equates to 89% delivered. A full breakdown of performance by individual services is provided in ***Appendix B***.

Services' Finance Committees continue to meet on a monthly basis to discuss their CIP performance and develop mitigations to counter scheme slippage.

Conclusion: Initial analysis work shows that 89% of CIPS have been delivered against a year to date target of £716k.

Statement of Financial Position (SoFP)

PERIOD: April 2016	2015/16 31/03/16 Draft £'000's	2016/17 30/04/16 April £'000's
NON CURRENT ASSETS		
Property, Plant and Equipment	201,580	201,678
Intangible assets	219	219
Trade and other receivables	389	389
Total Non Current Assets	**202,188**	**202,286**
CURRENT ASSETS		
Inventories	175	175
Trade and other receivables	11,559	12,387
Investments	0	0
Other Financial Assets		
Cash and Cash Equivalents	7,209	5,758
Total Current Assets	**18,943**	**18,320**
Non current assets held for sale	**0**	**0**
TOTAL ASSETS	**221,131**	**220,606**
CURRENT LIABILITIES		
Trade and other payables	(24,925)	(24,565)
Borrowings	(167)	(167)
Capital Investment Loan - Current	0	0
Provisions	(710)	(656)
Total Current Liabilities	**(25,802)**	**(25,388)**
NET CURRENT ASSETS (LIABILITIES)	**(6,859)**	**(7,068)**
NON CURRENT LIABILITIES		
Borrowings	(8,703)	(8,703)
Capital Investment Loan - Non Current	0	0
Trade and other payables	0	0
Provisions	(1,520)	(1,520)
Total Non Current Liabilities	**(10,223)**	**(10,223)**
TOTAL ASSETS EMPLOYED	**185,106**	**184,995**
TAXPAYERS' EQUITY		
Public Dividend Capital	82,380	82,380
Retained Earnings	41,588	41,477
Revaluation reserve	61,138	61,138
TOTAL TAXPAYERS EQUITY	**185,106**	**184,995**

Non-current assets
Property, plant and equipment (PPE) amounts to £202.3m. Capital spend of £98k offsets cumulative depreciation costs, resulting in a small increase in PPE balances since the start of the year.

Current Assets
Current assets include cash of £5.8m and receivables of £12.4m.

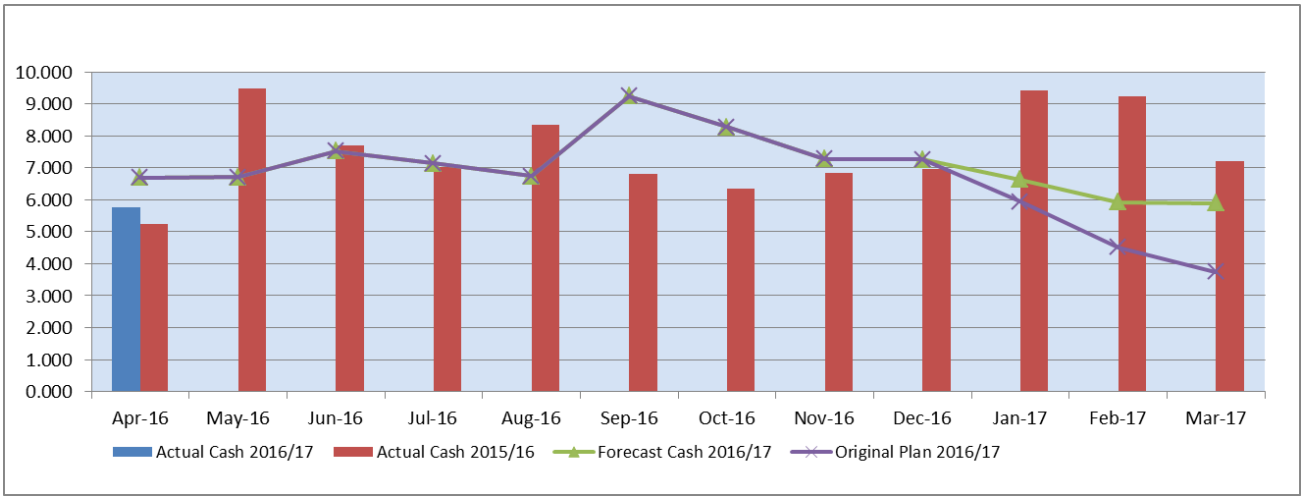
Working capital
Cash and changes in working capital are reviewed on the following pages.

Taxpayers' Equity
April's deficit of £47k is reflected within the retained earnings movement.

A forecast year end SoFP is expected to be included from month 2.

Cash and Working Capital

Rolling 12 Months Cash Analysis Apr 16 to Mar 17



Cash – Key Points

April's closing cash balance is £5.8m (Mar: £7.2m). This is a decrease of £1.4m during the month and £0.9m lower than the original planned cash balance of £6.7m for February.

The best, likely and worst case cash scenarios are difficult to predict early on in the year, this data will be included once more detailed information is available. Planned year end cash was initally £3.7m. However, the outcome of the final contract negotiations discussed in the introduction would be expected to improve the cash position by £2.1m compared to plan. Accordingly, initial forecasts now show an anticipated year end cash position of £5.8m

To ensure that the cash position is £5.8m by the end of the year, the finance team will work closely with the contracts team to actively pursue payment from commissioners for all upcoming contract variations and other non-block contract income. Updates will be applied to the forecast outturn when they become available. As contracts have only recently been agreed it is difficult to forecast any scenarios at this point in the financial year.

Should the forecast I&E break-even position not be achieved, this will have a detrimental impact on the cash position. In prior years, the Trust's aimed to keep retained cash at an amount equal to at least 11 days' cash operating expenses (just over £8m). At month 1 the closing balance of £5.8m equates to 8.1 days' operating expenses (as does the year end forecast cash balance)

Receivables

Current receivables (debtors) total £12.7m, representing a monthly decrease of £1.2m. This is due to outstanding invoices raised to UHL and the CCG's relating to various clinical recharges.

Receivables	April 2016/17 current month)					
	NHS £'000	Non NHS £'000	Emp's £'000	Total £'000	% Total	% Sales Ledger
Sales Ledger						
30 days or less	808	1,163	1	**1,972**	**15.5%**	**34.6%**
31 - 60 days	1,405	127	8	**1,540**	**12.1%**	**27.0%**
61 - 90 days	721	107	3	**831**	**6.5%**	**14.6%**
Over 90 days	1,104	122	130	**1,356**	**10.6%**	**23.8%**
	4,038	1,519	142	**5,699**	**44.7%**	**100.0%**
Non sales ledger	1,725	4,963	0	**6,688**	**52.5%**	
Total receivables current	**5,763**	**6,482**	**142**	**12,387**	**97.2%**	
Total receivables non current		360		360	**2.8%**	
Total	**5,763**	**6,842**	**142**	**12,747**	**100.0%**	**0.0%**

Receivables over 90 days should not account for more than 5% of the total receivables balance. The performance at Month 1 was 10.6%. While the outstanding amount remains high, the team are seeking a more proactive approach to collecting debt. A summary analysis of over 90 days debtors is shown below:

Category	£ Invoices	% Invoices
Debt not at risk of being written off	607	45%
Debt where considerable concerns over its recovery have been expressed	749	55%
Debt due to be written off / credited	0	0%
Total	1,356	100%

Of the £749k of debt with concerns over the level of recovery, £604k relates to the CCG PICU invoices.

Payables

The current payables position of £24.5m shows a reduction of £1.3m during the month.

Payables	April 2016/17 (current month)				
	NHS £'000	Non NHS £'000	Total £'000	% Total	% Purchase Ledger
Purchase Ledger					
30 days or less	581	4,863	**5,444**	**22.2%**	**64.7%**
31 - 60 days	1,234	118	**1,352**	**5.5%**	**16.1%**
61 - 90 days	223	80	**303**	**1.2%**	**3.6%**
Over 90 days	1,010	301	**1,311**	**5.3%**	**15.6%**
	3,048	5,362	**8,410**	**34.2%**	**100.0%**
Non purchase ledger	2,665	13,490	**16,155**	**65.8%**	
Total Payables Current	**5,713**	**18,852**	**24,565**	**100.0%**	
Total Payables Non Current	0	0	**0**		
Total	5,713	18,852	24,565	**100.0%**	

Better Payment Practice Code (BPPC)

The specific target is for the four categories of performance to be at or above 95% compliance with the 30-day target. Cumulatively the Trust achieved two of the four targets in April. The payment of NHS invoices, by number, within the required period is non-compliant at month 1, at 93.1% Non NHS payment performance, by value is achieved 90.6%. Further details are shown in ***Appendix C***.

The Finance team is contacting non-compliant managers and will continue to monitor and address areas of non-compliance until the cumulative position reaches the 95% target.

Capital Programme 2015/16

	Annual Plan	Apr YTD Plan	Apr YTD Actual	Apr YTD Variance	Year End Forecast	Revisions to Plan
Sources of Funds	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
I&E Surplus	803	67	67	0	803	0
Depreciation	6,500	542	542	0	6,500	0
Internally Generated cash	0	0	0	0	0	0
Property Disposals	1,450	0	0	0	1,450	0
TDA Capital Loan Investment	4,000	0	0	0	4,000	0
PDC Refund to DH	0	0	0	0	0	0
Total Capital funds	**12,753**	**609**	**609**	**0**	**12,753**	**0**
Application of Funds	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Estates & Innovation						
Strategic	(3,795)	0	0	0	(3,795)	0
Backlog Maintenance (inc capital staffing)	(1,500)	(63)	(1)	62	(1,500)	0
Medical Devices	(250)	(10)	(3)	7	(250)	0
Safety & Compliance	(1,949)	0	0	0	(1,949)	0
Estates Transformation	(1,060)	(44)	(35)	9	(1,060)	0
Innovation	(150)	0	0	0	(150)	0
Sub-total:	**(8,704)**	**(117)**	**(39)**	**78**	**(8,704)**	**0**
IT Programme						
IT Programme	(4,027)	(89)	(59)	30	(4,027)	0
Sub-total IT:	**(4,027)**	**(89)**	**(59)**	**30**	**(4,027)**	**0**
Total Capital Expenditure	**(12,731)**	**(206)**	**(98)**	**108**	**(12,731)**	**0**
(Over)/underspend against resource available	**22**	**403**	**511**	**108**	**22**	**0**

Capital expenditure to date totals £98k – this is £108k less than April's planned spend of £206k. Capital spend is less than plan mainly due to the delayed invoices relating to schemes currently taking place. The team are in the process of revising the expenditure profile of the capital plan to allow more accurate forecasting.

The Trust is due to draw down a £4m capital loan from the DH to allow all capital schemes to be delivered. The first instalment of the loan is due in May.

At month 1 there are no deviations from forecasted spend predicted. However these will be reported if they become apparent later in the year.

APPENDIX A - Statement of Comprehensive Income (SoCI)

Statement of Comprehensive Income for the period ended 30 April 2016	YTD Actual M01 £000	YTD Plan M01 £000	YTD Var. M01 £000	Year end forecast £000
Revenue				
Total income	22,488	22,498	(10)	272,106
Operating expenses	(21,986)	(22,146)	160	(265,577)
Operating surplus (deficit)	**502**	**352**	**150**	**6,529**
Investment revenue	0	3	(3)	36
Other gains and (losses)	0	0	0	0
Finance costs	(83)	(83)	0	(985)
Surplus/(deficit) for the period	**419**	**272**	**147**	**5,580**
Public dividend capital dividends payable	(467)	(467)	(0)	(5,604)
I&E surplus/(deficit) for the period (before tech. adjs)	**(48)**	**(195)**	**147**	**(24)**
IFRIC 12 adjustments	2	2	0	24
Donated/government grant asset reserve adj	0	0	0	0
Technical adjustment for impairments	0	0	0	0
TDA I&E control total surplus	**(46)**	**(193)**	**147**	**0**
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:	**(48)**	**(195)**	**147**	**(24)**
Trust EBITDA £000	**1,080**	**930**	**150**	**13,484**
Trust EBITDA margin %	**4.8%**	**4.1%**	**0.7%**	**5.0%**

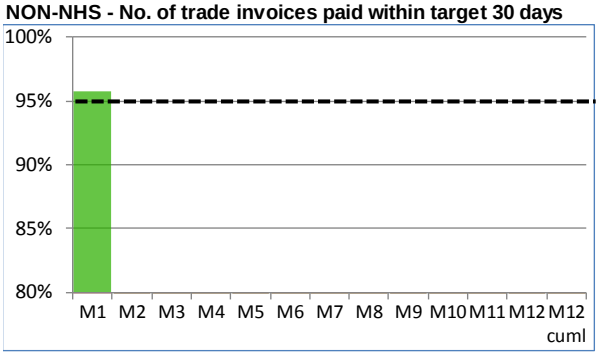
APPENDIX B – BPPC performance

Trust performance – current month (cumulative) v previous

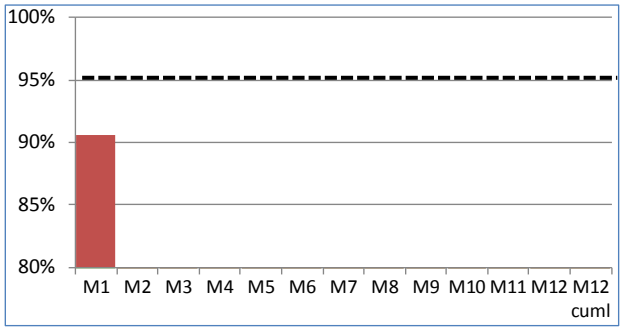
Better Payment Practice Code	April	
	Number	£000's
Total Non-NHS trade invoices paid in the year	3,058	10,461
Total Non NHS trade invoices paid within target	2,928	9,480
% of Non-NHS trade invoices paid within target	**95.7%**	**90.6%**
Total NHS trade invoices paid in the year	116	3,670
Total NHS trade invoices paid within target	108	3,594
% of NHS trade invoices paid within target	**93.1%**	**97.9%**
Grand total trade invoices paid in the year	3,174	14,131
Grand total trade invoices paid within target	3,036	13,074
% of total trade invoices paid within target	**95.7%**	**92.5%**

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

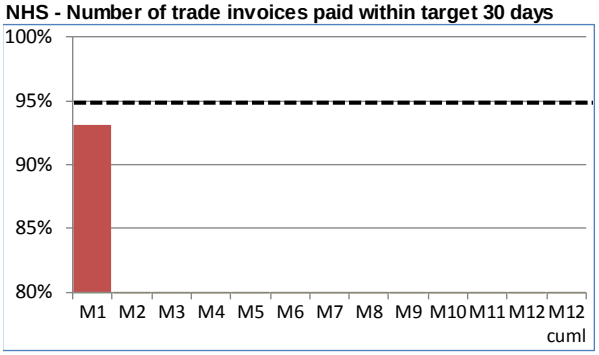
NON-NHS - No. of trade invoices paid within target 30 days



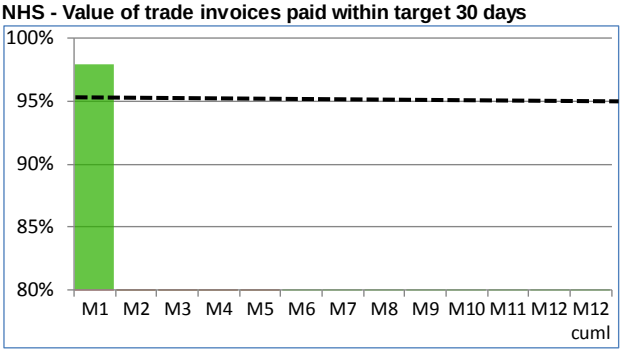
NON-NHS - Value of trade invoices paid within target 30 days



NHS - Number of trade invoices paid within target 30 days



NHS - Value of trade invoices paid within target 30 days



APPENDIX C – Agency staff expenditure

2016/17 Agency Expenditure (includes prior year comparators)	2015/16 M1 £000s Actual	2015/16 Outturn £000s Actual	2016/17 M1 YTD £000s Actual
AMH/LD			
Agency Consultant Costs	-71	-830	-80
Agency Nursing	-185	-1,676	-68
Agency Scient, Therap. & Tech	-20	-380	-15
Agency Non clinical staff costs	-23	-211	-5
Sub-total	**-299**	**-3,096**	**-168**
CHS			
Agency Consultant Costs	-27	-244	0
Agency Nursing	-324	-5,031	-265
Agency Scient, Therap. & Tech	-95	-1,526	-49
Agency Non clinical staff costs	-4	-226	-17
Sub-total	**-450**	**-7,026**	**-331**
FYPC			
Agency Consultant Costs	-40	-666	-60
Agency Nursing	-25	-117	-16
Agency Scient, Therap. & Tech	-15	-168	-18
Agency Non clinical staff costs	-33	-268	-17
Sub-total	**-113**	**-1,218**	**-111**
Enabling, Hosted & reserves			
Agency Consultant Costs	-1	-180	-27
Agency Nursing	1	93	0
Agency Scient, Therap. & Tech	-7	-313	-58
Agency Non clinical staff costs	-69	-596	-19
Sub-total	**-78**	**-995**	**-104**
TOTAL TRUST			
Agency Consultant Costs	-139	-1,919	-168
Agency Nursing	-533	-6,731	-349
Agency Scient, Therap. & Tech	-138	-2,386	-140
Agency Non clinical staff costs	-130	-1,300	-58
Total	**-940**	**-12,335**	**-715**

Agency expenditure target

The Trust was requested by NHSI to set a £7.7m agency spend target (against all staff groups) in the financial plan for 2016/17. This compares against a £12.3m outturn in 2015/16. Following internal discussions, the best case position for 2016/17 was estimated at £9.9m and this was included in the plan.

The trajectory for the £9.9m target included an estimate of £888k expenditure for month 1. Actual month 1 expenditure was £715k, meaning that the Trust is currently well within the internally set target.

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Leicestershire Partnership NHS
NHS Trust

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TRUST BOARD - 27th May 2016

INTEGRATED QUALITY & PERFORMANCE REPORT

Introduction

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

2. Work is underway to establish a fully automated data collection and reporting tool to be used for the production of the IQPR and other information reporting requirements.

3. The report format has received further refinement to align the key performance indicators (KPIs) against the Trust governance groups and the Corporate Risk Register with greater clarity.

4. It should be noted that the following Shadow Monitor compliance is demonstrated in the report:

Governance Rating	Green – No Concerns Identified
Continuity of Services Risk Rating	3 - Green

Aim

5. The aim of this report is to provide the Trust Board with an integrated quality and performance report showing levels of compliance with the Monitor Risk Assessment Framework and Care Quality Commission (CQC) registration, together with detailed analysis for those areas requiring additional action to ensure achievement of targets.

Recommendations

The Trust Board is recommended to;

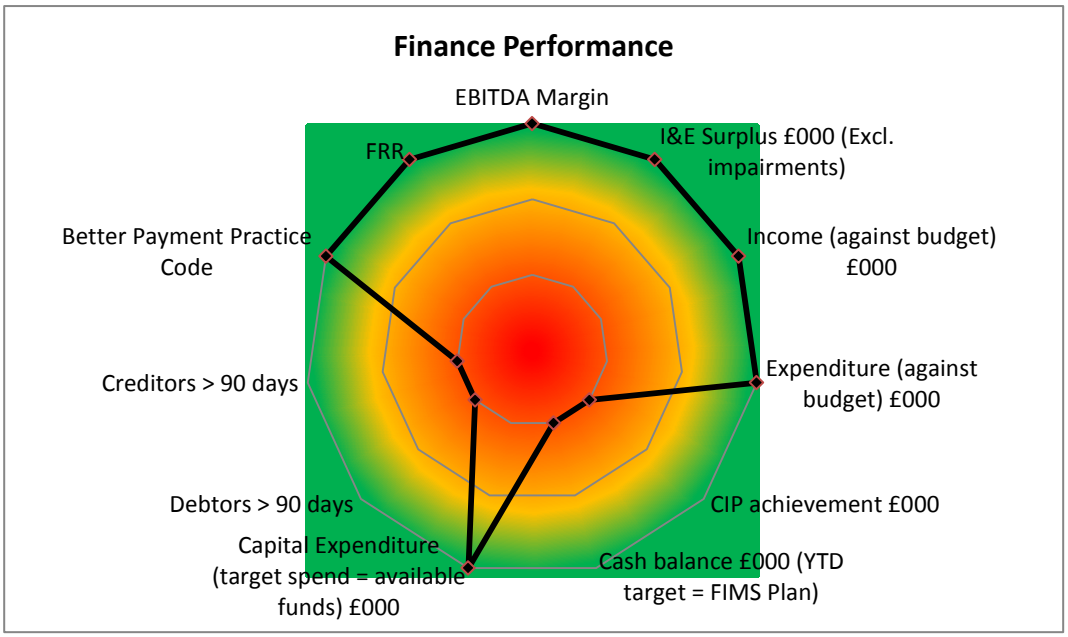
1. Receive assurance that the integrity of the data included in the report is being reviewed as part of the Trust-wide Data Quality Improvement Plan (DQIP);

2. Receive assurance with regard to areas of quality and performance where performance improvement action is being undertaken.

6. Finance and Performance Committee – Points for Discussion

Key Performance Indicator Overview

Finance

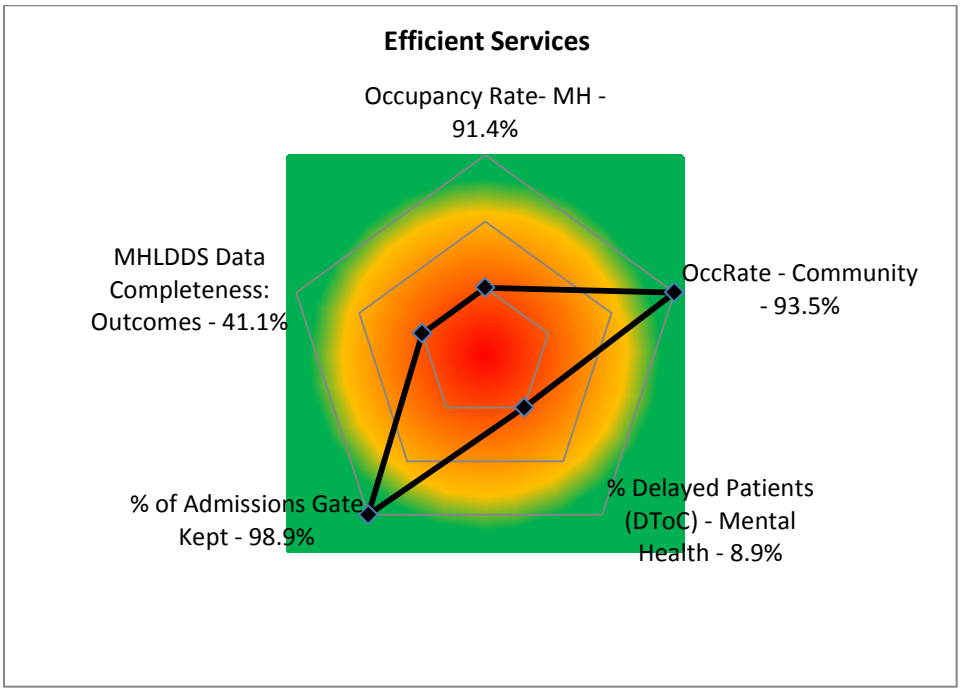


Month 01 Position: The Trust is reporting a deficit of £-46k against a planned deficit of £-193k. This is a favourable movement of £146k. The Trust is forecasting an income and expenditure break even position at the end of the year, which would be an improvement over the planned deficit of £2.1m.

- **EBITDA:** The EBITDA margin as at Month 01 is 4.8% against a year to date target of 4.1%. 89% of the year to date CIPs target was achieved as at April 2016. The planned CIP target for the financial year 2016/17 is £6.7m. The current forecast is in line with the plan as at Month 01.

- **Cash balance:** The cash balance at the end of Month 01 is £5.8m. Debtors over 90 days have increased to 10.6% in April 2016 from 10.1% in March 2016. Creditors over 90 days have increased to 5.3% in April 2016 from 4.6% in March 2016.

Performance



- **% Delayed Patients (DToC) - MH:** *Duplicate DTOC entries identified in December 2015 have been resolved with the service with one outstanding record which has been escalated to the system supplier for a technical resolution. This record adds approximately 100 days delay.*

  Patients being delayed during discharge for the month of April 2016 is the result of the following categories; Housing (20.2%), NHS (10.7%), Other (11.1%), Other (10.7%), Rehabilitation (9.5%), Multiple (8.3%), Joint (6.0%), Homes (6.0%), Social Worker (6.0%), Exercising choice (4.8%), Continuing care assessment incomplete (3.6%), Availability of place (no suitable alternative) (3.6%), Social services (3.6%), Refusing to co-operate (2.4%), Self-funded placement (1.2%), Medication (1.2%), Home adaptations - minor (1.2%), Legal issues (1.2%).

  Service representatives are continuing to meet with Housing Leads and Social Care representatives from both City and County Councils and are supportive of housing options. Clinical Commissioning Groups had initially funded Out of County placements to speed up the discharge process and reduce patient delays however this has now stopped.

- **% Delayed Patients (DToC) - Community:** Delays for community patients during the month of February 2016 are the result of the following discharge delay reasons; Exercising Choice (30.8%), NHS (16.9%), Home (15.4%) LA Funded care package (10.8%) and Other (26.2%).

- **% of Admissions Gate Kept by the Crisis Resolution & Home Treatment Team (CRHT):** 98.9% of admissions were gatekept in the month of April 2016 compared to 100% in March 2016.

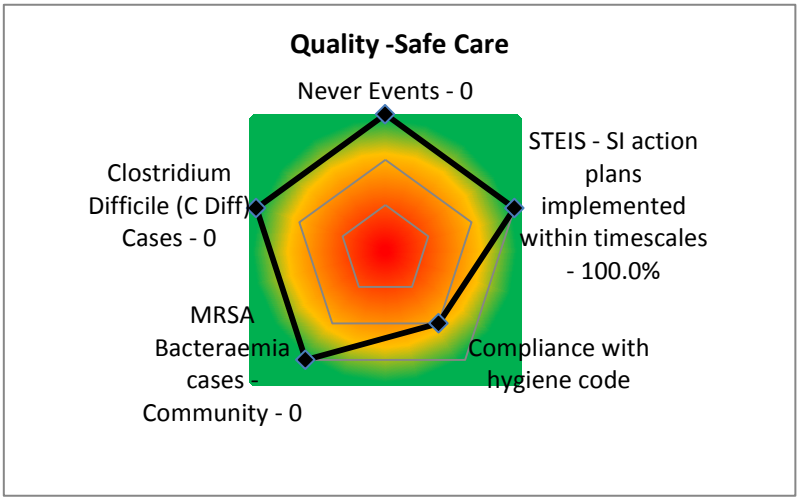
- **Total number of Home Treatment episodes carried out by Crisis Resolution Team (CRHT) year to date:** There has been a thorough review of the activity and pathway within CRHT, working with stakeholders including feedback from patients, commissioners and GP leads. A deep dive into the activity data has shown that a large proportion of referrals to the CRHT (approximately 60%)

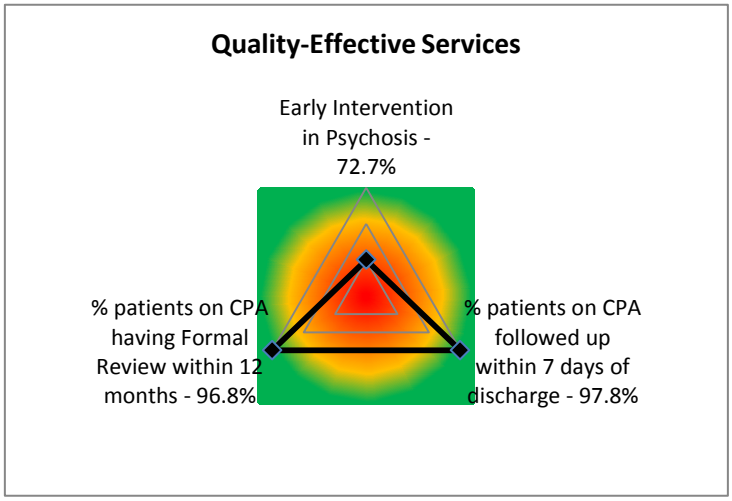
result in no further contact. This has shown these cases need an urgent response but are not genuine cases of crisis. This has resulted in large amounts of assessment activity but not transferring into home treatment activity. As such, the service has developed a new model for delivery, working with the community mental health service to ensure patient activity is delivered in the right place, at the right time and by the right service. This work aligns to the Better Care Together work and the AMH.LD Service Development Initiatives (SDI).

Year to date performance is currently 120.7% which equates to 175 episodes against a pro-rata target of 1740.

7. Quality Assurance Committee – Points for Discussion

Key Performance Indicator Overview





- **Care programme approach (CPA) patients: % receiving follow-up contact within seven days of discharge:** This KPI is reported a month in arrears to enable tracking of target. Please note that this indicator represents patients 18 years and over.

  During March 2016 there were 92 patients discharged of which 90 were followed up successfully within seven days.

- **Care programme approach (CPA) patients: % having formal review within 12 months:** 1957 patients were on CPA of which 1894 had a formal review within 12 months

  Families, Young Persons and Children's Services (100.0%), Community Health Services (99.0%) and AMHLD Services (96.4%) all met the 95% threshold.

  Based on performance during 2014/15, the accountable executive believes the reduction in compliance in AMHLD between March 2015 and November 2015 attributed to data quality and limitations in reporting across multiple systems rather than clinical performance. The reporting source has been corrected from December 2015 and is including patients aged under 18 and trackers which may inflate figures, but is now showing performance in line with service expectation.

- **Early Intervention in Psychosis - % 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.

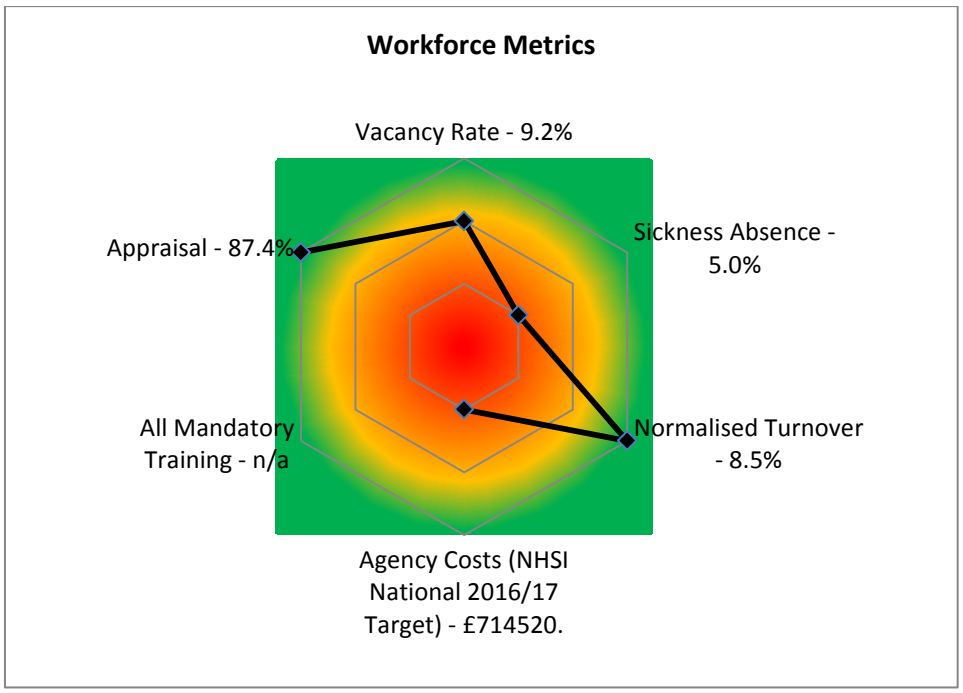
72.7% for the month of April 2016 is the result of 8 newly diagnosed cases against the provisional monthly commissioner target of 11. The service is dependent on the number of referrals received into the service and the appropriateness of the referral.

- **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, therefore the data quality rating for timeliness is amber. Year-end target of 0 (Zero) is based on the Commissioner target.

- **Clostridium Difficile (C Diff) Cases:** LPT have reported zero positive toxin case(s) for Clostridium Difficile for the month of April 2016.

  The total number of confirmed cases from April 2016 to the end of March 2017 is zero against a year-end Commissioner target of seven.

Key Performance Indicator Overview



- **% Vacancy Rate:** Vacancy Rate figures for March 2016 was 7.8% and has increased to 9.2% in April 2016.

- **% Sickness Absence:** The services are continuing focussed discussion on sickness to identify hot spots and to see what additional support can be offered e.g. additional support from AMICA, mentoring opportunities, additional training for managers and auditing how the policy is being implemented. Key themes include high levels of long term sickness (being pro-actively managed with a view to redeployment, reasonable adjustments and termination of contracts where appropriate) and a correlation between sickness and areas with high vacancy rates.

- **Agency Costs (NHSI National 2016/17 Target):** NHS Improvement (NHSI) have issued the Trust with an expenditure ceiling of £7,696,000 covering all agency and locum staff during 2016/17. By dividing this figure equally across the year this gives an monthly ceiling of £640,000. The Trust's financial plans forecast an annual spend of £8,935,431 on agency workers. The monthly forecast reduces from just over £1m at the start of 2016/17 to £0.5m by the end of 2016/17.

  In April 2016, the Trust agency spend was £714,520 which is above the NHSI average monthly target, but below the Trust's monthly forecast spend.

  Mandatory Training: During April 2016, uLearn was moved to a new cloud-based server and received an upgrade to include some new features. Following this upgrade the Trust is unable to provide training compliance figures for April 2016. The system supplier is working to resolve the issue as a matter of urgency.

  Staff are still able to use uLearn to book training, complete eLearning and undertake their appraisal. Compliance with appraisals has not been affected.

8. Summary of Shadow Monitor GR and CSSR

- The Trust Board's attention is drawn to the significant potential impact to the Trust Governance Rating.
- **Governance Rating (GR)** – Performance against the Monitor Risk Assessment Framework standard for **GR in March 2016 is Green (no concerns identified)** for the 'Access and Outcomes Metrics' and 'Quality Governance Indicator' categories.

  This indication must be taken as a 'point in time' score (end March 2016) for the current financial quarter.

- **Continuity of Services Risk Rating (CSRR)** – Performance against the Monitor Risk Assessment Framework standard for CSRR in February 2016 was at Level 3 (Green). This will be refreshed for the next monthly report.

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9. Conclusion

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

Appendix A – Monitor Risk Assessment Framework

Summary of Monitor triggers of governance concern

Category	Metrics	Governance concern triggered by
CQC information	• CQC judgments	• CQC warning notice issued • Civil and/or criminal action initiated
Access and outcomes metrics	For **acute trusts**, metrics including: • referral to treatment within 18 weeks • A&E waits (4 hours) • cancer waits (62 days) For **ambulance trusts**, Category A response times For **mental health trusts**, metrics including CPA follow-up and psychosis outreach	• Three consecutive quarters' breaches of a single metric *or* a service performance score of 4 or greater[1] • Breaching pre-determined annual C. difficile threshold (either three-quarters' breach of the year-to-date threshold or breaching the full year threshold at any time in the year)
	For **acute trusts**, metrics including: • C. difficile – national target For **mental health trusts**, metrics including tracking accommodation/employment status (data completeness only) For providers of community services, data completeness against selected elements of the CIDS dataset	• Breaching the A&E waiting times target in two quarters over any four-quarter period *and* in any additional quarter over the subsequent three quarters
Third party reports	• Ad hoc reports from GMC, the Ombudsman, commissioners, Healthwatch England, auditor reports, Health & Safety Executive, patient groups, complaints, whistleblowers, medical Royal Colleges etc.	• Judgment based on the severity and frequency of reports

Quality governance indicators	• Patient metrics
	  • patient satisfaction
	• Staff metrics
	  • high executive team turnover
	  • satisfaction
	  • sickness/absence rate
	  • proportion temporary staff
	  • staff turnover
		• Material reductions in satisfaction, or increases in sickness or turnover rates
		• Material increases in proportion of temporary staff

	• Aggressive cost reduction plans	• Cost reductions in excess of 5% in any given year
Financial risk	• Continuity of services risk rating	• Breaching any continuity of services licence condition as a result of governance • Inadequate planning processes

[1] For example a service performance score as per the metrics in Appendix A.

Monitor Risk Assessment Framework – Final Metrics

Leicestershire Partnership NHS Trust

Integrated Quality and Performance Report

Advancing health and well-being

End of April 2016 Position

Data to 30 April 2016 unless otherwise stated

Previous months data refreshed where available

Leicestershire Partnership NHS Trust

Contents

Leicestershire Partnership NHS Trust

Summary of Shadow Performance against Monitor Access and Outcomes Metrics

	Indicator	Target	Reporting Frequency	Reporting Period			Sparkline	Previous Quarter	Current Quarter	Travel	Quarter End Forecast	Year to Date Total	Performance against Mandated Standards	Comments	Accountable Director
				FEB	MAR	APR									
ACCESS	**Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate –** patients on an incomplete pathway	92%	Monthly	100.0%	100.0%	100.0%		100.0%	100.0%	→	100.0%	100.0%	0.0	RTT service lines relate to ADHD and Asperger's services. The Trust actively monitors its waiting lists. Monthly reports are sent to services to help manage waiting lists; and waiting times are monitored through service performance groups, corporate governance routes including Trust Board and with commissioners to ensure delivery of waiting times against targets.	Directors of Services
	Care programme approach (CPA) patients: % receiving follow-up contact within seven days of discharge	95%	Monthly (in arrears)	96.9%	97.8%			97.6%	97.1%	↓	97.1%	96.8%	0.0		Directors of Services
	Care programme approach (CPA) patients: % having formal review within 12 months	95%	Monthly	97.0%	96.9%	96.8%		97.0%	96.8%	↓	96.8%	96.8%	0.0	1957 patients were on CPA, of which 1894 had a formal review within 12 months. Families, Young Persons and Children's Services (100.0%), Community Health Services (99.0%) and AMHLD Services (96.4%) all met the 95% threshold. (This KPI has been derived from the new DQIP data warehouse)	Directors of Services
	Admissions to inpatient services had access to crisis resolution/ home treatment teams: % patients gate-kept by Crisis Resolution & Home Treatment Team	95%	Monthly	100.0%	100.0%	98.9%		100.0%	98.9%	↓	98.9%	98.9%	0.0	Monthly compliance is refreshed in line with national reporting timescales. February 2016 and March 2016 have not changed follow the refresh	Directors of Services
	Meeting commitment to serve new psychosis cases by early intervention teams: % newly diagnosed cases against commissioner contract	95%	Monthly	109.1%	100.0%	72.7%		112.1%	72.7%	↓	72.7%	72.7%	1.0	The relatively small numbers involved in the denominator of this indicator results in significant percentage shifts month on month.	Directors of Services
	Early intervention in psychosis (EIP): % people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral (Completed)	50%	Monthly (in arrears)	66.7%	75.0%			50.7%	80.6%	↑	80.6%	68.6%	0.0	This KPI is currently measuring internal and external referrals, patients aged 16-35 waiting within the PIER service and is calculated as date of referral to first contact for accepted patients only.	Directors of Services
OUTCOMES	**Minimising Mental Health Delayed Transfers of Care** (% Patients Delayed)	<=7.5%	Monthly	8.8%	8.1%	8.9%		8.2%	8.9%	↑	8.9%	8.9%	1.0	Duplicate DTOC entries have been resolved with the service with one outstanding record which has been escalated to the system supplier for a technical resolution. This record adds approx 100 days delay.	Directors of Services
	Infection Control: C Diff (MH & Community) Meeting the Clostridium Difficile Objective	7 (Year end Commissioner target)	Monthly	1	1	0		4	0	↑	0	0	0.0	Annual target reflects the local Commissioner target of 7 cases per annum. Total number of cases in 2015/16 was 12.	Directors of Services
	Mental Health & Learning Disability Dataset (MHLDDS) Data Completeness: Identifiers	97%	Monthly (in arrears)	98.8%	98.7%			99.6%	98.7%	↓	98.7%	99.5%	0.0	Previous months figures have been updated in line with national submission	Directors of Services
	Mental Health & Learning Disability Dataset (MHLDDS) Data Completeness: Outcomes for patients on CPA	50%	Monthly (in arrears)	43.9%	41.1%			57.0%		↑		60.3%	1.0	Data quality issues are attributed to difficulties in completing two separate forms on RiO. Services have been reminded to review the Identifiers and Outcomes report on RiO to help determine what data needs to be entered. Previous months' figures have been updated in line with national submissions.	Directors of Services
	Data Completeness: Community Services (Referral to Treatment Information)	50%	Monthly	100.0%	100.0%	100.0%		100.0%	100.0%	→	100.0%	100.0%	0.0		Directors of Services
	Data Completeness: Community Services (Referral Information)	50%	Monthly	83.8%	84.2%	83.8%		83.8%	83.8%	→	83.8%	83.8%	0.0		Directors of Services
	Data Completeness: Community Services (Treatment Activity Information)	50%	Monthly	99.9%	99.9%	99.9%		99.9%	99.9%	→	99.9%	99.9%	0.0		Directors of Services
	Access to Healthcare for All: Self Certification against compliance	4	Monthly	4	4	4		4	4	→	4	4	0.0		Directors of Services

Service Performance Score (based on current quarter performance)	3.0

NB: Monitor indicators are either RED or GREEN.

RAG status for Service Performance Score reflects Monitor Risk Assessment Framework guidance.
3 or below = Green, 4 or above = Red

Monitor Shadow Governance Rating

Category		Comments	Q4 Self Assessed Concerns	Q1 Forecasted Concerns
CQC Concerns	Care Quality Commission (CQC) judgements on the quality of care provided by the trust		No	No
Access & Outcomes Metrics	Performance against selected national access and outcomes standards	Service Performance Score = 3 based on current quarter performance Risk 1119 Data Quality: actions include delivery of data quality improvement programme Risk 729 Information Team Capacity and Capability: actions include additional training, support and restructure of service Risk 1238 Performance Management: actions include development and implementation of a performance management	No	No
3rd Party	Information and Ad hoc reports from third parties	No information from 3rd parties	No *	No *
Quality Governance Indicator	Operating metrics - Patient & Staff related metrics (satisfaction and turnover) to reflect quality governance	It is understood this indicator refers to material negative trends in patient and staff operational metrics and quality governance performance for the Trust. Due to areas under development, this category has been currently self-assessed to be 'Possibly' causing a trigger.	Possibly	Possibly
Financial Risk	Measure of financial robustness based on Liquidity and Capital Servicing Capacity	Continuity of Services Risk Rating (CSSR) = 3	No	No

Governance Status
No Evident Concerns

Governance Rating
Green

The 5 categories above are used by Monitor to assess the strength of governance at an NHS Foundation Trust and apply a Governance Risk Rating

Governance Risk Rating RAG:
Rated **GREEN** if no issues are identified and rated **RED** where enforcement action is being undertaken by Monitor. 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**.

* Judgment is based on the severity and frequency of Ad hoc reports from GMC, the Ombudsman, commissioners, Healthwatch England, auditor reports etc.

Leicestershire Partnership NHS Trust

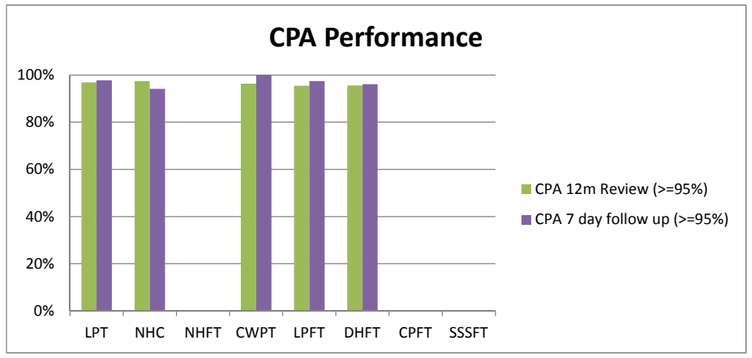
LPT Benchmarking Information - March 2016 Report

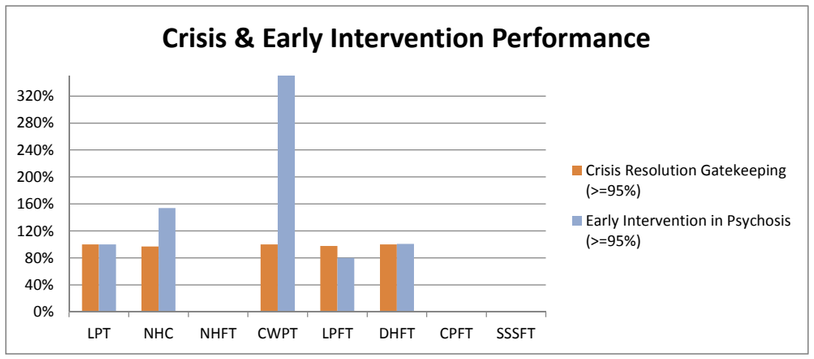
	Data Source	Data Reporting Period	CPA 12m Review (>=95%)	CPA 7 day follow up (>=95%)	DToC (Monitor) (<=7.5%)	Crisis Resolution Gatekeeping (>=95%)	Early Intervention in Psychosis (>=95%)	MHLDDS Completeness - Identifiers (>=97%)	MHLDDS Completeness - Outcomes (>=50%)	18 week wait time non admitted complete pathway (>=95%)	18 week wait time non admitted incomplete pathway (>=92%)	Comment
Leicestershire Partnership NHS Trust (LPT)	Trust Board Papers	Mar-16	96.9%	97.8%	8.1%	100.0%	100.0%	98.7%	41.1%	n/a	100.0%	
Nottinghamshire Healthcare NHS Trust (NHC)	Trust Board Papers	Mar-16	97.4%	94.1%	8.2%	97.0%	153.9%	98.9%	77.6%	99.4%	n/a	
Northamptonshire Healthcare FT (NHFT)	Trust Board Papers	Mar-16	not published	not published	not published	not published	not published	not published	not published	not published	not published	March 2016 Data not yet published
Coventry and Warwickshire Partnership Trust (CWPT)	Trust Board Papers	Mar-16	96.4%	100.0%	3.3%	100.0%	372.4%	99.6%	88.5%	100.0%	100.0%	
Lincolnshire Partnership NHS FT (LPFT)	Trust Board Papers	Mar-16	95.5%	97.4%	5.2%	97.6%	80.0%	98.6%	not published	98.1%	94.2%	
Derbyshire Healthcare NHS FT (DHFT)	Trust Board Papers	Mar-16	95.6%	96.2%	1.7%	100.0%	100.7%	99.4%	94.8%	n/a	97.1%	
Cambridge & Peterborough NHS FT (CPFT)	Trust Board Papers	Mar-16	not published	not published	not published	not published	not published	not published	not published	not published	not published	March 2016 Data not yet published
South Staffs and Shropshire Healthcare NHS FT (SSSFT)	Trust Board Papers	Mar-16	not published	not published	not published	not published	not published	not published	not published	not published	not published	March 2016 Data not yet published

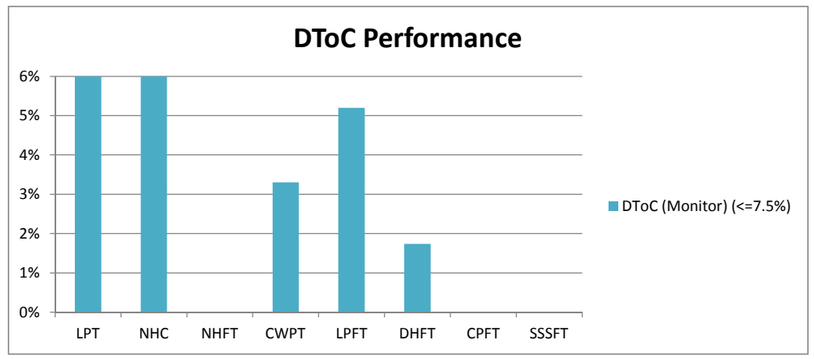
Notes:

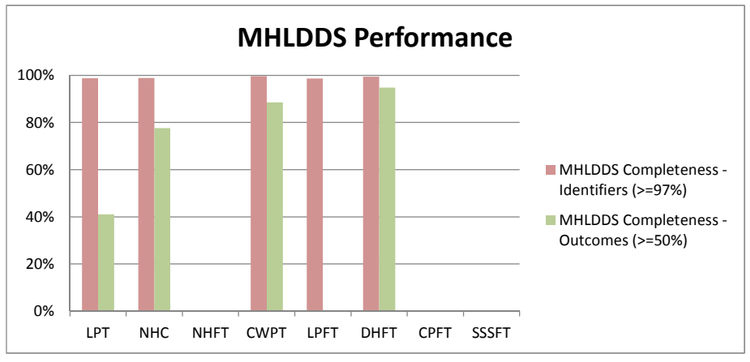
Analysis of the benchmarking data indicates the Trust achieved all of the Monitor indicators except DToC and MHLDDS Outcomes during the month of March 2016.

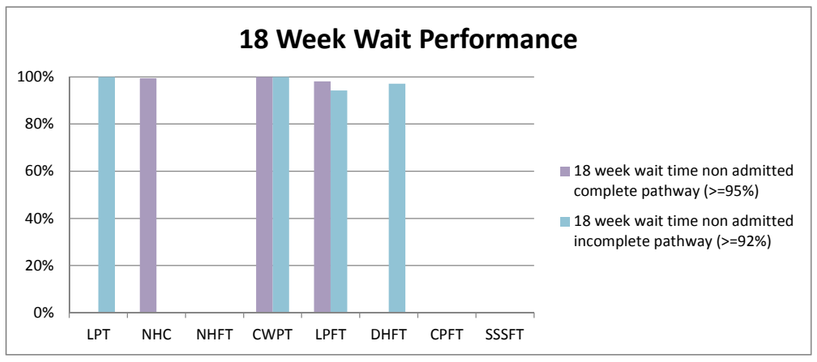
Analysis against peer Trusts showed that all thresholds were met with the exception of CPA 7 day follow-up for Nottinghamshire Healthcare NHS Trust during the month of March 2016.











Performance Dashboard

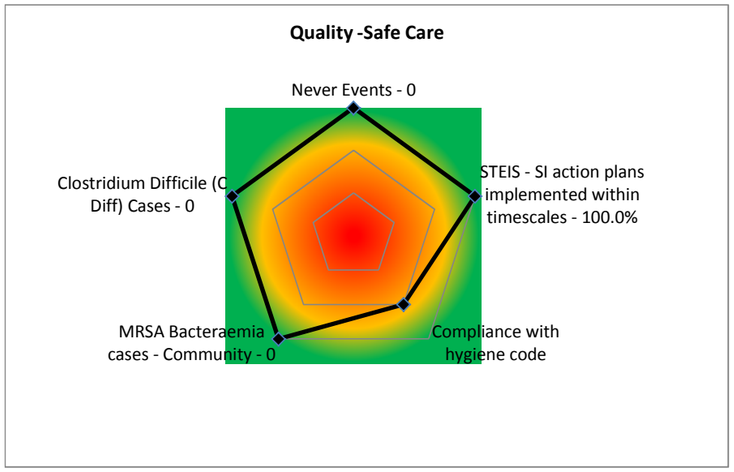
Trust Performance

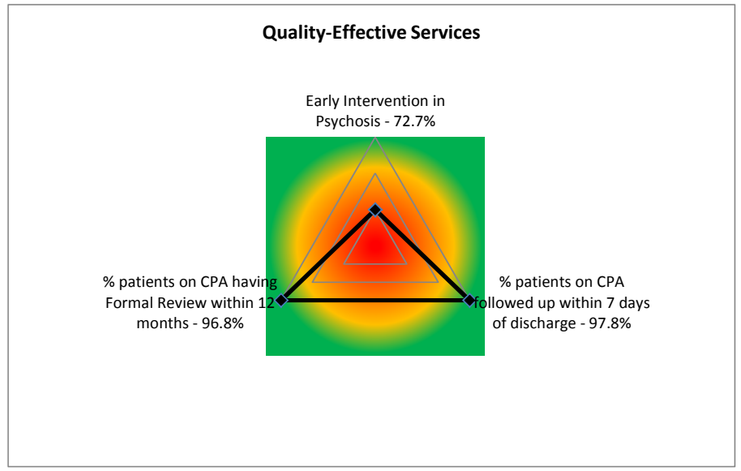
Chapter	Source	Reporting Frequency	Indicator Code	Risk	Indicator	Monthly Target	Data As At	Current Month Actual	Previous Month	Performance vs Previous Month	Year to Date Position	Sparkline	Year End Target	Executive Director Lead
Monitor Service Performance	MON	Monthly	MSP.13		Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	92%	APR	100.0%	100.0%	⇨	100.0%		92%	DoS
	MON	Monthly (In Arrears)	MSP.05		Care programme approach (CPA) patients: % receiving follow-up contact within seven days of discharge	95%	MAR	97.8%	96.9%	⇧	96.8%		95%	DoS
	MON	Monthly	MSP.06		Care programme approach (CPA) patients: % having formal review within 12 months	95%	APR	96.8%	96.9%	⇩	96.8%		95%	DoS
	MON	Monthly	MSP.08		Admissions to inpatient services had access to crisis resolution/ home treatment teams: % patients gate-kept by Crisis Resolution & Home Treatment Team	95%	APR	98.9%	100.0%	⇩	98.9%		95%	DoS
	MON	Monthly	MSP.09		Meeting commitment to serve new psychosis cases by early intervention teams: % newly diagnosed cases against commissioner contract	95%	APR	72.7%	100.0%	⇩	72.7%		95%	DoS
	MON	Monthly (In Arrears)	MSP.		Early intervention in psychosis (EIP): % people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral (Completed)	50%	MAR	75.0%	66.7%	⇧	68.6%		50%	DoS
	MON	Monthly	MSP.07		Minimising Mental Health Delayed Transfers of Care (% Patients Delayed)	<=7.5%	APR	8.9%	8.1%	⇩	8.9%		<=7.5%	DoS
	MON	Monthly	MSP.02	1397	Infection Control: C Diff (MH & Community) Meeting the Clostridium Difficile Objective		APR	0	1		0		7 (Year end Commissioner target)	DoS
	MON	Monthly (In Arrears)	MSP.10		Mental Health & Learning Disability Dataset (MHLDDS) Data Completeness: Identifiers	97%	MAR	98.7%	98.8%		99.5%		97%	DoS
	MON	Monthly (In Arrears)	MSP.11		Mental Health & Learning Disability Dataset (MHLDDS) Data Completeness: Outcomes for patients on CPA	50%	MAR	41.1%	43.9%	⇩	60.3%		50%	DoS
	MON	Monthly	MSP.14		Data Completeness: Community Services (Referral to Treatment Information)	50%	APR	100.0%	100.0%	⇨	100.0%		50%	DoS
	MON	Monthly	MSP.15		Data Completeness: Community Services (Referral Information)	50%	APR	83.8%	84.2%	⇩	83.8%		50%	DoS
	MON	Monthly	MSP.16		Data Completeness: Community Services (Treatment Activity Information)	50%	APR	99.9%	99.9%	⇨	99.9%		50%	DoS
	MON	Monthly	MSP.12		Access to Healthcare for All: Self Certification against compliance	4	APR	4	4	⇨	4		4	DoS
Quality - Personal Services	TRUST	Monthly	QPS.01		% people reporting being treated with dignity and respect									AC
	COM/DOH	Monthly	QPS.02		Mixed sex sleeping accommodation breaches		APR	0	0	⇨	0			DoS
	TRUST	Monthly	QPS.03		% adult service users reporting having out of hours (OOH) contact details	95%								TS
	TRUST	Monthly	QPS.04		Compliments received		APR	125	100	⇧	278			AC
	TRUST	Monthly	QPS.05		Total complaints received		APR	30	33	⇩	57			AC
	TRUST	Monthly	QPS.06		Complaints acknowledged within 3 working days	100%	APR	100.0%	100.0%	⇨	100.0%		100%	AC
	DOH	Monthly (In Arrears)	QPS_9		Friends and Family: Number of responses		MAR	1150	916	⇧	916			AC
	DOH	Monthly (In Arrears)	QPS_10		Friends and Family: Number of 'Extremely Likelys'		MAR	866	696	⇧	696			AC
	DOH	Monthly (In Arrears)	QPS_13		Friends and Family: Number of 'Likelys'		MAR	249	191	⇧	191			AC
	DOH	Monthly (In Arrears)	QPS_11		Friends and Family: Number of 'Don't Know's'		MAR	2	8	⇩	8			AC
	DOH	Monthly (In Arrears)	QPS_12		Friends and Family: Number of detractors		MAR	19	21	⇩	21			AC
	DOH	Monthly (In Arrears)	QPS_8	1029	Friends and Family: Overall Score		MAR	97.0%	96.8%	⇧	96.8%			AC
Quality - Safe Care	TRUST	Monthly	QSC.03		Never Events	0	APR	0	0	⇨	0		0	AC
	COM	Monthly	QSC.04		Total Serious Incidents (SIs)		APR	5	4	⇩	12			AC
	COM	Monthly	QSC.05		STEIS - SI action plans implemented within timescales	100%	APR	100.0%	100.0%	⇨	100.0%		100%	AC
	TRUST	Monthly	QSC.15		% Zero Harm (Patient Safety Incidents)	69%	APR	62.5%	63.8%	⇩	62.5%		69%	AC
	TRUST	Monthly	QSC.14		Incident Rate (Patient Safety Incidents)		APR	45.4	47.5	⇩	45.4			AC
	TRUST	Monthly	QSC.16		PST: Pressure Ulcer Harms		APR	3.4%	3.2%	⇩	3.4%			AC
	TRUST	Monthly	QSC.17		PST: Falls Harms		APR	0.0%	0.3%	⇧	0.0%			AC
	TRUST	Monthly	QSC.18		PST: Catheter UTI Harms		APR	0.1%	0.3%	⇧	0.1%			AC
	TRUST	Monthly	QSC.19		PST: VTE Harms		APR	0.1%	0.3%	⇧	0.1%			AC
	COM/DOH	Monthly	QSC.10		Compliance with hygiene code		APR			⇨				AC
	COM	Monthly	QSC.11		MRSA Bacteraemia cases - Community		APR	0	0	⇨	0		0	AC
	COM	Monthly	QSC.13b		Clostridium Difficile (C Diff) Cases		APR	0	1	⇧	0		7	AC
	TRUST	Monthly	QSC.23		Total incidents reported (including near misses)		APR	1360	1344	⇧	2816			AC
	TRUST	Monthly	QSC.20		Total incidents reported (Pressure Sore)		APR	392	346	⇧	725			AC
	TRUST	Monthly	QSC.21		Total incidents reported (Other)		APR	968	971	⇩	2091			AC
	TRUST	Monthly	QSC.22		Total patient safety incidents reported (including near misses)		APR	854	877	⇩	1777			AC
	DoH	Monthly	QSC.22a		Non-Compliance with Fundamental Standards resulting in a Major Impact on Patients	No	APR	No	No	⇨	No		No	AC
	DoH	Monthly	QSC.22b		Non-Compliance with CQC Fundamental Standards Resulting in Enforcement Action	No	APR	No	No		No		No	AC

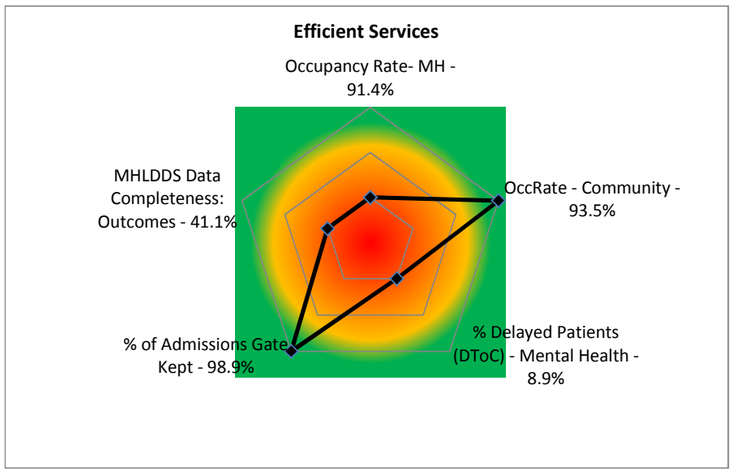
Chapter	Source	Reporting Frequency	Indicator Code	Risk	Indicator	Monthly Target	Data As At	Current Month Actual	Previous Month	Performance vs Previous Month	Year to Date Position	Sparkline	Year End Target	Executive Director Lead
Quality - Effective services	MON	Monthly	QES.03		Meeting commitment to serve new psychosis cases by early intervention teams: % newly diagnosed cases against commissioner contract	95%	APR	72.7%	100.0%	↓	72.7%		95%	TS
	MON	Monthly (In Arrears)	QES.04		Care programme approach (CPA) patients:% receiving follow-up contact within seven days of discharge	95%	MAR	97.8%	96.9%	↑	96.8%		95%	DoS
	MON	Monthly	QES.05		Care programme approach (CPA) patients:% having formal review within 12 months	95%	APR	96.8%	96.9%	↓	96.8%		95%	DoS
	NIHR CRN:EM	Quarterly	QES_11		Research & Development - Participant Recruitment	1342	Q4	560	398	↑	-492		1342	-
	NIHR CRN:EM & Internal	Quarterly	QES_12		Research & Development - Performance in Initiating and Delivering Research	80%	Q4	100.0%	90.0%	↑	87.0%		80%	-
	NIHR CRN:EM & Internal	Quarterly	QES_13		Research & Development - First Patient First Visit (FPFV)	100%	Q4	90.0%	87.0%	↑	73.0%		100%	-
	NIHR CRN:EM & Internal	Quarterly	QES_14		Research & Development - Delivering studies to Time & Target	80%	Q4	81.2%	75.8%	↑	71.0%		80%	-
	MON	Quarterly	QES.07		Access to Healthcare for All	4	Q4	4	4	→	4		4	TS
	COM/DoH	Quarterly	QES.08a		Breast Feeding- Status recorded at 6 - 8 weeks	County	Q4	97.6%	98.3%	↓	98.1%			HT
			QES.08b			City		98.2%	98.5%	↓	98.0%			HT
	COM/DoH	Quarterly	QES.09a		Breast Feeding- Prevalence at 6 - 8 weeks	County	Q4	45.5%	48.0%	↓	47.1%			HT
			QES.09b			City		62.5%	63.7%	↓	62.9%			HT
Quality - Efficient Services	COM	Monthly	QEFS.01		Average Length of Stay (ALoS) - Mental Health		APR	64.1	67.2	↑				DoS
	TRUST	Monthly	QEFS.02		Median Length of Stay (MLoS) - Mental Health		APR	21.0	30.5	↑	21.0			DoS
	TRUST	Monthly	QEFS.13		Average Length of Stay (ALoS) - Community hospital rehab wards		APR	17.0	15.9	↓	17.1			RB
	TRUST	Monthly	QEFS.14		Average Length of Stay (ALoS) - Stroke wards (Ward 1 St Lukes, Ward 1 Coalville)		APR	31.0	18.0	↓	29.3			RB
	TRUST	Monthly	QEFS.16		Average Length of Stay (ALoS) - City rehab beds		APR	17.1	16.1	↓	16.2			RB
	TRUST	Monthly	QEFS.17		Median Length of Stay (MLoS) - Community hospital rehab wards		APR	13.0	9.3	↓	13.9			RB
	TRUST	Monthly	QEFS.18		Median Length of Stay (MLoS) - Stroke wards (Ward 1 St Lukes, Ward 1 Coalville)		APR	29.0	20.3	↓	22.3			RB
	TRUST	Monthly	QEFS.19		Median Length of Stay (MLoS) - City rehab beds		APR	13.8	13.2	↓	10.1			RB
	TRUST	Monthly	QEFS.04		Occupancy Rate - Mental Health Beds (all services)	<=85%	APR	91.4%	91.2%	↓	91.4%		<=85%	DoS
	TRUST	Monthly	QEFS.05		Occupancy Rate - Community	>=93%	APR	93.5%	92.9%	↑	103.5%		>=93%	RB
	MON	Monthly	QEFS.06		% Delayed Patients (DToC) - Mental Health	<=7.5%	APR	8.9%	8.1%	↓	8.9%		<=7.5%	DoS
	COM	Monthly	QEFS.07		% Delayed Patients (DToC) - Community	<=2.12%	APR	0.84%	1.05%	↑	0.84%		<=2.12%	RB
	MON	Monthly	QEFS.08		Admissions to inpatient services had access to crisis resolution/ home treatment teams: % patients gate-kept by Crisis Resolution & Home Treatment Team	>=95%	APR	98.9%	100.0%	↓	98.9%		>=95%	TS
	COM	Monthly	QEFS.09		Total number of Home Treatment episodes carried out by Crisis Resolution team year to date.	1739 (Year end Target)	APR	175	2071	↑	175		1739 (Year end Target)	TS
	TRUST	Monthly	QEFS.10		% Discharge Summaries issued within 24 hours									DoS
	MON	Monthly (In Arrears)	QEFS.11		MHLDDS Data Completeness: Records	>=97%	MAR	98.7%	98.8%	↓	99.5%		>=97%	DoS
	MON	Monthly (In Arrears)	QEFS.12		MHLDDS Data Completeness: Outcomes	>=50%	MAR	41.1%	43.9%	↓	60.3%		>=50%	DoS
Performance - Finance		Monthly	PF.01	1043	EBITDA Margin		APR	4.8%	5.5%	↓	4.8%		4.2%	PC
		Monthly	PF.02	1043	I&E Surplus £000 (Excl. impairments)		APR	(46)	1,356	↓	(46)		-2098	PC
		Monthly	PF.03	916 1043	Income (against budget) £000		APR	22,488	275,421	-	22,488		270008	PC
		Monthly	PF.04	1043	Expenditure (against budget) £000		APR	22,535	274,066	-	22,535		272106	PC
		Monthly	PF.05	1043	CIP achievement £000		APR	641	7,900	-	641		10557	PC
		Monthly	PF.06		Cash balance £000 (as per original FIMS Plan)		APR	5,758	7,209	↓	5,758		3745	PC
		Monthly	PF.7	1043	Capital Expenditure (target spend = available funds) £000		APR	98	11,867	↓	98		12731	PC
		Monthly	PF.8		Debtors > 90 days		APR	10.6%	10.1%	↓	10.6%		5%	PC
		Monthly	PF.9		Creditors > 90 days		APR	5.3%	4.6%	↓	5.3%		5%	PC
		Monthly	PF.10		Better Payment Practice Code		APR	95.7%	93.1%	↑	95.7%		95%	PC
HR Workforce	TRUST	Monthly	PW.25	1036 1260	Number of WTE Employed		APR	4818.10419	4866.83255	↓				AD
	TRUST	Monthly (In Arrears)	PW.26		% of Sickness Absence (1 month in arrears)	<=4.5%	MAR	5.0%	5.4%	↓	5.0%		<=4.5%	AD
	TRUST	Monthly	PW.27		% Normalised Workforce Turnover (Rolling previous 12 months)	<=10%	APR	8.5%	8.4%	↓			<=10%	AD
	TRUST	Monthly	PW.34		% Vacancy Rate	<=7%	APR	9.2%	7.8%	↓			<=7%	AD
	TRUST	Monthly	PW.29		Number of staff at risk of redundancy		APR	5	5	→				AD
	TRUST	Monthly	PW.30		Number of open formal grievances		APR	1	3	↑	0			AD
	TRUST	Monthly	PW.31		Number of open formal disciplinaries		APR	20	21	↑	0			AD
	TRUST	Monthly	PW.14		% of Staff with a Completed Annual Appraisal	>=80%	APR	87.4%	87.4%	↑			>=80%	AD
	TRUST	Monthly	PW.19	366	% All Mandatory Training Compliance for substantive staff	>=85%	APR	n/a	89.8%	↑			>=85%	AD
	TRUST	Monthly	PW.35	1036 1260	Agency Costs (NHSI National 2016/17 Target)	<=£7.7m	APR	£ 714,520	£ 1,285,780	↓	£ 714,520		<=£7.7m	AD

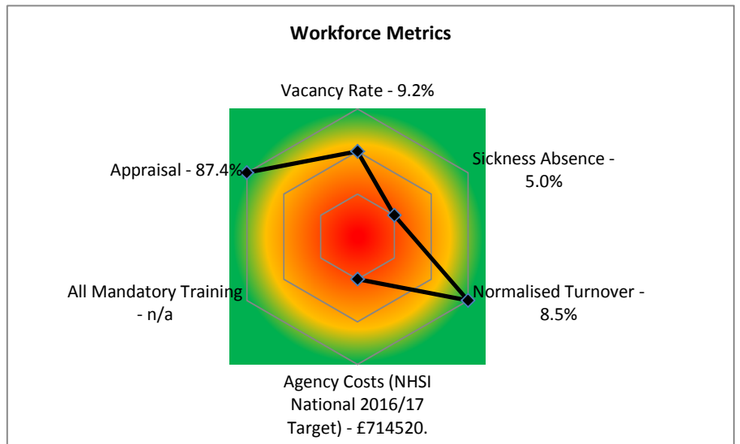
Leicestershire Partnership NHS Trust

Key Performance Indicators (KPIs): Overview









Key:- 3 = Green achieved target, 2= Amber Within 95% of Target, 1= Red Failing Target

Leicestershire Partnership NHS Trust

DETAILED EXCEPTION REPORT - % Delayed Patients (DToC) - Mental Health

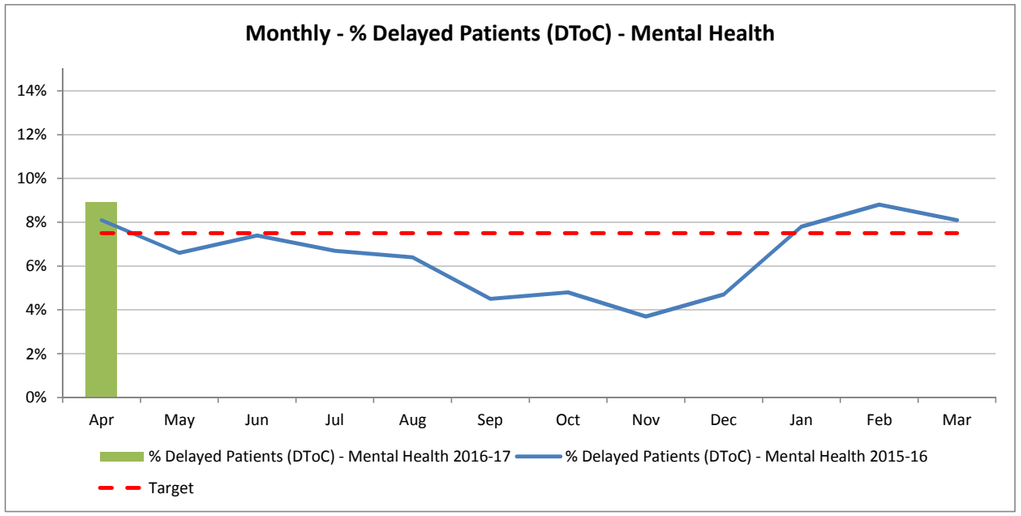
Responsible Director	Teresa Smith, Rachel Bilsborough, Helen Thompson
Responsible Committee	QAC

Responsible Services	AMH
KPI Reference ID	QEFS.06

Risk Reference		**Risk Description:**
Risk Owner		

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 during the quarter. 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) during the quarter. *Delayed transfers of care attributable to social are included.*

Performance (%)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
% Delayed Patients (DToC) - Mental Health 2015-16	8.1%	6.6%	7.4%	6.7%	6.4%	4.5%	4.8%	3.7%	4.7%	7.8%	8.8%	8.1%
% Delayed Patients (DToC) - Mental Health 2016-17	8.9%											
Target	*7.5%*	*7.5%*	*7.5%*	*7.5%*	*7.5%*	*7.5%*	*7.5%*	*7.5%*	*7.5%*	*7.5%*	*7.5%*	*7.5%*



Comments and Actions:

Duplicate DTOC entries identified in December 2015 have been resolved with the service with one outstanding record which has been escalated to the system supplier for a technical resolution. This record adds approximately 100 days delay.

% Delayed Patients (DToC) - MH: Patients being delayed during discharge for the month of April 2016 is the result of the following categories; Housing (20.2%), NHS (10.7%), Other (11.1%), Other (10.7%), Rehabilitation (9.5%), Multiple (8.3%), Joint (6.0%), Homes (6.0%), Social Worker (6.0%), Exercising choice (4.8%), Continuing care assessment incomplete (3.6%), Availability of place (no suitable alternative) (3.6%), Social services (3.6%), Refusing to co-operate (2.4%), Self-funded placement (1.2%), Medication (1.2%), Home adaptations - minor (1.2%), Legal issues (1.2%).

Service representatives are continuing to meet with Housing Leads and Social Care representatives from both City and County Councils and are supportive of housing options. Clinical Commissioning Groups had initially funded Out of County placements to speed up the discharge process and reduce patient delays however this has now stopped.

Risk Associated Actions:

Leicestershire Partnership NHS
NHS Trust

DETAILED EXCEPTION REPORT - Clostridium Difficile (C Diff) Cases

Responsible Director	Adrian Childs
Responsible Committee	QAC

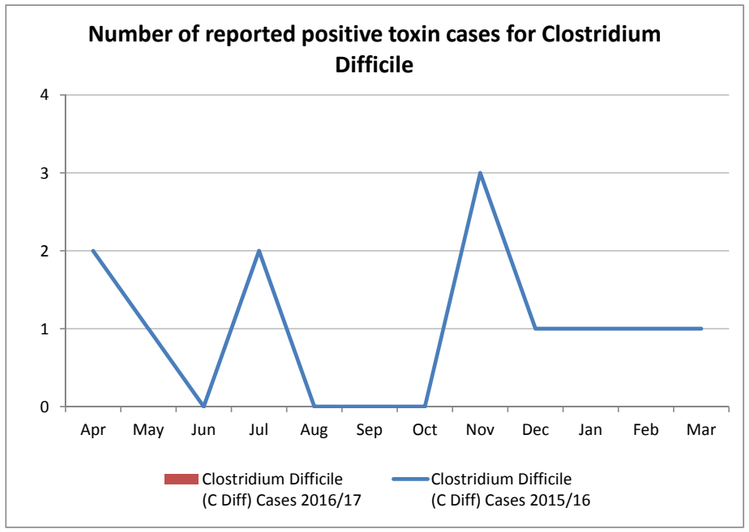
Responsible Services	All
KPI Reference ID	MSP.02

Risk Reference	1397
Risk Owner	Amanda Hemsley

Risk Description: The Trust has breached the trajectory of seven cases of Clostridium difficile cases set by the Leicester, Leicestershire and Rutland Commissioning Group.

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

Performance (%)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Clostridium Difficile (C Diff) Cases 2015/16	2	1	0	2	0	0	0	3	1	1	1	1
Wards	Ellistown, Snibston Ward - CV Hosp; General Ward - Fielding Palmer	General Ward - Fielding Palmer	-	General Ward - Fielding Palmer; East Ward - H&B	-	-	-	Clarendon Ward - Evington Centre; 2x North Ward - H&B	Clarendon Ward - Evington Centre	Swithland Ward - L'boro Hosp	Beechwood Ward - Evington Centre	Beechwood Ward - Evington Centre
Clostridium Difficile (C Diff) Cases 2016/17	0											
Wards	-											



Comments and Actions:

The trajectory for 2016-17 for Clostridium difficile has not yet been agreed with Leicester, Leicestershire and Rutland CCG's. LPT have had 0 reported positive toxin cases for Clostridium difficile for the month of April 2016.

DETAILED EXCEPTION REPORT - Agency Costs (NHSI National 2016/17 Target)

Responsible Director	Alan Duffell
Responsible Committee	QAC/FPC

Responsible Services	All
KPI Reference ID	PW.35

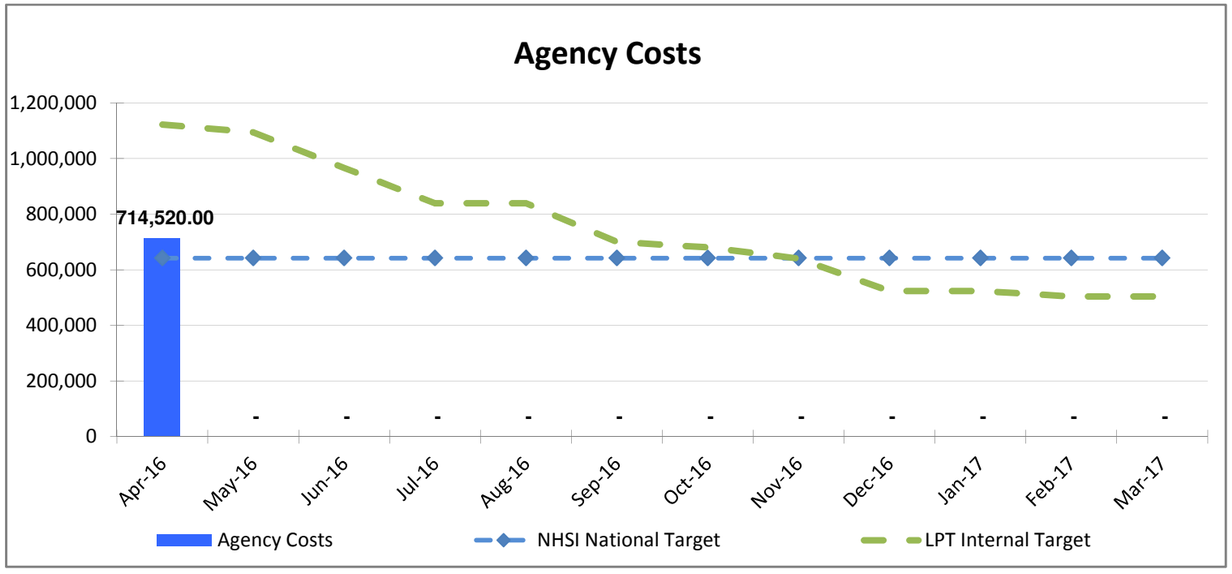
Risk Reference	1036	**Risk Description:** Without recruiting adequate staff we may be unable to run safe and efficient services as our services transform.
Risk Owner	Sarah Willis	

Risk Reference	1260	**Risk Description:** Nursing staff levels across the Trust are below establishment. This is having an impact on the ability to deliver high quality effective care on a consistent basis.
Risk Owner	Bal Johal	

Calculation Method	Total cost of Trust agency paybill

Split by Services

	Current Month	Previous Month
Adult Mental Health/ Learning Disabilities	167,870.00	321,850.00
Community Health Services	330,950.00	674,220.00
Enabling Services	48,770.00	- 30,290.00
Families, Young People and Children Services	111,420.00	161,380.00
Hosted Services	55,510.00	158,620.00



Comments and Actions:

NHS Improvement (NHSI) have issued the Trust with an expenditure ceiling of £7,696,000 covering all agency and locum staff during 2016/17. By dividing this figure equally across the year this gives an monthly ceiling of £640,000. The Trust's financial plans forecast an annual spend of £8,935,431 on agency workers. The monthly forecast reduces from just over £1m at the start of 2016/17 to £0.5m by the end of 2016/17.

In April 2016, the Trust agency spend was £714,520 which is above the NHSI average monthly target, but below the Trust's monthly forecast spend.

The chart above shows agency cost against both the NHSI ceiling and the LPT financial forecast.

Leicestershire Partnership NHS Trust

Quality - Personal Services

	Trust Performance										Data Quality				Services Performance - Latest Month		
	Source	Reporting Frequency	Monthly target	Data As At	Current Month Actual	Previous month	Travel on previous month	YTD Position	Year End Target	Sparkline	Timeliness	Central System	Exec Director Sign off	Exec Director Lead	Adult Mental Health/ Learning Disabilities	Community Health	Families, Young People & Children
% people reporting being treated with dignity and respect	TRUST	-												AC			
Mixed sex sleeping accommodation breaches	COM/DOH	Monthly	0	APR	0	0	→	0	0					DoS	0	0	0
% adult service users reporting having out of hours (OOH) contact details	TRUST	Monthly	95%											TS			
Compliments received	TRUST	Monthly		APR	125	100	↑	278						AC	7	94	22
Total complaints received	TRUST	Monthly		APR	30	33	↓	57						AC	15	11	3
Complaints acknowledged within 3 working days	TRUST	Monthly	100%	APR	100.0%	100.0%	→	100.0%	100%					AC	100.0%	100.0%	100.0%
Friends and Family: Number of responses	DOH	Monthly (In Arrears)		MAR	1150	916	↑	916						AC	72	527	551
Friends and Family: Number of 'Extremely Likelys'	DOH	Monthly (In Arrears)		MAR	866	696	↑	696						AC	46	426	394
Friends and Family: Number of 'Likelys'	DOH	Monthly (In Arrears)		MAR	249	191	↑	191						AC	13	96	140
Friends and Family: Number of 'Don't Know's'	DOH	Monthly (In Arrears)		MAR	2	8	↓	8						AC	0	2	1+1
Friends and Family: Number of detractors	DOH	Monthly (In Arrears)		MAR	19	21	↓	21						AC	13	6	4+11
Friends and Family: Overall Score	DOH	Monthly (In Arrears)		MAR	97.0%	96.8%	↑	96.8%						AC	81.9%	99.1%	96.9%

Comments and Actions:

Compliments: All figures received are subject to continual validation and any changes will be reported in the next IQPR. Robust systems are being put in place for Services to enter their own compliments via Safeguard Web. This may result in decreased figures whilst this transition occurs. There were 2 compliments received for Corporate Services in April 2016.

Complaints: All figures received are subject to continual validation and any changes following data validation will be reported in the next IQPR. There was 1 complaint for Corporate Services in April 2016.

** **Data Quality** is measured against the items below:

1) TIMELINESS:

GREEN: Data is submitted in time to the central system for accurate reporting (in line with trust policies) AND data is verified and any data quality issues are resolved in time for reporting deadlines AND data is extremely **unlikely** to change in subsequent months.

AMBER: Action Plans are in place to ensure business processes are adapted to meet the GREEN requirements.

RED: Data is not available in a timely fashion (according to trust policies) OR Data has not been verified and data quality issues haven't been resolved OR Data is likely to change in subsequent months

2) EXTRACTED FROM A CENTRAL SYSTEM:

GREEN: ALL reported data is extracted from the SAME central system (such as Safeguard, Maracis, ESR, Finance etc)

AMBER: Action plans are in place to submit data to central systems rather than using manual processes OR action plans are available for merging multiple systems into one central system.

RED: Data is extracted from a manual system (even if only in one particular area) OR data is extracted from multiple central systems.

3) SIGNED OFF BY AN EXECUTIVE DIRECTOR

GREEN: The position of data quality items 1) and 2) have been agreed and signed off by an Executive Director

RED: The data quality position has not been agreed and signed off by an Executive Director

Quality - Safe Care

	Trust Performance										Data Quality				Services Performance - Latest Month				
	Source	Reporting Frequency	Monthly target	Data As At	Current Month Actual	Previous month	Travel on previous month	Year to Date Position	Year End Target	Sparkline	Timeliness	Central System	Exec Director Sign off	Exec Director Lead	Adult Mental Health/ Learning Disabilities	Community Health	Families, Young People & Children	Enabling Services	3rd party/External
Incidents																			
Never Events	TRUST	Monthly	0	APR	0	0	⇨	0	0					AC	0	0	0		
Total Serious Incidents (SIs)	COM	Monthly		APR	5	4	⇩	12						AC	1	2	2		
STEIS - SI action plans implemented within timescales	COM	Monthly	100%	APR	100.0%	100.0%	⇨	100.0%	100%					AC	100.0%	100.0%	100.0%		
Total incidents reported (including near misses)	TRUST	Monthly		APR	1360	1344	⇧	2816						AC	487	703	83	8	79
Total incidents reported (Pressure Sore)	TRUST	Monthly		APR	392	346	⇧	725						AC	2	353	1	0	36
Total incidents reported (Other)	TRUST	Monthly		APR	968	971	⇩	2091						AC	485	350	82	8	43
Total patient safety incidents reported (including near misses)	TRUST	Monthly		APR	854	877	⇩	1777						AC	331	434	59	3	27
% Zero Harm (Patient Safety Incidents)	TRUST	Monthly	69%	APR	62.5%	63.8%	⇩	62.5%	69%					AC	76.1%	50.0%	67.8%		
Incident Rate (Patient Safety Incidents)	TRUST	Monthly		APR	45.4	47.5	⇩	45.4						AC	41.3	44.8	54.6		
Patient Safety Thermometer																			
PST: Pressure Ulcer Harms	TRUST	Monthly		APR	3.4%	3.2%	⇩	3.4%						AC		3.4%			
PST: Falls Harms	TRUST	Monthly		APR	0.0%	0.3%	⇧	0.0%						AC		0.0%			
PST: Catheter UTI Harms	TRUST	Monthly		APR	0.1%	0.3%	⇧	0.1%						AC		0.1%			
PST: VTE Harms	TRUST	Monthly		APR	0.1%	0.3%	⇧	0.1%						AC		0.1%			
Compliance with hygiene code	COM/DOH	Monthly		APR			⇨							AC					
MRSA Bacteraemia cases - Community	COM	Monthly		APR	0	0	⇨	0	0					AC		0			
Clostridium Difficile (C Diff) Cases	COM	Monthly		APR	0	1	⇧	0	7					AC	0	0	0		
Non-Compliance with Fundamental Standards resulting in a Major Impact on Patients	DoH	Monthly	No	APR	No	No	⇨	No	No					AC	No	No	No		
Non-Compliance with CQC Fundamental Standards Resulting in Enforcement Action	DoH	Monthly	No	APR	No	No	⇨	No	No					AC	No	No	No		

Comments and Actions:

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.

Incident Rate: This indicator is derived from the total number of patient safety incidents per month per thousand occupied bed days (excluding leave). This indicator is not appropriate to break down to sub-Trust level (service break-down is for information only).

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

Compliance With Hygiene Code - Compliance remains at amber due to the decontamination requirements for podiatry. A Task and finish group has been set up by the Director of Community Health Services to identify an options appraisal in order to move this forward. A meeting to report on this progress has been set for the 5 July 2016.
Further evidence of compliance with the health and social care act has been supplied to the TDA who had identified a number of actions and gaps in reporting. 61 of the 67 actions have been addressed and closed as green. Outstanding actions centre on the cleaning services.

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, therefore the data quality rating for timeliness is amber. Year end target of 0 (Zero) is based on the Commissioner target.

Clostridium Difficile (C Diff) Cases: The trajectory for 2016-17 for Clostridium difficile has not yet been set/identified by Leicester, Leicestershire and Rutland CCG's. LPT have had 0 reported positive toxin cases for Clostridium difficile for the month of April 2016.

Incident Reporting Direction of Travel Indicators: 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. This results in a 'green, up arrow' being applied when incident reporting has increased (for all incident related KPIs above except Pressure Sores), and a 'red, down arrow' being applied where incident reporting has decreased. In the case of Pressure Sores, a 'green, up arrow' depicts fewer reported Pressure Sores and a 'red, down arrow' showing an increase in pressure sores. For the % No Harm KPI, the Trust is aiming to achieve the highest percentage possible, so a 'green, up arrow' depicts improving performance (higher percentage) on the previous month whereas a 'red, down arrow' depicts poorer performance.

** **Data Quality** is measured against the items below:

1) TIMELINESS:
GREEN: Data is submitted in time to the central system for accurate reporting (in line with trust policies) AND data is verified and any data quality issues are resolved in time for reporting deadlines AND data is extremely **unlikely** to change in subsequent months.
AMBER: Action Plans are in place to ensure business processes are adapted to meet the GREEN requirements.
RED: Data is not available in a timely fashion (according to trust policies) OR Data has not been verified and data quality issues haven't been resolved OR Data is likely to change in subsequent months

2) EXTRACTED FROM A CENTRAL SYSTEM:
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GREEN: The position of data quality items 1) and 2) have been agreed and signed off by an Executive Director
RED: The data quality position has not been agreed and signed off by an Executive Director

Leicestershire Partnership NHS Trust

Compliments, Complaints and Incidents By Services

Compliments													
Services	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Sparkline
AMHLD	7												
CHS	94												
FYPC	22												
Total	**123**												

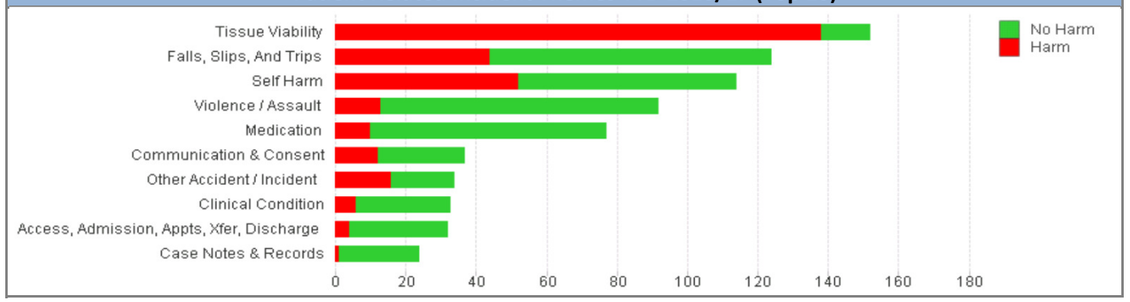
Complaints													
Services	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Sparkline
AMHLD	15												
CHS	11												
FYPC	3												
Total	**29**												

Total Incidents Reported													
Services	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Sparkline
AMHLD	487												
CHS	703												
FYPC	83												
Total	**1273**												

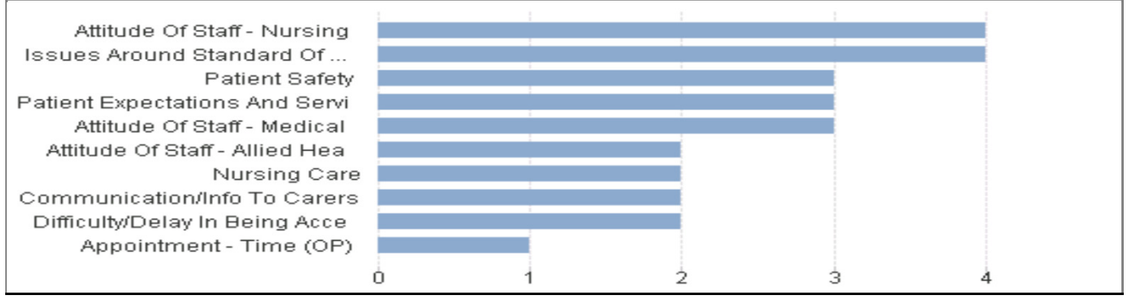
Degree of No Harm of Patient Incidents													
Services	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Sparkline
AMHLD	76.1%												
CHS	50.0%												
FYPC	67.8%												

Total Serious Incidents Logged													
Services	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Sparkline
AMHLD	1												
CHS	2												
FYPC	2												
Total	**5**												

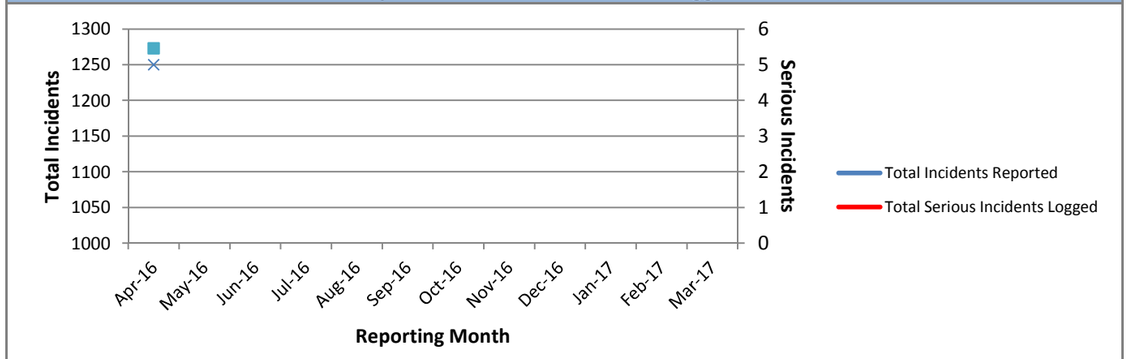
Patient Related Incident Themes YTD 2016/17 (Top 10)



Complaint Themes YTD 2016/17 (Top 10)



Incidents Reported and Serious Incidents Logged YTD 2016/17



Comments & Actions:

Leicestershire Partnership NHS
NHS Trust

Quality - Effective Services

	Trust Performance														Services Performance - Latest Month		
											Data Quality						
	Source	Reporting Frequency	Monthly target	Data As At	Current Month Actual	Previous month	Travel on previous month	Year to Date Position	Year End Target	Year End Forecast	Sparkline	Timeliness	Central System	Exec Director Sign off	Exec Director Lead	Adult Mental Health/ Learning Disabilities	Community Health	Families, Young People & Children
Meeting commitment to serve new psychosis cases by early intervention teams: % newly diagnosed cases against commissioner contract	MON	Monthly	95%	APR	72.7%	100.0%	↓	72.7%	95%	72.7%					TS			72.7%
Care programme approach (CPA) patients: % receiving follow-up contact within seven days of discharge	MON	Monthly (In Arrears)	95%	MAR	97.8%	96.9%	↑	96.8%	95%	96.8%					DoS	97.1%	100.0%	100.0%
Care programme approach (CPA) patients: % having formal review within 12 months	MON	Monthly	95%	APR	96.8%	96.9%	↓	96.8%	95%	96.8%					DoS	96.4%	99.0%	100.0%
Research & Development - Participant Recruitment	NIHR CRN:EM	Quarterly	1342	Q4	560	398	↑	-492	1342	1342					SK			
Research & Development - Performance in Initiating and Delivering Research	NIHR CRN:EM & Internal	Quarterly	80%	Q4	100.0%	90.0%	↑	87.0%	80%	80.0%					SK			
Research & Development - First Patient First Visit (FPFV)	NIHR CRN:EM & Internal	Quarterly	100%	Q4	90.0%	87.0%	↑	73.0%	100%	100.0%					SK			
Research & Development - Delivering studies to Time & Target	NIHR CRN:EM & Internal	Quarterly	80%	Q4	81.2%	75.8%	↑	71.0%	80%	80.0%					SK			
Access to Healthcare for All	MON	Quarterly	4	Q4	4	4	→	4	4	4					TS			
Breast Feeding- Status recorded at 6 - 8 weeks	COM/DoH	Quarterly	County	Q4	97.6%	98.3%	↓	98.1%		98.1%					HT			97.6%
			City		98.2%	98.5%	↓	98.0%		98.0%					HT			98.2%
Breast Feeding- Prevalence at 6 - 8 weeks	COM/DoH	Quarterly	County	Q4	45.5%	48.0%	↓	47.1%		47.1%					HT			45.5%
			City		62.5%	63.7%	↓	62.9%		62.9%					HT			62.5%

Comments and Actions:

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.

72.7% for the month of April 2016 is the result of 8 newly diagnosed cases against the provisional monthly commissioner target of 11. The service is dependent on the number of referrals received into the service and the appropriateness of the referral.

Care programme approach (CPA) patients: % receiving follow-up contact within seven days of discharge: This KPI is reported a month in arrears to enable tracking of target. Please note that this indicator represents patients 18 years and over. During March 2016 there were 92 patients discharged of which 90 were followed up successfully within seven days.

Care programme approach (CPA) patients: % having formal review within 12 months: 1957 patients were on CPA of which 1894 had a formal review within 12 months. Based on performance during 2014/15, the accountable executive believes the reduction in compliance in AMHLD between March 2015 and November 2015 attributed to data quality and limitations in reporting across multiple systems rather than clinical performance. The reporting source has been corrected from December 2015 and is including patients aged under 18 and trackers which may inflate figures, but is now showing performance in line with service expectation.

R&D Participant Recruitment (Overall): Recruitment is below target and LPT is consistent with all Trusts in the East Midlands and most nationally. This is especially true for studies in Division 4 of the CRN where the majority of our studies reside. We have however been awarded extra funds for our performance relative to the level of funding received.

Research & Development - Delivering studies to Time & Target: This figure pertains to all portfolio studies currently listed as live or recently closed. Approximately one third of these studies have not requested support from the CRN-funded delivery team, now relocated to Swithland House, and have therefore struggled to recruit or have closed at this site as no longer required. Time and target performance excluding these studies is 78%, largely through one study with a challenging recruitment window.

Breast Feeding: Performance figures will be updated monthly to reflect true performance and take into account late data entry and continual data validation. 2015-16 targets are as yet unavailable.

** **Data Quality** is measured against the items below:

1) **TIMELINESS:**
   GREEN: Data is submitted in time to the central system for accurate reporting (in line with trust policies) AND data is verified and any data quality issues are resolved in time for reporting deadlines AND data is extremely **unlikely** to change in subsequent months.
   AMBER: Action Plans are in place to ensure business processes are adapted to meet the GREEN requirements.
   RED: Data is not available in a timely fashion (according to trust policies) OR Data has not been verified and data quality issues haven't been resolved OR Data is likely to change in subsequent months
2) **EXTRACTED FROM A CENTRAL SYSTEM:**
   GREEN: ALL reported data is extracted from the SAME central system (such as Safeguard, Maracis, ESR, Finance etc.)
   AMBER: Action plans are in place to submit data to central systems rather than using manual processes OR action plans are available for merging multiple systems into one central system.
   RED: Data is extracted from a manual system (even if only in one particular area) OR data is extracted from multiple central systems.
3) **SIGNED OFF BY AN EXECUTIVE DIRECTOR**
   GREEN: The position of data quality items 1) and 2) have been agreed and signed off by an Executive Director
   RED: The data quality position has not been agreed and signed off by an Executive Director

National & Regional CQUINS 2015-16

CQUIN No	Description	Services	Funding Available	Q1 Target	Q1	Q2	Q3	Q4	Comment on Red & Amber Ratings
1a	LD (risk of choking)	AMHLD	£300,032		100.0%	100.0%	100.0%	100.0%	
1b	LD Preventing Admissions	AMHLD	£300,032		100.0%	100.0%	100.0%	100.0%	
2	Physical Activity (Assertive Outreach)	AMHLD	£290,656		100.0%	100.0%	100.0%	100.0%	
3	Carer Support	All	£431,296		100.0%	100.0%	100.0%	100.0%	

Commentary:
Blue background indicates that the data is forecasted data. LPT received full Q1, Q2 and Q3 payment and is forecasted to receive full payment for Q4.

Local CQUINS 2015-16

CQUIN No	Description	Services	Funding Available	Q1 Target	Q1	Q2	Q3	Q4	Comment on Red & Amber Ratings
4	Leg Ulcer Pathway	CHS	£515,679		100.0%	100.0%	100.0%	100.0%	
5	Dementia Care and discharge Planning	CHS	£553,183		100.0%	N/A	60.0%	60.0%	Q3 - Demand and capacity issues highlighted at meetings held with Commissioners in Qtr 2 are still impacting on throughput of patients; as such only a 60% achievement of the final 100% in Qtr 4 is expected. Q4 - 55.2% of patients referred to memory clinic recived memory clinic within 6 weeks (target 60%).
6	Patient Experience	All	£468,800		100.0%	100.0%	100.0%	100.0%	Subjective nature of the complainent survey has been sucessfully renegotiated
7a	CAMHS	FYPC	£478,175		100.0%	100.0%	100.0%	5.0%	The Trust has only met the treshold of 100% in 1 of the 8 criteria and therefore will only recive 5% of possible 40%
8	Continuing Health Care (CHC)	All	£759,455		100.0%	0.0%	75.0%	75.0%	Q2 - Confirmed £23,933 loss - Commissioners to support LPT in order to improve communication with GEM. Q3 - improved compliance with target 2 and the quality of completed DST's submitted. However guidance from GEM is still outstanding regarding the rationale for triaging. Q4 - Target of assesssments sent to GEM = 95% each month (performance = Jan 88% Feb 83% March 92%)
9a	Cardio metabolic assessment for patients with Psychosis	All	£459,424		100.0%	N/A	100.0%	100.0%	
9b	Patients on CPA: Communication with general practitioners	All	£131,264		N/A	N/A	100.0%	N/A	

Commentary:
Blue background indicates that the data is forecasted data. LPT received full Q1 payment for all of the CQUINS. Q2 payment have been fully received except for CQUIN 8 – Continuing Health Care (CHC) which has been confirmed as a £23,933 loss. Q3 payment has been fully confirmed except for CQUIN 5 (Dementia Care) and CQUIN 8 (CHC). There is a predicted loss in Q4 for the same CQUIN's. FYPC also report challenges in meeting all the Q4 targets for CQUIN 7 (CAMHS Quality Standards).
NB: The subjective nature of the complainant survey required in Q4 for CQUIN 6 (Patient Experience) has been re-negotiated and as a result it is forecasted that this CQUIN should be fully achievable.

Performance - Efficient Services

	Trust Performance										Data Quality				Services Performance - Latest Month		
	Source	Reporting Frequency	Monthly target	Data As At	Current Month Actual	Previous month	Travel on previous month	Year to Date Position	Year End Target	Sparkline	Timeliness	Central System	Exec Director Sign off	Exec Director Lead	Adult Mental Health/ Learning Disabilities	Community Health	Families, Young People & Children
Average Length of Stay (ALoS) - Mental Health	COM	Monthly		APR	64.1	67.2	↑							DoS	61.8	76.8	49.1
Median Length of Stay (MLoS) - Mental Health	TRUST	Monthly		APR	21.0	30.5	↑	21.0						DoS	14.0	69.5	50.0
Average Length of Stay (ALoS) - Community hospital rehab wards	TRUST	Monthly		APR	17.0	15.9	↓	17.1						RB		17.0	
Average Length of Stay (ALoS) - Stroke wards (Ward 1 St Lukes, Ward 1 Coalville)	TRUST	Monthly		APR	31.0	18.0	↓	29.3						RB		31.0	
Average Length of Stay (ALoS) - City rehab beds	TRUST	Monthly		APR	17.1	16.1	↓	16.2						RB		17.1	
Median Length of Stay (MLoS) - Community hospital rehab wards	TRUST	Monthly		APR	13.0	9.3	↓	13.9						RB		13.0	
Median Length of Stay (MLoS) - Stroke wards (Ward 1 St Lukes, Ward 1 Coalville)	TRUST	Monthly		APR	29.0	20.3	↓	22.3						RB		29.0	
Median Length of Stay (MLoS) - City rehab beds	TRUST	Monthly		APR	13.8	13.2	↓	10.1						RB		13.8	
Occupancy Rate - Mental Health Beds (all services)	TRUST	Monthly	<=85%	APR	91.4%	91.2%	↓	91.4%	<=85%					DoS	89.9%	94.9%	94.9%
Occupancy Rate - Community	TRUST	Monthly	>=93%	APR	93.5%	92.9%	↑	103.5%	>=93%					RB		93.5%	
% Delayed Patients (DToC) - Mental Health	MON	Monthly	<=7.5%	APR	8.9%	8.1%	↓	8.9%	<=7.5%					DoS	6.4%	19.5%	0.0%
% Delayed Patients (DToC) - Community	COM	Monthly	<=2.12%	APR	0.84%	1.05%	↑	0.84%	<=2.12%					RB		0.84%	
Admissions to inpatient services had access to crisis resolution/ home treatment teams: % patients gate-kept by Crisis Resolution & Home Treatment Team	MON	Monthly	>=95%	APR	98.9%	100.0%	↓	98.9%	>=95%					TS	98.9%		
Total number of Home Treatment episodes carried out by Crisis Resolution team year to date.	COM	Monthly	1739 (Year end Target)	APR	175	2071	↑	175	1740					TS	175		
% Discharge Summaries issued within 24 hours	TRUST	-												DoS			
MHLDDS Data Completeness: Records	MON	Monthly (in arrears)	>=97%	MAR	98.7%	98.8%	↓	99.5%	>=97%					DoS	98.7%		
MHLDDS Data Completeness: Outcomes	MON	Monthly (in arrears	>=50%	MAR	41.1%	43.9%	↓	60.3%	>=50%					DoS	41.1%		

Comments & Actions:

Mental Health Average Length of Stay: The average length of stay displayed for Mental Health & LD is the national operating framework definition, which takes data from Hospital Episode Statistics (HES) and includes ALL services and lengths. All previous month's figures are updated each month to allow for late entry of data.

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 4 new Intensive Support beds but 85% otherwise. There are no Service targets yet set and thus 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) - MH: *Duplicate DTOC entries identified in December 2015 have been resolved with the service with one outstanding record which has been escalated to the system supplier for a technical resolution. This record adds approximately 100 days delay.*
% Delayed Patients (DToC) - MH: Patients being delayed during discharge for the month of April 2016 is the result of the following categories; Housing (20.2%), NHS (10.7%), Other (11.1%), Other (10.7%), Rehabilitation (9.5%), Multiple (8.3%), Joint (6.0%), Homes (6.0%), Social Worker (6.0%), Exercising choice (4.8%), Continuing care assessment incomplete (3.6%), Availability of place (no suitable alternative) (3.6%), Social services (3.6%), Refusing to co-operate (2.4%), Self-funded placement (1.2%), Medication (1.2%), Home adaptations - minor (1.2%), Legal issues (1.2%).

Service representatives are continuing to meet with Housing Leads and Social Care representatives from both City and County Councils and are supportive of housing options. Clinical Commissioning Groups had initially funded Out of County placements to speed up the discharge process and reduce patient delays however this has now stopped.

% Delayed Patients (DToC) - Community: Delays for community patients during the month of April 2016 are the result of the following discharge delay reasons; Exercising Choice (24.1%), Other (9.2%), NHS Self-funded Placement (9.2%) and NHS (8.5%).

Total number of Home Treatment episodes carried out by Crisis Resolution team year to date: Year to date performance is currently 120.7% which equates to 175 episodes against a pro-rata target of 1740.

MHLDDS Data Completeness: Outcomes: Data quality issues are attributed to difficulties in completing two separate forms on RiO. Actions to resolve this include the development of a single form and data quality reports due to be delivered from June 2016.

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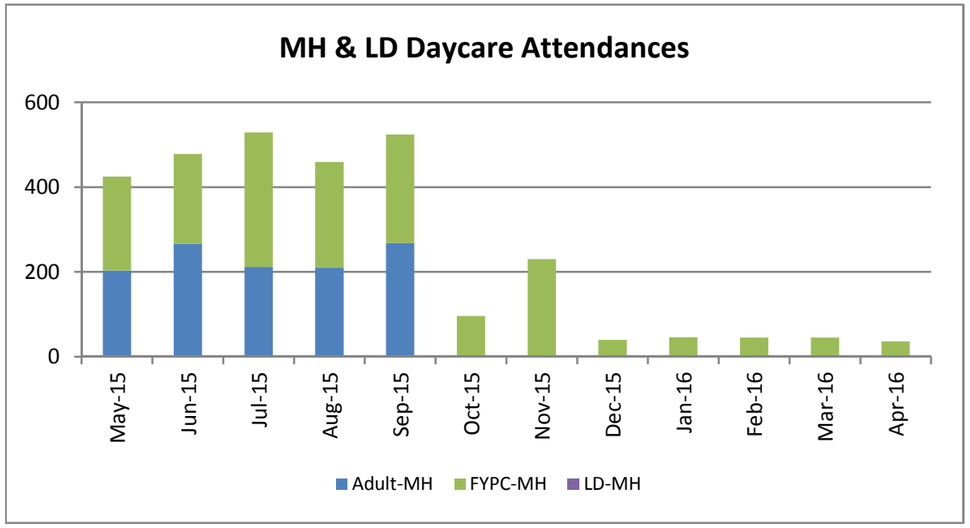
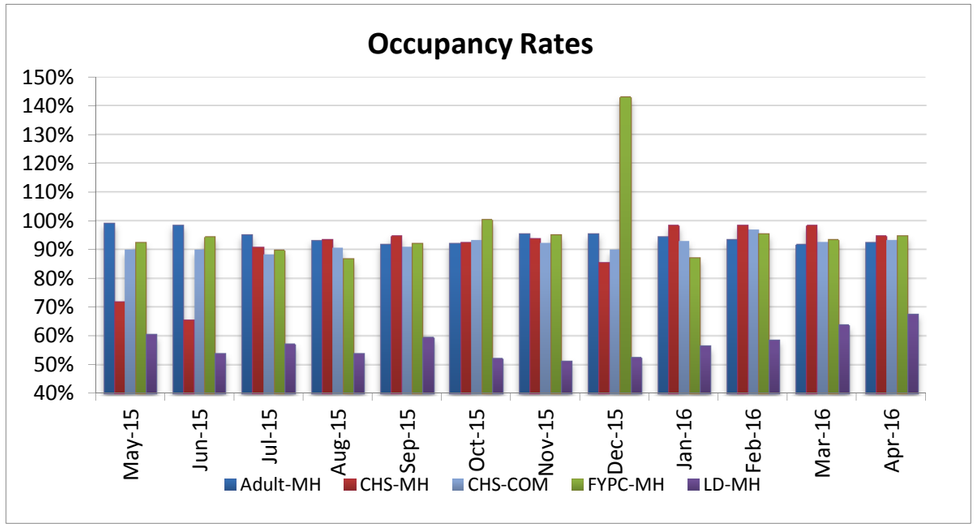
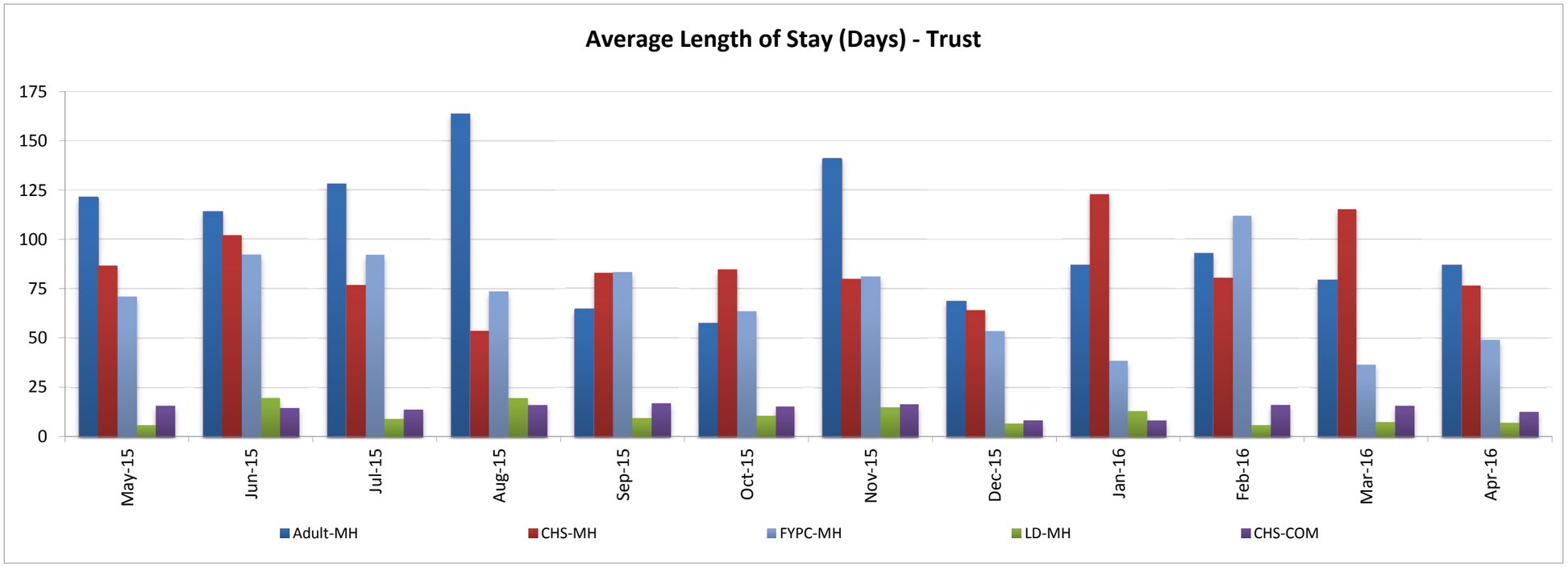
Leicestershire Partnership NHS
NHS Trust

Performance - Efficiency



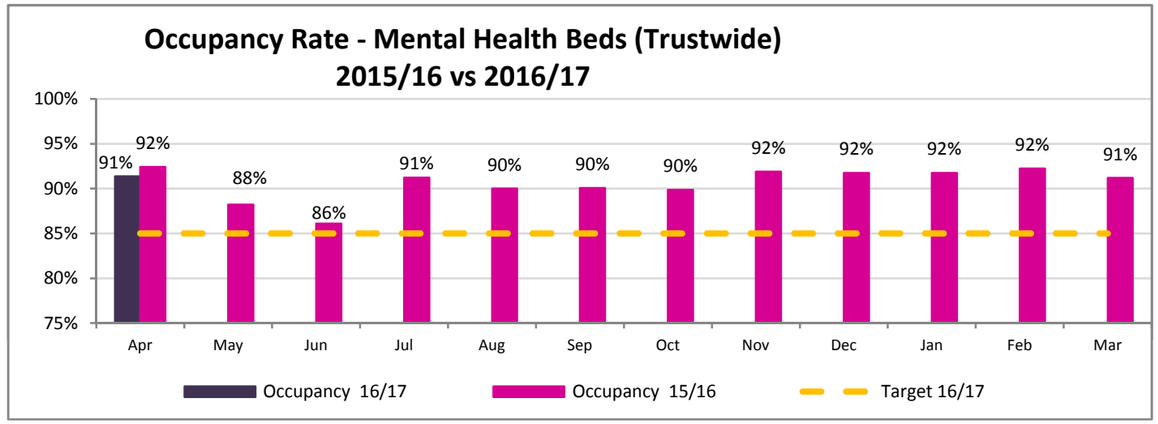


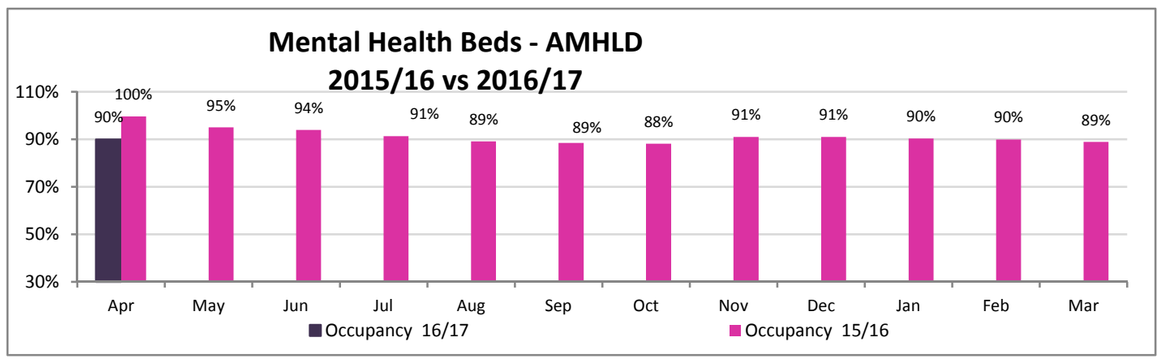


Comments:

Leicestershire Partnership NHS Trust

Mental Health Bed Occupancy Rate (%)



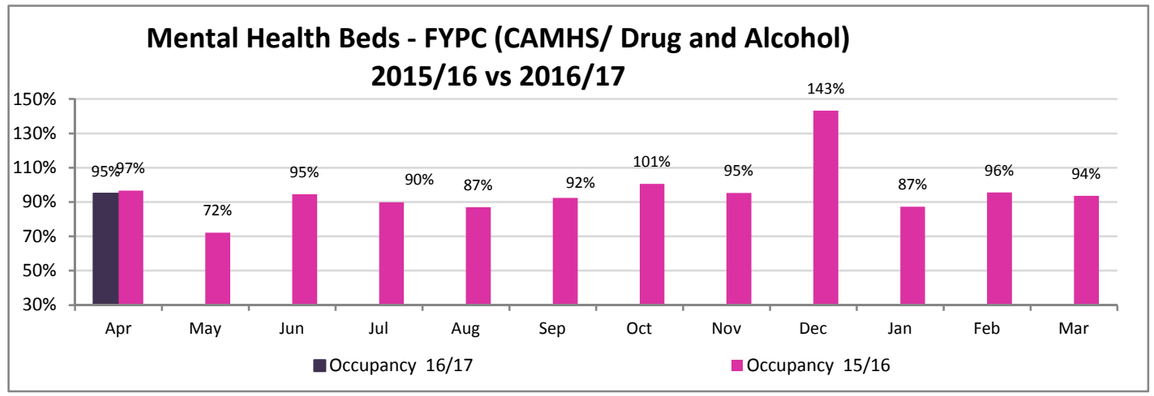


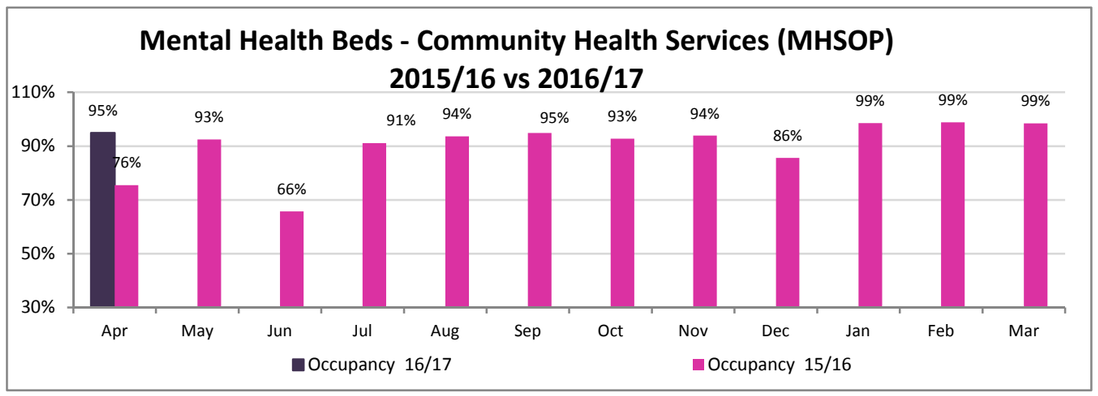
Responsible Lead: Directors of Services
Indicator Source: COM/DOH Operating Framework

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%





Waiting Times Compliance - Community Health Services

	Service Details					Complete Pathways Target 95%						Incomplete Pathways						Number of Referrals		Information Assurance Framework				
	Target Waiting Time	Source	Reporting Frequency	Data Source	Data As At	Target Achievement Month	No of Patients Within Target	No of Patients Outside Target	Current Month Actual	Previous month	Travel on previous month	No of Patients Within Target	Patients > target <= 52 weeks	Patients > target > 52 weeks	Current Month Actual	Previous month	Travel on previous month	Current Month	Previous month	Service Line Mapped Agreed	Targets Agreed	Data Entry SOP	PTL Validation	KPI Authorisied
MHSOP - Memory Clinic	High Priority 4 weeks	COM	Monthly (In arrears)	RiO	Mar-16	TBC	1	0	100.0%	33.3%	↑	1	0	0	100.0%	100.0%	→	4	2					
	Routine 6 weeks	COM	Monthly (In arrears)	RiO	Mar-16	TBC	137	139	49.6%	44.3%	↑	414	519	2	44.3%	51.5%	↓	269	313					
MHSOP - Community Teams	High Priority 4 weeks	COM	Monthly (In arrears)	RiO	Mar-16	TBC	23	19	54.8%	35.6%	↑	31	33	2	47.0%	37.0%	↑	51	40					
	Routine 6 weeks	COM	Monthly (In arrears)	RiO	Mar-16	TBC	125	62	66.8%	63.4%	↑	193	151	95	44.0%	43.7%	↑	242	271					
MHSOP - Outpatient	High Priority 4 weeks	COM	Monthly (In arrears)	RiO	Mar-16	TBC	3	1	75.0%	36.4%	↑	3	5	3	27.3%	37.3%	↓	5	36					
	Routine 6 weeks	COM	Monthly (In arrears)	RiO	Mar-16	TBC	24	24	50.0%	35.4%	↑	88	90	13	46.1%	43.6%	↑	78	56					
MSK Physiotherapy	Routine	COM	Monthly (In arrears)	TIARA	Mar-16	Contract	466	1228	27.5%	31.4%	↓	1462	3486	10	29.5%	33.2%	↓	1671	1761					
	Urgent	COM	Monthly (In arrears)	TIARA	Mar-16	Contract	257	410	38.5%	36.6%	↑	120	206	0	36.8%	18.4%	↑	710	742					
Podiatry	Routine	COM	Monthly (In arrears)	TIARA	Mar-16	Contract	1682	215	88.7%	99.6%	↓	866	17	1	98.0%	75.4%	↑	1686	1646					
	Urgent	COM	Monthly (In arrears)	TIARA	Mar-16	Contract	5	8	38.5%	100.0%	↓	2	0	0	100.0%	0.0%	↑	5	3					
Speech	Routine	COM	Monthly (In arrears)	TIARA	Mar-16	Contract	177	5	97.3%	95.0%	↑	112	19	2	84.2%	90.8%	↓	176	128					
	Urgent	COM	Monthly (In arrears)	TIARA	Mar-16	Contract	104	1	99.0%	99.3%	↓	34	1	0	97.1%	88.9%	↑	111	167					
Community Therapy	3 Working Days	COM	Monthly (In arrears)	SystmOne	Mar-16	TBC	341	190	64.2%	67.8%	↓	0	79	0	0.0%	0.0%	→	674	713					
	10 working days	COM	Monthly (In arrears)	SystmOne	Mar-16	TBC	251	273	47.9%	44.3%	↑	98	734	0	11.8%	24.5%	↓	875	874					
	20 working days	COM	Monthly (In arrears)	SystmOne	Mar-16	TBC	144	50	74.2%	67.5%	↑	125	142	0	46.8%	48.4%	↓	489	425					
Heart Failure	3 Days	COM	Monthly (In arrears)	SystmOne	Mar-16	TBC	9	9	50.0%	100.0%	↓	0	2	0	0.0%	0.0%	→	20	11					
	4 Weeks	COM	Monthly (In arrears)	SystmOne	Mar-16	TBC	102	42	70.8%	89.7%	↓	51	34	0	60.0%	82.4%	↓	187	188					
	EOL 2 Weeks	COM	Monthly (In arrears)	SystmOne	Mar-16	TBC	4	0	100.0%	100.0%	→	0	0	0	N/A	N/A	→	3	5					
Respiratory	3 Days	COM	Monthly (In arrears)	SystmOne	Mar-16	TBC	4	0	100.0%	100.0%	→	0	0	0	N/A	N/A	→	9	2					
	4 Weeks	COM	Monthly (In arrears)	SystmOne	Mar-16	TBC	170	15	91.9%	93.4%	↓	59	29	0	67.0%	92.4%	↓	274	272					
	EOL 2 Weeks	COM	Monthly (In arrears)	SystmOne	Mar-16	TBC	0	0	N/A	N/A	→	0	0	0	N/A	N/A	→	1	0					
Continence	4 Working Weeks	COM	Monthly (In arrears)	SystmOne	Mar-16	TBC	250	26	90.6%	95.1%	↓	471	187	90	63.0%	65.3%	↓	434	355					

Comments & Actions:

Please note, the information in this report is based on data which is in the process of going through a Data Quality Improvement Programme, and now reflects both internal and external referrals. To allow the Trust to focus on implementing robust processes around waiting times management, five assurance indicators have been put in place which will allow progress to be tracked via RAG rating against each indicator, for each service.

Complete:
Waiting time performance reporting for all services is based on the number of patients that received treatment in the month and the percentage of those completed waits that were within the target waiting time. The agreement with commissioners requires revised waiting time targets to be met from a certain month in the year and these 'target achievement months' are listed. Some target months haven't yet been agreed with commissioners and are marked as 'to be confirmed' (TBC).

Target Achievement Month: Contract = now contractual, Date = month when target will become contractual, TBC = Service redesign or not yet agreed

Where the target is not yet in effect, waiting list service name field is colour coded in blue in line with LPT Trust Board request.

All RAG thresholds are as follows; >=95% green; No of Patients Outside Target < 10 AND <95% amber; <95% red.

Incomplete:
Incomplete pathways waiting list performance is based on the number of patients waiting to receive treatment/assessment at month end and the percentage of those within the target waiting times.

Waiting Times Compliance - Adult Mental Health Services and Learning Disabilities

	Service Details					Complete Pathways Target 95%						Incomplete Pathways						Number of Referrals		Information Assurance Framework				
	Target Waiting Time	Source	Reporting Frequency	Data Source	Data As At	Target Achievement Month	No of Patients Within Target	No of Patients Outside Target	Current Month Actual	Previous month	Travel on previous month	No of Patients Within Target	Patients > target <= 52 weeks	Patients > target > 52 weeks	Current Month Actual	Previous month	Travel on previous month	Current Month	Previous month	Service Line Mapped Agreed	Targets Agreed	Data Entry SOP	PTL Validation	KPI Authorised
LD - Community Teams	8 Weeks	COM	Monthly (In arrears)	RiO	Mar-16	Contract	63	23	73.3%	60.2%	↑	100	83	11	51.5%	40.1%	↑	111	84					
Assertive Outreach	6 Weeks	COM	Monthly (In arrears)	RiO	Mar-16	Contract	0	2	0.0%	83.3%	↓	4	3	0	57.1%	20.0%	↑	7	4					
Personality Disorders	13 Weeks	COM	Monthly (In arrears)	RiO	Mar-16	Contract	52	1	98.1%	98.9%	↓	226	22	3	90.0%	89.3%	↑	109	100					
Dynamic Psychotherapy	13 Weeks	COM	Monthly (In arrears)	RiO	Mar-16	Contract	15	3	83.3%	66.7%	↑	75	22	0	77.3%	78.3%	↓	58	37					
Liaison - Perinatal Outpatient & Community	4 Weeks	COM	Monthly (In arrears)	RiO	Mar-16	Contract	21	4	84.0%	90.0%	↓	26	16	0	61.9%	59.1%	↑	35	37					
Liaison - Psycho Oncology	Routine	COM	Monthly (In arrears)	RiO	Mar-16	Contract	13	1	92.9%	58.3%	↑	40	46	8	42.6%	32.5%	↑	37	29					
	Urgent	COM	Monthly (In arrears)	RiO	Mar-16	Contract	0	0	N/A	N/A	→	0	3	0	0.0%	N/A	↓	0	0					
Liaison - Psychiatry	13 Weeks	COM	Monthly (In arrears)	RiO	Mar-16	Contract	62	16	79.5%	56.5%	↑	72	158	0	31.3%	38.2%	↓	104	121					
Cognitive Behavioural Therapy	13 Weeks	COM	Monthly (In arrears)	RiO	Mar-16	Contract	51	4	92.7%	95.5%	↓	157	13	0	92.4%	92.7%	↓	96	71					
Forensic - Community and Out Patients	8 Weeks	COM	Monthly (In arrears)	RiO	Mar-16	Contract	6	0	100.0%	83.3%	↑	24	10	5	61.5%	50.0%	↑	13	1					
Adult General Psychiatry - Community Mental Health Teams and Outpatients - Treatment	6 Weeks	COM	Monthly (In arrears)	RiO	Mar-16	Contract	392	195	66.8%	60.3%	↑	833	985	102	43.4%	46.8%	↓	951	916					
	5 Days	COM	Monthly (In arrears)	RiO	Mar-16	Contract	14	27	34.1%	47.4%	↓	4	31	1	11.1%	0.0%	↑	69	48					
Mett Day Centre and Linnaeus Nursery	4 Weeks	COM	Monthly (In arrears)	RiO	Mar-16	Contract	8	2	80.0%	57.1%	↑	3	1	0	75.0%	100.0%	↓	5	5					
Homeless Service	1 Week	COM	Monthly (In arrears)	RiO	Mar-16	Contract	31	6	83.8%	92.6%	↓	3	6	0	33.3%	57.1%	↓	42	42					
Adult ADHD Service	18 Weeks	COM	Monthly (In arrears)	RiO	Mar-16	Contract	52	0	100.0%	100.0%	→	113	0	0	100.0%	100.0%	→	61	82					
Huntington's Disease	4 Weeks	COM	Monthly (In arrears)	RiO	Mar-16	Contract	0	1	0.0%	100.0%	↓	2	3	0	40.0%	40.0%	→	3	5					
Aspergers Assessment	18 Weeks	COM	Monthly (In arrears)	RiO	Mar-16	Contract	19	0	100.0%	100.0%	→	55	0	0	100.0%	100.0%	→	14	24					
IAPT - City	28 Days	COM	Monthly (In arrears)	PCMIS	Mar-16	Contract	166	49	77.2%	78.1%	↓	This service is no longer provided by LPT												
IAPT - 2015/16 SDIP	6 weeks	COM	Monthly (In arrears)	PCMIS	Mar-16	TBC	169	12	93.4%	88.3%	↑	This service is no longer provided by LPT												
	18 weeks	COM	Monthly (In arrears)	PCMIS	Mar-16	TBC	180	1	99.4%	99.5%	↓	This service is no longer provided by LPT												
Crisis Intervention	4 Hours Crisis	COM	Monthly (In arrears)	RiO	Mar-16	Contract	5	5	50.0%	38.9%	↑	TBC	TBC	TBC	TBC	TBC	TBC	18	16					
	24 Hours Crisis	COM	Monthly (In arrears)	RiO	Mar-16	Contract	140	96	59.3%	63.9%	↓	TBC	TBC	TBC	TBC	TBC	TBC	324	246					
Deliberate Self Harm	2 Hours Emergency	COM	Monthly (In arrears)	RiO	Mar-16	Contract	136	1	99.3%	89.8%	↑	TBC	TBC	TBC	TBC	TBC	TBC	171	178					
	4 Hours Crisis	COM	Monthly (In arrears)	RiO	Mar-16	Contract	12	0	100.0%	100.0%	→	TBC	TBC	TBC	TBC	TBC	TBC	16	TBC					

Comments & Actions:

Please note, the information in this report is based on data which is in the process of going through a Data Quality Improvement Programme, and now reflects both internal and external referrals. To allow the Trust to focus on implementing robust processes around waiting times management, five assurance indicators have been put in place which will allow progress to be tracked via RAG rating against each indicator, for each service.

Complete:
Waiting time performance reporting for all services is based on the number of patients that received treatment/assessment in the month and the percentage of those completed waits that were within the target waiting time. The agreement with commissioners requires revised waiting time targets to be met from a certain month in the year and these 'target achievement months' are listed. Some target months haven't yet been agreed with commissioners and are marked as 'to be confirmed' (TBC).

Target Achievement Month: Contract = now contractual, Date = month when target will become contractual, TBC = Service redesign or not yet agreed

Where the target is not yet in effect, waiting list service name field is colour coded in blue in line with LPT Trust Board request.

All RAG thresholds are as follows; >=95% green; No of Patients Outside Target < 10 AND <95% amber; <95% red.

Incomplete:
Incomplete pathways waiting list performance is based on the number of patients waiting to receive treatment at month end and the percentage of those within the target waiting times.

Acute Assessment Service (4 Hours Crisis):
Increased demand for 4 hours due to piloting new referral criteria.
A New Crisis Model was implemented on 23rd February 2015. Referrals to the service have either a 4hr or 24 hr urgency.
Data for February Forensic Community and Outpatients has been excluded in February 2015 Compliance report due to issues within the RiO data.

IAPT SDIP 2015/16: Waiting Times has now been included to show those completing treatment in the month and have been seen within 6 weeks of referral (70.1% by 1-Jul-15, 71% by 1-Oct-15, 73% by 1-Jan-16, 75% by 1-Apr-16) and 18 weeks of referral (95% target).

IAPT: The service has logged a fault call with PCMIS to address issues with reporting. (Last update 07/01/2016) - Fault now corrected and Business Team have gained agreement to back date the figures from October 2015 (Last update 03/02/2016)

Waiting Times Compliance - Families, Young People and Children's Services

	Service Details					Complete Pathways Target 95%						Incomplete Pathways						Number of Referrals		Information Assurance Framework				
	Target Waiting Time	Source	Reporting Frequency	Data Source	Data As At	Target Achievement Month	No of Patients Within Target	No of Patients Outside Target	Current Month Actual	Previous month	Travel on previous month	No of Patients Within Target	Patients > target <= 52 weeks	Patients > target > 52 weeks	Current Month Actual	Previous month	Travel on previous month	Current Month	Previous month	Service Line Mapped Agreed	Targets Agreed	Data Entry SOP	PTL Validation	KPI Authorisied
CAMHS- Outpatient & Community (Routine) (includes ED)	13 Weeks	COM	Monthly (In arrears)	Maracis	Mar-16	Contract	92	137	40.2%	47.9%	↓	271	179	0	60.2%	73.8%	↓	389	285					
CAMHS- Outpatient & Community (Urgent)	4 Weeks	COM	Monthly (In arrears)	Maracis	Mar-16	Contract	5	0	100.0%	100.0%	→	10	3	0	76.9%	100.0%	↓	59	76					
CAMHS - Young People Team	13 Weeks	COM	Monthly (In arrears)	Maracis	Mar-16	Contract	13	8	61.9%	56.5%	↑	30	12	0	71.4%	100.0%	↓	27	26					
CAMHS - Learning Disability Service	18 weeks	COM	Monthly (In arrears)	Maracis	Mar-16	Contract	9	0	100.0%	87.5%	↑	18	1	0	94.7%	100.0%	↓	19	14					
Dietetics Outpatients	18 weeks to treatment	COM	Monthly (In arrears)	TIARA	Mar-16	Contract	239	0	100.0%	100.0%	→	458	9	5	97.0%	95.8%	↑	257	115					
Childrens OT	18 weeks to treatment	COM	Monthly (In arrears)	SystmOne	Mar-16	Contract	19	0	100.0%	97.4%	↑	128	2	0	98.5%	100.0%	↓	79	99					
Childrens Physio	18 weeks to treatment	COM	Monthly (In arrears)	SystmOne	Mar-16	Contract	27	0	100.0%	100.0%	→	81	2	4	93.1%	96.0%	↓	25	31					
Childrens SALT	18 weeks to treatment	COM	Monthly (In arrears)	SystmOne	Mar-16	Contract	171	7	96.1%	96.5%	↓	733	25	11	95.3%	98.4%	↓	221	294					
PIER	4 Weeks	COM	Monthly (In arrears)	RiO	Mar-16	Contract	1	1	100%	100%	→	0	1	0	0.0%	N/A	↓							
	2 Weeks	COM	Monthly (In arrears)	RiO	Mar-16	Contract	27	6	81.8%	73.9%	↑	10	4	0	71.4%	64.7%	↑	30	32					
Paediatrics	RTT 18 Weeks	COM	Monthly (In arrears)	SystmOne	Mar-16	Contract	53	6	89.8%	87.8%	↑	260	7	13	92.9%	96.3%	↓	246	293					
Audiology	Routine Assessment - 6 Weeks	COM	Monthly (In arrears)	SystmOne	Mar-16	Contract	367	10	97.3%	98.1%	↓	505	0	0	100.0%	100.0%	→	428	576					
Dietetics Domiciliary Visits	4 Weeks	COM	Monthly (In arrears)	TIARA	Mar-16	Contract	93	29	76.2%	75.0%	↑	58	33	0	63.7%	76.7%	↓	116	94					

Comments & Actions:

Please note, the information in this report is based on data which is in the process of going through a Data Quality Improvement Programme, and now reflects both internal and external referrals. To allow the Trust to focus on implementing robust processes around waiting times management, five assurance indicators have been put in place which will allow progress to be tracked via RAG rating against each indicator, for each service.

PIER - The target has been changed from 4 weeks to 2 weeks from December 2015. There are no clock restarts used in this calculation as per the National RTT reporting for Early Intervention Services. Complete figures have been calculated against this methodology from May 2015 to date.

Complete
Waiting Time performance reporting for all services is based on the number of patients that received treatment/assessment in the month and the percentage of those completed waits that were within the target waiting time. The agreement with commissioners requires revised waiting time targets to be met from a certain month in the year and these 'target achievement months' are listed. Some target months haven't yet been agreed with commissioners and are marked as 'to be confirmed' (TBC).

Target Achievement Month: Contract = now contractual, Date = month when target will become contractual, TBC = Service redesign or not yet agreed

Where the target is not yet in effect, waiting list service name field is colour coded in blue in line with LPT Trust Board request.

All RAG thresholds are as follows; >=95% green; No of Patients Outside Target < 10 AND <95% amber; <95% red.

Incomplete
Incomplete pathways waiting list performance is based on the number of patients waiting to receive treatment at month end and the percentage of those within the target waiting times.

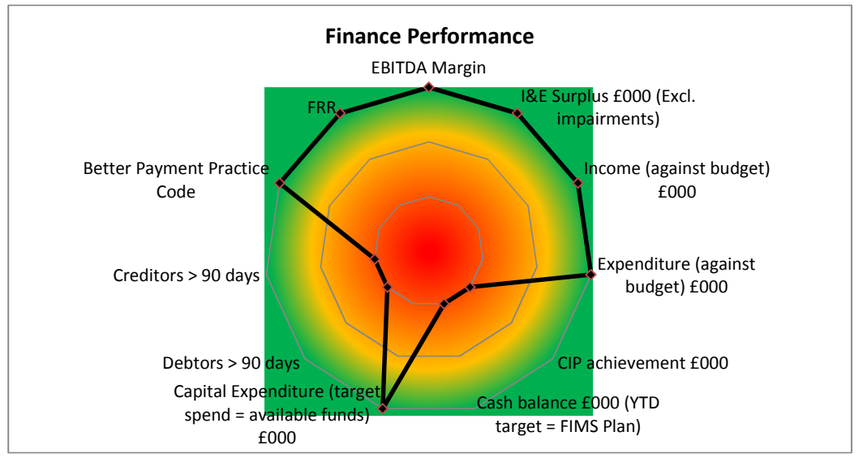
Leicestershire Partnership NHS Trust

Performance - Finance April 2016 (MONTH 01)

Month 01 Position: The Trust is reporting a deficit of £-46k against a planned deficit of £-193k. This is a favourable movement of £146k. The Trust is forecasting an income and expenditure break even position at the end of the year, which would be an improvement over the planned deficit of £2.1m.

EBITDA: The EBITDA margin as at Month 01 is 4.8% against a year to date target of 4.1%. 89% of the year to date CIPs target was achieved as at April 2016. The planned CIP target for the financial year 2016/17 is £6.7m. The current forecast is in line with the plan as at Month 01.

Cash Balance: The cash balance at the end of Month 01 is £5.8m. Debtors over 90 days have increased to 10.6% in April 2016 from 10.1% in March 2016. Creditors over 90 days have increased to 5.3% in April 2016 from 4.6% in March 2016.



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	4.1%	4.8%	4.2%	5.0%												
I&E Surplus £000 (Excl. impairments)	(193)	(46)	(2,098)	0												
Income (against budget) £000	22,361	22,488	270,008	272,106												
Expenditure (against budget) £000	22,554	22,535	272,106	272,106												
CIP achievement £000	716	641	10,557	10,515	30	30	181	167	107	100	59	48	263	229	76	67
Cash balance £000 (YTD target = FIMS Plan)	6,690	5,758	3,745	5,845												
Capital Expenditure (target spend = available funds) £000	98	98	12,731	12,731												
Debtors > 90 days	5.0%	10.6%	5.0%	5.0%												
Creditors > 90 days	5.0%	5.3%	5.0%	5.0%												
Better Payment Practice Code	95.0%	95.7%	95.0%	95.0%	95.0%	91.4%	95.0%	88.3%	95.0%	97.9%	95.0%	98.5%	0	0	1	96.1%

FINANCIAL SUSTAINABILITY RISK RATING (FSRR)			FSRR SCORE	
Financial Risk Metrics			Annual target	Updated annual forecast
Combined FSRR			2	3

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

Leicestershire Partnership NHS
NHS Trust

Human Resources - Workforce

	Trust Performance												Services Performance - Latest Month				
									Data Quality								
	Source	Monthly target	Data As At	Current Month Actual	Previous month	Travel on previous month	Year to Date Position	Year End Target	Sparkline	Timeliness	Central System	Exec Director Sign off	Exec Director Lead	Adult Mental Health/ Learning Disabilities	Community Health	Enabling Services	Families, Young People & Children	Hosted Services
Number of WTE Employed	TRUST		APR	4818	4867	↓							AD	1227.8	1798.3	501.7	1092.7	197.6
% of Sickness Absence (1 month in arrears)	TRUST	<=4.5%	MAR	5.0%	5.4%	↓	5.0%	<=4.5%					AD	5.8%	5.1%	3.5%	4.9%	2.2%
% Normalised Workforce Turnover (Rolling previous 12 months)	TRUST	<=10%	APR	8.5%	8.4%	↓		<=10%					AD	6.9%	10.4%	9.9%	7.6%	8.9%
% Vacancy Rate	TRUST	<=7%	APR	9.2%	7.8%	↓		<=7%					AD	9.8%	13.7%	5.3%	3.2%	0%
Number of staff at risk of redundancy	TRUST		APR	5	5	→							AD	1	0	0	1	3
Number of open formal grievances	TRUST		APR	1	3	↑							AD	1	0	0	0	0
Number of open formal disciplinaries	TRUST		APR	20	21	↑							AD	6	10	2	2	0
% of Staff with a Completed Annual Appraisal	TRUST	>=80%	APR	87.4%	87.4%	↑		>=80%					AD	83.3%	88.0%	87.3%	90.0%	90.8%
% All Mandatory Training Compliance for substantive staff	TRUST	>=85%	APR	n/a	89.8%	↑		>=85%					AD	n/a	n/a	n/a	n/a	n/a
Agency Costs (NHSI National 2016/17 Target)	TRUST	<=£7.7m	APR	£ 714,520	£ 1,285,780	↓	£ 714,520	<=£7.7m					AD	£ 167,870	£ 330,950	£ 48,770	£ 111,420	£ 55,510

Comments & Actions:

% Sickness Absence:
The services are continuing focussed discussion on sickness to identify hot spots and to see what additional support can be offered e.g. additional support from AMICA, mentoring opportunities, additional training for managers and auditing how the policy is being implemented. Key themes include high levels of long term sickness (being pro-actively managed with a view to redeployment, reasonable adjustments and termination of contracts where appropriate) and a correlation between sickness and areas with high vacancy rates.

% All Mandatory Training Compliance for Substantive Staff
During April 2016, uLearn was moved to a new cloud-based server and received an upgrade to include some new features. Following this upgrade the Trust is unable to provide training compliance figures for April 2016. The system supplier is working to resolve the issue as a matter of urgency.

Staff are still able to use uLearn to book training, complete eLearning and undertake their appraisal. Compliance with appraisals has not been affected.

** **Data Quality** is measured against the items below:

1) TIMELINESS:
GREEN: Data is submitted in time to the central system for accurate reporting (in line with trust policies) AND data is verified and any data quality issues are resolved in time for reporting deadlines AND data is extremely **unlikely** to change in subsequent months.
AMBER: Action Plans are in place to ensure business processes are adapted to meet the GREEN requirements.
RED: Data is not available in a timely fashion (according to trust policies) OR Data has not been verified and data quality issues haven't been resolved OR Data is likely to change in subsequent months

2) EXTRACTED FROM A CENTRAL SYSTEM:
GREEN: ALL reported data is extracted from the SAME central system (such as Safeguard, Maracis, ESR, Finance etc)
AMBER: Action plans are in place to submit data to central systems rather than using manual processes OR action plans are available for merging multiple systems into one central system.
RED: Data is extracted from a manual system (even if only in one particular area) OR data is extracted from multiple central systems.

3) SIGNED OFF BY AN EXECUTIVE DIRECTOR
GREEN: The position of data quality items 1) and 2) have been agreed and signed off by an Executive Director
RED: The data quality position has not been agreed and signed off by an Executive Director

HR Workforce Extended Metrics Data

Workforce Profile	Target	2015-16 Position	2016-17 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Sparkline	YTD Change	Comments
Number of WTE Employed		4866.8	4818.1													+0.0	
Substantive Staff Headcount		5568	5522													+0.0	
Bank Only Headcount			1045														
Vacancy Rate	<=7%	7.8%	9.2%														All staff groups, all bands, all areas
% Staff From a BME Background (quarterly)	>=20%	19.7%	19.6%													+0.0%	
% of Males Employed (quarterly)		16.8%	16.7%													+0.0%	
% Staff Aged 18-29 Years (quarterly)	>=12%	13.4%	12.4%													+0.0%	

Sickness Absence (1 month in arrears)	Target	2015-16 Position	2016-17 Mar-16	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Sparkline	YTD Position	Comments
% Sickness Absence	<=4.5%	5.1%	5.0%													5.0%	Recalculated each month
WTE Days Lost to Sickness		89037	7413													7413	Recalculated each month
% Short Term Sickness			2.6%														
% Long Term Sickness			2.3%														
Cost of Sickness (£)		£7,631,663	£647,230													£647,230	Recalculated each month

Turnover	Target	2015-16 Position	2016-17 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Sparkline	YTD Position	Comments
% Normalised Workforce Turnover (Rolling previous 12 months)	<=10%	8.4%	8.5%														All Staff rolling previous 12 months with TUPE, Medical and Psychology Students omitted
% Total Workforce Turnover (Rolling previous 12 months)	<=10%	9.1%	9.2%														All Staff rolling previous 12 months - Excluding Medical and Psychology Students
Stability Index Number of employees with one or more years' service now / Number of employees employed one year ago x 100		91.0%	90.0%														

Temporary Staffing	Target	2015-16 Position	2016-17 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Sparkline	YTD Position	Comments
Bank Costs		£11,172,770	£1,011,920													£1,011,920	All staff groups, all bands, all areas
Agency Costs (NHSI National 2016/17 Target)	<=£7.7m	£12,335,060	£714,520													£714,520	This metric is RAG rated against the target set by the TDA for 2016/17. The annual target is spread evenly across the year, with a monthly target of less then £641,666
Agency Costs (LPT Internal Target)	<=£9m	£12,335,060	£714,520													£714,520	This metric is RAG rated against LPTs planned monthly agency expenditure for 2016/17
Temporary Staffing Spend as a % of Total Paybill (inc bank, agency and additional hours worked)		11.6%	10.0%													10.0%	All staff groups, all bands, all areas
Total Qualified Nursing Agency Spend as a % of Total Qualified Nursing Pay Bill	<=5%		5.4%													5.4%	
Total 'business as usual' Qualified Nursing Agency Spend as a % of Total Qualified Nursing Pay Bill			5.4%													5.4%	
No of Off Framework Agency Usages			14													14	
No of Breaches to Agency Price Cap			1417													1417	
% Split of Substantive to Bank to Agency Staff (Nurses band 2-6, inpatient areas only, taken from Trust portal)		72.1% 20.3% 7.6%	72.3% 23.1% 4.6%														
% Split of Qualified to Unqualified Staff (Nurses band 2-6, inpatient areas only, taken from Trust portal)		38.4% 61.6%	37.2% 62.8%														Increased numbers of HCA/ HCSW in addition to planned staffing levels will skew the expected 60:40 split.

Organisational Change	Target	2015-16 Position	2016-17 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Sparkline	YTD Average	Comments
Number of Staff Affected by Change		296	388													388	YTD and 2015-16 position is average
Number of Staff Newly Affected by Change			192														
Number of Staff at Risk of Redundancy		5	5													5	YTD and 2015-16 position is average
Number of Staff on Notice of Redundancy		5	4													4	YTD and 2015-16 position is average
Number of Staff Redeployed		167	0														
Number of Staff Made Redundant		9	0													0	YTD and 2015-16 position is average
Number of Staff on Pay Protection		105	95													95	YTD and 2015-16 position is average

Employee Relations	Target	2015-16 Position	2016-17 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Sparkline	Distinct no. of Cases	Comments
Number of Open Formal Grievances		11	1													0	Distinct number of cases opened in-year to date
Number of Open Bullying and Harassment Cases		19	12													0	Distinct number of cases opened in-year to date
Number of Open Formal Disciplinaries		40	20													3	Distinct number of cases opened in-year to date
Number of Open Capability Cases		7	8													0	Distinct number of cases opened in-year to date
Number of Ill Health Terminations		13	3													3	Distinct number of cases opened in-year to date
Number of Open Employment Tribunals		5	3													0	Distinct number of cases opened in-year to date
Number of Staff on Suspension		12	7													0	Distinct number of cases opened in-year to date
Number of Completed Weeks Lost to Suspension			62														
Number of Issues Raised through Whistleblowing		9	5														
Number of employment relations cases open for Bank Only employees			26														

Employee Engagement	Target	2015-16 Position	2016-17 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Sparkline	YTD Average	Comments
% Staff recommend LPT as a place to work	>=57%	64%															
% Staff happy with standard of care provided	>=67%	71%															ie recommend as a place to receive treatment
Pulse and Staff Survey Response Rate	>=50%	18%															

Recruitment	Target	2015-16 Position	2016-17 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Sparkline	YTD Average	Comments
Average Time to Recruit (Weeks)	<=12	11.1%	11.4														
Average Number of Applicants Per Advertised Qualified Nursing Posts			4														

Learning and Development Overview	Target	2015-16 Position	2016-17 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Sparkline	YTD Average	Comments
% of Consultants with a completed annual appraisal	>=90%	94.8%	94.0%													94.0%	Excludes those on maternity leave, long term sickness or a new starter within the last 12 months
% of Staff with a completed annual appraisal	>=80%	78.8%	87.4%													87.4%	Excluding medical staff
% All Mandatory Training Compliance for substantive staff	>=85%		n/a													#DIV/0!	
% All Mandatory Training Compliance for bank-only nursing staff	>=75%		n/a														
% of Spaces on Mandatory Training that were booked	>=85%	81.7%	72.8%													72.8%	
% of Mandatory Training DNAs	<=15%	13.7%	10.1%													10.1%	
% of new starters who attended Trust Induction on their first day (excluding bank staff)	>=85%	86.6%	76.7%													76.7%	

Learning and Development - Detail for Substantive Staff	Target	2015-16 Position	2016-17 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Sparkline	YTD Average	Comments
% Core Mandatory Training Compliance for substative staff	>=85%	95.1%	n/a														
% Fire Safety training compliance for substantive staff	>=85%	80.6%	n/a													#DIV/0!	
% of Information Governance training compliance for substative staff	>=95%	87.6%	n/a													#DIV/0!	
% Resuscitation training compliance for substantive staff	>=85%	81.7%	n/a													#DIV/0!	
% Prevention and management of aggression training compliance for substantive staff	>=85%	76.9%	n/a													#DIV/0!	
% Moving and Handling training compliance for substantive staff	>=85%	79.7%	n/a													#DIV/0!	Moving and Handling is now required every 2 years rather than annually.
% Safeguarding training compliance for substative staff	>=85%	89.5%	n/a													#DIV/0!	
% Clinical Mandatory training compliance for substantive staff	>=85%	88.6%	n/a													#DIV/0!	
% Mental Health act training compliance for substantive staff	>=85%	55.5%	n/a													#DIV/0!	This topic area became mandatory from 1st Nov 2015

Declaration of Protected Characteristics	Target	2015-16 Position	2016-17 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Sparkline	YTD Average	Comments
Declared Disability	>=85%	69%	71.8%													71.8%	Excludes declaration of 'do not wish to disclose'
Declared Sexual Orientation	>=85%	75%	76.3%													76.3%	Excludes declaration of 'do not wish to disclose'
Declared Religious Belief	>=85%	75%	76.3%													76.3%	Excludes declaration of 'do not wish to disclose'

ESR Data Quality (1 month in arrears)	Target	2015-16 Position	2016-17 Mar 16	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Sparkline	YTD Average	Comments
No. of Level 1 - Critical Errors	0	4	0													0	Reported 1 month in arrears
No. of Level 2 - Reporting Errors	5	10	2													2	Reported 1 month in arrears
No. of Level 3 - Diversity Errors	5	9	0													0	Reported 1 month in arrears

Comments & Actions:

Learning Development
During April 2016, uLearn was moved to a new cloud-based server and received an upgrade to include some new features. Following this upgrade the Trust is unable to provide training compliance figures for April 2016. The system supplier is working to resolve the issue as a matter of urgency.

Staff are still able to use uLearn to book training, complete eLearning and undertake their appraisal. Compliance with appraisals has not been affected.

Appendix 1: IQPR Change Log

Date	Indicator Code	Indicator Description	Requested by	Change
April 2014	PW.32	Ratio of Bank Usage to Agency Usage	WOD	Indicator removed from 'HR Workforce' tab
	-	Summary Dashboard	QAC	Risk Scores added against indicators
	PW.27	% Total Workforce Turnover (Rolling previous 12 months)	WOD	Indicator description updated
	PW.14	% of Staff with a Completed Annual Appraisal	WOD	Indicator description updated
	PW.72	% Applicants with Protected Characteristics	WOD	Indicator description updated
	PW.73		WOD	Indicator description updated
	PW.47	Stability Index (% of leavers who left with <12 months service) (excl FTC, apprentices, TUPE, redundancy, dismissals)	WOD	Indicator description updated
	PW.72	% Applicants with Protected Characteristics		
	PW.73	Ratio of Shortlisted Candidates to Appointees with Protected Characteristics		
	PW.6	% Total Workforce Turnover including training grade medics (Projected to Mar-14)	WOD	Indicator Removed
	PW.7	% Turnover for Clinical Registered Staff *(Projected to Mar-14)	WOD	Indicator Removed
	PW.8	% Turnover for Clinical Non Registered Staff(Projected to Mar-14)	WOD	Indicator Removed
	PW.9	% Turnover for Non-Clinical Staff(Projected to Mar-14)	WOD	Indicator Removed
	PW.12	Ratio of Agency Spend to Bank Spend	WOD	Indicator Removed
	PW.13	Cost of Pay Protection (£)	WOD	Indicator Removed
	PW.40	% Staff Aged 18-29 Years	WOD	New Indicator to the 'HR Workforce (Extended Metrics)' tab
	PW.46	% Turnover for All Clinical Staff excl Medics (Projected To March 2014)	WOD	New Indicator to the 'HR Workforce (Extended Metrics)' tab
	PW.52	Temporary Staffing Spend as a % of Total Employee Benefit Expenditure (inc bank, agency and additional hours worked)	WOD	New Indicator to the 'HR Workforce (Extended Metrics)' tab
	PW.53	% Split of Substantive to Bank to Agency Staff (inpatient areas only, taken from Trust portal)	WOD	New Indicator to the 'HR Workforce (Extended Metrics)' tab
	PW.54	% Split of Qualified to Unqualified Staff (inpatient areas only, taken from Trust portal)	WOD	New Indicator to the 'HR Workforce (Extended Metrics)' tab
	PW.76	No. of Current Student Placements (Pre-registration nursing only)	WOD	New Indicator to the 'HR Workforce (Extended Metrics)' tab
	PW.77	Declared Disability	WOD	New Indicator to the 'HR Workforce (Extended Metrics)' tab
	PW.78	Declared Sexual Orientation	WOD	New Indicator to the 'HR Workforce (Extended Metrics)' tab
	PW.79	Declared Religious Belief	WOD	New Indicator to the 'HR Workforce (Extended Metrics)' tab
	PW.80	No. of Level 1 - Critical Errors	WOD	New Indicator to the 'HR Workforce (Extended Metrics)' tab
	PW.81	No. of Level 2 - Reporting Errors	WOD	New Indicator to the 'HR Workforce (Extended Metrics)' tab
	PW.82	No. of Level 3 - Diversity Errors	WOD	New Indicator to the 'HR Workforce (Extended Metrics)' tab
May-14	PW.54	% Split of Qualified to Unqualified Staff (inpatient areas only, taken from Trust portal)	WOD	Indicator Removed
	PW.83	% Shifts in Month Planned Staffing Met	WOD	New Indicator to the 'HR Workforce (Extended Metrics)' tab
		All Applicable	CIO	Paul Miller / COO References removed, updated with appropriate lead directors, 'DD' where all divisional directors
	-	Waiting Times Compliance-CHS	Trust Board	Tab removed
	-	Waiting Times Compliance-AMHS	Trust Board	Tab removed
	-	Waiting Times Compliance-FYPC	Trust Board	Tab removed
Jun-14	-	CQUIN 13-14 tab removed	WL	Tab removed
	-	CQUIN 14-15 tab added	WL	Tab added
Oct-14	-	CPA Formal Review	BIM	Tab added
Jan-15		Exception reports		Changes to Exception reports to include Risk
Feb-15		Exception reports		Added MH DTOC * Gate Keeping exception pages

Appendix 1: IQPR Change Log

Date	Indicator Code	Indicator Description	Requested by	Change
Apr-15		HR Workforce (Extended Metrics)		This metric is now split out into resuscitation, moving and handing, safeguarding, prevention and management of aggression and clinical mandatory training to give greater transparency of where issues of low compliance lie.
				This information along with context is provided in a quarterly report at the Learning and Development Group. Any concerns or issues will be escalated as required.
				The data for this metric is not available to report on in NHS Jobs 2. A number of other Equalities KPI's are being proposed.
				The data for this metric is not available to report on in NHS Jobs 2. A number of other Equalities KPI's are being proposed.
				This metric was used last year as there was not 12 months historic turnover data available which meant a rolling 12 month calculation was not possible. We now have this historic data so this metric is no longer needed.
				This metrics has not been reported in since June 2014 due to inability to provide accurate information.
May-15		Efficient Services		Median LOS added for Community beds
		CQUINs 15-16		Page added to reflect new 15/16 CQUINs
Jun-15		All Applicable		Division' replaced with 'Services'
Jul-15		Quality - Personal Services	Committee	% Complaints closed within timescales hidden
Oct-15		Exception reports	FPC and QAC	Qualified Nursing Agency Spend as a % of Total Nursing Pay Bill Exception report added
Oct-15		HR Workforce	FPC and QAC	Qualified Nursing Agency Spend as a % of Qualified Nursing Pay Bill added
Dec-15		Infection Control: C Diff (MH & Community) Meeting the Clostridium Difficle Objective	Committee	Monitor target of 12 removed. Using local target of 7
Jan-16		Early intervention in psychosis (EIP): % people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral (Completed)	FPC and QAC	Monitor target changed to 2 weeks. Remains 4 weeks on waiting times compliance until CV is completed to change local target

Appendix 2: CQUIN Achievement Targets 2015-2016

						Achievement Target % of Payment				
CQUIN No	CQUIN Detail	Quarter	% allocated each Quarter	Quarterly Payments	Reporting Date	100%	75%	50%	25%	0%
1a	LD (Risk of Choking)									
		Q1	10%		August					
		Q2	20%		November					
		Q3	15%		February					
		Q4	55%		May					
1b	LD Preventing Admissions									
		Q1	10%		August					
		Q2	25%		November					
		Q3	25%		February					
		Q4	40%		May					
2	Physical Activity (Assertive Outreach)									
		Q1	10%		August					
		Q2	15%		November					
		Q3	15%		February					
		Q4	60%		May					
3	Carer Support									
		Q1	10%		August					
		Q2	10%		November					
		Q3	10%		February					
		Q4	70%		May					
4	Leg Ulcer Pathway									
		Q1	20%		August					
		Q2	20%		November					
		Q3	20%		February					
		Q4	40%		May					
5	Dementia Care and discharge Planning									
		Q1	20%		August					
		Q2	15%		November					
		Q3	15%		February					
		Q4	50%		May					
6	Patient Experience									
		Q1	30%		August					
		Q2	20%		November					
		Q3	20%		February					
		Q4	30%		May					
7a	CAMHS									
		Q1	40%		August					
		Q2	10%		November					
		Q3	10%		February					
		Q4	40%		May					
8	CHC									
		Q1	25%		August					
		Q2	25%		November					
		Q3	25%		February					
		Q4	25%		May					
9a	Cardio metabolic assessment for patients with Psychosis									
		Q1	20%		August					
		Q2	20%		November					
		Q4	60%		May					
9b	Patients on CPA: Communication with general practitioners									
		Q2	100%		November					

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TRUST BOARD – 27 May 2016

AUDIT AND ASSURANCE COMMITTEE – 5 May 2016

OVERVIEW REPORT TO BOARD

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

Assurance level	Colour to use in 'Assurance level*' column below
Not assured	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans If red, commentary is needed in "Next Actions" to indicate what will move the matter to "full assurance"
Partially assured	Amber - there are gaps in assurance but we are assured appropriate action plans are in place to address these
Assured	Green – there are no gaps in assurance

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
CRR/BAF long-standing risks		No changes seen as needed.	None	None
External Auditors progress report		Reviewed and work on payroll noted and being reviewed by Director of Finance.	None	None
Internal Audit Progress report		Reviewed. Discussion around the number of limited assurance reports being issued recently.	Limited assurance reports now being reviewed at board committees with outstanding follow-up actions to Trust Secretary.	None
Internal Audit Reports limited assurance reviews		Process had been agreed by Board committee chairs for progress reviews by the pertinent Board committees.	Any First Follow-up reports with actions still outstanding would be passed to the Trust Secretary.	None
Data Quality Programme		The Committee wanted originally an extended scope of the DQIP review as it was quite narrow with more sampling than the one area originally proposed.	Agreed scope by Executive Lead Chief Nurse to be brought back to the meeting in July. A decision would then be made how this would fit in with the Internal Audit	July 2016

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
			programme.	
Draft Head of Internal Audit Opinion Report		Reviewed and significant assurance outcome. Annual customer satisfaction survey discussed and more regular feedback to committee requested.	Internal Audit to initiative more customer satisfaction surveys, ie quarterly.	October 2016
Counter Fraud annual report		Assurance received. Changes to NHS Protect at national level reported.	"Watching brief" for developments to committee.	None
Review of final draft Annual Accounts 2015/16		Assurance received that accounts will be finalised in time for May Trust Board.	Actions from 21 April committee review to be completed. Sign-off at May Extraordinary Trust Board	27 May 2016
Review of going concern assessment 2016/17		Assurance received.	Sign-off at May Extraordinary Trust Board	27 May 2016
Review of draft Annual Governance Statement (AGS) 2015/16		Assurance received and all previous comments included.	Sign-off at May Extraordinary Trust Board	27 May 2016
Quality Assurance Committee Annual review		Comprehensive report received to give assurance. Debate about the challenging scope of work for QAC agendas and number of reporting in committees. Suggested making achievements and goals more specific and not as much about committee processes.	QAC report to be reviewed ahead of being submitted to Trust Board	July 2016
Strategic Workforce Group annual review		Members' attendance record not recorded correctly. Amendment for the terms of reference to remove safe staffing as duplicated with QAC. Suggested SMART objectives looking	SWG report to be reviewed ahead of being submitted to Trust Board	July 2016

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
		ahead needed to ensure strategic focus to work.		
Draft Quality Accounts 2015/16		Timeline for submission confirmed.	Draft to May Extraordinary Trust Board, with request for delegated authority for sign off by end June 2016	June 2016
Clinical governance programme		Agreed to receive clinical audit annual report	Amend committee schedule	October 2016

Recommendation	The Trust Board receives and reviews the issues raised in the highlight report.
Author	Chris Burns, NED Frank Lusk, Trust Secretary
Presented by (Chair of committee)	Chris Burns

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Leicestershire Partnership NHS
NHS Trust

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TRUST BOARD – 27 May 2016

AUDITOR PANEL MEETING – 5 May 2016

OVERVIEW REPORT TO AUDIT AND ASSURANCE COMMITTEE

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

Assurance level	Colour to use in 'Assurance level*' column below
Not assured	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans If red, commentary is needed in "Next Actions" to indicate what will move the matter to "full assurance"
Partially assured	Amber - there are gaps in assurance but we are assured appropriate action plans are in place to address these
Assured	Green – there are no gaps in assurance

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
Tender evaluation document		The panel reviewed the draft tender evaluation questions and presentation title for assessing each tenderer's submissions. The document has been approved, subject to minor changes.	Evaluation of tenders will be undertaken using the agreed questions. Presentations will be provided by those tenderers invited to interview.	12th August
Choice of Framework		The Panel reviewed the frameworks that are available for External audit services. It was agreed that LPT would access the East of England (EoE) framework, as the framework is compliant with the NAO code of practice and EoE state that they have carried out due diligence to ensure that providers are RSB authorised.	Proceed with preferred option in line with agreed timescales	See action plan for timescales
Service Specification development		The draft service specification was approved subject to any minor changes required after a last check through		

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
		against the DH guidance.		
Action plan		The critical path remains on track to ensure a decision date of October 2016 is delivered. See summary Action Plan in Appendix 1 for more information. As the interview dates for tenderers have been moved to August (to accommodate panel availability), the date to issue tender documents has been moved back from April to June. This won't affect the implementation timetable.	Proceed to mini-competition exercise through the framework arrangement	June 2016
Reporting		Progress report shared and discussed with the Audit Committee	Highlight report to Trust Board	May 2016

Recommendation	The Trust Board receives and notes the issues raised in the highlight report.
Author	Sharon Murphy – Deputy Director of Finance and Procurement
Presented by (Chair of committee)	Liz Rowbotham, Non-Executive Director

Timeline for Appointment of external auditors

	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Action to be taken by:														
Trust Board	Approve the establishment of an Auditor panel						Receive update from the Auditor Panel				Receive the appointment advice from the Audit Committee and decide whether to accept the advice & appoint the recommended auditors			
Audit Committee			Terms of reference to be amended to recognise Auditor panel as a sub-committee		Trust SFIs to be reviewed and approved						Receive the appointment advice from the Auditor Panel and prepare report for Trust Board			
Auditor Panel		Auditor panel members confirmed and chair agreed.	Auditor panel pre-meet	Auditor panel meets & agrees Tender specification; Agree appointment process (whether to re-appoint KPMG or go out to tender)					Auditor panel shortlist candidates (29th July)	Auditor panel assessment day for candidates (12th August)	Conclude procurement process and prepare appointment advice for the audit committee			
Procurement process			Investigate Framework availability (see details on Tab 2)	If instructed by auditor panel, start procurement process	Identify tender evaluation panel; Service specification and mini competition document development			Issue mini competition to chosen framework supplier	Return date (15th July) for submissions and panel evaluations	Clarification Period	Award Decision Made	Finalisation of Contract and implementation period		
Other		Any NED contractual amendments to be confirmed; procedure to be developed for the removal or resignation of the Auditor Panel and its chair.	Trust SFIs to be amended as required (for presentation at February FPC)	Trust SFIs to be amended as required (for presentation at March Audit Committee)									Auditors formally appointed & relevant notices issued	Auditors must be appointed by 31st December 2016

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Leicestershire Partnership NHS
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REPORT TO THE TRUST BOARD – 27 May 2016	
Title	Listening to and Engaging our Staff

Executive summary

The Trust is committed to improving staff experience and the levels of staff engagement and satisfaction. Improved staff experience will enable the Trust to recruit and retain high quality staff and there is a correlation between the positive experience of staff and the quality of care provided to our patients and service users.

The 'Listening to and Engaging our Staff' report provides a brief overview of the mechanisms and processes we have in place to listen to staff, it includes what staff have been telling us about working for the Trust and details the actions that have been taken to improve staff experience and staff engagement.

The focus of this report is on the service improvements brought about as a result of the work of cohort 5 of Listening into Action, the Trust-wide focus in responding to the 2015 NHS Staff Survey and the approach of clinical services to identifying their own response.

LPT's overall staff engagement score has improved significantly with an increase from 3.63% in the 2014 NHS Staff Survey to 3.72% in 2015. However, this remains significantly below the comparator Trust average of 3.81 and national average across all sectors of 3.78. This indicator has shown an increase nationally from 3.71 in 2014.

There have been 41 Trust Board member visits to clinical services during the period October 2015 to March 2016. Themes from staff feedback are included with associated actions. Just 2 questions were posed to the CEO as part of the 'Ask the Boss' initiative and the format of this will change as part of development of the Communication Strategy.

Reports are to be presented to Trust Board 3 times per year. The next report will be presented in September 2016.

Recommendations

Trust Board is recommended to:

1. Support the current mechanisms and activities in place for engaging staff and the actions being taken.
2. Review progress made in terms of engaging staff and responding to staff feedback.

Related Trust objectives	Staff will be proud to work here and we will attract and retain the best people. Sub-objective is: Develop a workforce that is engaged, committed and supported.
Risk and assurance	Risk 1037: Without effectively engaging and supporting our staff we may be unable to deliver high quality services and support transformational change.
Legal implications/ regulatory requirements	Care Quality Commission outcomes 12, 13 and 14 relating to staff.
Evidence for the Quality Governance Framework	Paper provides evidence for board engagement with staff. (3C)
Presenting Director	Alan Duffell, Director of HR and OD
Author(s)	Kathryn Burt, Head of Operational Human Resources
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.	

Listening to and Engaging our Staff

1. Introduction

The Trust is committed to improving staff experience and the levels of staff engagement and satisfaction. Improved staff experience will enable the Trust to recruit and retain high quality staff and there is a correlation between the positive experience of staff and the quality of care provided to our patients and service users.

There are a number of ways in which staff can tell us about their experience of working for the Trust, put forward ideas for improving the services we provide and enhance overall staff experience – a summary of these are included in the report. There is a focus on LiA in this report as cohort 5 comes to an end and cohort 6 commences the LiA 20 week journey. There is also a review of the NHS Staff Survey results and the areas of focus for the Trust.

Development of the Communication Strategy which is due to go to the Board in June and further proposals around line manager and team development and staff health and wellbeing will further enhance engagement with staff and ensure they are able to influence their working lives and practices.

2. Aim

The aim of the report is to:

- Provide assurance for Trust Board that the current mechanisms and activities in place to engage with staff and gain their views on their experience of working for the Trust are being used and acted upon.
- Provide an update on actions taken which are linked to staff feedback.

3. Recommendations

Trust Board is recommended to:

1. Support the current mechanisms and activities in place for engaging staff and the actions being taken.
2. Review progress made in terms of engaging staff and responding to staff feedback.

4. Feedback from Staff - Mechanisms

The Trust has a number of mechanisms in place through which staff are able to share their views of what it is like to work for LPT. There are formal consultative forums, both at a Trust and Clinical Service level; annual NHS Staff Survey and quarterly Friends and Family Test (FFT)/Pulse Surveys; staff support groups for carers, BME, LGBT, disability; a feedback email address/phone line/hard copy forms and 'Ask the Boss' facility where questions can be posed directly to the Chief Executive. Staff views are also obtained through Trust Board member visits to clinical areas ('Board Walks') and the Listening into Action (LiA) programme enables teams to work together and make a difference to their working lives. The Learning and Development Team collate relevant feedback from course delegates and all staff leaving the Trust or moving within the Trust are encouraged to complete exit questionnaires.

5. Listening into Action (LiA)

Staff engagement is improved where staff are able to contribute to improvements at work, show initiative, make suggestions for improvement and feel involved in making decisions about changes that affect them at work. All those involved in LiA teams have made changes and table 1 below records the notable achievements of cohort 5 which were celebrated at the Pass it On event on 23 March 2016.

Table 1 – Actions taken by LiA Cohort 5

Team	**Actions Taken**
Agile working	City Health Visiting Team reported great improvements following their pilot of agile working and introducing technology to enable them to work away from base. Benefits include increased contact with service users, improved staff morale and more flexibility in day to day working. The team have reported feeling more relaxed and this approach is now being rolled out across the Trust.
Communication Team	Interactive event and additional 'drop in' sessions held to gain staff opinions and ideas. A new software package has been purchased – News Weaver' – to produce eNewsletter and provide staff with an interactive facility to improve communication and enable instant 'polling' and feedback. Ear phones provided for staff to enable them to listen to vodcasts.
Team	**Actions Taken**
Accessible Information Standards Group	Held a big conversation which was attended by over 50 member s of staff and service users. The team is working on actions which will ensure service users have information in the format that they need.
Speech and Language Therapy (SALT)	The team are now working with LPT co-design colleagues to get further parent views to improve their service. All SALT therapists to attend 'cluster meetings' to share good practice and develop team working in neighbourhoods. Special school therapists to be enabled to work more flexibly in term time to support the families of these children at home
Pharmacy	The Pharmacy Team wanted to align the practice of prescribing and administering hypnotics. They are now in the process of implementing Zopiclone as a patient group directive and rolling out training to nurses at the Bradgate Unit. If successful consideration will be given to implementing this on a wider scale within the Trust. Sleep packs are being created for wards to encourage a reduction in the use of this medication. The leads for this from Pharmacy are keen to publish the results from using the LiA approach as it is the first time it has been used in addressing standardisation of medication use.
Childrens Community Phlebotomy Service	This team are producing a video aimed at preventing GPs from prescribing EMLA cream and informing them of alternative options available. The film is also being used for to inform parents and carers of the options available to them.
Criminal Justice and Liaison Youth Service	This team took a different approach to LiA. As a new service, they needed to raise their profile and improve the process of screening of young people in custody. They have now increased their referral rate from an average of 4 per week to approximately 40. They have also improved the process by which they see young people in custody to improve service user experience. Posters and leaflets are being printed to further promote their service.
PIER Team	This team are now updating the letters and information given out to service users prior to assessment to improve information available and reduce DNAs. . Where possible appointments will be made by telephone and backed up with a letter. Liaising with referrers (GPs and LPT) to improve referral process and ensure all information is available.

In addition to the above, Trust wide events to seek staff feedback and inform the direction of travel for the LPT Change Programme and 'Talent - what Talent Management means for LPT and what qualities do we expect from our leaders?' The outcome of this is being developed for consideration by the Executive Team.

Cohort 6 took up the LiA baton at the Pass it On event and their missions are included in Table 2. The next pass it on event will be held on 30 September 2016.

Table 2 – LiA missions for Cohort 6

Team	**Mission**
Community Hospitals	Aim to simplify the discharge process and improve patient flow
Patient Safety Team	Want to discuss what works and what can be improved when conducting a serious incident investigation
Care Navigation	What does brilliant Care Navigation look like? What is done well and what could be better?
Flu Campaign	Aims to bust the myths around the flu vaccination and increase the staff uptake in 2016
CPA care planning	Aims to improve service users and carers' involvement in CPA care planning?
Team	**Mission**
Prospects Group	Is asking for staff and service user involvement to help shape and improve this social group that is run for mental health patients in the community.
Information requests Team	Aims to improve requestor/ patient experience and service delivery of requests for information and increase staff awareness of the Information Requests Team and all they have to offer.
Veterans Liaison Champion	Aims to look at how a support group for Military veterans of Leicestershire and Rutland can be established.
Young People in LPT	A Campaign to target and support young people working for LPT
Violence and Risk reduction Group	Aims to look at how we provide support and training for staff that is relevant and appropriate for the patients they care for and the service they work in.

LiA continues to be an effective way of engaging staff and enabling them to make a difference. Consideration is being given to how LiA can be developed to increase involvement and expand uptake and proposals about how this can be achieved will be considered by the LiA Sponsor Group later in the month.

5. Surveys

The Trust currently undertakes a number of surveys to gauge staff experience. The annual NHS Staff Survey enables the Trust to monitor year on year improvement in staff experience and also enables comparison with other similar Trusts nationally. The Staff Friends and Family Test (FFT)/Pulse Survey enables progress to be measured in year. In addition, staff are invited to contribute to consultation on either local, Trust or wider health economy initiatives. The work undertaken by the Communications Team as part of their LiA consultation has indicated that staff's preference would be to feed back via polls and short surveys and the purchase of 'Newsweaver' software will enable this to happen.

5.1 2015 NHS Staff Survey

The results of the 2015 NHS Staff Survey were released in February 2016. Table 3 below summarises the 5 top and bottom ranking scores and the 5 areas where staff experience has improved the most since 2014.

Table 3 – 2015 NHS Staff Survey Results

Top 5 ranking scores (i.e. where the Trust compares most favourably with other Trusts)	% of staff reporting good communication between senior management and staff
	% of staff experiencing harassment, bullying or abuse from patients, relatives or the public
	% of staff working extra hours
	Quality of appraisals
	% of staff believing that the organisation provides equal opportunities for career progression or promotion
Where staff experience has improved most in LPT	Staff motivation at work
	% of staff able to contribute towards improvements at work
	% of staff suffering work related stress in last 12 months
	Effective use of patient / service user feedback
	Staff recommendation of the organisation as a place to work or receive treatment
Bottom 5 ranking scores (i.e. where the Trust compares least favourably with other Trusts)	Staff satisfaction with the quality of work and patient care they are able to deliver
	Effective team working
	Support from immediate managers
	% of staff feeling pressure in the last 3 months to attend work when feeling unwell
	Quality of non-mandatory training, learning or development

LPT's overall **staff engagement score** has improved significantly with an increase from 3.63% in 2014 to 3.72% in 2015. However, this remains significantly below the comparator Trust average of 3.81 and national average across all sectors of 3.78. This indicator has shown an increase nationally from 3.71 in 2014.

There is significant variation in results across services within the Trust and work continues within Clinical Services to determine what needs to be done at a local level to make changes based on staff feedback. All areas are engaging with staff to inform decisions and AMH/LD have launched a 'Share it, Shape it' campaign, with SMT members attending teams to talk to them about how staff experience can be improved. Plans within Clinical Services will be finalised during May and early June.

Trust wide priorities have also been considered and the Trust's approach to developing teams, developing and supporting line managers and improving overall staff engagement are all being considered at the Strategic Workforce Group in May.

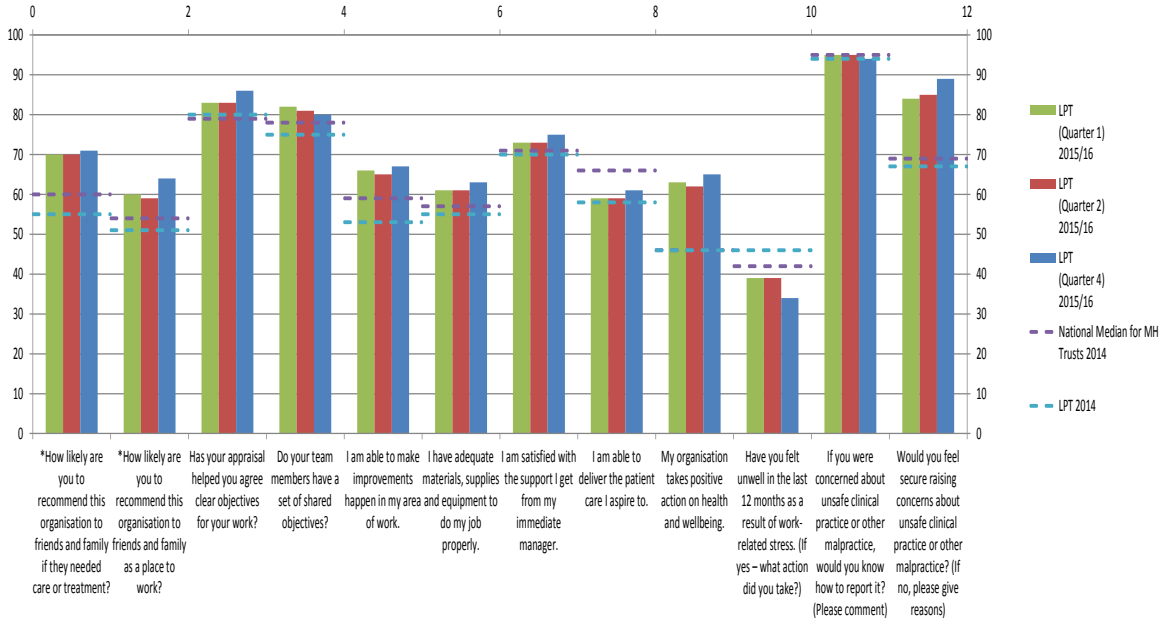
5.2 Q4 Staff Friends and Family Test/Pulse Survey 2015/16

The Q4 Staff Friends and Family Test/Pulse Survey was undertaken for a period of 2 weeks in late January/early February. Staff were offered an incentive to complete the survey in order to encourage completion in addition to communication about what had been done as a result of staff feedback. There was an increase on the Q2 return rate to 18% – see table 4 - but consideration will need to be given to alternative methods of completion and promotion as we move into 2016/17. Results are included in Table 5.

Table 4 – Staff FFT/Pulse Survey Response rate

Year	Quarter	LPT	AMH/LD	CHS	ENAB	FYPC	Hosted
2015/16	Q4	991	196	295	184	280	36
2015/16	Q2	912	189	276	131	287	29
2015/16	Q1	1025	224	312	144	314	31

Table 5 – Q4 Staff FFT/Pulse Survey Results



There was positive movement in relation to a number of questions in Q4. Question 4 relating to teams having shared objectives has not improved which correlates with the main staff survey results relating to team working. More staff tell us that they would feel secure raising concerns (Question 12) and there has been a reduced number of staff saying they have felt unwell as a result of stress which again correlates with staff survey results, although mental health issues remain the most prevalent reason for sickness absence.

6. Formal Staff Consultation Arrangements

One of the main areas of focus for staff representatives through the Trust's Joint Staff Consultative and Negotiating Committee (JSCNC) is improving how we deal with bullying and harassment within the Trust. This links with the staff survey results which indicate that 21% of respondents feel they have experienced harassment, bullying or abuse from staff in the last 12 months of which only 45% reported it. Although not out of line with other Trusts in terms of the numbers feeling they have been subject to bullying, we considers this percentage to be too high and the percentage of staff reporting bullying is below the national average.

In order to address this issue, staff side, human resources and the equalities team are working together to look at how we promote support that is available to staff and how cases of alleged bullying are handled when they are raised to ensure that they are resolved at as lower level and as swiftly as possible. The Trust has dealt with around 20 formal cases of bullying and harassment during 2015/16 which suggests that a substantial number of staff are resolving issues informally.

7. Engaging with the Board and Senior Managers – Board Walks

Board Walks are where Trust Board members visit services and areas across the Trust with the aim of further developing two-way communication and relationships between Trust board members, frontline staff, patients and their carers.

During quarter three (October to December 2015) 20 board walks were carried out by board members across the organisation, 11 in Adult Mental Health and Learning Disability Services (AMH/LD), 5 in Community Health Services (CHS) 3 in Families Young People's and Children's Services (FYPC) and 1 within Voluntary Services. In quarter 4 (January to March 2016) a further 21 board walks were undertaken with 9 within AMH/LD services, 5 within FYPC and 7 within CHS.

Analysis of the completed feedback forms has been completed and has identified both some recurrent themes and a number of actions that have been undertaken as a result of the visits. Only the staff related themes and actions are include in table 6 as patient related issues will be picked up through Patient Experience reporting.

Table 6 – Analysis of recurrent themes and actions from Q3 and Q4 Board Walks

Board Walks Q3	
Themes/Feedback	**Actions**
Staff are welcoming, professional and have a good rapport with patients.	
High numbers of vacancies and problems recruiting staff is a recurring concern.	Recruitment strategy and associated plan being delivered to address recruitment and retention issues.
Improvements required to ensure staff have access to the internet and can find policies and other core information on the intranet.	Improvement proposed as part of HIS strategy and developing Communications Strategy. A review of the way that tough books are used is being carried out on Ashby Ward to increase computer access and support record keeping.
Board Walks Q4	
Themes/Feedback	**Actions**
Evidence of enthusiastic, positive, welcoming staff teams.	
Issues noted with staff sickness resulting in bank or agency cover	Proposals around actions necessary to reduce sickness absence to be developed during June. Developing increased offer in terms of improving staff health and wellbeing.
Team working – evidence of person centred approaches and compassionate care.	Consideration being given to extending recognition to recognising teams as well as individuals.

The board walks process is being further developed to include five 'top themes' relating to risk, safety, experience and audit for each service (by inpatient and outpatient) which will be reviewed and updated each quarter. The top themes will be shared with board members prior to each board walk giving them a prompt for some areas to focus on. Staff will also be asked *'What is the one thing that would improve your experience at work and enable you to provide improved care to patients?*'.

8. Equalities

The Equalities team is undertaking a number of initiatives to ensure we engage with all staff and are inclusive in our activities.

8.1 Stonewall Index

The Trust submitted its application for the Stonewall Workplace Index 2016 – including information obtained from a survey of staff - resulting in the Trust being placed at 102 out of over 400 organisations. We continue to work in partnership with local public sector organisations to improve access to services and employment opportunities within the Trust. We will also continue to work with the various Lesbian, Gay, Bi-sexual and Transgender (LGBT) centre(s) and other local services to improve access and also promote and raise awareness that improves staff understanding of this agenda and address some of the issues experienced by the target group.

We are now in the process of planning and organising a number of workshops in 2016 to provide staff/managers with further understanding of equality legislation and application of

this provision for the LGBT community, as well as awareness of unconscious bias and bullying and harassment issues.

8.4 Discrimination Survey

The Equality and Human Rights Team assisted with the development of a survey to investigate discrimination, bullying and harassment and career progression in the Adult Mental Health and Learning Difficulties (AMH/LD) service in response to issues raised through internal procedures. Responses have been analysed and a report will be considered at the AMH/LD Workforce Group where appropriate actions will be identified.

The Equality and Human Rights Team will provide an equality breakdown of the 2015 Staff Survey responses after full results have been released. This will help inform the equality perspective in workforce planning and may identify areas of the workforce where there is a need for specific intervention on issues such as discrimination, bullying and harassment, job satisfaction, and career progression.

9. Recognition

Recognition of staff's contribution is another building block in improving staff engagement and we have made significant progress with this.

9.1 Valued Star Award

The Valued Star monthly award continues to be popular with staff, and generates a good response on social media especially Facebook. 120 nominations were received between January and April. Proposals are being considered to expanding this initiative to include 'Valued teams', potentially on a quarterly basis.

9.2 Celebrating Excellence

The annual staff excellence awards were held on the evening of 21 April 2016. The event was a sponsored evening event for the first time and was a great success with staff. Plans are already underway for the 2017 event.

10. Ask the Boss

Ask the Boss questions and responses are uploaded to eSource but only 2 questions have been submitted during the reporting period – one relating to Trust Board membership which Cathy Ellis responded to and one relating to why bank workers aren't included in the staff survey – an issue which is determined nationally. As a result of the query about bank workers, consideration will be given to expanding the range of the staff FFT/Pulse Survey. 'Ask the Boss' will be included as part of future staff engagement but the format will be reviewed to increase take up. Consideration is being given to delivering 'Ask the Boss' as a monthly webchat.

11. Learning and Development

Learning and Development staff are in a privileged position to talk to large numbers of staff and seek feedback. Issues raised by staff via this route from January to April 2016 include: issues with recruitment; staffing shortages; inability to take a break and staff support. We are looking to develop better ways to collate and theme feedback from training and also to provide details of action taken. The current themes do not currently raise any concerns about areas that are not already being addressed through the recruitment strategy, action on bank and agency and our approach to health and wellbeing.

12. Exit Questionnaires

An annual report on exit questionnaires will be presented to the Workforce and Wellbeing Group on 31 May 2016 but the 3 most common reasons for leaving the Trust are career development, promotion elsewhere and style of management/attitudes. We are addressing the style of

management/attitudes through strengthening our offer to develop supportive management behaviours and enable our line managers to have healthy conversations with staff.

13. Themes

The Trust currently addresses all feedback from staff under the themes of:

1. Health and wellbeing (including stress/work pressure)
2. Effective leadership/management support (including quality of appraisal)
3. Effective teams
4. Communication and engagement (including recognition)

The 2015 NHS Staff Survey would suggest that these remain the areas where we should put our attention to accelerate the positive improvement achieved to date.

14. Conclusion

The Trust continues to ensure that it maximises all opportunities to receive and act on staff feedback and that the feedback is presented in a co-ordinated way through this report. We will continue to review and enhance our overall approach to staff engagement.

Leicestershire Partnership NHS
NHS Trust

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TRUST BOARD – 27 May 2016

Mental Health Act Assurance Committee (MHAC) – 27 April 2015

OVERVIEW REPORT TO BOARD

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

Assurance level	Colour to use in 'Assurance level*' column below
Not assured	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans If red, commentary is needed in "Next Actions" to indicate what will move the matter to "full assurance"
Partially assured	Amber - there are gaps in assurance but we are assured appropriate action plans are in place to address these
Assured	Green – there are no gaps in assurance

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
Strategic developments				
Multi agency Policies and procedures for effective working with partner organisations		Multi-agency partners (CCG, LA) attended MHAC and agreed to work together on reviewing the joint policies with a view to determining areas of joint responsibility. Multi agency members shall be invited to attend MHAC on a quarterly basis.	It was agreed to as the first step to review the procedure in place clarifying the s117 Aftercare arrangements. It was agreed to identify shared policy/procedures.	3 months To be reviewed in June 2016.
The MHAC approved the revised Overarching Mental Health Act Policy.		Agreed to send to QAC for approval prior to intranet upload.	Planned for receipt at May QAC meeting. Upload onto intranet.	30 May 2016

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
Development of Quality Collaborative		Clinical leads identified for developing a multi-agency quality collaborative to support MHAC in leading a continuous quality improvement.	Agreed to organise the first listening event involving LPT clinicians as well as LA practitioners.	May 2016
Improvement actions and evidence of progress				
Audit on prescribing compliance against T2/T3s (consent) showing variable compliance.		Audit highlighted prescribing outside the T2/T3 plan. This shows lack of awareness while prescribing (doctors) as well as lack of checking while administering medications (Nurses). Committee approved the action plan for the audit. It was also agreed that all noncompliance identified would be incident reported and that the pharmacy team would contact prescribers directly to highlight any concerns.	MHAC will be updated on the progress of actions through report from the clinical audit team.	3 months
Audit on compliance with Section 2 renewals prior to lapsing.		Audit conducted in MHSOP inpatient areas showed that sections 2 are allowed lapse rather than ending after review by the clinicians. Action plan to address this was approved with minor changes.	MHAC will be updated of the progress of actions through report from the clinical audit team. .	3 months

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
Mental Health Act Training		Discussed the latest training achievement rates from Learning & Development. While the training rate for nurses is improving slowly, the Members noted that 11% of places booked resulted in DNA and 23% of places remained unfulfilled. Lack of capacity to release staff remains an issue. Training rate for Junior doctors has dropped due to the training date delayed.	Mental Health Act leads in each directorate to make sure that the training opportunities are taken up. The inpatient areas would be prioritized. Deputy MD to work with the training lead to integrate the MHA training for junior doctors as part of induction.	Update in June 2016 Update in June 2016
CQC action plan. Members received progress update against the X3 Requirement Notices assigned to the MHAC.		S17 leave forms; 132 and Consent to Treatment forms have all been updated and are awaiting RiO mitigation. All request forms are complete.	Agreed turnaround timeframe as 4 weeks.	May 2016
Ward Level MHA improvement tool report		Reporting from all areas with very little omissions. The report shows improvement in key areas, further improvement required in Section 17 leave details, copy being given to patients, patient being informed of Section 132 rights consistently as well as recording consent.	Mental Health Act leads to work with the ward level champions; 1. Corrective actions are followed up for individual patients immediately after each audit. 2. To feedback the ward level results to all staff for creating	Update in June 2016

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
			continuous improvement.	

Recommendation	The Trust Board receives and notes the issues raised in the highlight report.
Author	Helen Wallace, Regulation & Assurance Lead Dr Satheesh Kumar, Medical Director
Presented by (Chair of committee)	Dr Satheesh Kumar, Medical Director

Leicestershire Partnership NHS
NHS Trust

TRUST BOARD – 27 May 2016

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Safer Staffing – April 2016 Monthly Review

Introduction/ Background

1. In November 2013, the National Quality Board (NQB) issued guidance to optimise nursing, midwifery and care staffing capability and capacity. The guidance followed national research which demonstrated that staffing levels are linked to the safety of care; and a right for patients and the public to have access to easily accessible information to know how their hospitals and inpatient units are being run.

2. The guidance specified a number of expectations which trusts needed to commit to by the end of June 2014:

    a) to present a report to Trust Board every six months describing the staffing capacity and capability, provide an establishment review and use evidence based tools where possible;
    b) to display ward level information about the nurses, midwives and care staff deployed for each shift compared to what has been planned;
    c) to present a report to Trust Board each month containing details of planned and actual staffing on a shift-by-shift basis at ward level for the previous month;
    d) to publish the monthly report on the Trust's website and link or upload the report to the relevant hospital(s) webpage on NHS Choices.

3. This paper responds to expectation c) *to present a report to Trust Board each month containing details of planned and actual staffing on a shift-by-shift basis at ward level for the previous month.*

Aim

4. The aim of this report is to provide the Trust Board with an analysis of March 2016 Safer Staffing data.

Recommendations

5. The Trust Board is recommended to:

    - Receive this report as the current Trust position with regards to the NQB Safer Staffing requirements;
    - Receive assurance that all efforts are being employed to ensure the highest level of data quality possible, with detailed internal oversight and scrutiny in place over both completion and performance.

Discussion

Trust Board Responsibilities from June 2014

6. Each month, the Chief Nurse presents to the Trust Board an analysis of the following Safer Staffing indicators:
    a) Use of temporary workers vs substantive staff
    b) Planned vs actual number of staff
    c) Skill mix of nursing staff

7. Every six months, the Trust Board receives an 'Inpatient Staffing Establishment Review' report which provides an overview of the work being undertaken to ensure safer staffing standards are met across all our inpatient wards.

8. The monthly reports are publically available via the NHS Choices website and our Trust internet page.

9. The Chief Nurse has given responsibility to lead nurses for ensuring the accurate collection of staffing and acuity information into the Trust's bespoke Safer Staffing portal.

10. A Safer Staffing dashboard is produced each month (see Appendix A) to provide an overview of staffing during the period in review. Lead nurses provide further qualitative narrative to identify particular 'hot spots', the risks they pose and the mitigating actions and longer term plans which are in place to ensure our wards remain safe.

Analysis of Safer Staffing in April 2016

The table below provides an overarching summary of the Trust 'hot spots' with regard to maintain safer staffing

	February 2016	**March 2016**	**April 2016**
Community Health Services Directorate	St Lukes Hospital- Ward 1 and Ward 3 Rutland Ward	St Lukes Hospital- Ward 1 and Ward 3	St Lukes Hospital- Ward 3
Families, Young People and Childrens Directorate	-	-	-
Adult Mental Health & Learning Disability Services Directorate	Mill Lodge – Buttercup Ward and Bluebell Ward	Mill Lodge- Bluebell ward	Mill Lodge- Bluebell ward
	Bradgate unit – all wards except Belvoir ward	Bradgate unit – all wards except Belvoir ward	Bradgate unit – all wards except Belvoir ward

Community Health Services (CHS)

11. The current 'hotspot' area(s) for Inpatient Community Hospitals is:
    - St Luke's Hospital - Ward 3

			Day (Early & Late Shift)		Night				
			Average % fill rate registered nurses	Average % fill rate care staff	Average % fill rate registered nurses	Average % fill rate care staff	Skill Mix Met based on 1:8 plus 60:40 split	Funded Staffing Levels Met by Shift	% Temporary Workers
Ward Group	Ward name	Average no. of Beds Occupied	>= 80%	>= 80%	>= 80%	>= 80%	>= 80%	>= 80%	<20%
St Luke's	SL Ward 3	15	96.7%	97.5%	200.0%	100.0%	94.44%	96.7%	42.1%

Table 1 Community Hospital Hot Spots

12. There are no 'hotspot' areas identified with Mental Health Services for Older People (MHSOP). Bennion Centre – Welford Ward as well as Evington Centre - Coleman and Wakerley Wards are red as an exception for the use of temporary workers (22.1%, 40.2% and 33.2% respectively). Bennion Centre - Welford Ward's usage is attributed to increased long term sickness. Evington Centre - Coleman and Wakerley wards' usage is due to an increased number of patients requiring level 1 observation and higher acuity levels resulting in a need for additional staffing to ensure patients' needs have been met and safety maintained.

13. The 'hotspot' area for Community Hospitals shows a higher percentage of temporary workers used (42.1%). There is a clear correlation between high usage of temporary workers to the high numbers of vacancies and increased rates of sickness within this area. Staffing levels have been maintained by the movement of staff from other areas and the use of regular temporary workers.

14. The Safer Staffing dashboard for April 2016 highlights City Beds - Beechwood Ward as using 25.1% of temporary workers. This increase is attributed to additional staff required to provide specialling/ enhanced care to confused patients and due to an increased rate of sickness.

15. The in-month achievement of funded staffing levels for Bennion Centre- Welford Ward, Bennion Centre – Kirby Ward, Hinckley and Bosworth – East Ward and City Beds - Beechwood Wards are currently below 80%. The wards have on occasion not had the planned third registered nurse on duty due to increased sickness; however appropriate staffing levels have been maintained on these occasions.

The risks this presents us with

16. There are potential risks associated with the increased reliance on temporary workers to cover vacancies, sickness and observations which will potentially impact on the quality and effectiveness of patient care and also on patient and staff experience.

Mitigating actions in place to prevent these risks

17. Immediate mitigating actions include:
    - Daily risk assessments using the dynamic risk assessment tool to assess patient acuity and ensure all patient clinical needs are met;
    - Proactively identifying staffing risks and ensuring subsequent actions are taken, discussed across the service daily and at a weekly staffing conference;
    - Movement of staff across the service to address shortfalls and to review skill and experience on a shift by shift basis;

- Reviewing patient experience feedback, Nurse Sensitive Indicator data and risks to ensure quality is not impacted.

18. Mitigating actions in the 'hot spot' areas include:
    - St Luke's – Ward 3: Continued implementation of a clinical support plan to address the nurse vacancies and increased clinical incidents linked to Nurse Sensitive Indicators. The actions put into place through the support plan have had a positive impact on patient safety outcomes and patient and staff experience. The plan includes a matron working on site with the new Ward Sister for clinical leadership and support. Continuation of a tailored clinical education programme to enhance staff skills and knowledge as well as planned clinical supervision sessions for all staff;
    - Maintenance of staffing levels with the utilisation of regular bank and agency workers and moving substantive staff across from other wards when possible to ensure continuity, quality and safety.

Longer term plan to eradicate the risks and address the staffing issues

19. Longer term plans to eradicate the risks and address staffing issues include:
    - Rolling recruitment including, open days, monthly interviews, attendance at local recruitment events/ job fairs;
    - Individual ward review of staffing levels shift by shift completed and submitted to commissioners;
    - Review of recruitment strategy to develop a proposal to implement a recruitment and retention premium for band 5 posts at St Luke's - Ward 3.
    - Scale up and roll out of the specialling/ enhanced care project across all community hospital wards commencing April 2016 by the end of July 2016.

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

20. There are two inpatient services within FYPC:
    - 15 bedded Adult Eating Disorder Service (Langley Ward)
    - 10 bedded Adolescent Unit (Coalville Hospital - Ward 3, formally Oakham House)

			Day (Early & Late Shift) Night		Day (Early & Late Shift) Night				
			Average % fill rate registered nurses	Average % fill rate care staff	Average % fill rate registered nurses	Average % fill rate care staff	Skill Mix Met based on 1:8 plus 60:40 split	Funded Staffing Levels Met by Shift	% Temporary Workers
Ward Group	Ward name	Average no. of Beds Occupied	>= 80%	>= 80%	>= 80%	>= 80%	>= 80%	>= 80%	<20%
Bennion Centre/ Langley	Langley	17	150.8%	117.5%	50.0%	440.0%	54.44%	95.6%	48.1%
Adolescent Psychiatric Unit	Ward 3 (formally Oakham House)	17	108.8%	158.8%	109.3%	113.0%	95.56%	92.2%	11.8%

Table 2 – Children's Inpatient Services Hot Spots

21. The Quality Network for Inpatient Child & Adolescent Mental Health Services (QNIC - CAMHS 2009) highlights that a typical unit with 10-12 patients should be staffed with a minimum of two registered nurses (RN) per day shift and one RN per night shift.

22. QNIC are an independent organisation who have developed a range of standards which specialist CAMHS Tier 4 inpatient units can be measured against to achieve accreditation. QNIC Standards are also used by NHS England.

23. The standards measure a range of factors including:
    - Environment and Facilities
    - Staffing and Training
    - Access, Admission and Discharge
    - Care and Treatment
    - Information, Consent and Confidentiality
    - Young People's Rights and Safeguarding

24. The Leicestershire Medicines Code specifies two RNs are required to administer medication to children at all times.

Glenfield Site - Langley Ward

25. Langley Ward is part of the Leicestershire Adult Eating Disorder Service and is one of the largest and most comprehensive such services in the UK. It has a reputation both nationally and internationally for the clinical work and service model, enhanced by the research department within the service. Langley Ward is a mixed-sex, inpatient ward providing specialist treatment for patients with severe and complex eating disorders. Almost all patients have a diagnosis of anorexia nervosa. The ward has 15 beds which are commissioned by NHS England. Almost all admissions are planned and most are elective. There are usually a small number of patients detained under the Mental Health Act.

26. Inpatients are referred from the outpatient arm of the service, other county partner Eating Disorder Services (Derbyshire, Nottinghamshire, Lincolnshire, Northamptonshire and Milton Keynes) and occasionally from local secondary or tertiary mental health services. Very occasionally, the service also takes referrals from other parts of the United Kingdom, usually due to a bed pressure in the referrer's locality.

27. The funded establishment of the ward allows for an approximate establishment of 4:4:2 (4 staff on an early shift, 4 staff on a late shift; 2 staff on a night shift).

28. Langley Ward is able to operate a safer staffing level of 5:5:3 with a minimum requirement for two registered nurses (RNs) to work on each day shift and one on a night shift. This is achieved because of the income generated by the ward and flexible use of bank workers.

29. The safer staffing dashboard for April 2016 highlights Langley Ward has several "hot spots" firstly in relation to the average fill rate of registered nurses on duty at night and the skill mix met, based on a 1:8 plus 60/40 split. This figure is representative of night duty where there is a reduced RN to Health Care Support Worker (HCSW) skill mix. Previously, Langley Ward were allocated the role of Fire Coordinator on a night shift and in respect of this required two RNs on duty every third week. The Fire Coordinator role is no longer allocated to Langley Ward on night duty and therefore the requirement for two RNs is not required. The unit has met the minimum requirement for one RN on a night shift at all times. Patient needs have been met and patient safety has been maintained with no immediate/ long term risks identified.

30. In addition Langley Ward has utilised additional HCSWs to meet the care needs of the patients and this is reflected in the dashboard in respect of the fill rates for HCSWs.

31. There is also clear correlation between high usage of temporary workers and the number of vacancies within this area.

32. In addition where patient acuity levels have increased, additional staff have been utilised to ensure patient needs have been met and safely maintained.

33. The increased figure for temporary workers also reflects the operation of a safer staffing level of 5:5:3 as opposed to the funded establishment of 4:4:2.

34. No safer staffing incidences relating to Langley Ward have occurred during April 2016.

35. Currently there are vacancies for 3.0 whole time equivalent (wte) RNs. Langley Ward is currently over-established with band 3 HCSWs.

36. Recruitment and retention has been an issue for the ward in the past 18-24 months, where historically this has not been the case. Probable reasons for this include:
    - A local and national shortage of qualified nurses – recent recruitment efforts support this reason as the service saw a reduced number of applications for the posts;
    - More choice for prospective and existing staff – in line with the above;
    - A stable but ageing workforce on Langley Ward resulting in several retirements within a short period of time;
    - A lack of nursing students on the ward for a period of more than a year due a potential conflict of professional interest – historically the ward has mostly recruited from student nurses expressing an interest in this area;
    - Possible lack of career progression for band 2 HCSWs staff – this was highlighted by the staff group at the Royal College visit.

37. The applicant previously recruited to a RN vacancy has now commenced employment. The latest round of RN recruitment has seen three nurses offered positions, two due to qualify in September 2016; the other has been recruited from elsewhere within LPT

38. In the most recent recruitment round for HCSW posts, three candidates were offered HCSW posts and all have accepted pending recruitment checks. Two have now commenced in post.

39. There are currently no members of nursing staff on long term sick leave on Langley Ward. Short term sickness is currently at a low level and is managed by the ward manager in conjunction with Human Resources (HR) via regular return to work meetings, ill health reviews and the setting of attendance targets where necessary.

40. Additional pressures previously reported on staffing for March 2016 included a requirement for ‘round the clock’ nursing input to a patient within University Hospitals of Leicester (UHL) awaiting admission to Langley Ward. This is in line with the joint MARSIPAN care pathway between UHL and the eating disorder service. This nursing input is currently paid for from the Langley Ward staffing budget. This has continued intermittently throughout April 2016 and again reflects the need for additional staff.

41. Additional recruitment within the wider Adult Eating Disorder service has seen an occupational therapist and a deputy ward manager from Langley Ward being recruited to other posts. This too will have an impact on the wider staffing of the ward. Further recruitment is to take place during May / June 2016.

The risks this presents us with

- Langley Ward remains underfunded and this poses the risk that the ward will not be able to meet the required safer staffing levels. This staffing risk could affect the successful delivery of the full programme of care; and affect the high levels of routine observations and patient support this specialist programme necessitates;
- The staffing situation will continue to pose a risk through March 2016, particularly covering the RN vacancies. Langley Ward is currently utilising regular bank nursing workers to undertake extra shifts to cover the RN vacancies;
- The risks associated with the increased reliance of temporary workers may impact upon the quality and effectiveness of patient care and also on patient and staff experience;
- There is an increased financial risk to the service and wider Trust as Langley Ward continues to fund nursing cover for patients at UHL.

Mitigating actions in place to prevent these risks

42. Immediate mitigating actions include:

- Commencing a further recruitment process to fill the existing vacancies;
- Continual monitoring of staffing levels on Langley Ward;
- Continued use of pool of regular bank workers who are familiar with the environment and can offer patients consistency in their specialist programme of care;
- Reviewing of patient experience feedback, incidents and risks to ensure quality of care is not impacted;
- Proactively identifying possible staff risks and ensuring subsequent actions are taken and escalated as appropriate;
- Ensuring any issues regarding meeting the expected number and mix of staff on duty are escalated to the Head of Service;
- Completing an incident form where safer staffing levels cannot be met - reflecting exactly what the staffing issue is, why this has occurred, what mitigation was in place to ensure patient safety, who it was escalated to and the outcome;
- Contract team to continue to pursue agreement with UHL regarding payment for specialist nursing input;
- Attendance at the May 2016 recruitment fair hosted by LPT.

Longer term plan to eradicate the risks and address the staffing issues

43. Longer term plans to eradicate the risks and address staffing issues include:

- Continuing to support a member of staff to undertake the Open University course leading to a nursing registration;
- Planning and regulating admissions to Langley Ward according to the staffing resource available;
- Continued review of monthly safer staffing data to ensure standards are maintained and can accommodate changes to the services and pathways;

- Individual ward review of staffing levels, including analysis of acuity and dependency, environmental factors, benchmarking against national recommendations where appropriate and professional judgement;
- Retention strategies to be identified and developed such as “in house” development programmes for staff and staff engagement sessions;
- Identify potential careers fairs to promote recruitment opportunities.

Coalville Hospital – Ward 3 (formally Oakham House)

44. Coalville Hospital - Ward 3 is a CAMHS 10 bedded inpatient ward based within the local community hospital at Coalville. The ward relocated to this site in March 2015. Coalville Hospital remains a temporary location whilst work continues to identify a permanent solution. Coalville Hospital - Ward 3 provides assessment, planning and treatment to adolescents aged from 11 years to 18 years presenting with acute and complex or suspected mental illness. This service is commissioned by NHS England. Admissions are also managed by NHS England in conjunction with the senior clinical team on Coalville Hospital - Ward 3, to ensure young people who present in mental health crisis and who require specialist inpatient admission are placed in the most appropriate inpatient unit where there is bed availability.

45. There is no current commissioned place of safety specifically for children in the area of Leicester, Leicestershire and Rutland. This places Coalville Hospital - Ward 3 in this position by default requiring the appropriate staffing to manage these acute, complex and unpredictable admissions. This has a domino effect on the planned work for Coalville Hospital - Ward 3 and furthermore makes planning the rotas with the appropriate skill mix complex. There is an expectation that Coalville Hospital - Ward 3 staff will provide support to University Hospitals of Leicester (UHL) when such patients present at Accident and Emergency (A&E). This is an area of work which is unpredictable in its nature.

46. The particular QNIC Service Standards (Seventh edition) 2013 used to ascertain staffing levels at Coalville Hospital - Ward 3 relate to:

- **Standard 2.1.1:** Where there are high dependency / high acuity cases (e.g. high levels of observation, use of seclusion, increased risk of violence or self-harm) there is a minimum ward staff to patient ratio of 1:1 to 3:1 for these most highly disturbed cases;
- **Standard 2.1.2:** Where young people are on general observation there is ward staff to patient ratio of 1:3.

47. Coalville Hospital – Ward 3 is funded to provide 11.47wte RNs and currently has 9.93wte RNs in post. Three RNs are designated to provide front line senior leadership to shifts.

48. Coalville Hospital – Ward 3 also has a Senior RN with a Registered Mental Health Nurse (RMN) qualification with the aim of providing visible leadership and clinical expertise. This post is supernumerary and is not funded as part of the establishment.

49. There is over staffing above these figures to provide staff to cover the emergency department and the Agnes Unit when admissions present and a bed is not available nationally. This overstaffing distorts the staffing ratio in relation to regular staff and bank

worker usage and reflects the increased number of temporary workers utilised within this area which can be seen as a “hot spot” on the dashboard

50. Coalville Hospital – Ward 3 has two vacant RN posts. These posts went out to advert with an interview date for the end of March 2016. Candidates offered an interview did not attend due to successful employment elsewhere, therefore these vacancies remained. Recruitment plans remain ongoing. There is currently one RN on maternity leave.

51. There were nil safer staffing incidents recorded for April 2016 and there were nil admissions to the Agnes Unit for April 2016.

52. The Team Manager who returned from secondment to Coalville Hospital - Ward 3 left the post in March 2016. A Senior Matron position 0.2 wte has been allocated to this area as a result of a change of structure within the services. This person will provide leadership and support to the Coalville Hospital - Ward 3 environment and nursing team.

53. A CAMHS Lead Matron has been appointed and will within their designated job role provide arm’s length leadership support to Coalville Hospital - Ward 3. The post holder has now commenced this role and there will be a requirement to monitor safer staffing levels.

54. The Lead Nurse for Mental Health has retired leaving a gap in this service line in relation to mental health knowledge. This affects both Langley Ward and Coalville Hospital - Ward 3. The lead nurse for Physical Health is supporting both areas. In addition, a Deputy Lead Nurse with a mental health focus has been recruited on a six month secondment, this post again will have a requirement to monitor safer staffing levels and provide support to both inpatient areas.

The risks this presents us with

- Possible admissions to the Agnes Unit pose a risk to the safer staffing levels at Coalville Hospital – Ward 3 due to the requirement to provide appropriate and effective staffing to two separate units;
- The unit does use an increased number of temporary workers; there are associated risks with temporary workers which may impact upon the quality and effectiveness of patient care as well as patient and staff experience.

Mitigating actions in place to prevent these risks

55. Immediate mitigating actions include:
- The CAMHS Lead Matron, Deputy Lead Nurse and Senior Matron continue to providing leadership support to the Ward Matron and nursing team at Coalville Hospital;
- Reviewing patient experience feedback, incidents and risks to ensure quality of care is not impacted;
- Proactively identifying possible staff risks and ensuring subsequent actions are taken/ escalated as appropriate;
- Escalating safer staffing issues as they arise to the team manager;

- Completion of an incident form where safer staffing levels cannot be met - reflecting exactly what the staffing issue is, why this has occurred, what mitigation was in place to ensure patient safety, who it was escalated to and the outcome;
- Utilising the Band 7 Ward Matron to support shifts clinically if required.

Longer term plan to eradicate the risks and address the staffing issues

56. Longer term plan to eradicate the risks and address the staffing issues include:
    - Consideration of the expansion of Coalville Hospital – Ward 4 to mitigate the risk of increased admissions;
    - Agreeing changes to the service with Commissioners to develop a Children and Adolescent Mental Health Service (CAMHS) Crisis Team. Three band 6 RNs have been recruited and the expectation is to recruit one band 7 RN post. These posts will form the basis of the new team. It is envisaged this team will reduce the number of emergency admissions and make the planning of staffing on Coalville Hospital – Ward 3 more predictable;
    - Individual ward review of staffing levels, including analysis of acuity and dependency, environmental factors, benchmarking against national recommendations where appropriate and professional judgement;
    - Retention strategies to be identified;
    - An "in house" development programme for staff and staff engagement sessions are being explored;
    - Identification of careers fairs to promote the recruitment opportunities;
    - The continued reviews of monthly safer staffing data to ensure standards are maintained and can accommodate changes to the service or pathways.

57. The Lead Nurse has now completed an overarching review of staffing across the FYPC wards, taking into account the emerging changes, clarifying the ongoing position and plans; and making explicit any reviewed agreements with service commissioners. This is being shared at the May 2016 Quality Assurance Committee (QAC).

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

Short Break Homes - The Gillivers, 3 Rubicon Close and 1 the Grange

			Day (Early & Late Shift)		Night				
			Average % fill rate registered nurses	Average % fill rate care staff	Average % fill rate registered nurses	Average % fill rate care staff	Skill Mix Met based on 1:8 plus 60:40 split	Funded Staffing Levels Met by Shift	% Temporary Workers
Ward Group	Ward name	Average no. of Beds Occupied	>= 80%	>= 80%	>= 80%	>= 80%	>= 80%	>= 80%	<20%
3 Rubicon Close	3 Rubicon Close	18	121.7%	190.0%	100.0%	120.0%	100.00%	96.7%	12.6%
Gillivers	Gillivers	17	85.0%	191.0%	83.3%	116.7%	83.33%	81.1%	16.7%
The Grange	The Grange	18	-	175.0%	-	203.4%	96.63%	98.9%	20.3%

Table 3 – Short Break Home Hot Spots

58. The Short Break Homes are meeting all thresholds for safer staffing based on the 1:5 ratio of registered nurses to patients in April 2016. The Gillivers and 3 Rubicon Close plan to have a registered nurse on duty to meet the 1:5 ratio, unless the patients' needs do not dictate this requirement. 1 The Grange does not always need a registered nurse

on duty. The band 3 Health Care Support Workers (HCSWs), have received additional training to meet the needs of the service users.

59. The Gillivers has met all of the shifts requiring registered nurses but has used 16.7% of temporary workers this is a reduction of 8.7% from March 2016 due to lower sickness. The Grange has used 20.3% a reduction of 8.7% since March 2016, again due to lower sickness levels. Some of the temporary workers used are substantive staff working bank shifts due to the complexity of patients in the home. This has maintained patient safety, but there is a need to train more bank workers to carry out a range of additional health care tasks; this is being developed with the bank team.

60. The Short Break Homes continue to be an outlier nationally in meeting the safer staffing standards. The rational for this is related to some of the homes not always requiring registered nurses on duty; this is dependent on patient needs.

Longer term plan to eradicate the risks and address the staffing issues

61. The review using adapted tools in the Mental Health Staffing Framework, developed by Health Education East Midlands and NHS England has suggested that for Rubicon Close and The Gillivers there is the appropriate staffing to meet patient needs, however non nursing duties are not included; therefore there is a need for extra provision in this area. Both homes have small amount of administrative support and housekeeping positions which would support nurse's time to be left to patient care, however these are in recruitment. As the complexity of patients physical health needs are increasing at The Gillivers the Team Manager and Practice Development Nurse have reviewed the skill mix and are looking at increasing the qualified nurse cover. The Local Authority Short Break Review has commenced again and this will affect the long term plans for the use of the homes.

Agnes Unit

			Day (Early & Late Shift)		Night				
			Average % fill rate registered nurses	Average % fill rate care staff	Average % fill rate registered nurses	Average % fill rate care staff	Skill Mix Met based on 1:8 plus 60:40 split	Funded Staffing Levels Met by Shift	% Temporary Workers
Ward Group	Ward name	Average no. of Beds Occupied	>= 80%	>= 80%	>= 80%	>= 80%	>= 80%	>= 80%	<20%
Agnes Unit	Agnes Unit	16	126.2%	605.3%	86.7%	428.3%	88.89%	96.7%	47.5%

Table 4 - Agnes Unit Hot Spots

62. The Agnes Unit's current staffing reflects the layout of the building and provides care in 4 pods each with 4 patients. Each pod has a RN overseeing safe patient care; however the ratio of registered nurses to HCSW is usually less than the 60:40 recommended.

63. In April 2016, the unit was compliant with all thresholds but did use 47.5% of bank workers to support 1.6 wte registered nurses vacancies, increased patient acuity and 10.3 wte HCSW vacancies. The Unit has had some patients with difficult challenging behaviour during April 2016 and there has been the need to increase staffing to manage some patient mix and safeguarding risk issues between patients.

The risks this presents us with

64. There is a local staffing risk for the Agnes Unit relating to staffing difficulties posed by registered nurses sickness/ vacancies and HCSW recruitment, which is being managed

by the AMH.LD Service. The vacant HCSW posts are in recruitment; although recent interviews identified few suitable candidates. Regular workers are used to support safer staffing and provide continuity of care. 4.3 wte Band 2 posts have been moved to increase the Band 5 budget to allow recruitment of 3 wte Band 5 nurses.

Low Secure Services

			Day (Early & Late Shift)		Night				
			Average % fill rate registered nurses	Average % fill rate care staff	Average % fill rate registered nurses	Average % fill rate care staff	Skill Mix Met based on 1:8 plus 60:40 split	Funded Staffing Levels Met by Shift	% Temporary Workers
Ward Group	Ward name	Average no. of Beds Occupied	>= 80%	>= 80%	>= 80%	>= 80%	>= 80%	>= 80%	<20%
Herschel Prins	HP Griffin	-	-	-	-	-	-	-	-
Herschel Prins	HP Phoenix	18	101.7%	207.5%	100.0%	198.3%	88.89%	100.0%	33.1%

Table 5 - Low Secure Service Hot Spots

65. Herschel Prins – Phoenix Ward has met the required thresholds for safer staffing in March 2016, although the ward did use 37.4% of bank workers to support vacancies and short term sickness. From mid-January 2016, Herschel Prins - Griffin Ward was closed for refurbishment and there has been increased night staffing for Herschel Prins - Phoenix to support with any patient incidents (1.0wte RN and 4.0wte HCSW).

66. Herschel Prins – Griffin Ward has been closed for refurbishment during March 2016 and eight staff were distributed to the Bradgate wards. Hershel Prins – Griffin ward is due to re-open in May 2016.

67. Hershel Prins - Phoenix Ward has met the required thresholds for safer staffing in April 2016, however the ward did use 33.1% of bank workers to support vacancies and short term sickness. From mid-January Hershel Prins - Griffin Ward was closed for refurbishment and there has been increased night staffing for Hershel Prins – Phoenix Ward to support with any patient incidents and environmental risks (one registered nurse and four HCSW).

Rehabilitation

			Day (Early & Late Shift)		Night				
			Average % fill rate registered nurses	Average % fill rate care staff	Average % fill rate registered nurses	Average % fill rate care staff	Skill Mix Met based on 1:8 plus 60:40 split	Funded Staffing Levels Met by Shift	% Temporary Workers
Ward Group	Ward name	Average no. of Beds Occupied	>= 80%	>= 80%	>= 80%	>= 80%	>= 80%	>= 80%	<20%
Mill Lodge	ML Bluebell	17	103.3%	200.0%	96.7%	100.0%	95.56%	14.4%	30.3%
Mill Lodge	ML Buttercup	18	110.0%	232.3%	96.7%	156.7%	95.56%	97.8%	10.8%
Stewart House	SH Skye Wing	15	128.3%	165.6%	193.3%	150.0%	93.33%	98.9%	42.3%
The Willows	Willows Unit	17	162.9%	232.6%	132.5%	259.2%	98.89%	98.9%	27.0%

Table 6 - Rehabilitation Hot Spots

68. The Willows Unit has met all thresholds for safer staffing in April 2016 despite some long and short term sickness across the four wards and a pregnant registered nurse on restricted duties, a registered nurse who has been suspended from duty and increased patient levels of observation on Maple Ward and Acacia Ward. The unit has used 27% of temporary workers to support safer staffing.

69. Mill Lodge – Bluebell Ward is a 'hotspot' for funded staffing levels met by shift. Additional HCSW's were used to support care and the nurses provided cover between Mill Lodge - Bluebell and Buttercup wards. The temporary workers use was 50.1% a reduction of 10.3% across the two wards to support a higher level of maternity leave/ pregnancy and short term staff sickness and 6.0 wte band 5 registered nurse vacancies, 6.2 wte band 2 and 1.0 wte Band 7 vacancy. Incident reporting has highlighted that due to sudden sickness and the deteriorating health of a patient towards end of life care, the unit has had to re-distribute staff to achieve adequate staffing. The Team Manager and Service Manager have reviewed staffing and are introducing the following to manage risks; regular booking of agency workers, active recruitment and using staff from other rehabilitation wards at Mill Lodge. The service is due to move from the site at Kegworth in Autumn 2016 and there are some planned bed reductions taking place prior to the move to facilitate safe transfer of patients and maintain adequate staffing levels.

70. Stewart House - Skye Ward has met the thresholds for safer staffing but has utilised 42.3% of temporary workers due to four registered nurse vacancies that are in the recruitment process and short term sickness.

The risks this presents us with

71. The Lead Nurse and Service Manager have reviewed the increase in patients at Stewart House with the staffing and identified a risk of not meeting safer staffing requirements until the relocation of Mill Lodge to Stewart House is completed as Stewart House has increased its bed numbers to 30. A risk assessment has been completed by the Service Manager and the safer staffing toolkit has been used to assess staffing; recruitment to nursing posts in April 2016 was successful and four staff are in the recruitment process. Mill Lodge staffing is reviewed by the Team Manager each week and redeployment of staff from other rehabilitation areas takes place to meet sudden staffing issues.

Bradgate Unit

			Day (Early & Late Shift)		Night				
			Average % fill rate registered nurses	Average % fill rate care staff	Average % fill rate registered nurses	Average % fill rate care staff	Skill Mix Met based on 1:8 plus 60:40 split	Funded Staffing Levels Met by Shift	% Temporary Workers
Ward Group	Ward name	Average no. of Beds Occupied	>= 80%	>= 80%	>= 80%	>= 80%	>= 80%	>= 80%	<20%
Bradgate MHU	Ashby	18	94.4%	175.8%	90.0%	376.7%	74.44%	97.8%	49.3%
Bradgate MHU	Aston	15	94.4%	152.5%	96.7%	240.0%	78.89%	95.6%	36.9%
Bradgate MHU	Beaumont	16	89.4%	191.7%	98.3%	263.3%	67.78%	100.0%	31.2%
Belvoir ICU	Belvoir Unit	18	113.3%	343.8%	113.3%	408.3%	100.00%	100.0%	42.2%
Bradgate MHU	Bosworth	16	82.2%	144.2%	91.7%	176.7%	52.22%	97.8%	21.0%
Bradgate MHU	Heather	17	87.8%	152.5%	96.7%	206.7%	73.33%	98.9%	32.1%
Bradgate MHU	Thornton	14	85.6%	136.7%	96.6%	262.1%	67.42%	93.3%	18.2%
Bradgate MHU	Watermead	15	74.4%	215.8%	96.7%	343.3%	45.56%	98.9%	42.2%

Table 7 - Bradgate Unit Hot Spots

72. The Bradgate Unit is made up of eight wards – Ashby, Aston, Beaumont, Bosworth, Heather, Thornton, Watermead and Belvoir Ward – Psychiatric Intensive Care Unit (PICU).

73. The Bradgate Unit Wards continue to utilise high numbers of temporary workers to support patient acuity, registered nurse vacancies, sickness absence and maternity cover.

74. There are 116. 76 wte Band 6 and 5 registered nurses available to work at the unit each month; the band 6 nurses are also part of a co-ordinator rota and are therefore not always available within the ward numbers. A new Duty Manager post will be in place in May 2016 which will release the band 6 nurses back to the wards. At the end of April 2016 there were 30.24 wte registered nurse vacancies and nine RN's were on maternity leave or long term sick. These numbers do not include those nurses at work but cannot work within the numbers due to pregnancy, health issues or investigation or on career break. As at 31st April 2016 this was three nurses. Out of 116.76 wte registered nurses available to work during March 2016 there were 42.24 wte not available due to vacancies, long term sickness, maternity leave, career breaks or other reasons. This is an increase of 4.72 wte nurses from last month. There are also 9.84 wte HCSW vacancies across the eight wards. All wards used bank workers to support vacancies, sickness and patient acuity for level 1 observation.

75. All new appointments to posts for qualified nurses require preceptorship and the current preceptees are coming to the end of this period.

76. Bradgate Unit - Belvoir Ward was the only area to meet the 1:8 and 60:40 skill mix threshold but Belvoir Ward did use 42.2% of bank workers to support sickness and vacancies. This is a reduction of 11.6% from last month.

77. All Bradgate wards apart from Watermead have identified challenges in meeting the fill rate for registered nurses on day shifts. This was due to the number of vacancies and ability to get the required cover for all shifts, but all wards met the fill rate for RNs on night shifts. All Bradgate wards other than Belvoir Ward struggled to meet the 1:8, 60/40 skill mix. This will have been affected by the night staffing expected numbers of night not always being two registered nurses on night duty and three on day shifts.

The risks this presents us with

78. There is a risk that inappropriate staffing levels could lead to the ability of staff to support patients to have leave, maintain good standards of care, ensure continuity of care, facilitate good documentation and allow for staff training and supervision to take place.

79. Types of staffing challenges include:
    - Newly qualified nurses employed on each ward;
    - Below RN numbers to meet a 1:8 RN to patient ratio;
    - Below RN numbers to meet a 60:40 RN to HCSW ratio;
    - High usage of temporary workers.

80. **Management and Risk Mitigation Strategies in place during April 2016**

    a) The Senior Matrons and Team Manager meet every Monday and Thursday morning with Ward Matrons to review the staffing rotas on all wards and ensure that all day and night duty staffing is coordinated and early requests for cover can be made to Central Staffing Solutions (bank service). Staffing issues are discussed at the Bed Management Meetings to review the bed demand and patient acuity alongside staffing

to determine if the Bradgate Unit is offering safe and effective care. Any concerns identified are escalated to the Service SMT to consider contingency plans;

b) The Bradgate Unit has been divided into two ends for the management of night duty safer staffing if the required numbers of qualified nurses cannot be met following bank requests and consideration of agency worker use. Aston, Thornton and Bosworth end of the unit consists of three wards with a total of 61 beds and should have six qualified staff per night; the minimum proposal is four per night, with the allocated ward for that week having two experienced nurses on duty.
Ashby, Heather, Beaumont and Watermead have 80 beds at this end of the unit and they should have eight qualified per night, the minimum proposal for this end is five per night, with the allocated ward for that week having two experienced nurses on duty. The wards not allocated to having two experienced staff on duty still try to achieve the two qualified per night and this could be met by an experienced staff member with a preceptorship nurse on duty. The unit has one additional HCSW at night who are the 'unit floater', it is proposed that each end of the unit has one HCSW that is a floater and allocated to wards on a rostered basis. These two staff will support when wards have patients requiring escorts to other hospitals for example Accident and Emergency (A&E), increased levels 1 observations agreed during the night, seclusion observation, response teams and increased activity or patient acuity issues;

c) The unit co-ordinator is a band 6 Deputy Matron who is not included in ward staffing numbers. From May 2016 there will be permanent Duty Managers in place to cover inpatient areas in the adult mental health service and the band 6 deputies will be part of the ward rota at all times. This will improve the numbers of experienced staff available for the rota;

d) All issues regarding meeting the expected number and mix of staff on duty should be escalated to the Team Manager/ On Call Manager and where staffing cannot be met as required an incident form should be completed to allow further monitoring. The Team Manager/ On Call Manager will discuss with ward staff patient acuity and safety across the unit and where required authorise the use of agency staff, in accordance with the escalation process for approval. Matrons have been asked to discuss the information required for a detailed incident form that reflects the exact staffing issue, why this occurred, what mitigation was put in place to ensure patient safety and who this was escalated too and the outcome;

e) The Service has a rolling advertisement registered nursing staff; however interest has been low, particularly from experienced staff. Recruitment has been advertised on social media and the service has attended several careers fairs. This is being explored further in the Service Recruitment and Retention Sub Group and the 'Golden Hello' (£200 incentive to join the Trust) has been offered on the current recruitment adverts. HR are supporting staff with robust sickness absence management;

f) Due to the temporary closure of Hershel Prins - Griffin Ward, an additional eight staff have been released to support the Bradgate Unit Wards for six months;

g) Block booking bank/ agency workers to specific wards;

h) Service Managers review internal moves and vacancies to renegotiate start dates for staff transferring to the vacancies in community/ crisis/ other posts;

i) Band 7 Ward Matrons and Senior Matrons to support shifts clinically when required;

j) In April 2016, a workshop took place with Matrons to explore other roles on the wards – Secretaries for Matrons, Developmental Band 6 posts, Assistant Practitioner roles, and increased numbers of Psychological therapists were all identified. A paper will be sent to the AMH/LD Divisional Assurance Group and Finance and Performance Committee in May 2016 to agree the plans; this will involve changes to some nursing posts.

81. **Further safer monitoring in the Service –** At the end of January 2016, the nurse staffing has started to be monitored within the Prison Services, Crisis and Community Services. These were refined further in March 2016 and enable refined risk management and staffing escalation when required. A review of the staffing issues in the AMH Community Service Development Initiative (SDI) has taken place and this will be monitored during the new ways of working projects.

Conclusion

82. The Trust continues to demonstrate compliance with the NQB expectations and associated deadlines. The safer staffing data is being regularly monitored and scrutinised for completeness and performance by the Chief Nurse and reported to NHS England via mandatory Unify2 national returns on a site-by-site basis.

83. Where there are variances in safer staffing standards, the lead nurses have oversight of the plans in place to mitigate risks for each ward to ensure safe care standards are maintained.

Appendix A – Safer Staffing Dashboard for April 2016

			Fill Rate Analysis (National Unify2 Return)				Skill Mix Met	Funded Staffing Levels Met by Shift	% Temporary Workers
			Actual Hours Worked divided by Planned Hours						
			Day (Early & Late Shift)		Night		(based on 1:8 plus 60:40 split)		
Ward Group	Ward name	Average no. of Occupied Beds	Average % fill rate registered nurses	Average % fill rate care staff	Average % fill rate registered nurses	Average % fill rate care staff			
			>= 80%	>= 80%	>= 80%	>= 80%	>= 80%	>= 80%	<20%
Bradgate MHU	Ashby	18	94.4%	175.8%	90.0%	376.7%	74.44%	97.8%	49.3%
Bradgate MHU	Aston	15	94.4%	152.5%	96.7%	240.0%	78.89%	95.6%	36.9%
Bradgate MHU	Beaumont	16	89.4%	191.7%	98.3%	263.3%	67.78%	100.0%	31.2%
Belvoir ICU	Belvoir Unit	18	113.3%	343.8%	113.3%	408.3%	100.00%	100.0%	42.2%
Bradgate MHU	Bosworth	16	82.2%	144.2%	91.7%	176.7%	52.22%	97.8%	21.0%
Bradgate MHU	Heather	17	87.8%	152.5%	96.7%	206.7%	73.33%	98.9%	32.1%
Bradgate MHU	Thornton	14	85.6%	136.7%	96.6%	262.1%	67.42%	93.3%	18.2%
Bradgate MHU	Watermead	15	74.4%	215.8%	96.7%	343.3%	45.56%	98.9%	42.2%
Herschel Prins	HP Griffin	-	-	-	-	-	-	-	-
Herschel Prins	HP Phoenix	18	101.7%	207.5%	100.0%	198.3%	88.89%	100.0%	33.1%
Mill Lodge	ML Bluebell	17	103.3%	200.0%	96.7%	100.0%	95.56%	14.4%	30.3%
Mill Lodge	ML Buttercup	18	110.0%	232.3%	96.7%	156.7%	95.56%	97.8%	10.8%
Stewart House	SH Skye Wing	15	128.3%	165.6%	193.3%	150.0%	93.33%	98.9%	42.3%
The Willows	Willows Unit	17	162.9%	232.6%	132.5%	259.2%	98.89%	98.9%	27.0%
Bennion Centre/ Langley	BC Kirby	17	81.3%	182.8%	100.0%	110.0%	63.33%	92.2%	8.5%
Bennion Centre/ Langley	BC Welford	16	87.3%	190.8%	95.0%	148.3%	73.33%	95.6%	22.1%
Evington Centre	CB Beechwood	16	97.3%	223.6%	98.3%	141.7%	78.89%	92.2%	25.1%
Evington Centre	CB Clarendon	16	102.0%	185.8%	100.0%	106.7%	86.67%	88.9%	17.5%
Evington Centre	EC Coleman	15	109.2%	306.0%	95.0%	258.3%	95.56%	98.9%	40.2%
Evington Centre	EC Gwendolen	-	-	-	-	-	-	-	-
Evington Centre	EC Wakerley	13	98.3%	210.1%	91.7%	180.0%	92.22%	91.1%	33.2%
Fielding Palmer Hospital	FP General	17	110.8%	95.6%	100.0%	-	93.33%	96.7%	11.8%
Melton Mowbray Hospital	MM Dalgleish	11	99.2%	121.1%	96.7%	110.0%	95.56%	93.3%	12.0%
Rutland Hospital	Rutland	15	100.0%	117.4%	100.0%	110.0%	88.89%	50.0%	13.1%
St Luke's	SL Ward 1 Stroke	18	98.3%	167.5%	100.0%	100.0%	95.56%	38.9%	15.7%
St Luke's	SL Ward 3	15	96.7%	97.5%	200.0%	100.0%	94.44%	96.7%	42.1%
Coalville Hospital	CV Ellistown 2	17	132.5%	189.2%	196.7%	141.7%	97.78%	90.0%	17.0%
Coalville Hospital	CV Snibston 1	17	129.2%	220.8%	98.3%	98.3%	97.78%	81.1%	2.6%
Hinckley & Bosworth Hospital	HB East Ward	16	85.6%	195.8%	96.7%	98.3%	72.22%	85.6%	15.0%
Hinckley & Bosworth Hospital	HB North Ward	15	98.3%	163.1%	100.0%	100.0%	97.78%	94.4%	16.0%
Loughborough Hospital	Lough Swithland	17	100.0%	204.2%	100.0%	200.0%	100.00%	100.0%	13.4%
Bennion Centre/ Langley	Langley	17	150.8%	117.5%	50.0%	440.0%	54.44%	95.6%	48.1%
Adolescent Psychiatric Unit	Ward 3 (formally Oakham House)	17	108.8%	158.8%	109.3%	113.0%	95.56%	92.2%	11.8%
3 Rubicon Close	3 Rubicon Close	18	121.7%	190.0%	100.0%	120.0%	100.00%	96.7%	12.6%
Agnes Unit	Agnes Unit	16	126.2%	605.3%	86.7%	428.3%	88.89%	96.7%	47.5%
Gillivers	Gillivers	17	85.0%	191.0%	83.3%	116.7%	83.33%	81.1%	16.7%
The Grange	The Grange	18	-	175.0%	-	203.4%	96.63%	98.9%	20.3%

Annex 1 – Definition of Safer Staffing Measures

1. Temporary Workers

These workers are non-substantive and hold either a bank contract with the Trust or are resourced via a 3rd party recruitment agency

2. Safer Staffing Level Performance

The Trust has identified 3 methodologies for measuring safer staffing level performance across our inpatient units.

Methodology	Measure	Measure Source
Fill Rate Analysis (National Unify2 Return)	Actual hours worked divided by Planned hours (split by RN/ HCSW)	NHS TDA (Trust Development Authority)
Skill Mix Met	Proportion of shirts where the following was met: 1:8 RN to patient ratio plus 60:40 skill mix ratio of RN to HCSWs	RCN (Royal College of Nursing) guidelines
Funded Staffing Levels Met by Shift	No. of shifts where funded staff numbers were met divided by Total number of shifts	LPT Quality Improvement Programme Board (QIP)

2.1. Fill Rate Analysis (National Unify2 Return)

The Trust is required by the TDA to publish our inpatient staffing levels on the NHS Choices website via a national Unify2 return. This return requires us to identify the number of hours we plan to utilise with nursing staff and the number of hours actually worked during each month. This information allows us to calculate a 'fill rate' which can be benchmarked nationally against other trusts with inpatient provisions.

This methodology takes into account skill mix and bed occupancy which allow us to amend our 'Planned Staff Hours' based on the needs of the ward and is the most reflective measure of staffing on our inpatient wards.

'Planned Staff Hours' are calculated using the RCN guidance of 1:8 RN to patient ratio. 1 RN is equal to 7.5 hours of planned work.

The 'Fill Rate' is calculated by dividing the 'Planned Staff Hours' by the 'Actual Worked Staff Hours'.

The fill rate will show in excess of 100% where shifts have utilised more staff than planned or where patient acuity was high and necessitated additional staff.

2.2. Skill Mix Met

A 'Skill Mix Met' calculation has been used to identify whether the appropriate registered nursing (RN) to Health Care Support Worker (HCSW) ratio was in place on each shift.

We currently have 2 measures of 'planned skill mix' staffing:

a) Funded establishment by staff type
   and;
b) RCN guidelines of 1:8 RN to patient ratio plus a 60:40 skill mix ratio of RNs to HCSWs

For the 'Skill Mix Met' calculation, the Trust has chosen to use the measure which results in the lowest staffing levels on a shift by shift basis as this will best account for both our funded establishment and where beds are not being used for patient care.

2.3. Funded Staffing Levels Met by Shift

'Funded Staffing Levels Met' is based on the funded headcount and does not reflect the level of bed occupancy or changes in acuity in any of the inpatient environments. It also does not account for skill mix between RNs and HCSWs.

The 'Funded Staffing Levels Met' is calculated by dividing the total number of shifts where the funded staffing level was achieved by the total number of shifts worked.

Annex 2 – Planned Staffing Levels

The table below shows the planned staffing levels (headcount) by skill mix and shift type.

				Registered Nurse (RN)			Health Care Support Worker (HCSW)		
Group	Ward	Ward Specialty (based on Unify2 categories)	Ave. no. of Available Beds*	Early	Late	Night	Early	Late	Night
AMH Bradgate	Ashby	ADULT MENTAL ILLNESS	19	3	3	2	2	2	1
	Aston	ADULT MENTAL ILLNESS	21	3	3	2	2	2	1
	Beaumont	ADULT MENTAL ILLNESS	22	3	3	2	2	2	1
	Belvoir Unit	PICU	10	2	2	1	3	3	3
	Bosworth	ADULT MENTAL ILLNESS	20	3	3	2	2	2	1
	Heather	ADULT MENTAL ILLNESS	18	3	3	2	2	2	1
	Thornton	ADULT MENTAL ILLNESS	23	3	3	2	2	2	1
	Watermead	ADULT MENTAL ILLNESS	19	3	3	2	2	2	1
AMH Other	HP Griffin	FORENSIC PSYCHIATRY	-	2	2	1	2	2	2
	HP Phoenix	FORENSIC PSYCHIATRY	12	2	2	1	3	3	2
	ML Bluebell	ADULT MENTAL ILLNESS	8	1	1	1	3	3	2
	ML Buttercup	ADULT MENTAL ILLNESS	8	1	1	1	2	2	1
	SH Skye Wing	REHABILITATION	29	2	2	1	4	4	2
	Willows Unit	ADULT MENTAL ILLNESS	37	4	4	4	8	8	8
CHS City	BC Kirby	OLD AGE PSYCHIATRY	23	3	2	2	3	3	2
	BC Welford	OLD AGE PSYCHIATRY	22	3	2	2	3	3	2
	CB Beechwood	COMMUNITY CARE	16	3	2	2	4	3	2
	CB Clarendon	COMMUNITY CARE	21	3	2	2	4	3	2
	EC Coleman	OLD AGE PSYCHIATRY	20	2	2	2	3	3	2
	EC Gwendolen	OLD AGE PSYCHIATRY	-	2	2	2	3	3	2
	EC Wakerley	OLD AGE PSYCHIATRY	20	2	2	2	5	4	2
CHS East	FP General	REHABILITATION	12	2	2	2	2	1	0
	MM Dalgleish	REHABILITATION	13	2	2	2	3	2	1
	Rutland	REHABILITATION	12	2	2	2	4	3	1
	SL Ward 1 Stroke	REHABILITATION	15	3	2	2	5	4	2
	SL Ward 3	REHABILITATION	13	2	2	1	2	2	1
CHS West	CV Ellistown 2	REHABILITATION	23	2	2	1	5	2	2
	CV Snibston 1	REHABILITATION	22	2	2	2	6	4	2
	HB East Ward	REHABILITATION	22	3	3	2	4	3	2
	HB North Ward	REHABILITATION	13	2	2	2	4	2	2
	Lough Swithland	REHABILITATION	22	2	2	2	4	2	1
FYPC	Langley	CHILD & ADOLESCENT PSYCHIATRY	13	3	3	2	2	2	1
	CV Ward 3 (formally Oakham House)	CHILD & ADOLESCENT PSYCHIATRY	8 (plus 2 cost per case)**	2	2	2	3	3	2
LD	3 Rubicon Close	LEARNING DISABILITY	3	1	1	1	2	2	1
	Agnes Unit	LEARNING DISABILITY	11	3	3	2	8	8	4
	The Gillivers	LEARNING DISABILITY	3	1	1	1	2	2	1
	The Grange	LEARNING DISABILITY	2	0	0	0	2	2	2

*The number of available beds can fluctuate dependant on the ward situation and is shown as an average in the month

** The number of beds has been confirmed by the service as accurate

Leicestershire Partnership NHS
NHS Trust

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TRUST BOARD – 27th May 2016

Introduction/Background

Following the Care Quality Commission (CQC) comprehensive inspection in March 2015 the Trust has responded to both the initial concerns raised shortly after the inspection, as well as the comprehensive inspection reports published in July 2015 with a range of improvement measures collated as formal action plans

Aim

This paper provides an overview of the progress made to date in addressing the CQC 'Requirement Actions' as well as describing systems in place for governance of those actions.

Recommendations

The Board is requested to:

- Receive the update provided

Discussion

The CQC Comprehensive Inspection commenced on 9th March 2015, followed by initial verbal feedback on Friday 13th March 2015.
The CQC published 16 Core Service Reports, plus the overall provider-level report on Friday July 10th 2015.

Overall Compass has received and accepted evidence of completion for 27 actions (Blue), 30 actions remain on track for completion with an additional 22 rated as potentially slipping their target date with assurance that a robust remedial plan is in place to deliver (amber). One action is now rated as having missed their target date (Red), this is described in detail overleaf.

RAG Colour	No. RAG Actions THIS Month (May 2016)	Movement from last month	April RAG	March RAG	Feb RAG	Jan RAG	Dec RAG	Nov RAG
Red	1	0	1	1	5	1	1	4
Amber	22	-1	23	25	20	26	22	12
Green	30	-3	33	35	44	44	53	61
Blue	27	4	23	19	11	9	4	3
	80							

Red Action exception report

Overarching Reference Code	Provider Report 'Requirement action'	Action Reference	Core Service Report	Core Service 'Requirement Action'	Comments/ Remedial Actions	RAG Rating
16	The Trust must review its systems for ensuring staff receive adequate supervision, training and appraisals	16.3	End of Life Care	The Trust must ensure that mandatory training includes Duty of Candour and end of life care training for Advanced Nurse Practitioners	Revised DNACPR policy under development via Patietn Safety Group, anticipated in April 2016, expected to be ratified at May QAC	

Further action, mitigation and risk

End of Life care still has one red action. The outstanding item relates to the formalisation of protocol through a Trust wide all-age End of Life Policy.

Conclusions

This paper provides assurance that systems and processes are in place to respond to the CQC Inspection of March 2015. The establishment of a task and finish group to internally govern this process will provide QAC with assurance via a monthly highlight report.

Appended for reference: CQC Comprehensive Action Plan

Leicestershire Partnership NHS
NHS Trust

CQC ACTION PLAN - In response to the CQC Comprehensive inspection of LPT services

Summary Position and Progress

RAG Colour	No. RAG Actions THIS Month (May 2016)	Movement from last month	April RAG	March RAG	February RAG	January RAG	December RAG	November RAG
Red	1	0	1	1	5	1	1	4
Amber	22	-1	23	25	20	26	22	12
Green	30	-3	33	35	44	44	53	61
Blue	27	4	23	19	11	9	4	3
	80							

Leicestershire Partnership NHS Trust

TRUST WIDE CQC ACTION PLAN

CQC ACTION PLAN - In response to the CQC Comprehensive inspection of LPT services

Overarching Reference Code	Provider Report 'Requirement action'	Action Reference	Core Service Report	Core Service 'Requirement Action'	Please describe clearly the high level actions you are going to take to meet the regulation supported by what intend to achieve	Executive oversight will be provided by;	Manager responsible for delivering the action?	What will evidence that the action has been implemented?	Insert the date the action AND evidence will be provided	Comments/ Remedial Actions	RAG Rating	Expected Divisional Governance (earliest)	Expected Corporate Governance (earliest)	Corporate Governance Group	Expected CompAss (earliest)
PROVIDER LEVEL REPORT															
1	The Trust must ensure that medicines prescribed to patients who use the service are stored, administered, recorded and disposed of safely	1.1	Provider Level Report	OVERARCHING TRUSTWIDE ACTION	a.) We will investigate electronic solutions for the monitoring of fridge and clinic room temperatures in clinical areas to ensure that any instances of storage outside of required temperature ranges is highlighted b.) Any such breaches will be treated as reportable incidents and medications involved quarantined c.) Appropriate heating/cooling systems will be introduced in any areas with persistent breaches d.) The Trust will review the Rapid Tranquillisation Policy to make reference to oral medication used in this way and in particular any monitoring that needs to be carried out after the administration of such medicines	Medical Director	Head of Pharmacy	Electronic solution in place and appropriately monitored Revised Policy in place	31st December 2015 31st October 2015			n/a	**Feb-16**	**Medication Risk Reduction**	**Mar-16**
		1.2	Long Stay/Rehabilitation Mental Health Wards for Working Age Adults	The Trust must demonstrate that they have effective systems in place for safe management of medication	a.) We will scope converting a MHN post into a RGN post within the rehab wards to drive the physical health strategy to incorporate all AMH inpatient areas b.) We will progress CQUIN 9a (Cardio metabolic assessment for patients with psychosis) across all AMH inpatient areas	Director of Service AMH/LD	Head of Service Inpatient, Crisis and Liaison	Results of the scoping report, identifying decision made or alternative strategy if not agreed	a.) 31st October 2015 b.) 31st October 2015			Nov-15			
		1.3	Substance Misuse Services	The Trust must review its systems for storing records, including the management of prescriptions and controlled stationery	a.)We will ensure records including prescriptions are stored in lockable receptacles when the room is not in use (e.g. evening, weekends etc.) b.) We will produce documentation to record the monitoring of the systems and processes that have been put in place c.)We will monitor staff adherence to the Standard Operating Procedure that has been developed and implemented following a review of systems in the service to describe the procedures required to manage the safe storage of prescriptions including completed and blank prescriptions.	Director of Service FYPC	Family Services Manager, Health & Wellbeing	a.) Records including completed prescriptions are stored in lockable receptacles. Completed prescriptions are stored in a lockable receptacle. Blank prescriptions are stored in in a separate lockable receptacle. b.) Processes in place to carry spot checks that receptacles are locked at times when the room is not in use. Processes are in place for the monitoring of blank prescriptions on a weekly basis as well as through spot checks. c.) process of monitoring staff adherence to the SOPs agreed and documentation available that staff have understood the their responsibilities within the processes regarding prescription management as per the SOP.	a.)Independent confirmation that records and prescriptions are stored in locked receptacles by 31st August 2015 Documentation will be available to document the weekly monitoring processes and the spot checks by 31st August 2015 Audit programme agreed by 30th September 2015			Oct-15			
		1.4	Long Stay/Rehabilitation Mental Health Wards for Working Age Adults	The Trust must improve the recording and storing of T2 and T3 documents	a.) We will review the current process for T2 and T3 document recording and storing process to find a sustained and more effective solution.	Director of Service AMH/LD	Head of Service Inpatient, Crisis and Liaison	a.) Written report and recommendations MHA weekly/ monthly audits	30th September 2015			Oct-15			
		1.5	Mental Health Crisis Services and Health-Based Places of Safety	The Trust must protect people who use the service against the risks associated with the unsafe management of medicines	a.) We will install a medication storage thermometer and implement daily checks regarding temperature recording, expiration date checking and signing in and out process	Director of Service AMH/LD	Head of Service Inpatient, Crisis and Liaison	a.) Process flow chart and evidence of thermometer installation	31st August 2015			Sep-15			
		1.6	Acute Wards for Adults of Working Age and Psychiatric Intensive Care Units	The Trust must ensure appropriate arrangements are in place for the safe keeping of medicines	a.) We will implement robust and consistent daily checks regarding temperature recording, expiration date checking and signing in and out process and a clear escalation-process	Director of Service AMH/LD	Head of Service Inpatient, Crisis and Liaison	a.) Process flow chart and revised logging form to evidence action taken	31st August 2015			Sep-15			

CQC ACTION PLAN - In response to the CQC Comprehensive inspection of LPT services															
Overarching Reference Code	**Provider Report 'Requirement action'**	**Action Reference**	**Core Service Report**	**Core Service 'Requirement Action'**	**Please describe clearly the high level actions you are going to take to meet the regulation supported by what intend to achieve**	**Executive oversight will be provided by;**	**Manager responsible for delivering the action?**	**What will evidence that the action has been implemented?**	**Insert the date the action AND evidence will be provided**	**Comments/ Remedial Actions**	**RAG Rating**	**Expected Divisional Governance (earliest)**	**Expected Corporate Governance (earliest)**	**Corporate Governance Group**	**Expected CompAss (earliest)**
2	The Trust must ensure that the use of syringes and needles meet the Health and Safety Executive regulations	2.1	Provider Level Report	OVERARCHING TRUSTWIDE ACTION	a.) We will continue to review and trial safer products as they are manufactured and benchmark with other healthcare organisations on trials already carried out. b.) We will continue to address the risks involving the use or disposal of sharps. c.) We will continue our staff communication and awareness raising waste road shows (already held 17th & 20th of July, with further road shows planned for October 2015). d.) We will continue to work with the CCG's to promote good practice within Primary Care with the GP's encouraging the prescribing of known safer devices for the administration of insulin.	Director of HR/OD	Head of Health and Safety	a.) b.) c.) and d.) The Safer Sharps Group will review and escalate risk to the Health and Safety Committee and the Infection, Prevention Control Committee.	a.) b.) c.) and d.) - work already commenced and will form a perpetual review as new devices become available through medical devices market	To enhance the work of the Safer Sharps group:- pharmacy are reviewing the known safer sharps already in use and undertaking a piece of work to identify if there are other medications that can be administered via a safer sharps; we are working with the CCG's and GPs to find a unified resolution for the provision of safer sharps in the community for the administration of insulin; we have introduced a sharps bin that incorporates a needle remover within the bin lid to support staff with the safer disposal of sharps that do not currently have a safer sharps alternative; AMH are trialling a safer sharps for the administration of insulin & depot; FYPCS are trialling a safer sharps for finger pricks; CHS DN's are trialling a safer sharps for the administration of insulin		n/a	Mar-16	Health & Safety	**Apr-16**
		2.2	Acute Wards for Adults of Working Age and Psychiatric Intensive Care Units	The Trust must review the use of current sharps(for example, needles) in light of Health and Safety Executive regulations	We will review use of -Safer sharps across AMH inpatient areas with support from Lead Nurse/Senior Matrons/Practice Development Nurse, Infection , Prevention and Control and pharmacy	Director of Service AMH/LD	Head of Nursing AMH/LD	Report submitted to Divisional Infection, Prevention and Control Group and Divisional Assurance Group highlighting findings regarding current practice and implementation plan to make necessary changes to practice.	31st October 2015	Directorate part of Trust wide pilot due to be completed in December 2015		Jan-16			
3	The Trust must ensure that action is taken so that the environment does not increase the risks to patients' safety	3.1	Provider Level Report	OVERARCHING TRUSTWIDE ACTION	a) We will continue to escalate building safety concerns to Trust's Head of Health and Safety. b) We will utilise available information, including the annual Patient Led Assessment of the Care Environment (PLACE) inspection, to drive our estates programme for the building fabric and its condition.	Director of Finance, Business & Estates	Associate Director Estates and Facilities	a.) Interserve escalation logs b.) Annual PLACE report is discussed at Board level together with supporting Action Plan. Minuted monthly QAC and Health and Safety Meetings (bi-monthly). Additionally Statutory Compliance regime (incl electrical and water safety systems) and the Backlog Maintenance regimes are monitored at both the Contract Management Panel (with Interserve in attendance) and Finance & Performance Committee.	a.) Complete b.) PLACE update reports to QAC by 31st December 2015	awaiting confirmation of evidence from H&S Committee		n/a	Mar-16	Health & Safety	**Apr-16**
		3.2	Acute Wards for Adults of Working Age and Psychiatric Intensive Care Units	The Trust must review governance systems relating to the buildings management and maintenance	a) We will continue to escalate building safety concerns to Trust's Head of Health and Safety. b) We will utilise available information, including the annual Patient Led Assessment of the Care Environment (PLACE) inspection, to drive our estates programme for the building fabric and its condition. c) AMH /LD – We will set up fortnightly progress meetings for AMH inpatient areas with estates and facilities input	Director of Finance, Business & Estates	Associate Director Estates and Facilities	a.) Interserve escalation logs b.)Annual PLACE report is discussed at Board level together with supporting Action Plan. Minuted monthly QAC and Health and Safety Meetings (bi-monthly). Additionally Statutory Compliance regime (incl electrical and water safety systems) and the Backlog Maintenance regimes are monitored at both the Contract Management Panel (with Interserve in attendance) and Finance & Performance Committee. c.) AMH/LD - Notes from meeting	a.) Complete b.) PLACE update reports to QAC by 31st December 2015 c.) 31st August 2015			Jan-16			
4	The Trust must ensure that action is taken to remove identified ligature risks and to mitigate where there are poor lines of sight	4.1	Provider Level Report	OVERARCHING TRUSTWIDE ACTION	a.) Works planning meeting will be arranged with full works plan to be agreed by November 2015	Director of Service AMH/LD	Head of Service Inpatient, Crisis and Liaison	a.) Notes from meeting, dates of 6 monthly reviews, evidence of patient to bed risk assessments	a.) 30th November 2015			n/a		Patient Safety	**April**
		4.2	Forensic Inpatient/Secure Wards	The Trust must remove ligature risks from the wards	a.) Works planning meeting will be arranged with full works plan to be agreed by November 2015	Director of Service AMH/LD	Head of Service Inpatient, Crisis and Liaison	a.) Works plan agreed and written	a.) 30th November 2015						
		4.3	Acute Wards for Adults of Working Age and Psychiatric Intensive Care Units	The Trust must ensure that action is taken to remove identified ligature risks and to mitigate where there are poor lines of sight	a.) We will set up fortnightly progress meetings for AMH inpatient areas with estates and facilities input to ensure final planned works completed on time. b.) We will ensure 6 monthly full ward ligature risk reviews are in place. c.) We will begin formal documentation of matching patient risk to allocated bed risk.	Director of Service AMH/LD	Head of Service Inpatient, Crisis and Liaison	a.) Notes from meeting b.) dates of 6 monthly reviews c.) evidence of patient to bed risk assessments	a.) b.) and c.) 31st July 2015						

CQC ACTION PLAN - In response to the CQC Comprehensive inspection of LPT services															
Overarching Reference Code	**Provider Report 'Requirement action'**	**Action Reference**	**Core Service Report**	**Core Service 'Requirement Action'**	**Please describe clearly the high level actions you are going to take to meet the regulation supported by what intend to achieve**	**Executive oversight will be provided by;**	**Manager responsible for delivering the action?**	**What will evidence that the action has been implemented?**	**Insert the date the action AND evidence will be provided**	**Comments/ Remedial Actions**	**RAG Rating**	**Expected Divisional Governance (earliest)**	**Expected Corporate Governance (earliest)**	**Corporate Governance Group**	**Expected CompAss (earliest)**
5	The Trust must ensure that all mixed sex accommodation meets guidance and promotes safety and dignity	5.1	Provider Level Report	OVERARCHING TRUSTWIDE ACTION	a.) We will explore options for potential breaches re screening of all future in patient ward redesign. b.) We will develop a clear policy re same sex accommodation of walk through of opposite sex on wards. c.) We will implement an assurance process within the policy for monitoring adherence to the policy requirements	Chief Nurse/ Deputy Chief Executive	Head of Professional Practice and Education	a.) b.) and c.) Mixed sex accommodation policy	a.) b.) and c.) 30th November 2015			n/a	Dec-15	Safeguarding	**Jan-16**
		5.2	Acute Wards for Adults of Working Age and Psychiatric Intensive Care Units	The Trust must ensure that it complies with Department of Health guidance in relation to mixed sex accommodation	a.) We will cease to admit female patients to PICU with commitment to deliver female PICU review to Commissioners b.) We will review the 3 wards at The Bradgate Unit that deliver mixed sex accommodation in shared environments (Aston/ Ashby and Bosworth) and designate wards as single sex as part of Inpatient Pathway Review (patient/ care consultation included).	Director of Service AMH/LD	a.) Service Manager b.)Head of Nursing AMH/LD	a.) No female patients admitted to PICU from July 2015. Completed review and recommendations b.) Written report regarding bed occupancy trends and recommendations regarding the move to single sex wards in identified wards to Inpatient, Crisis and Liaison Operational and Governance meetings.	a.) 30th September 2015 b.) 31st October 2015			Nov-15			
6	The Trust must ensure that staff and patients have a means to raise an alarm in an emergency	6.1	Provider Level Report	OVERARCHING TRUSTWIDE ACTION	a) We will review systems in place for all lone workers in Community Mental Health Teams b) We will establish improved systems for the maintenance and repair of lone worker devices c) We will review the need for patient call-bell facilities across all inpatient areas	Chief Nurse/ Deputy Chief Executive	Head of Assurance	a) and b) Paper to Patient Safety Group establishing required actions c) Review paper from each service to Clinical Effectiveness Group establishing required actions	a) and b) October 2015 c) November 2015	CMHT lone worker review ongoing, maintenance contracts in place and communicated to staff, inpatient assistance review completed at accepted at CEG. Anticipated completion end March 2016		n/a	Apr-16	Clinical Effectiveness	**May-16**
7	The Trust must ensure that emergency equipment is checked on a regular basis	7.1	Provider Level Report	OVERARCHING TRUSTWIDE ACTION	We will review and improve the operational inventory for checking equipment and improve the monitoring, assurance and remedial action processes in place for emergency equipment	Chief Nurse/ Deputy Chief Executive	Head of Assurance	Resuscitation Committee receipt of monitoring audit and improvement action progress reports. Resuscitation Committee highlight reports to Patient Safety Group	November 30th 2015	resus audit to PSG expected March 2016		n/a	Mar-16	Patient Safety	**Apr-16**
8	The Trust must ensure that seclusion facilities are safe and appropriate and that seclusion and restraint are managed within the safeguards of the MHA Code of Practice and national guidance. The Trust should ensure it meets the guidance on restraint practice set out in Department of Health guidance	8.1	Provider Level Report	OVERARCHING TRUSTWIDE ACTION	a.) Review of all Trust Seclusion facilities against MHA/ AIMS standards and report regarding required changes to meet compliance and develop a work plan to address requirements b.) Review the use of seclusion to confirm it is used appropriately c.) Complete an audit regarding the use of restrictive practices, and reflect improvement strategies in the Trust Action Plan.	Director of Service AMH/LD	a. & b.) Head of Nursing AMHLD and Team Manager AMHLD c.) Positive and Safe Work stream 3 / Head of Nursing AMH/LD	a.) Report received at Seclusion Group and implementation plan is in place b.) Report regarding the review of seclusion practice is discussed at the Seclusion Group and Divisional Assurance Group c.) Audit report and action plan is received.	a.) 31st August 2015 b.) 31st October 2015 c.) 31st October 2015	A majority of the evidence has been received. The one outstanding action is the Trust wide seclusion audit which is starting this month. The Head of Nursing has asked that the deadline for this action to be extended to the end of January 2016 in order to complete the audit, analysis and action plan. Revised deadline of January 2016 to accommodate Trust wide seclusion audit.		n/a	Mar-16	Patient Safety	**Apr-16**

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Overarching Reference Code	**Provider Report 'Requirement action'**	**Action Reference**	**Core Service Report**	**Core Service 'Requirement Action'**	**Please describe clearly the high level actions you are going to take to meet the regulation supported by what intend to achieve**	**Executive oversight will be provided by;**	**Manager responsible for delivering the action?**	**What will evidence that the action has been implemented?**	**Insert the date the action AND evidence will be provided**	**Comments/ Remedial Actions**	**RAG Rating**	**Expected Divisional Governance (earliest)**	**Expected Corporate Governance (earliest)**	**Corporate Governance Group**	**Expected CompAss (earliest)**
9	The Trust must ensure there are sufficient and appropriately qualified staff at all times to provide care to meet patients' needs	9.1	Provider Level Report	OVERARCHING TRUSTWIDE ACTION	a.) Monthly safer staffing assurance reports will be provided to the Trust Board, 6 monthly establishment review detailing plans for ensuring safer staffing standards are met	Chief Nurse/ Deputy Chief Executive	Deputy Chief Nurse	a.) Board Assurance Reports and associated plans. Weekly monitoring through the electronic reporting system	a.) 31st July 2015			n/a	Mar-16	Strategic workforce	**Apr-16**
		9.2	Community-Based Mental Health Services for Adults of Working Age	The Trust must ensure sufficient numbers of suitably qualified, competent and skilled staff to provide care and treatment	a.) We will scope current psychological therapy provision and identify gaps in service delivery within AMHLD and develop a plan to act on findings	Director of Service AMH/LD	Head of Service COMMUNITY Prisons and Learning Disabilities	a.) Report and delivery of action plan	a.) 31st October 2015			Nov-15			
		9.3	Community Health Inpatient Services	The Trust must ensure qualified nurse levels per shift are within safe staffing levels at Rutland Memorial Hospital	a.) We will have daily reviews of planned and actual staffing levels.	Director of Service CHS	Head of Service - CHS	a.) Daily reporting on safe staffing portal b.) Weekly safer staffing submission to lead nurse c.) Monthly Trust safer staffing dashboard d.) Dynamic risk assessment tool developed	a-d.) 30th June 2015	Actions in place		Jul-15			
		9.4	Community Health Inpatient Services	The Trust must ensure the use of bank agency staff to cover shifts is managed to provide appropriate, consistent care	a.) We will have weekly teleconference across inpatient wards to review staffing and identify appropriate substantive staff movement. B.) Application of SOP for use of bank and agency will be used c.) All temporary staff will receive local induction.	Director of Service CHS	Head of Service - CHS	a) Monthly Trust safer staffing dashboard b) Monthly review of inpatient governance reports to include incidents, serious incidents, complaints and patient experience feedback c) Spot checks of agency/bank induction checklists	a-c.) 31st December 2015	All actions in place. Review of agency induction documentation to be undertaken. Spot checks to be undertaken monthly to ensure embedded. Full review completed by December		Jan-16			
		9.5	Acute Wards for Adults of Working Age and Psychiatric Intensive Care Units	The Trust must ensure there are sufficient, experienced, staff on duty at all times to provide care to meet patients' needs	a.) We will undertake review of staffing and skill mix requirements for wards using new AMH/LD Workforce staffing tools	Director of Service AMH/LD	Head of Nursing AMH/LD	a.) Report to Inpatient, Crisis and Liaison Operational Group and Divisional Assurance Group/ Chief Nurse b.) Risk Management tools in place	a.) and b.) 31st October 2015	The LD skill mix review was completed first. The AMH assessment will be completed in November. Use of tool delayed by trialling first in LD. Review underway to be completed in December 2015		Nov-15			
		9.6	Acute Wards for Adults of Working Age and Psychiatric Intensive Care Units	The Trust must review the provision of staffing in the multidisciplinary teams, specifically in relation to psychological input	a.) We will formalise plan for training and development for staff to support patients with psychological interventions b.) We will review benefits of further investment into Psychologist input with commissioners	Director of Service AMH/LD	Head of Service AMH/LD	a.) Formal training plan b.) Benefit analysis.	a.) 31st August 2015 b.) 31st December 2015			Jan-16			
		9.7	Wards for People with Learning Disabilities or Autism	The Trust must ensure there are sufficient, suitably qualified and experienced staff to meet patients' needs safely	a.) We will undertake review of staffing and skill mix requirements for wards using new AMH/LD Workforce staffing tools	Director of Service AMH/LD	Head of Service - Community Prisons and Learning Disabilities	a.) Report to Community Prisons and Learning Disabilities Operational Group and Divisional Assurance Group/ Chief Nurse	a.) 31st October 2015	The skill mix review is complete and the report is in draft.		Nov-15			
10	The Trust must ensure that there is appropriate access to medical staff where required	10.1	Provider Level Report	OVERARCHING TRUSTWIDE ACTION	a.) We will ensure that the Medical cover for Out of Hours is reviewed in all our services including; Community Mental Health Team; End of Life teams ;Secure Services b.) Medical Director will lead a review of appropriateness and timeliness of the medical cover across the services identified.	Medical Director	a.) Associate Medical Director b.) Medical Director	a.) Confirmation of the cover arrangement for all areas out of hours b.) Report outlining the outcome of the review to Clinical Effectiveness Group and completion of actions outlined in the review	a.) 30th September 2015 b.) 31st October 2015			n/a	Nov-15	Clinical Effectiveness	**Dec-15**
11	The Trust must ensure that people receive the right care at the right time by placing them in suitable placements that meet their needs	11.1	Provider Level Report	OVERARCHING TRUSTWIDE ACTION	a.) Develop a Trust wide Performance Management Framework b.) Develop an Access Policy c.) Refine Performance and Quality Reporting through the Boards Integrated Quality and Performance Report (IQPR)	Chief Nurse/ Deputy Chief Executive	Head of Assurance	a.) Framework in place and operational b.) Policy in place and operational c.) Updated IQPR - Internal Audit review	a-c.) Actions complete: 31st December 2015. Evidence 31st March 2016			n/a	Apr-16	Finance & Performance	**May-16**
`	The Trust must ensure that there are not significant delays in treatment	12.1	Provider Level Report	OVERARCHING TRUSTWIDE ACTION	We will develop and implement automated waiting lists for acute admission to AMH beds a.) dedicated team within the business unit will interrogate the information systems to keep track of patient flow in order to identify potential breaches, alert relevant clinical teams and ensure that patients are seen within the target timelines b.) Demand and capacity modelling of high risk services to be completed to densify resource gaps in order to inform negotiations with commissioners to procure the requisite investment to enhance the capacity within the services to match demand c.) To develop a training programme and procurement of associated resource to facilitate the development of the requisite IT skills and data management competencies within clinicians to enhance their capability to effectively use the information systems to manage the waiting times d.) A suite of protocols (SOPS and quick guides) for the robust and effective monitoring and management of priority waiting time performance indicators is to be developed.	Directors of Service AMH/LD, FYPC, CHS	Associate Director Business Development and Head of Assurance	Reportable wait times a.) Monthly performance reports, which include waiting time targets, provided to the clinical governance oversight groups to support robust waiting times and performance management b.) Completed demand and capacity modelling in place c.)Clinician training undertaken and training records in place d.) Signed off SOP	31st January 2016 a.) 31st July 2015 b.) 31st October 2015 c.) 31st March 2016 d.) 30th September 2015	Delivery of all actions are supported by the Trust Wide DQIP		n/a	May-16	Finance & Performance	**Jul-16**

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13	The Trust must ensure that all risk assessments and care plans are updated consistently in line with changes to patients' needs or risks	13.1	Provider Level Report	OVERARCHING TRUSTWIDE ACTION	a.) We will review current standards and expectations across service lines of person centred care plans and risk assessments identifying a clear standard and ensure through an audit cycle that improvements are embedded in practice	Chief Nurse/ Deputy Chief Executive	Head of Professional Practice and Education	a.) Clear divisional standards for care planning	a.) 31st March 2016 - care planning audit results			n/a	Apr-16	Clinical Effectiveness	**May-16**
		13.2	Forensic Inpatient/Secure Wards	The Trust must ensure that care plans and risk assessments are sufficiently detailed so that all staff know how to support each patient safely and must record patients' involvement	a.) We will link care plans to risk tools and ensure patient and carers involvement is documented on RiO	Director of Service AMH/LD	Team Manager/ Senior Matron Head of Service Inpatient, Crisis and Liaison	a.) Care plan audit results	a.) 30th September 2015			Oct-15			
		13.3	Wards for People with Learning Disabilities or Autism	The Trust must ensure that all risk assessments are reviewed regularly and updated to reflect patients' changing needs	a.) A process to promote the regular review of patients risk assessments will be developed as part of the Inpatient/ Short Breaks Pathway Review	Director of Service AMH/LD	Team Manager/ Practice Development Nurse	a.) Written report detailing the changes to the pathway to ensure regular review of risk assessments / Audit of process	a.) 31st October 2015			Nov-15			

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14	The Trust must carry out assessments of capacity and record these in the care records	14.1	Provider Level Report	OVERARCHING TRUSTWIDE ACTION	The Trust will provide assurance for MCA assessments. a.) Consent training by teaching, learning and e-learning b.) Audits will be carried out across MHSOP and the community c.) Consent to treatment and medication audits will be weekly for DOLS and MCA and submitted to Matrons and Safeguarding Team d.) Consent Awareness training will be part of a one day Safeguarding programme (currently under review) e.) This will be part of a record keeping audit	Chief Nurse/ Deputy Chief Executive	Head of Professional Practice and Education	a.) training in place b.) Audit reports c.) Audit reports d.) Revised Programme e.) Audit Report	a.) 31st October 2015 b.) 31st December 2015 c.) 31st October 2015 d.) 31st January 2016 e.) Commencing August 2015 (rolling two-year programme)			n/a	May-16	Safeguarding	**Jun-16**
		14.2	Community Based Mental Health Services for Older People	The Trust must ensure that consent to treatment is properly sought and recorded	a.) We will include Consent as a focus at the August 2015 MCA/DoLS champions group b.) Trust wide audit will be undertaken around consent c.) Champions will be identified in each inpatient setting and will disseminate and discuss the use of MCA assessment forms attached to the policy and their use in supporting best interest decisions. Feedback to be provided at November 2015 MCA/DOLS Champions Group	Director of Service CHS	Head of Service for Mental Health and Well Being Services for Older People	a.) MCA/DOLS Champions Group Agenda b.) Audit report c.) MCA/DOLS Champions Group Agenda	a.) 31st August 2015 b.) 31st March 2016 c.) 30th November 2015	consent audit commencing March 2016		de 15			
		14.3	Community Based Mental Health Services for Older People	The Trust must ensure that formal capacity assessments and best interests decisions are properly recorded	a.) Safeguarding Adult Nurse will discuss individual cases with staff as appropriate in relation to the recording of consent, capacity and best interest. b) All patients on dementia wards who are not admitted on a section of the MH Act will be reviewed in respect of their capacity on admission and DoLS applications made for those who lack capacity in line with Cheshire West Ruling and policy.	Director of Service CHS	Head of Service for Mental Health and Well Being Services for Older People	a.) Recording of individual cases discussed to be included on the monthly monitoring sheet b.) MHSOP care planning monitoring tool	a.) 31st October 2015 b.) 30th September 2015	No substantive replacement in place is impacting on progress with the DOLs agenda and timely follow through and support of staff. Recruitment process underway - expected in post January 2016 with a focus on completing this action by the end of March 2016		Nov-15			
		14.4	Forensic Inpatient/Secure Wards	The Trust must put systems in place to ensure that patients' capacity to consent is assessed and their human rights are protected	a.) The Forensic Inpatient Pathway will be reviewed to ensure capacity assessments and consent is undertaken and documented.	Director of Service AMH/LD	Lead Consultant Forensic Service	a.) Written evidence of inclusion in the Pathway care processes and audit evidence of compliance.	a.) 30th November 2015	Draft HPC pathway out for comment		Dec-15			
		14.5	Child and Adolescent Mental Health Wards	The Trust must review its procedures for recording mental capacity and consent to treatment assessments of patients	a.) File audit will be undertaken for outpatient teams in line with local CQUIN 7a (CAMHS Quality Standards) b.) Substantive recruitment will be made to Lead Nurse post with focused remit of clinical standards c.) SOP will be designed and implemented to ensure care plan updates are made d.) Consent to treatment proforma will be developed and implemented.	Director of Service FYPC	Head of Children and Families	a.) Completed File audit of 66 files from City and County Teams b.) Action Plan developed by the CAMHS Lead Nurse. c.) Actions completed and re-audit d.) a Job description written and matched e.) Recruitment completed f.) SOP Redesigned and tested g.) SOP signed off and implemented in service h.) Designed and Tested i.) Signed off and implemented in service	a.) 31st August 2015 b.) 30th September 2015 c.) 29th February 2016 d.) 31st August 2015 e.) 31st January 2016 f.) 30th September 2015 g.) 30th November 2015 h.) 30th September 2015 i.) 30th November 2015	Standard Operating Procedure approved at CAMHS Ops 8.1.16 Lead Nurse for CAMHS commenced in post on 1/2/16		Mar-16			
		14.6	Acute Wards for Adults of Working Age and Psychiatric Intensive Care Units	The Trust must carry out assessments of each patient's capacity and record these in the care records	a.) The Inpatient Pathway will be reviewed to ensure capacity assessments and consent is undertaken and documented within care processes.	Director of Service AMH/LD	Clinical Director Inpatient, Crisis an Liaison	a.) Written evidence of inclusion in the Inpatient Pathway care processes and audit evidence of compliance.	a.) 30th November 2015	revised pathway acepted in pronciple at Feb 2016 MHAAG, need for integral monitoring to be built in acknowledged		Dec-15			
		14.7	Acute Wards for Adults of Working Age and Psychiatric Intensive Care Units	The Trust must review governance systems relating to the monitoring of the administration of, and adherence with, the Mental Health Act 1983	a.) The MHA process and paperwork will be reviewed and integrated into the Inpatient Pathway care processes; including systems for compliance monitoring	Director of Service AMH/LD	Head of Nursing AMH/LD & Inpatient Clinical Director	a.) Written evidence of inclusion in the Inpatient Pathway care processes and audit evidence of compliance.	a.) 30th November 2015	revised pathway acepted in pronciple at Feb 2016 MHAAG, need for integral monitoring to be built in acknowledged		Dec-15			
		14.8	Wards for People with Learning Disabilities or Autism	The Trust must ensure that all staff are aware of the implications of the MHA and the MCA and how it affects patients' safety rights	a.) Review approaches for staff training in the MHA and MCA and will develop a revised programme with Trust Leads for MHA/MCA.	Director of Service AMH/LD	Head of Nursing AMH/LD	a.) Written evidence of training review and revised training programme.	a.) 30th September 2015.			Oct-15			
		14.9	Wards for Older People with Mental Health Problems	The Trust must ensure that consent to treatment is properly sought and recorded for those patients subject to Deprivation of Liberty Safeguards authorisation	a.) Consent will be included as a focus at the August 2015 MCA/DoLS champions group b.) Trust wide audit will be undertaken around consent c.) Champions will be identified in each inpatient setting and will disseminate and discuss the use of MCA assessment forms attached to the policy and their use in supporting best interest decisions. Feedback to be provided at November 2015 MCA/DOLS Champions Group	Director of Service CHS	Head of Service for Mental Health and Well Being Services for Older People	a.) MCA/DOLS Champions Group Agenda b.) Audit report c.) MCA/DOLS Champions Group Agenda	a.) 31st August 2015 b.) 31st March 2016 c.) 30th November 2015			Apr-16			
		14.10	Wards for Older People with Mental Health Problems	The Trust must improve recording of formal capacity assessments and best interests decisions	a.) Safeguarding Adult Nurse will discuss individual cases with staff as appropriate in relation to the recording of consent, capacity and best interest. b) All patients on dementia wards who are not admitted on a section of the MH Act will be reviewed in respect of their capacity on admission and DoLS applications made for those who lack capacity in line with Cheshire West Ruling and policy.	Director of Service CHS	Head of Service for Mental Health and Well Being Services for Older People	a.) Recording of individual cases discussed to be included on the monthly monitoring sheet b.) MHSOP care planning monitoring tool	a.) 31st October 2015 b.) 30th September 2015	No substantive replacement in place is impacting on progress with the DOLs agenda and timely follow through and support of staff. Recruitment process underway - expected in post January 2016 with a focus on completing this action by the end of March 2016		Nov-15			

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15	The Trust must ensure all staff including bank and agency have completed statutory mandatory and where relevant specialist training	15.1	Provider Level Report	OVERARCHING TRUSTWIDE ACTION	a.) We will be implementing cohort based recruitment for all new bank staff so bank staff do not commence work without having had the training. b.) Restructured the temporary staffing team with training administrator in post. c.) All bank staff to be targeted to attend the training and to include restriction from working until training is complete. d.) Redesigned provision and contract for agency nurses training monitoring will be part of the spec and contract. d.) Mandatory training compliance for bank staff is monitored as part of the monthly reporting process, including a report to SWG, where actions to improve compliance are reviewed. e.) An options appraisal paper will be presented to Exec Team in August 2015 to increase our capacity to deliver mandatory training to the required level.	Director of HR/OD	Head of Learning & Development and Head of Employment Services	a.) Cohort training recruitment model in place b.) Post recruited to. c.) Regular training reports updated. d.) Centralised temporary staffing function and reporting. e.) Capacity demonstrated to provide sufficient mandatory training spaces.	a.) b.) c.) d.) and e.) 30th November 2015	Proposals to Exec Team 7th March 2016 to invest or reconfigure capacity to deliver MAPA training, both options will release capcaity and improve performance		n/a	Feb-16	Strategic workforce	**Mar-16**
		15.2	Specialist Community Health Services for Children and Young People	The Trust should review its systems for ensuring staff receive adequate supervision, training and appraisals	a.). Supervision will be audited across Outpatients b.) Recording of supervision via U-Learn to be improved by the introduction of safe practice days.	Director of Service FYPC	Head of Service FYPC	a.) Completed audit b.) Safe practice days across CAMHS and Improvement in U learn recording of supervision	a.) 31st October 2015 b.) 31st December 2015.	A review of the training report dated 1st February showed that there has been an improvement to the clinical supervision compliance recorded on ULearn. CAMHS City out-patient team are 66% complaint and County team 61%. Appraisals CAMHS City team 90.9% compliant County team 76.5% complaint		Jan-16			

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16	The Trust must review its systems for ensuring staff receive adequate supervision, training and appraisals	16.1	Provider Level Report	OVERARCHING TRUSTWIDE ACTION	a.) We will continue to deliver our project plan, monitored through the Trust Learning & OD Group, to further progress the use of ULearn and exploit its potential in facilitating access to supervision, training and appraisals. b.) We will launch a communication campaign to ensure staff understand their responsibilities and are aware of the opportunities and access for supervision, training and appraisal.	Director of HR/OD	Head of Learning & Development	a.) 31st December 2015 b.) to commence in August 2015	a.) and b.) Reports on Compliance for training and appraisal to L&OD Group and SWG from August 2015 onwards Report on supervision to CEG from August 2015 onwards			n/a	May-16	Strategic workforce	**Jun-16**
		16.2	Forensic Inpatient/Secure Wards	The Trust must ensure that all staff receive training and supervision to ensure they are able to meet patients' needs	a.) We will strengthen leadership on the wards via the band 7 development sessions being run over the next 12 months. b.) Both HPC matrons will attend Implementation of psychologist led reflective practice c.) We will review clinical supervision approach and specialist training needs of staff	Director of Service AMH/LD	Head of Service AMH/LD & Head of Nursing	a.) Development session agendas and attendance b.) attendance at sessions c.) reviewed and updated approach to supervision and training need	a.) Started, continuous improvement expected over the 12 month period b.) and c.) 31st October 2015			Nov-15			
		16.3	End of Life Care	The Trust must ensure that mandatory training includes Duty of Candour and end of life care training for Advanced Nurse Practitioners	a.) All ANP staff will receive training on the medical-legal aspects of completing DNAR-CPR forms and Advanced Communication in relation to end of life discussions b.) All ANPs will receive an annual update on end of Life care as part of training programme c.) The DNAR-CPR competency Framework to facilitate completion of DNAR-CPR forms and will form part of the new DNAR-CPR policy ~~d.) Scoping will be undertaken to Identify if E-Prescribing can establish treatment protocols for end of life care~~	Director of Service CHS	Head of Service - CHS	Increase in compliance (6 months) evidenced through an audit and ongoing monitoring of the DNAR-CPR competency framework and policy	a.) ANP Training evidence 31st July 2015 b.) 31st October 2015 c.) 30th September 2015 d.) 31st October 2015	Revised DNACPR policy under development via Patietn Safety Group, anticipated in April 2016, expected to be ratified at May QAC		Apr-16			
		16.4	Community Health Services for Adult	The Trust must ensure bank staff complete mandatory training in line with Trust requirements	a.) We will be implementing cohort based recruitment for all new bank staff so bank staff do not commence work without having had the training. b.) Restructured the temporary staffing team with training administrator in post. c.) All bank staff to be targeted to attend the training and to include restriction from working until training is complete. d.) Redesigned provision and contract for agency nurses training monitoring will be part of the spec and contract. d.) Mandatory training compliance for bank staff is monitored as part of the monthly reporting process, including a report to SWG, where actions to improve compliance are reviewed. e.) An options appraisal paper will be presented to Exec Team in August 2015 to increase our capacity to deliver mandatory training to the required level.	Director of HR/OD	Head of Learning & Development and Head of Employment Services	a.) Cohort training recruitment model in place b.) Post recruited to. c.) Regular training reports updated. d.) Centralised temporary staffing function and reporting. e.) Capacity demonstrated to provide sufficient mandatory training spaces.	a.) b.) c.) d.) and e.) 30th November 2015	Proposals to Exec Team 7th March 2016 to invest or reconfigure capacity to deliver MAPA training, both options will release capcaity and improve performance		Dec-15			
		16.5	Community Health Services for Adult	The Trust must ensure teams are adequately staffed to prevent impacts on workloads due to staffing shortages	a.) Implement actions from Divisional Recruitment Sub-group action plan b.) A proposal for staff will be developed for wellbeing and incentive schemes to maximise wellbeing and attendance of workforce	Director of Service CHS	Director CHS	a.) Improved recruitment rate evidenced through performance reporting b.) Staff wellbeing and incentive scheme in place and improved staff feedback	a.) 31st October 2015 b.) 31st October 2015			Nov-15			
		16.6	Community Health Inpatient Services	The Trust must ensure all staff complete mandatory training	All wards will have processes in place to ensure consistent compliance across all core training	Director of Service CHS	Head of Service - CHS	Monthly workforce reports outlining compliance with mandatory training	30th November 2015	Inpatient wards compliant with core mandatory training. Compliant with most clinical mandatory training with the exception of ILS. Capacity issues for training being addressed. Non-compliant with BLS across a number of teams. Compliance due 30th November but remains ongoing.		Dec-15			
		16.7	Child and Adolescent Mental Health Wards	The Trust must review its systems for ensuring staff receive adequate supervision, training and appraisals	a.)Recording of supervision and eLearning via U-Learn will be improved by the introduction of safe practice days b.) We will review recording consistency of U-Learn c.) Mandatory training will be part of performance reviews at service level d.) There will be substantive recruitment to Lead Nurse post with focused remit of clinical standards.	Director of Service FYPC	Head of Children and Families	a.) Attendance at safe practice days b.) Service level reports of use of ULearn and triangulation with reports from staff c.) Service level performance reports d.) Job description written and matched and Recruitment completed	a.) 30th November 2015 b.) 30th November 2015 c.) 31st December 2015 d.) 31st January 2016	A review of the training report dated 1st February showed 25% compliance with clinical supervision and 69.8% with appraisals.		Feb-16			
		16.8	Mental Health Crisis Services and Health-Based Places of Safety	The Trust must ensure that all staff receive regular managerial supervision in line with their own policy and protocols	We will build on regular delivery of supervision within the team to ensure robust recording processes via ULearn are in place	Director of Service AMH/LD	Head of Service Inpatient, Crisis and Liaison	ULearn reporting	30th September 2015	54% had received an appraisal		Oct-15			

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17	The Trust must ensure that proper procedures are followed for detention under the Mental Health Act and that the required records relating to patient's detention are in order	17.1	Provider Level Report	OVERARCHING TRUSTWIDE ACTION	a.) We will introduce a robust scrutiny process to ensure that proper procedures are followed for patient's detained under the MHA Act b.) We will introduce a trust wide standard for MHA training and monitor compliance with attendance c.) We will introduce an appropriate audit process to ensure correct application of the MHA for patient's.	Medical Director	Head of Assurance	a.) Approved Trust wide scrutiny procedure for inpatient settings b.) Agreement of a trust wide standard for MHA training for both inpatients and community based services, captured and monitored by ULearn c.) Production and agreement of a suitable audit tool to test MHA 'outcomes' at the point of care in inpatient settings, supported by analysis with a feedback product for inpatient staff.	a.) 31st July 2015 b.) 31st July 2015 c.) 31st October 2015	All Actions complete and evidence received at MHAAG		n/a	Apr-16	Mental Health Act Assurance	**May-16**
		17.2	Long Stay/Rehabilitation Mental Health Wards for Working Age Adults	The Trust must ensure that they adhere to the Mental Health Act Code of Practice and their own guidance notes and record this properly	The MHA process and paperwork will be reviewed and integrated into the Inpatient care processes; including systems for compliance monitoring. The care processes will be reviewed against the Code of Practice.	Director of Service AMH/LD	Head of Nursing AMH/LD & Inpatient Clinical Director	Written evidence of inclusion in the inpatient care processes and audit evidence of compliance.	30th November 2015	revised pathway acepted in pronciple at Feb 2016 MHAAG, need for integral monitoring to be built in acknowledged		Dec-15			
		17.3	Acute Wards for Adults of Working Age and Psychiatric Intensive Care Units	The Trust must adhere to the requirements of the Mental Health Act 1983 and Mental Health Act 1983 Code of Practice	The MHA process and paperwork will be reviewed and integrated into the Inpatient Pathway care processes; including systems for compliance monitoring. The care processes will be reviewed against the Code of Practice.	Director of Service AMH/LD	Head of Nursing AMH/LD & Inpatient Clinical Director	Written evidence of inclusion in the Inpatient Pathway care processes and audit evidence of compliance.	30th November 2015	revised pathway acepted in pronciple at Feb 2016 MHAAG, need for integral monitoring to be built in acknowledged		Dec-15			
		17.4	Child and Adolescent Mental Health Wards	The Trust must review its procedures for informing detained and informal patients of their legal rights	a.) File audit will be undertaken for outpatient teams in line with local CQUIN 7a (CAMHS Quality Standards) recommendations b.) There will be substantive recruitment to Lead Nurse post with focused remit of clinical standards c.) We will implement consistent process, in line with LPT Policy, for risk assessment and review for whole service d.) We will implement consistent process for informing detained and informal patients of their legal rights.	Director of Service FYPC	Head of Service Children and Families	a.) a Completed File audit of 66 files from City and County Teams b.) Action Plan developed by the CAMHS Lead Nurse. c.) Actions completed and re-audit d.) a Job description written and matched e.) Recruitment completed f.) SOP Redesigned and tested g.) SOP signed off and implemented in service h.) Designed and Tested i.) Signed off and implemented in service	a.) 31st August 2015 b.) 30th September 2015 c.) 29th February 2016 d.) 31st August 2015 e.) 31st January 2015 f.) 30th September 2015 g.) 30th November 2015 h.) 30th September 2015 i.) 30th November 2015	Standard Operating Procedure approved at CAMHS Ops 8.1.16.		Mar-16			
18	The Trust must ensure that arrangements for patients taking section 17 leave are clear and in line with the Mental Health Act for their safety and that of others	18.1	Provider Level Report	OVERARCHING TRUSTWIDE ACTION	a.) We will introduce a robust scrutiny process to ensure that proper procedures are followed for patient's detained under the MHA Act. b.) We will introduce a trust wide standard for MHA training and monitor compliance with attendance c.) We will introduce an appropriate audit process to ensure correct application of the MHA for patient's.	Medical Director	Head of Assurance	a.) Approved Trust wide scrutiny procedure for inpatient settings b.) Agreement of a trust wide standard for MHA training for both inpatients and community based services, captured and monitored by ULearn c.) Production and agreement of a suitable audit tool to test MHA 'outcomes' at the point of care in inpatient settings, supported by analysis with a feedback product for inpatient staff.	a.) 31st July 2015 b.) 31st July 2015 c.) 31st October 2015			n/a	Nov-15	Mental Health Act Assurance	**Dec-15**
19	The Trust must ensure that patients who are detained under the Mental Health Act have information on how to contact the CQC	19.1	Provider Level Report	OVERARCHING TRUSTWIDE ACTION	a.) We will strengthen our leadership arrangements in support of the MHA b.) We will produce a range of products to enable staff to have access to resource at the point of care c.) We will ensure continued supply of appropriate MHA information for patients at the point of care.	Medical Director	Head of Assurance	a.) Agreement for strengthened MHA Leadership arrangements from Trust Board to staff at point of care. b.) Agreement and distribution of a set of 'products' which promote and communicate information about the MHA from a trust and national perspective c.) Visual checks which indicate appropriate supply of MHA products as agreed - at the point of care for patients (inpatients).	a.) 30th September 2015 b) 31st October 2015 c.) 31st October 2015	MHAAG and MHA Managers governance redesign December 2015 - March 2016		n/a	Apr-16	Mental Health Act Assurance	**May-16**
20	The Trust must ensure that procedures required under the Mental Capacity Act are followed	20.1	Provider Level Report	OVERARCHING TRUSTWIDE ACTION	We will explore a Trust wide assurance programme to ensure we are compliant with the Mental capacity act	Chief Nurse/ Deputy Chief Executive	Head of Professional Practice and Education	Robust assurance framework for mental capacity act in place	31st December 2015			n/a	Jan-16	Safeguarding	**Feb-16**

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21	The Trust must ensure access is facilitated to psychological therapy in a timely way	21.1	Provider Level Report	OVERARCHING TRUSTWIDE ACTION	a.) AMHLD Inpatients - We will formalise a plan for training and development for staff to support patients with Psychological interventions. Review benefits of further investment into Psychologist input with commissioners b.) AMHLD Community - We will scope current psychological therapy provision and identify gaps in service delivery within AMHLD and develop a plan to act on findings	Director of Service AMH/LD	Head of Service AMH/LD	a.)Formal training plan. Benefit analysis b.) Community report	a.) 31st August 2015 31st December 2015 b.) 31st October 2015	Review of capacity and demand undertaken. Business case developed for additioanl investment. A training plan has been received at the Directorate SDI meeting and will be progressed through governance and through to Compass.		n/a	Jan-16	Clinical Effectiveness	**Feb-16**
22	The Trust must ensure that there are systems in place to monitor quality and performance and that governance processes lead to required and sustained improvement	22.1	Provider Level Report	OVERARCHING TRUSTWIDE ACTION	a.) Develop a Trust wide Performance Management Framework b.) Develop an Access Policy c.) Refine Performance and Quality Reporting through the Boards Integrated Quality and Performance Report (IQPR)	Chief Nurse/ Deputy Chief Executive	Head of Assurance	a.) Framework in place and operational b.) Policy in place and operational c.) Updated IQPR - Internal Audit review	a-c.) Actions complete 31st December 2015. Evidence 31st March 2016			n/a	**Nov-15**	**Finance & Performance**	**Jun-16**
		22.2	Specialist Community Health Services for Children and Young People	The Trust must review its procedures to ensure that the learning from investigations and actions are embedded in CAMHS teams	a.) SI's discussed routinely at FYPC Assurance Day, Group Leadership Team and CAMHS Ops Meetings b.) Process for sharing of SI learning to be strengthened through the clinical and operational leadership to ensure all team members across the service learn from incidents.	Director of Service FYPC	Head of Children and Families	a.) Meeting minutes b).Spot checking of embedded learning - exception report to quality and safety group	a.) Monthly - commencing August 2015	Full process now in place. Staff involved in an SI meet with the FYPC Investigator following closure to reflect on the incident and learning points. The discussion is recorded on a Clinical Supervision template which can be uploaded to Ulearn. Learning from SI newsletter and Executive Summaries are shared at CAMHS Ops meetings, and then cascaded to inform team meeting discussion. A programme of spot checking of embedded learning is taking place via SMT front-line visits, Governance Team spot checks and Trust Patient Safety Team visits.		Oct-15			
23	The Trust must review its procedures for maintaining records, storage and accessibility	23.1	Provider Level Report	OVERARCHING TRUSTWIDE ACTION	a.) We will roll out an Electronic Patient Record to all Mental Health Services in line with roll out plan b.) We will move Child and Adolescent Mental Health Services onto EPR c.) We will develop an EPR Policy for the Trust d.) Services will develop standard operating procedures for the operational use and ownership of paper and electronic records e.) We will review current clinical records management policies and procedures to identify gaps f.) We will establish Service Users Groups for operational management of EPRs including changes g.) We will work with local health partners to establish use of Medical Interoperability Gateway (MIG) to allow appropriate sharing of patient information for the purposes of direct care	Chief Nurse/ Deputy Chief Executive	IM&T Programme & Strategy Manager	a.) Completion of roll out of EPR b.) Service moved onto EPR c.) New policy in place d.) SOP's in place e.) Revised IG policy map showing where new policies/procedures required and reviewed policies/procedures f.) Terms of Reference and notes of meetings g.) MIG in use	a.) 30th April 2016 b.) 30th September 2016 c.) 30th April 2016 d.) 31st March 2016 e.) 31st December 2015 f.) 30th November 2015 g.) 30th April 2016			n/a	Oct-16	Records & Information Governance	**Nov-16**
		23.2	Forensic Inpatient/Secure Wards	The Trust must make patient information available for all staff to access	a.) We will ensure RiO implementation has settled to mean all documentation for all patients is now readily accessible b.)We will review the timeliness of the process for staff to gain access to electronic patient records with the RiO Team.	Director of Service AMH/LD	Head of Service AMH/LD	a.) RiO records b.) Revised RiO process for staff to gain access to RiO	a.) 30th September 2015 b.) 31st October 2015	The specific action regarding RiO has been completed and an audit of compliance has been carried out on one ward. We are awaiting the results of the other ward in order to close.		Nov-15			
		23.3	Community Based Mental Health Services for Adult of Working Age	The Trust must ensure consistency and accuracy of records across all teams which are available to all relevant staff providing care and treatment for each individual	a.) Implementation of RiO	Director of Service AMH/LD	Head of Service Community Prisons and Learning Disabilities	a.) RiO in operation	a.) Complete						
		23.4	Community Based Mental Health Services for Adult of Working Age	The Trust must review its procedures for maintaining records, storage and accessibility including out of hours provision	a.) Implementation of RiO	Director of Service AMH/LD	Head of Service Community Prisons and Learning Disabilities	a.) RiO in operation	a.) Complete						

CQC ACTION PLAN - In response to the CQC Comprehensive inspection of LPT services															
Overarching Reference Code	**Provider Report 'Requirement action'**	**Action Reference**	**Core Service Report**	**Core Service 'Requirement Action'**	**Please describe clearly the high level actions you are going to take to meet the regulation supported by what intend to achieve**	**Executive oversight will be provided by;**	**Manager responsible for delivering the action?**	**What will evidence that the action has been implemented?**	**Insert the date the action AND evidence will be provided**	**Comments/ Remedial Actions**	**RAG Rating**	**Expected Divisional Governance (earliest)**	**Expected Corporate Governance (earliest)**	**Corporate Governance Group**	**Expected CompAss (earliest)**
Specialist Community Health Services for Children and Young People															
24		24.1	Specialist Community Health Services for Children and Young People	The Trust must review its health and safety assessment procedures at CAMHS sites	a.) Environmental risk assessments will to be carried out at CAMHS sites b.) We will review environmental management plans for all patients (City Team) c.) There will be Service Comms to all staff regarding any managed risks in environment and actions for risk assessments for patients	Director of Service FYPC	Head of Children and Families	a.) Completed Environmental Risk Assessments b.) Environmental management plans for all patients (City Team). c.) Emails and meeting minutes	a.) 31st August 2015 b.) 31st December 2015 c.) 31st January 2016	Evidence accepted at Compass, require evidence that future H&S inspections are incorporated into FYPC H&S grop workplan - on receipt action can turn Blue		Feb-16	n/a	n/a	**Mar-16**
25		25.1	Specialist Community Health Services for Children and Young People	The Trust must review its provision of assessment and treatment of young people to ensure they receive it in a timely manner	a.) We will implement Tier 3 re-design and a new clinical model.	Director of Service FYPC	Head of Children and Families	a.) Completion and evaluation of pilot B.) Full implementation	a.) 31stDecember 2015 b.) 30th April 2016			**May-16**	n/a	n/a	**Jun-16**
26		26.1	Specialist Community Health Services for Children and Young People	The Trust must review its provisions of crisis services for young people to ensure that young people using crisis services have an assessment by appropriately skilled staff to a responsive standard	a.) CAMHS Crisis service will be developed	Director of Service FYPC	Head of Children and Families	a.) CAMHS Crisis business case completed and to be submitted for August Commission meeting. b.) Use of 'secure and share' audited and actions taken as needed. c.) Interim capacity recruitment.	a.) 31st August 2015 b.) 30th September 2015 c.) 30th September 2015			Oct-15	n/a	n/a	
Substance Misuse Services															
27		27.1	Substance Misuse Services	The Trust must ensure that a patient group directive (PGD) is in place for the dispensing of the medication Naloxone as a take home dose	We will ensure that a patient group directive is: a.) Developed and signed off b.) Implemented for the dispensing of the medication Naloxone as a take home dose.	Director of Service FYPC	Family Services Manager, Health & Wellbeing	a.)PGD will be signed off b.) PGD will be being used in the service when dispensing the medication Naloxone	a.) PGD document will be available by 30th September 2015 b.) Records of Naloxone medication dispensed will be available by 31st October 2015			Nov-15	n/a	n/a	**Mar-16**
28		28.1	Substance Misuse Services	The Trust must review physical health monitoring and prescribing practise in line with NICE guidance	a.) We will set up a service task and finish group to review the NICE guidance in relation to physical health monitoring and prescribing b.) We will ensure that the protocols in the service accurately reflect the guidance and develop new guidance if there are deficits identified c.) We will ensure that processes are in place to review NICE guidance in relation to new/ revised NICE guidance	Director of Service FYPC	Family Services Manager, Health & Wellbeing	a.) A task and finish group is established, has met and identified the specific NICE guidance requiring review b.) Current service protocols that require reviewing and amending are identified. New protocols that are required are identified. c.) The service has a process in place to ensure that NICE guidance is used to review / develop protocols in relation to physical health monitoring and prescribing.	a.) By 31st August 2015 the task and finish group will have met and identified the appropriate NICE guidance, the service protocols requiring review and what new protocols need to be developed. b.) By 30th September 2015 the current protocols will have been reviewed and amended. By 31st October the reviewed protocols will be distributed to staff. By 31st October 2015 drafts for any new protocols will be developed. c.) By **31st** November any new protocols will be approved and agreed.			**Dec-15**	n/a	n/a	**Jan-16**
29		29.1	Substance Misuse Services	The Trust must ensure that people receiving substitute medication for opiate dependence are seen regularly and reviewed by a prescriber	We will ensure that the written agreement developed and distributed to practitioners within the prescribing policy and guidelines regarding: a.) minimum standard on frequency of patient reviews b.) method(s) in which patient reviews will take place c.) role of the recovery navigators and enhanced practitioners in assisting prescribers with the patient reviews, is being adhered to by practitioners	Director of Service FYPC	Family Services Manager, Health & Wellbeing	a.) Practitioners agree that they have received a copy of the prescribing policy and guidelines and have understood their responsibilities within them b.) Rolling audit programme developed to ensure that service users are being seen in line with the policy and guidelines.	a.) Signed evidence that they have received the policy and guidelines and understood their role by the 31st July 2015. b.) Audit programme drawn up by the 30th September 2015.			Oct-15	n/a	n/a	**Nov-15**
Long Stay/Rehabilitation Mental Health Wards for Working Age Adults															
30		30.1	Long Stay/Rehabilitation Mental Health Wards for Working Age Adults	The Trust must demonstrate that they have effective systems in place to ensure that medical tests are carried out in line with the doctor's recommendation	a.) Review patient documentation to ensure instructions on medical investigations are clear, ensuring any remedial actions required are implemented and embedded in practice	Director of Service AMH/LD	Head of Service Inpatient, Crisis and Liaison	a.) Outcome of the review	a.) 30th September 2015			Oct-15	n/a	n/a	**Nov-15**
Forensic Inpatient/Secure Wards															
31		31.1	Forensic Inpatient/Secure Wards	The Trust must reduce the blind spots in seclusion rooms so that staff can observe patients at all times when secluded	a.) We will undertake a local survey to assess the issue b.) We will liaise with estates to cost and assess need for alterations to the current facilities if possible	Director of Service AMH/LD	Head of Nursing AMH/LD	a.) Survey report and options appraisal b.) Seclusion audit against standards	a.) 31st August 2015 b.) 30th November 2015			Dec-15	n/a	n/a	**Jan-16**

CQC ACTION PLAN - In response to the CQC Comprehensive inspection of LPT services															
Overarching Reference Code	**Provider Report 'Requirement action'**	**Action Reference**	**Core Service Report**	**Core Service 'Requirement Action'**	**Please describe clearly the high level actions you are going to take to meet the regulation supported by what intend to achieve**	**Executive oversight will be provided by;**	**Manager responsible for delivering the action?**	**What will evidence that the action has been implemented?**	**Insert the date the action AND evidence will be provided**	**Comments/ Remedial Actions**	**RAG Rating**	**Expected Divisional Governance (earliest)**	**Expected Corporate Governance (earliest)**	**Corporate Governance Group**	**Expected CompAss (earliest)**
End of Life Care															
32		32.1	End of Life Care	The Trust must implement the alternative care plan developed after the withdrawal of the Liverpool Care Pathway	a.) We will re-launch the Care in the Last Days of Life developed to take place across LPT with a robust implementation plan	Director of Service CHS	Head of Nursing - CHS	a.) Audit from Systm1 in conjunction with the preferred place of death audit b) Minutes of the M&M Meeting where appropriate	a.) 31st December 2015	~~System1 Audit unable to commence with current configuration work to resolve underway~~. M&M minutes received and accepted. . Last Days of Life Champions Cascade training has commenced Date for Completion: May 2016 This action is also to be enhanced with a clinical audit programme to be implemented from April 2016.		Jan-16	n/a	n/a	**Feb-16**
33		33.1	End of Life Care	The Trust must develop and follow an end of life care strategy	a.) We will develop an End of Life Care ~~Strategy~~ framewrok across services and establish a LPT wide ~~strategy~~ group to produce an end of life strategy. This group to work with the Better Care Together EOL work stream to develop an LLR wide end of life strategy aligned with the action plan of the LTTIC task force FYPC to contribute to Trust wide EOL strategy with Adults Services.	Directors of Service CHS & FYPC	Head of Professional Practice and Education	Approved End of Life Strategy a.) Formation of LPT EOL Strategy Group. Development and implementation of a LPT end of life care strategy. Completed End of Life Strategy. This will be Trust-Wide	To ensure effective implementation by June 2016 a) 31st December 2015			Jan-16	n/a	n/a	**Feb-16**
34		34.1	End of Life Care	The Trust must ensure that effective medical supervision is arranged for staff working within end of life services	a.) We will ensure that all staff receive medical supervision as appropriate either by general practice, medics within LOROS or Consultant Geriatrician ~~b.) We will re-launch of the Care in the Last Days of Life training to reinforce supervision requirements~~ c.) The CHS M&M meeting will identify the level of medical supervision required as a result of the case review for all palliative deaths presented d.) Medical support will be provided by Out of Hours GP's and Rainbows Children's Hospice to be reflected in new ~~strategy~~ framework e.) A palliative care lead nurse post (nurse prescribing and palliative care) will be recruited to	Directors of Service CHS & FYPC	Head of Service CHS & Head of Service FYPC	a.) Recording of clinical supervision b.) Training records c.) M&M minutes d.) ~~Strategy~~ framework to reflect medical support in FYPC e.) Recruitment to the post of Palliative Care Nurse Lead.	a) 31st October 2015 b) 31st March 2016 c) 31st August 2015 d) 31st December 2015 e) 31st December 2015	As 32 plus - Resources need to be identified across service lines. JD is being written. December deadline will not be met. Remains outstanding> results of pilot being presented in December and feedback to be received by the EOL Steering Group. CELS are leading on the implementation plan. Action remains amber, scoping work of the role is being carried out by Head of Professional Practice and Education. JS to obtain update.		**Apr-16**	n/a	n/a	**May-16**
Community Health Inpatient Services															
35		35.1	Community Health Inpatient Services	The Trust must ensure sluice doors are kept locked to prevent patients and visitors having potential access to harmful products	a.) We will remind staff to ensure that all hazardous substances are locked away b.) Spot checks will be established on all wards to ensure compliance	Director of Service CHS	Head of Service - CHS	a.) Ward minutes b.)Spot checks to be included into existing ward check processes	a-b.) 30th September 2015			**Feb-16**	n/a	n/a	**Mar-16**
36		36.1	Child and Adolescent Mental Health Wards	The Trust must review its use of low stimulus unit to ensure that the Trust seclusion policy is followed and people's rights are protected	a.)New guidance will be written by Senior Matron to ensure compliance with MHA Code of Practice, MCA and DOLS b.) Ratification approval will be gained via FYPC Quality Sub-Group and MHAAG c.) We will review and update local Ward 3 Operational Policy d.) We will Introduce new paperwork to enact policy	Director of Service FYPC	Head of Children and Families	a.) Completed guidance b.) Guidance approved c.) New ward 3 Operational Policy d.) Spot check on new paperwork	a.) 31st August 2015 b.) 30th November 2015 c.) 31st December 2015 d.) 31st December 2015			Feb-16	n/a	n/a	**Mar-16**
Mental Health Crisis Services and Health-Based Places of Safety															
37		37.1	Mental Health Crisis Services and Health-Based Places of Safety	The Trust must address the identified safety concerns in the health-based place of safety	a.) The physical environment of the Place of Safety will be continually reviewed to ensure it meets current and future guidance b.) Staffing models and other ways of using the PSAU will be reviewed and option appraised.	Director of Service AMH/LD	Head of Service AMH/LD	a.) AMH/LD Governance group work plan b.) Completed options appraisal	a.) 30th September 2015 b.) 30th September 2015			Oct-15	n/a	n/a	**Nov-15**
38		38.1	Mental Health Crisis Services and Health-Based Places of Safety	The Trust must develop mechanisms to regularly assess and monitor the quality of the service provided and develop active plans where there are issues	a.) We will implement a comprehensive and commissioner agreed dashboard for the Crisis Service	Director of Service AMH/LD	Head of Service AMH/LD	a.) New dashboard	a.) Complete			Aug-15	n/a	n/a	**Nov-15**

Leicestershire Partnership NHS Trust

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REPORT TO THE TRUST BOARD - 27th May 2016	
Title	Care Quality Commission Inspection of Her Majesty's Prison (HMP) Leicester

Executive summary

In October 2015 the Care Quality Commission (CQC) undertook an inspection of HMP Leicester with Her Majesty's Inspectorate of Prisons. As a result of that inspection two requirement notices were issued regarding safe services and staffing and effective services regarding the provision of mental health and physical health provision.

On 5th April 2016 the CQC undertook a follow up inspection to focus particularly on the two previous requirement notices. The inspection reviewed a range of information, spoke with staff and commissioners and reviewed a range of records focussing particularly on are the services safe and are the services effective?

The key findings from the inspection were that:

- Staffing levels across primary health care and primary mental health care had improved resulting in improved assessment, care planning and delivery.
- Patients were receiving appropriate person-centred care and the care planning for those with complex needs had improved.

As a result both requirement notices were removed. This report was received by the Trust on 17th May 2016 and therefore has not been considered by the Quality Assurance Committee.

No date has been identified for any further inspection of these services.

Recommendation

The Trust Board is recommended to:

- Receive the CQC report on the follow up inspection of HMP Leicester
- Acknowledge the removal of the two requirement notices
- Acknowledge the improvements in service provision my the staff involved in the delivery of the service.

Related Trust objectives	Deliver safe, effective, patient-centred care in the top 20% of our peers
Risk and assurance	
Legal implications/ regulatory	Failure to demonstrate compliance with the CQC Essential standards of quality and safety may result in services being

requirements	de-registered.
Presenting Director	Adrian Childs Chief Nurse/Deputy Chief Executive
Author(s)	Adrian Childs Chief Nurse/Deputy Chief Executive
*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.	

HMP Leicester

Quality Report

116 Welford Road
Leicester
Leicestershire
LE2 7AJ
Tel: Tel: 0116 228 3000
Website:

Date of inspection visit: 5 April 2016
Date of publication: This is auto-populated when the report is published

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Summary of this inspection

Detailed findings from this inspection

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?
We did not inspect the safe domain in full at this inspection. We inspected only those aspects mentioned in the Requirement Notices issued on 5 October 2015. We found that all the required improvements had been made.

Are services effective?
We did not inspect the effective domain in full at this inspection. We inspected only those aspects mentioned in the Requirement Notices issued on 5 October 2015. We found that all the required improvements had been made.

Are services caring?
We did not inspect the caring domain at this inspection.

Are services responsive to people's needs?
We did not inspect the responsive domain at this inspection.

Are services well-led?
We did not inspect the well-led domain at this inspection.

HMP Leicester

Detailed findings

Our inspection team

Our inspection team was led by:

The inspection was led by a CQC health and justice inspector who had access to remote specialist advice.

Background to HMP Leicester

HMP Leicester operates as a local prison for 408 adult males. Leicestershire Partnership NHS Trust provides a range of healthcare services to prisoners, comparable to those found in the wider community.

Our key findings were:

- Staffing levels across primary health care and primary mental health care including the use of regular psychiatry staff had increased. This combined with a review of all staff roles and duties meant that patients' needs were better assessed; care was planned and delivered in the most appropriate way.
- Patients received appropriate person-centred care and treatment. Care planning for patients with complex health care needs and mental health needs had improved.

Why we carried out this inspection

This was a follow up focused inspection of the service under Section 60 of the Health and Social Care Act 2008. In October 2015 we undertook a joint inspection of health services at HMP Leicester with Her Majesty's Inspectorate of Prisons under a memorandum of understanding agreement. We found areas of concern about the service provided by Leicestershire Partnership NHS Trust and issued two requirement notices which were followed up during this focused inspection.

The inspection report can be found at www.justiceinspectorates.gov.uk/hmiprisons/inspections

How we carried out this inspection

Before our inspection we reviewed a range of information that we held about the service. We asked the provider to share with us a range of information which we reviewed as part of the inspection. We spoke with staff, commissioners' and sampled a range of records.

To get to the heart of patients' experiences of care and treatment on this inspection we asked the following questions:

- Is it safe?
- Is it effective?

Are services safe?

Our findings

Staffing and recruitment

- During our previous inspection in October 2016, we found the service had At this focused inspection we found that the trust had undertaken a series of initiatives and arrangements were in place
- Since our last inspection a new head of physical healthcare had been appointed and they worked alongside the head of mental health services and the head of healthcare.
- The service had recruited three registered general nurses (RGN) and there were plans to recruit two registered mental health nurses (RMN) with interviews scheduled to take place the week of our inspection.
- The overall number of health care support workers had increased from three to five, two of whom were assigned to work specifically with mental health nurses and patients who required emotional support and basic coping strategies. This development had enabled RMNs to concentrate on those patients with secondary mental health needs and patients who required to be transferred out of the prison to secure psychiatric hospital facilities.
- Other staffing initiatives included the appointment of a health care support worker with lead responsibility for smoking cessation.HMP Leicester was trialling the use of 'e cigarettes' with prisoners.
- In response to concerns highlighted at our previous inspection the head of health care had reviewed the RMNs' working day to ensure that these staff were able to fulfil their duties, alongside reviewing nurses' caseloads and working closer with safer custody staff when agreeing the most appropriate response to prisoners with mental health needs and those who frequently self-harmed.
- Patients' medicines had been reviewed and as a consequence of this there had been an increase in the number of patients who held their medicines in possession. This meant nurses had more time during their working day to undertake direct one to one care and treatment with patients.
- Nursing staff we spoke with told us they had more time to complete care plans, care records and risk assessments. They now had time to spend time with patients and undertake direct one to one work with patients. To support staff to achieve this, time had been built into the working week to enable staff to write care plans and review records. All staff completed care plan and record keeping training.
- We sampled care records and found them to be detailed including assessments and care plans. It was clear from care records what support patients were receiving and the purpose and goal of staff intervention.
- Reception health care templates had been reviewed and heads of nursing told us these assisted staff in focusing on where patients' highest needs were and where to refer or signpost patients.
- Two permanent experienced psychiatrists had been appointed since our last inspection; each had responsibility for a specific caseload and regular twice weekly psychiatry clinics took place.Patients received a consistent treatment and were seen in a timely manner.Previous concerns about prescribing practices had been resolved through their appointment and through partnership working between psychiatrists and RMNs.
- Previously we reported that there was no psychology input to the service. The service provided Cognitive Behavioural Therapy but this was no longer available. The trust was actively seeking to recruit a sessional psychologist.

Are services effective?

(for example, treatment is effective)

Our findings

Mental health

- During our previous inspection in October 2016, we were concerned that patients with mental health needs were not receiving care and treatment that met their needs.During this focussed inspection we found that the trust had undertaken a series of initiatives to address this concern including holding a weekly allocation meeting of all mental health referrals that had been received following a mental health triage assessment.The first allocation meeting was scheduled to take place on the 15 April 2016. This had been delayed due to the team not having enough staff in post to support new planned ways of working.It was anticipated that at the weekly meeting patients would be allocated to a nurse or health care support worker for follow up.It was also planned that the weekly allocation meeting would be used to discuss complex cases and patients awaiting transfer to secure hospital accommodation.
- The mental health manager had undertaken a review of RMNs'caseloads and of all patients engaged with the service. As a consequence of this caseloads had been reduced.Nurses told us this meant that they now had time to do direct one to one work and offer ongoing support to those patients with the most need.
- The mental health pathway had been reviewed and clear referral criteria had been introduced.We saw evidence that for patients experiencing a low mood, mild depression and anxiety, alternative measures were in place to meet these needs including listener schemes, peer mentors and signposting to chaplaincy for support.Additionally two health care support workers had been specifically assigned to work with the mental health team to respond to these patients' needs and offer assistance with signposting to other services.
- The head of health care and leads for mental health and physical health were working closely with the prison governor and the safer custody governor, to ensure that those prisoners who required nursing input due to their mental health needs were clearly identified.
- Nursing staff told us they felt in control of their working day, they felt better able to manage their time and patient caseloads.We observed that the atmosphere within health care was calmer and nurses were working in a focussed manner. Nurses told us they now had time within their working day to review the work they were doing with a patient and to write care plans and review risk assessments.
- The head of health care and leads for mental health and physical health had reviewed the role of RMNs' in dispensing medicines and had agreed that one nurse per day would be available to assist with this.Consequently this also meant that RMNs' had time to focus on other areas of their work including mental health triage.
- The trust operated a named nurse scheme and previously we had observed that patients saw up to five different nurses during the course of their support and treatment.We saw that as a consequence of reviewing the service provided RMN staff were able to provide regular contact with patients on their caseload.RMNs' told us that there were plans to develop a number of support groups ie anxiety management, once the team was fully staffed.RMN staff told us that the appointment of two health care support workers to the RMN team meant patients with low level mental health needs were seen quickly and this also impacted upon the amount of time they had to spend with patients with enduring mental health needs.
- Access to psychological therapies was still not happening.The head of healthcare assured us that the trust was actively recruiting sessional psychology for the patient population at the prison and RMN staff were confident that group work would begin once the team was fully staffed.
- We observed that care planning had improved. Records were detailed and it was apparent from reading records what support patients were receiving and what the aims of planned patient interventions were.

Physical care:

- Similarly we observed that care planning for patients with complex health needs and lifelong conditions had improved. The head of physical health had started to prioritise developing care plans for patients with diabetes.We saw that patients diagnosed with diabetes routinely had a care plan and this guided staff on how to meet a patients' needs.We saw evidence that these care plans were regularly reviewed.

Are services effective?

(for example, treatment is effective)

- We spoke with a nurse who led on this area of work. They told us that the management of patients with diabetes and other long term conditions was GP led and reviews were completed by RGN staff. Facilities had been developed on the wing and this had been successful in that nurses were getting to see more patients. Staff we spoke with were positive about the developments that they saw had taken place in patient care since our previous inspection.
- We were told that three new RGN staff had been recruited and once these staff members had completed induction there were plans to review what clinics was needed for patients with long term conditions.We saw a range of care plan templates had been developed to address this and all RGN staff had completed training in their use and care planning.
- Previously we had concerns about the support that was offered to patients where English was not their first language, we found some practices had put patients at risk.To address this, a mandatory section had been introduced on the initial health care screen and staff were prompted to fully consider whether a patient could understand English, both written and verbal.Resources were in place such as interpreting services and language line to support patients.
- As part of quality monitoring arrangements patients who did not attend healthcare appointments were followed up.The reasons for non-attendance were collated and actioned, including discussions with operational prison staff where it had been identified that prison restrictions had impacted on service delivery.

Are services caring?

Our findings

We did not inspect the caring domain at this inspection.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We did not inspect the responsive domain at this inspection.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

We did not inspect the well-led domain at this inspection.

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Leicestershire Partnership NHS
NHS Trust

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REPORT TO THE TRUST BOARD – 27 May 2016	
Title	Equality Update 2015 – 2016

Executive summary

The information in this report is due to be presented at Strategic Workforce Group on 24 May 2016, and maybe subject to change. Any updates will be recorded and reported at Trust Board.

LPT continues to ensure that the Equality agenda is advanced by embedding initiatives that put the agenda at the heart of policies, practices and functions that protect people from being discriminated, victimised, harassed or bullied.

Mainstreaming the equality agenda strengthens the Trust values; Respect, Compassion, Integrity and Trust; delivering services that meet the individual service user and patient needs with the penultimate aim to having a service that is second to none.

Recognising this, makes it crucial to have a workforce that is skilled and knowledgeable to deliver services that are in line with care pathways.

This report provides reassurance of the progress made to embed and drive forward the equality agenda in line with our legal obligation under the Equality Act 2010 and the Public Sector Equality Duty (PSED).

The report contains an update from the November 2015 report; outlining the achievements and our plans for the year ahead. Also, attached for information is the;

- Partnership Engagement on the Equality Delivery System 2 and completed EDS2 template;
- Summary finding of the 14/15 service user data;
- Workforce Race Equality Standard

The report entails an overview of the activities delivered during 2015/16 and the planned activities for 2016/17. LPT will continue to progress the work in this area, ensuring equality sits at the heart of everything we do.

Recommendation

The recommendation is that the Trust Board;

Appendix 1 – give assurance that work in this area is continually being improved to improving the health and wellbeing of people in Leicester, Leicestershire and Rutland within the framework of the Equality Act 2010 and related guidelines and processes;

Appendix 2 – to support the integration of EDS2 in to the monitoring and evaluation of service delivery and workforce planning process;

Appendix 3 – to address disadvantages and barriers faced by underrepresented groups.

Appendix 4 – to support service areas to build actions plans that address gaps in services.

Related Trust objectives	Staff will be proud to work here, and we will attract and retain the best people.
Risk and assurance	1036 - Without recruiting adequate staff we may be unable to run safe and efficient services and meet the demands of Better Care Together: 366 - If we do not meet mandatory training compliance rates there may be an adverse impact on care delivery: 1037 - Without effectively engaging and supporting our staff we may be unable to deliver high quality services and support transformational change: 1038 - Inability to create high quality management and leadership capabilities may impact on the delivery of efficient and effective services.
Legal implications/ regulatory requirements	All public bodies have a responsibility to comply with the Equality Act 2010 (general and specific duties). Under the Equality Act 2010, there is a legal obligation to provide fair and accessible services for all. Failure to do so, may lead to litigation and substantial financial implications. Furthermore, the EHRC has the right to issue a compliance notice should the Trust fail to meet its duties under the Act. We are also monitored by CQC and the areas for which equality will have most relevance in relation to the standard are: 4, 16, 7, 9, 5, 10, 11, 1, 2, 17, 13, 14.
Presenting Director	Alan Duffell – Director of HR and OD
Author(s)	Sandy Zavery Equality and Human Rights Lead Sarah Willis Head of Employment Services
*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.	

Summary of Papers to Trust Board

Appendix 1 – Equality Update 2015 - 2016

This paper provides an overview of the progress and achievements by the Equality team to drive forward the equality agenda. It highlights:

a. the work against the Single Equality Approach and Action Plan 2015 – 2016, indicating the work against each objective and the progress, as well as our objectives for 2016/17.

b. An update on the progress made to embed the Equality Delivery System 2 (EDS2) to ensure equality sits at the heart of everything we do. The Trust undertook a self-assessment against the 4 Goals and 18 outcomes for which an overall grading has been given, in light of the evidence gathered from the process. The final grading template issued by NHS England shows our grading against the standard. The equality team are now engaging with staff and service users/patients to verify the grades.

c. Summary analysis of service user data by protected characteristics, with a full link to the data on the Trust website. The next stage will be for service areas to review the information and pull together a plan to address any gaps identified.

d. The Workforce Race Equality Standard will need to be published by 1st July 2016 and will need to include a summary of planned actions and progress made to address specific inequalities identified between minority ethnic groups in the workforce.

Appendix 2 – Partnership EDS2 Report

As part of our commitment to embed and mainstream the Equality Delivery System 2 (EDS2) into all parts of service delivery and employment practices, the Trust is partnership with City CCG's and UHL organised a number of engagement and involvement events to gather information that would support the grades allocated against the 4 Goals and 18 Outcomes. The outcome from the events helped to inform the self-assessment process.

Appendix 3 – Workforce Race Equality Standard

The workforce data gathered has been split into the categories outlined in the WRES template measuring;

i. proportion of staff from minority ethnic groups within the Agenda for Change bands in comparison to White staff;
ii. relative likelihood of staff being appointed from shortlisting across all posts;
iii. relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation;

iv. relative likelihood of staff accessing non-mandatory training and CPD;
v. percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months;
vi. percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months;
vii. percentage believing that trust provides equal opportunities for career progression or promotion;
viii. percentage difference between the organisations' Board voting membership and its overall workforce.

From the data identified, the Trust is required to implement actions that will start to address the inequalities and disadvantages faced by some protected groups. The WRES is supported by a more detailed analysis of the workforce which integrates findings related to all protected characteristics in terms of identifying and addressing the issues outlined above.

Appendix 4 – Service User Data

This report brings together a summary of findings from the equality monitoring of service users in the 2014/15 financial year. The intention of the reports is to inform service delivery, planning, and decision-making.

Some of the findings within the reports may reflect differences in need and the types of conditions treated for different groups of people. Other findings may reflect equality issues that can be addressed by the Trust. There will be a need to identify those areas where the Trust can make a difference and to prioritise actions to address these areas.

Appendix 1

Leicestershire Partnership NHS
NHS Trust

Equality Update 2015 – 2016

1. Introduction

Leicestershire Partnership NHS Trust (the Trust) believes that equality and diversity is fundamental to ensuring services delivered are appropriate and meet the needs of individuals in our care. The business case for supporting the equality agenda is paramount to implementing care pathways that are accessible and catered for the local community of Leicester, Leicestershire and Rutland.

We continue to make efforts to ensure fair and equitable services and drive equality at the heart of everything we do to ensure that our staff have the right skills and knowledge to deliver a service that embraces diversity and values difference.

The implementation of the Single Equality Approach and Action Plan 2013 – 2017, introduction of the Equality Delivery System 2 (EDS2) and Workforce Race Equality Standards have started to help make that difference to improving care and recovery for service users and patients. The progress includes:

1.1 Single Equality Approach and Action Plan 2015/16

The equality team have continued the progress the actions outlined in the Single Equality Approach and Action Plan to improve staff understanding of the equality agenda and service user experience, when accessing care. Details of our progress for 2015/16, can be viewed in section 4 – Activity Update, as well as the plans for 2016/17.

1.2 Equality Delivery System 2 (EDS2)

The Trust has a contractual requirement to embed and mainstream the Equality Delivery System 2 (EDS2), into all service delivery. As part of the process, Trusts are required to provide evidence of their progress against the standard and a grading to reflect their position at the end of the financial year.

LPT has verified its position against the 4 Goal and 18 outcomes (please see

The Equality Delivery System 2 (EDS2) will assist the Trust to engage and involve local people in its delivery of services. It will also help the Trust meet the Public Sector Equality Duty (PSED) under the Equality Act 2010, NHS Mandate, NHS Outcomes Framework, the NHS Constitution, Care Quality Commission (CQC), Monitor and Trust Development Authority (TDA).

The organisation will work closely with local Trust's, CCGs and UHL on joint engagement events across the city and county including workshops focused at protected groups to inform local people of the work undertaken by the Trust to date and understand what more can be done to improve service provision and employment practices.

The Trust self-assessment process against the standard has led to grading its position as follows;

- Goals 1 and 2: Amber – developing;
- Goal 3 and 4: Green - achieving.

The details of this can be viewed in Appendix A and the NHS England template.

The Equality team are holding two engagement and involvement events in May 2016 to share the self-assessment with staff and service users; providing an opportunity to challenge the grades against the four goals and 18 outcomes. The results from the events will determine the final assessment and any future actions to address gaps in service provision and employment practices.

2 Aim

This report provides Trust Board with an update on the equality and human rights activity and reassurance how the Trust meets its obligation under the Equality Act 2010 and the public sector equality duty.

3 Recommendation

The recommendation is that the Trust Board;

Appendix 1 – give assurance that work in this area is continually being improved to improving the health and wellbeing of people in Leicester, Leicestershire and Rutland within the framework of the Equality Act 2010 and related guidelines and processes;

Appendix 2 – to support the integration of EDS2 in to the monitoring and evaluation of service delivery and workforce planning process;

Appendix 3 – to address disadvantages and barriers faced by underrepresented groups.

Appendix 4 – to support service areas to build actions plans that address gaps in services.

4 Activity Update

The Trust has achieved a great deal to progress the equality agenda. However, the most significant achievement has been the pledge to breakdown the stigma and barriers faced by people with hearing impairments and mental health issues. This commitment extended to signing up to the British Deaf Association and Mindful Employer Charter and the Time to Change pledge.

We also held our first staff conference in October 2015 in recognition of World Mental Health Day called ‘Mental Health and Wellbeing conference’ to provide information and support to staff and/or their friends and family experiencing mental health issues.

Following this, we promoted ‘Time to Talk’ day on the 4th February, introducing a host of material to support staff, introducing articles and video post of staff sharing personal stories and the on-line introduction of personal advice from a clinician called ‘Dear Matthew’.

The workplace index supports the Trust in implementing positive policies and practices for staff to improve their experiences in the workplace and is part of the diversity champion programme. The index is open for any organisation or industry.

We continue to progress our work around the Lesbian, Gay, Bisexual and Transgender (LGBT) agenda and committed funds to undertake a detailed survey to identify whether LGBT staff were experiencing disadvantages in the workplace. It was encouraging to see that over 250 staff completed the survey, s significant difference from the Staff Survey and that overall staff in this group were having positive experiences in the workplace.

The report had outlined a number of recommendations for driving this agenda forward such as LGBT service users focus groups, management content-led workshops, allies mentoring program, new education resources on LGBT issues for all staff, re-benchmark every two years and marketing of the Trust to attract best workforce talent.

The equality team aim to integrate the recommendation into their plans for 2016/17.

For the first time, the Trust have a category in the staff Excellence Awards, themed Equality and Diversity. It will be in recognition of the work undertaken by staff in the Trust, who have gone over and above their normal day to day role to promote and raise awareness of the value and benefits equality and diversity has for an organisation.

The Trust continues to drive the agenda forward and work with staff across the Trust to address issues of discrimination, bullying and harassment and inappropriate behaviour that violates a person dignity, progressing activity that raises the profile of the equality agenda. Supplementary to this, to make that all-important difference for service users and staff, the equality team have been driving forward initiatives to make that cultural change.

4.1 Achievements 2015/16

Our continuous efforts to drive the agenda forward and in recognition of achievements during 2015/16 entail;

- Sign up to the British Deaf Association charter;
- Mindful Employer Charter;
- ‘Time to Change’ agenda;
- Out Now Survey;
- LiA events to understand issues around data completion and access for Deaf community;
- Progress of the Accessible Information Standards

The Trust will continue to drive the agenda forward with the support of Chief Executive, Directors, Senior Managers and staff ensuring the Trust meets its obligations under the Equality Act 2010, but more importantly considering individual needs that improve service users care pathway. We will do this by delivering the following key activities for 2015/16:

No	Activity	Achievements	Rag Rating
1.	Provide regular Annual Report Updates	The Equality team has provided bi-annual report to Executive Team and Trust Board demonstrating the Trust progress around the equality agenda.	
2.	Review and sustain Single Equality Approach and action plans	The Single Equality Approach and Action Plan will be reviewed in 2016/17, to ensure it is in line with the Strategic HR and OD Strategy.	
3.	Engaging on the NHS Employers partnership programme	The Trust was successful in gaining membership status on the NHS Employer Equality and Diversity Partnership Programme. The engagement on the programme has help drive forward the equality agenda within the Trust.	
4.	Launch in partnership with UHL and Leicester CCG a virtual staff support group e-forum	Work on going with Leicestershire County Council Staff support groups towards collaborative meetings including LGBT and BME groups. Awaiting opportunity to pilot virtual e forum with UHL and CCG staff groups	
5.	Develop and roll out Equality and Human Rights e-learning resources	The Equality team has worked hard to design and develop an equality module that will be converted to e learning programme. Additionally, we have a e learning programme that raises awareness of lesbian, gay, bi-sexual and transgender needs (LGBT).	
6.	Sign up to the Time to Change Charter	In October 2015, the Trust signed up to the Time to Change Charter. We have also undertaken activity to promote awareness of mental health in the workplace such as our engagement on 4th February –	

		Time to talk day.	
7.	Facilitate a staff support group seminar promoting World Mental Health Day 2015	The Trust held its first Mental Health and Wellbeing conference in October 2015. The conference highlighted key ways in which staff could access support and generally, have positive mental health and wellbeing.	
8.	Launch the British Deaf Association (BDA) Charter and Pledge	In April 2015, the Trust signed up to the BDA charter, to start breaking down the barriers faced by people with hearing impairments when accessing health services. We also undertook and engagement through the LiA process and the information gathered will feed into the Accessible Information Standards activity.	
9.	Maximise training and development opportunities in equality and human rights awareness	The Equality team have re-designed the mandatory training programme for staff and have also designed, developed and delivered bespoke training for staff, facing specific issues.	
10.	Equality Champions identified and supported throughout the Trust	The Equality team continue to meet with the Equality Champions quarterly to raise awareness of the equality agenda.	
11.	Publish Staff Equality Newsletter	The Equality team have published the staff equality newsletter which highlights main activity and key progress around the equality agenda.	
12.	Review Equality website content to ensure it is up to date and relevant	The equality team have updated the equality website to provide easy access to information.	
13.	Invest in an equality promotional banner	The banner has been designed. However, financial constraints have prevented the development of an equality banner. This will be reviewed in the new financial year.	

14.	EDHR week promotion	The Equality team provided a variety of key information links to promote EDHR week's main theme of 'Linking Our Thinking' - focusing on how diversity of thought can contribute to addressing and solving problems for all under-represented and disadvantaged groups and individuals within the workplace. Resources included a communication tool-kit, EDHR week calendar and an interactive map of activities. The initiatives were supported by all of the Trust staff support groups	
15.	Develop joint objectives with other teams across the Trust	The equality team continue to work with services and teams across the Trust to develop joint objectives that help to drive forward the equality agenda and meet our requirements against EDS2 and the WRES.	
16.	Submit Stonewall Workplace Equality Index	The Trust came 102 in the 2016, Stonewall Workplace Index.	
17.	Quality schedule revised with a new template	The equality team have provided an update against the Quality Schedule, as part of our requirements by CCGs.	
18.	Data analysis, presentation to directors and divisional teams to implement action for improvements	The Trust has published its service user and workforce data, in line with our requirements against PSED.	
19.	New timeline for gathering and analysing equality monitoring information	The new timeline was presented and agreed.	
20.	Implementation of the Workforce Race Equality Standard	The WRES has been implemented and reported against in 2016. The data has been presented to Executive Team and Senior Managers.	
21.	Publication of workforce information	The Trust workforce data was published according to our PSED	

		requirements.	
22.	LiA event on the gathering of workforce and patients equality monitoring information	The Equality and Human Rights Team worked with the Listening into Action Lead to undertake a roadshow to discuss barriers to collecting equality monitoring information with staff from across the Trust. The roadshow took place in November and December 2015. A thematic analysis was undertaken of the opinions collected. Q1 Why do some staff choose to withhold information about their demographics /protected characteristics? • Confidentiality • Mistrust or fear of misuse regarding how the information will be used • Lack of appreciation of the value and purpose of the information • Burden of collecting / capacity to collect or provide the information Q2 Where systems allow, why are data on certain demographic domains/ protected characteristics not being collected / recorded from service users (especially in the domains of religion and sexual orientation, but also in relation to ethnicity for some.)? • Burden of collecting the information alongside other priorities • Mistrust regarding confidentiality and use of the information	

		• Inadequate systems / processes for recording the information • Lack of appreciation of the value and purpose of the information • Difficulty in asking the patient for information / justifying the equality monitoring questions / answering the patient's queries about the questions Q3 What can be done to address any identified barriers to collecting complete demographic/ protected characteristic information about our workforce and service users? • Better explain why the information is collected / demonstrate impact and value / safeguards • Reduce the burden in relation to collection • Improve systems for collection (provision to record all the information / share information already collected elsewhere / mandatory fields) **Recommendations arising** • Improve the specification of information systems across LPT (especially systems holding service user data) to be able to record adequate information across all protected characteristics, for the purposes of equality monitoring. Ensure that system specifications allow for efficient data entry and reporting, with mandatory fields for equality monitoring information and alerts or system flags where the	

		information is incomplete. The equality monitoring fields should allow for “prefer not to say” and “service user not asked at this time” type values. Simultaneously, lessen the burden of equality monitoring (and improve the availability of information for patient care) by linking patient records across systems and ensuring ubiquitous use of a unique identifier such as the NHS Number. • Better provide and publicise the benefits of giving or seeking complete equality monitoring information. Reinforce this message with evidence from case vignettes or other sources to demonstrate how equality monitoring information has been used to contribute towards workplace improvements and better service provision. State clearly how the information will be used and explain the safeguards in place to protect confidentiality and prevent misuse of the information. Encourage staff to revisit their equality monitoring information held on the staff record and to update or complete as necessary (exercise undertaken in March 2016). • Provide support and training to staff who collect equality monitoring information from service users in order to help them to ask the question of service users. Provide resources to help these staff members to give the rationale for equality monitoring and to answer service users’ questions around equality monitoring to include addressing what the information will be used for, the real-world impact and value of equality monitoring, and safeguards to prevent breaches of confidentiality and misuse.	

23.	Partnership working on EDS2 engagement and involvement	The Trust in partnership with UHL and City CCG undertook a range of engagement events across diverse communities. The information was pulled into a report and shared. The Trust will report against it progress areas outlined in the report.	
24.	Partnership working across Public Sector organisations	As part of the LeicesterShire Equalities Forum and the Regional Equality Group, he Equality team have continued to work in partnership to drive forward the equality agenda. Additionally, links have also been made with our national colleagues to ensure our work is in line with the national NHS agenda.	
25.	Introduction of Excellence award around Equality and Diversity	The Trust has recognised the value added to embedding the equality and diversity agenda. For the first time, the category has been included to award staff that have gone beyond their normal day to day duty to promote equality in the workplace.	

Year Ahead 2016/17

The Trust continuous the work in this area backing the equality team in its perseverance to mainstreaming equality and an inclusive agenda that delivers a service that respects the people we serve and the people we employ.

Activity	Activity
1. Bi-annually Equality Update Reports • Trust Board • Strategic Workforce Group • Workforce Groups	11. Review Single Equality Approach and action plans, in line with Human Resources and Organisational Development Strategy
2. Staff Support Group • Maintain and support the groups; • Launch of virtual e-forum Staff group with UHL and Leicester CCG; • Links developed with Leicestershire County Council support groups;	12. Training and Development • Revised Equality and Diversity Training; • Roll out of Equality e-learning resources; • Bespoke Equality and Diversity Training
3. Sign up and progressing activity against; • British Deaf Association Charter and pledge; • Mindful Employer Charter;	13. Equality Champions identified and supported throughout the Trust

• Time to Change charter; • Accessible Information Standards;	
4. Publish Staff Equality Newsletter	14. Continues review of Equality and Diversity website
5. Equality Promotional Banner	15. EDHR week • Promotion of Equality material; • Equality Act 2010 and Transgender workshop; • Unconscious Bias;
6. Joint objectives with teams across the Trust	16. Quality Schedule revised and reported against;
7. Analysis, presentation and publication of Data; • Workforce • Service Users:	17. Compliance against standards; • Equality Delivery System 2; • Workforce Race Equality Standard; • Accessible Information Standard;
8. Revised timeframe for gathering and analysing equality monitoring information	18. Engagement, involvement and consultation with: • CCGs and UHL; • Regional Trusts • LeicesterShire Equalities Forum • Healthwatch

	• Voluntary and Community Sector
9. Learning Disability Project	19. Positive Action – supporting recruitment activity to raise awareness and encourage applications from minority groups.
10. LGBT activity – continuing to drive forward the LGBT promotional work to support our application in 2017/18.	20. Staff Excellence Awards recognition in Equality and Diversity.

4.2 Reporting on Equality Data

4.2.1 Service User Data

Equality monitoring information in relation to service use in the 2014/15 financial year has been analysed and published on our website at the end of January 2016, in accordance with the requirements of the Equality Act 2010 and the Public Sector Equality Duty:

- Leicestershire Partnership NHS Trust: Adult Mental Health and Learning Disability Services, Community Health Services, Families Young People and Children's Services: April 2014 to March 2015; A quantitative equality analysis of service users' access to mental health services, care episode events, and outcome scores
- Leicester City Increasing Access to Psychological Therapies Service: April 2014 to March 2015; Summary of a quantitative equality analysis of access, outcomes, and experience indicators for users of the Increasing Access to Psychological Therapies service
- Adult Mental Health Patient Discharge Questionnaire: April 2014 to March 2015; A quantitative equality analysis considering ward, age, gender, ethnicity, religion or belief, and sexual orientation
- Leicestershire Partnership NHS Trust: CQC Mental Health Community Service User Survey 2015; A quantitative equality analysis considering organisational unit, age, gender, and ethnicity: Summary of findings
- Leicestershire Partnership NHS Trust: Adult Mental Health and Learning Disability Services, Community Health Services, Families, Young People, and Children's Services: April 2014 to March 2015; A quantitative equality analysis of complainants

The published reports can be accessed at http://www.leicspart.nhs.uk/_Aboutus-EqualityandHumanRights-PublicationofEqualityInformation.aspx under the headings "Equality information for the 2014/15 financial year, published January 2016" and "Information about our service users." (Information about the Leicester City Increasing Access to Psychological Therapies Service is included for completeness; however, the service has since moved to another provider.) Work is underway to communicate the findings of these equality analyses to relevant areas of the Trust and to support action to address identified equality issues.

4.2.2 Workforce Race Equality Standard

Workforce related equality monitoring information for the 2015/16 financial year has been analysed to the latest specification of the Workforce Race Equality Standard (as released by NHS England on 12th April 2016). Actions to address identified equality issues are being developed. The Workforce Race Equality Standard will be published

by 1st July 2016 and will include a summary of planned actions and updates on actions in progress, as specified in NHS England's publication template.

4.2.3 Workforce Data

Workforce equality monitoring information for the 2015/16 is being analysed and interpreted. These analyses cover a broader range of indicators than the Workforce Race Equality Standard, in greater detail, following technical guidance issued by the Equality and Human Rights Commission. A report on these equality analyses will be presented at an Executive Team meeting, ready for Trust Board in July 2016.

5 Conclusion

Driving forward the equality agenda for the Trust has required systematic improvements to promote positive outcomes for services users and staff.

For instance, the Equality and Human Rights Team has supported work to address workplace bullying, harassment, and discrimination in areas where specific problems have been identified. Additionally, efforts continue with regard to improving the quality and completeness of equality monitoring information on staff and service users, supporting work to improve the Trust's patient information systems to facilitate better equality monitoring, and developing avenues to feed the findings of equality monitoring into practice.

A number of equality-related challenges face the Trust over the coming year. For instance, there is a need to change a culture of discrimination experienced by minority groups in some areas. There is also a need to further develop a workforce with the right skills and knowledge to serve our diverse local communities.

Additionally, the coming year will see the implementation of the Accessible Information Standards, greater scrutiny of equality in the workplace for disabled employees with the development of a national Workforce Disability Equality Standard, and greater emphasis on gender equality in relation to pay for all organisations and industries.

The Equality and Human Rights Team will continue to help the Trust meet the challenges it faces. To do this, the Equality and Human Rights Team will continue to work in partnership with other teams within the Trust, the Trust's Equality Champions, stakeholders, and the voluntary and community sector. Ensuring that equality sits at the heart of the work of the Trust will help the Trust to provide the best possible working environment for our staff and the best possible care for those who depend upon us.

Appendix A

Leicestershire Partnership NHS Trust

Equality Delivery System 2

Grading for Service Areas – Goals 1 and 2

	Goal 1 - Better Health Outcomes				
	Outcome 1.1	Outcome 1.2	Outcome 1.3	Outcome 1.4	Outcome 1.5
	Services are commissioned, procured, designed and delivered to meet the health needs of local communities.	Individual people's health needs are assessed and met in appropriate and effective ways.	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed.	When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse.	Screening, vaccination and other health promotion services reach and benefit all local communities.
AMH/LD					
CHS					
FYPC					

	Goal 2 - Improved patient access and experience				
	Outcome 2.1	Outcome 2.2	Outcome 2.3	Outcome 2.4	
	People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds.	People are informed and supported to be as involved as they wish to be in decisions about their care.	People report positive experiences of the NHS.	People's complaints about services are handled respectfully and efficiently.	
AMH/LD					
CHS					
FYPC					

Note: The above tables: Goal 1 and Goal 2 have been left blank pending Executive Team decision on whether evidence and information will be supplied against each sub-section of each Goal. On the basis of evidence currently available most would be graded 'Red' with the possibiity of some at 'Amber'.

Grading for Service Areas – Goals 3 and 4

	Goal 3 - A representative and supported workforce					
	Outcome 3.1	Outcome 3.2	Outcome 3.3	Outcome 3.4	Outcome 3.5	Outcome 3.6
	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations	Training and development opportunities are taken up and positively evaluated by all staff	When at work, staff are free from abuse, harassment, bullying and violence from any source	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	Staff report positive experiences of their membership of the workforce
AMH/LD						
CHS						
FYPC						

	Goal 4 - Inclusive Leadership		
	Outcome 4.1	Outcome 4.2	Outcome 4.3
	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination
AMH/LD			
CHS			
FYPC			

Key - Grading Levels

Underdeveloped	
Developed	
Achieving	
Excellent	

Appendix 2

Leicestershire Partnership NHS
NHS Trust

Equality Delivery System 2

Grading 2015/16

1. Introduction

The Trust is committed to embedding and mainstreaming the Equality Delivery System 2 (EDS2) into all parts of service delivery and employment practices, with the aim to meeting NHS contractual requirements.

This report outlines evidence gathered through the engagement process and the grades allocated on the basis of the information made available by each area of the organisation against the goals and outcomes of the EDS2 Standard.

2. Background

The Equality Delivery System 2 was relaunched in November 2013 as EDS2, in order to help NHS Trusts to review and improve their quality and performance for people, across the protected characteristics, and to help deliver the Public Sector Equality Duty (PSED).

The standard was brought about as a result of NHS England's commitment to an inclusive NHS that is fair and accessible to all. EDS2 has been designed in collaboration with the NHS. Trusts now have a contractual obligation to implement EDS2 into their practices and report their position against each area.

We have worked in partnership with other local Trusts to gather the information to help us assess Leicestershire Partnership NHS Trust's position against the EDS2.

3. Engagement

Engagement activity has helped the Trust to understand how well service users and patients are able to access services delivered by the Trust across some of the protected groups, listed under the Equality Act 2010.

The engagement involved a number of community events in the city with target equality groups such as;

- disabled people, gypsy and traveller community, somali community, polish community, Leicestershire Aids Support Service (including new arrival communities), learning disabilities (Speaking Up for Health and Rethink), LGBT Centre, African Caribbean community and young people.

The programme of engagement led to information being gathered about the experiences of service users when accessing NHS services across Leicester City *(please see Appendix A for details).* The information was segregated by area of principle responsibility (acute, general practitioners and mental health services) to provide outcomes for the three main Trusts.

4. Outcomes

The engagement involved asking key questions related to the areas under Goals 1 and 2 of EDS2; obtaining clear insight into issues experienced by the local communities, when accessing healthcare. The information was gathered into a report by the Leicester City CCG Equality Lead.

LPT's Equality Lead has pulled out the main information that highlights the experiences of those accessing the services under LPT's remit. The information gathered will be used to help assess the grades given within each outcome, as well as any corporate activity related to the areas specified in the standard *(please click here for details)*.

We have also been able to draw from the service user and workforce equality monitoring data analysis and findings 2014/15 collated against the EDS2 objectives, to further support the grading (*please see appendix B for details*).

The gradings for the subsections of Goals 1 and 2 are "underdeveloped" (red) or "developing" (amber) - *(please see Appendix C)*. These goals relate to health outcomes and patient access/experience; the grades reflect the evidence made available to the Equality and Human Rights team by individual services. Unfortunately the evidence provided has been limited.

The gradings for the subsections of Goals 3 and 4 have been set at "achieving" (green) on detailed analysis of various information sources including workforce data and the staff survey evidence *(please see Appendix C)*.

We now ask that Executive Directors review the gradings given for the subsections of Goals 1 and 2, by service, and for Goals 3 and 4 for the organisation overall. The gradings can be confirmed and approved or the gradings can be challenged and evidence provided where a different grading is thought appropriate. Ultimately these gradings will be shared with community members and reported upon in the QSI4a, b and 5 report to CCG's in March 2016.

5. Reporting

Information gathered will provide an overall grading for the 4 goals and 18 outcomes of the EDS2 which will need to be shared with patients, service users and staff, who will have the opportunity to agree with or challenge the grading.

We will then be required to amend the grades or provide further evidence to support the grades. The grades and supporting evidence are to be published by the end of March 2016, as part of our reporting requirements to NHS England.

We have also been asked to include the EDS2 information as part of our QSI4a, 4b and 5 reporting structure to the CCG's, with evidence of the work undertaken by the Trust to meet the needs of the target groups.

Any gaps identified will need to be addressed in our future plans outlined by service area in LPT's five year plan.

6. Conclusion

The Equality team recognise the value of partnership working. This piece of collective work has provided an opportunity to bring together key pieces of information for across numerous communities that we serve; demonstrating a collective commitment and approach amongst local healthcare providers and commissioners to embedding and mainstreaming the EDS2 toolkit.

We are mindful of the need to apply a consistent approach in the way that LPT designs and develops future services and employment practices.

The Equality and Human Rights team is confident of the gradings derived for Goals 3 and 4, which show positive trends and improvements for staff at LPT. However, the gradings for Goals 1 and 2 reflect a lack of evidence provided by services and not necessarily that services are underdeveloped or just developing in these areas. Services have not engaged with the Business Planning process across LPT in providing evidence against EDS2, despite requests from and support offered by the Equality and Human Rights team.

We recognise the hard work and commitment that staff in service areas put in to improve service users and patient's pathways; reducing health inequalities. However, limited engagement with the EDS2 and the Equality and Human Rights team has reduced the ability for the Equality and Human Rights team to demonstrate this work effectively.

It makes good business sense to have equality as a 'the golden thread' that runs through our service delivery and employment practices; reducing barriers that often restrict positive outcomes for service users, patients and staff.

7. Recommendation

The recommendation is that Executive Directors are asked to either:

a. accept that the Trust and its individual services are variously underdeveloped (red) or developing (amber) in terms of health outcomes (Goal 1) and patient access/experience (Goal 2); or

b. allocate resources and staff within individual services to identify and supply evidence that the Trust and its individual services are achieving (green) or excellent (purple) in terms of health outcomes (Goal 1) and patient access/experience (Goal 2).

Equality Delivery System 2 (Please note the comments below are from service users, carers or their relatives)

Goal 1 – Better Health Outcomes

1.1 Services are commissioned, procured, designed and delivered to meet the health needs of local communities		
Equality Group	**Negative**	**Positive**
Eastern European	LPT - What about mental health -too many people suffer in silent? Where to go? Who to ask? No information at all. Some people just need a chat and coffee with others, why we cannot have Polish drop in session for mental health service users?	No comment
LASS	LPT - I was very depressed and in a bad place for 2 years; I have been using the service for 4 years and I am in a better place now. However it took 2 years to get referred to the service.	No comment

1.2 Individual people's health needs are assessed and met in appropriate and effective ways		
Equality Group	**Negative**	**Positive**
African Caribbean	Some individuals felt that culturally staff didn't always understand their ''loudness'' we don't mean to be aggressive but people sometimes expect us to be and treat us differently.'' If we are upset we sometimes shout. If this happens we are then labelled as having a mental health problem.''	No comment
Disability	Front line staff need training to deal with deaf and	There are communication issues so I would say the service

	hard of hearing people. Re mental health – police get involved and paramedics cannot enter the scene until the police have given clearance, this delays treatment and cause patients to become worse. Some doctors aren't supportive of mental health. Leicester's communication is difficult especially in Mental Health. Deaf people do get issues in Mental Health and barriers makes Mental Health worse. Training for people who deal with deaf people.	is doing ok but there is room for improvement I came across a person with mental health issues; she looked agitated and had a wound on her arm. I called the emergency services and the operator was very good, I felt reassured, especially because it was a stranger.

1.3 Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed		
Equality Group	**Negative**	**Positive**
LGBT	LPT - I have to travel to clinics in London or Nottingham to access mental health service, there was one in Leicester which has been closed down. There is a big LGBT community in Leicester and there is a need for access to mental health services specific to the LGBT community in Leicester. I don't understand why they do not have mental services available for the transgender community in Leicester. I can't always afford to travel to Nottingham for the mental health clinic. The appointments are early morning so you have to travel during peak hours on the train which is very expensive.	No comment

1.4 When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse		
Equality Group	**Negative**	**Positive**
Disability	Student with mental health needs -students don't feel reassurance about the information given by GP's, particularly when it comes to complex information. Students with Mental Health issues – there is a trust issue and uncertainty about what they can be told by healthcare professionals. Example provided – where GP's didn't take what was being said by student seriously and felt it was just anxiety, not a Mental Health issue. No – for deaf people, if you don't know what's going on, no explanation.	No comment

1.5 Screening, vaccination and other health promotion services reach and benefit all local communities		
Equality Group	**Negative**	**Positive**
No comment gathered relevant to this area		

Goal 2 – Improved patient access and experience

2.1 People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds		
Equality Group	**Negative**	**Positive**
Disability	Isolation an issue when accessing MH residential services as unable to engage / communicate with other service users.	No comments

	Accessing LPT MH services. A patient in crisis was given an appointment with MH facilitator after three weeks. Deaf / hard of hearing patients don't get informed about new services or health campaigns. MH services available to prevent escalation to crisis but patients not aware of service so how can they stop escalation. Bradgate Unit - least accessible place to get to by bus from the city. (10 minutes to get there than the bus station). Crisis house – put in the wrong place. Crisis team – get through to crisis team when needed is hit and miss, needs improving. Crisis team – scare badly. Accessibility of beds in mental health – not enough beds locally. Bradgate unit least accessible place. Front of Glenfield hospital ok but no travel to Bradgate unit. Crisis house in wrong area and housing crisis team creates more crises. Communication a problem when deaf and use BSL.	

	Ambulance staff doesn't always deal well with patients that have mental health needs in addition to physical issues they're called out for. With response to service users – (hard missed – when it comes to GP's. Deaf people need interpreters, they don't have problems with the GP as such but finding they are having problems with receptionist staff – understanding of booking an interpreter – cost is taken into account and being reluctant to book an interpreter GP and medical staff want to use family members rather than using a professional interpreter. Mental health service users that are deaf have added barriers with communication and this can make MH condition worse. Buildings difficult to access, signage, language	
Somali	LPT - Mental health issues a taboo subject in Somali community. Interpreters are used but not always qualified to interpret as required (lack of knowledge around the subject area they are interpreting for). Physical obstacles – older Somali community not being given access to services, unable to get out of homes, lack of transport provision, Afro-Caribbean community have minibuses etc.	

2.2 People are informed and supported to be as involved as they wish to be in decisions about their care		
Equality Group	**Negative**	**Positive**
No comment gathered relevant to this area		

2.3 People report positive experiences of the NHS		
Equality Group	**Negative**	**Positive**
Carers- Learning Disabilities	More support needs to be provided by Learning Disabilities nurses. They make the hospital appointments but do not attend with the LD person and carer. A shortage of staff is always the same explanation that is given for not attending. Refusing health services as worried about who will care for the LD service user during the night, i.e., offer of overnight stay declined. Not being offered respite according to the level of service user's needs I am not trusting of respite services, as they cannot provide the same level of care.	These services are much better. For example the dentist (D W) is brilliant for people with Learning Disabilities. It is the same experience with the optician who comes to the carer's home: Mansion House Day Centre. The mental health doctor is also very good. Everyone should have support like this.
Disability	No comments	I saw a speech and language therapist from LPT and she was very good, but received better physio from UHL. Transition from one service to another is fine. Seeing the same GP each time helps as they're aware of the patients' needs etc.

2.4 People's complaints about services are handled respectfully and efficiently		
Equality Group	**Negative**	**Positive**
Somali	The complaints process is a long and complicated procedure and language barriers. Community feel ignored and not everyone is aware of discrimination and neglect. LPT - No information around complaints procedure and language barrier an issue. People do not know how to complain but there are many issues.	No comments

Appendix B

Service user and workforce equality monitoring data analysis findings 2014/15 collated against the EDS2 objectives

	Negative	Positive
1 Better health outcomes		
1.1 Services are commissioned, procured, designed and delivered to meet the health needs of local communities	Adult Mental Health Patient Discharge Questionnaire: April 2014 to March 2015 - BME people and people of religions or beliefs other than Christianity or No Religion understood less well why they were taking medication, whilst people of religions or beliefs other than Christianity or No Religion also understood less well the side effects of the medication they were taking. Leicester City Increasing Access to Psychological Therapies Service: April 2014 to March 2015 - Young adults (under 29 years old) were less likely to enter treatment, were more likely to drop out of treatment through an unscheduled discontinuation or through the patient declining treatment (18 to 29 year olds), and were overrepresented amongst those who did not attend their second appointment (18 to 29 year olds).	
1.2 Individual people's health needs are assessed and met in appropriate and effective ways		Leicester City Increasing Access to Psychological Therapies Service: April 2014 to March 2015 - Recovery rates for clinical cases were

		equitable by age, ethnicity, gender, religion or belief, and sexual orientation.
1.3 Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed		
1.4 When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse		
1.5 Screening, vaccination and other health promotion services reach and benefit all local communities		
2 Improved patient access and experience		
2.1 People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds	Leicester City Increasing Access to Psychological Therapies Service: April 2014 to March 2015 - Compared to the age profile of the population of Leicester City aged 16 years old and over, older adults (aged 60 years and over), Asian or Asian British people, and men were underrepresented amongst referrals and those who entered treatment with the IAPT service. - If referred to the IAPT service, Black or Black British and Mixed race people were less likely than other ethnic groups to enter treatment with the service. - Compared to a national estimate for the sexual orientation profile of the population,	Leicester City Increasing Access to Psychological Therapies Service: April 2014 to March 2015 - Compared to a national estimate for the sexual orientation profile of the population, people who were not heterosexual were overrepresented amongst all referrals and amongst those who entered treatment, especially via the OPEN MIND self-referral route.

	people who were not heterosexual were overrepresented amongst all referrals and amongst those who entered treatment, especially via the OPEN MIND self-referral route. Leicestershire Partnership NHS Trust: Adult Mental Health and Learning Disability Services, Community Health Services, Families Young People and Children's Services: April 2014 to March 2015 – In Adult Mental Health and Learning Disability Services there were underrepresentations of younger BME adults (e.g., "other" White, Asian or Asian British, Black or Black British, and Chinese people). – In Families, Young People and Children's Services (mental health) there were underrepresentations of girls, Asian or Asian British children, younger Asian or Asian British and Chinese adults, and young, White British men.	
2.2 People are informed and supported to be as involved as they wish to be in decisions about their care	CQC Mental Health Community Service User Survey 2015 - Younger service users (aged 18 to 35 years old) were less likely to feel as involved as they wanted to be in discussing how their care was working and were less likely to feel that decisions were made together between them and the person they saw during this discussion. Adult Mental Health Patient Discharge	

	Questionnaire: April 2014 to March 2015 - People of religions or beliefs other than Christianity or No Religion felt that they were less involved than they wanted to be in decisions about their care and treatment, and were less involved than they wanted to be in the planning of their discharge from the ward.	
2.3 People report positive experiences of the NHS	Adult Mental Health Patient Discharge Questionnaire: April 2014 to March 2015 - People of religions or beliefs other than Christianity or No Religion gave less positive ratings in terms of - feeling welcome when they arrived on the ward, - feeling that staff knew about their condition and fully understood their needs, - the ease of finding a nurse or another member of staff on the ward that they could talk to about any worries or fears, - feeling the staff were kind and caring towards them while they were on the ward - recommending the ward to friends or family if they needed similar care or treatment.	Adult Mental Health Patient Discharge Questionnaire: April 2014 to March 2015 - The vast majority of respondents (88.3%) were either likely or extremely likely to recommend the ward to friends and family if they needed similar care or treatment.
2.4 People's complaints about services are handled respectfully and efficiently		
3 A representative and supported workforce		
3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	Leicestershire Partnership NHS Trust's substantive workforce as at end March 2015 - Workforce Race Equality Standard	

	- BME people were underrepresented amongst senior managers, - BME people were 0.58 times as likely as (i.e., less likely than) White people to be appointed if shortlisted. Leicestershire Partnership NHS Trust's substantive workforce as at end March 2015 - Men were overrepresented amongst senior managers. - Compared to the local working age population, younger people (29 years old and under), Asian or Asian British people, and men were underrepresented in the workforce. Leicestershire Partnership NHS Trust's NHS Staff Survey 2014 - Disabled staff, BME staff in general (by the WRES definition), Asian or Asian British staff, and Black or Black British staff (especially African and Caribbean staff) were less likely to feel that the organisation acts fairly with regard to career progression / promotion.	
3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations.	Leicestershire Partnership NHS Trust's NHS Staff Survey 2014 - African staff were less satisfied with their level of pay (as were unqualified nurses)	
3.3 Training and development opportunities are taken up and positively evaluated by all staff		Leicestershire Partnership NHS Trust's substantive workforce as at end March 2015 - The uptake of non-mandatory training was equitable across age, disability, ethnicity, gender, marital status, maternity, religion or

		belief, and sexual orientation. Leicestershire Partnership NHS Trust's NHS Staff Survey 2014 - In terms of the percentage of staff whose manager supported them to receive any training, learning or development identified in their appraisal/review, compared to the Trust Benchmark there were no significant variations on this measure by Protected Characteristic. - Staff aged 21 to 30 years old, BME staff overall (as defined in the WRES), Asian or Asian British staff (especially Indian staff), Black or Black British staff (especially African staff), and Muslim staff were more likely to agree that their appraisal/review has helped them to improve how they do their job. - BME staff overall (as defined in the WRES) and Asian or Asian British staff were more likely to feel that their work is valued by the organisation following an appraisal/review.
3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source	Leicestershire Partnership NHS Trust's NHS Staff Survey 2014 - Broadly, Black or Black British staff (and especially African staff) were most at risk of all forms abuse, from service users and colleagues alike, including physical violence from both sources. - Other staff groups and areas at a heightened risk of abuse from service users: - disabled staff, male staff, and staff who were not heterosexual, with patterns varying by type of abuse;	

	- abuse was borne principally by qualified and unqualified nurses. - Other staff groups and areas at a heightened risk of abuse from colleagues: -disabled staff and male staff, with patterns varying by type of abuse; -physical violence was borne principally by unqualified nurses. Amongst those staff who had experienced discrimination at work, the most common grounds of discrimination was ethnicity (as in the National Benchmark); with BME staff disproportionately affected (particularly Asian or Asian British staff and Black or Black British staff, and especially African staff).	
3.5 Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	Leicestershire Partnership NHS Trust's substantive workforce as at end March 2015 – Younger people (29 years old and under), Asian or Asian British people, Black or Black British people, and men were less likely to work part-time.	
3.6 Staff report positive experiences of their membership of the workforce	Leicestershire Partnership NHS Trust's NHS Staff Survey 2014 - Staff aged 51 to 65 years old and disabled staff were less likely to recommend the organisation as a place to work.	Leicestershire Partnership NHS Trust's NHS Staff Survey 2014 - Staff aged 21 to 30 years old, BME staff in general (by the WRES definition); Asian or Asian British staff, African staff, and Muslim staff were more likely to recommend the organisation as a place to work.
4. Inclusive leadership		
4.1 Boards and senior leaders routinely		

demonstrate their commitment to promoting equality within and beyond their organisations		
4.2 Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed		
4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination		

Appendix C

Leicestershire Partnership NHS
NHS Trust

Equality Delivery System 2

Grading for Service Areas – Goals 1 and 2

	Goal 1 - Better Health Outcomes				
	Outcome 1.1	Outcome 1.2	Outcome 1.3	Outcome 1.4	Outcome 1.5
	Services are commissioned, procured, designed and delivered to meet the health needs of local communities.	Individual people's health needs are assessed and met in appropriate and effective ways.	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed.	When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse.	Screening, vaccination and other health promotion services reach and benefit all local communities.
AMH/LD					
CHS					
FYPC					

	Goal 2 - Improved patient access and experience				
	Outcome 2.1	Outcome 2.2	Outcome 2.3	Outcome 2.4	
	People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds.	People are informed and supported to be as involved as they wish to be in decisions about their care.	People report positive experiences of the NHS.	People's complaints about services are handled respectfully and efficiently.	
AMH/LD					
CHS					
FYPC					

Note: The above tables: Goal 1 and Goal 2 have been left blank pending Executive Team decision on whether evidence and information will be supplied against each sub-section of each Goal. On the basis of evidence currently available most would be graded 'Red' with the possibiity of some at 'Amber'.

Grading for Service Areas – Goals 3 and 4

	Goal 3 - A representative and supported workforce					
	Outcome 3.1	Outcome 3.2	Outcome 3.3	Outcome 3.4	Outcome 3.5	Outcome 3.6
	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations	Training and development opportunities are taken up and positively evaluated by all staff	When at work, staff are free from abuse, harassment, bullying and violence from any source	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	Staff report positive experiences of their membership of the workforce
AMH/LD						
CHS						
FYPC						

	Goal 4 - Inclusive Leadership		
	Outcome 4.1	Outcome 4.2	Outcome 4.3
	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination
AMH/LD			
CHS			
FYPC			

Key - Grading Levels

Underdeveloped	
Developed	
Achieving	
Excellent	

Equality Delivery System for the NHS

EDS2 Summary Report

Implementation of the Equality Delivery System – EDS2 is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS2 in accordance with the '9 Steps for EDS2 Implementation' as outlined in the 2013 EDS2 guidance document. The document can be found at: **http://www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf**

This *EDS2 Summary Report* is designed to give an overview of the organisation's most recent EDS2 implementation. It is recommended that once completed, this Summary Report is published on the organisation's website.

NHS organisation name:

Leicestershire Partnership NHS Trust

Organisation's Board lead for EDS2:

Peter Miller and Alan Duffell

Organisation's EDS2 lead (name/email):

Sarah Willis and Sandy Zavery

Level of stakeholder involvement in EDS2 grading and subsequent actions:

The Trust in partnership with local Trust have undertaken a number of engagement activity with service users, patients, carers and staff. The work has entailed capturing positive and negative experiences. The information has been gathered and a report pulled together to help the Trust assess what further work needs to be done to improve outcomes.

The Big conversation has led to engagement with staff and service users, patients, carers and community and voluntary groups to confirm our grades and start to progress our work around improving health and wellbeing for target groups.

Organisation's Equality Objectives (including duration period):

The equality objectives entail (from 2013 - 2017):

- Continue to deliver the current LLR equality Objectives from an LPT perspective;
- Develop, consult and launch the Single Equality Approach and Action Plan in line with the revised Equality Delivery System (EDS2);
- Develop and implement training to support staff in the delivery of service to the diverse community of LLR;
- Work in partnership with other agencies to address specific issues faced by target

Headline good practice examples of EDS2 outcomes (for patients/community/workforce):

To access evidence provided by all service in context of the EDS2 agenda please cut and paste this link into your web browser - http://www.leicspart.nhs.uk/_Aboutus-EqualityandHumanRights-EqualityDeliverySystem2.aspx

Publication Gateway Reference Number: 03247

Date of EDS2 grading March 2016 **Date of next EDS2 grading** March 2017

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Better health outcomes	1.1	**Services are commissioned, procured, designed and delivered to meet the health needs of local communities** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ☐ Age; ☐ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ☐ Sex; ☐ Sexual orientation Evidence drawn upon for rating: • Procurement activity consider positive equality outcomes i.e. do suppliers have a commitment to equality and diversity; • Due regard is undertaken in all activities in order the service cater for the population that it targets i.e. access for disabled people such as understanding treatments, easy read material used, BSL interpreters provided, promotional material, etc.	☐
	1.2	**Individual people's health needs are assessed and met in appropriate and effective ways** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ☐ Age; ☐ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ☐ Sex; ☐ Sexual orientation Evidence drawn upon for rating: • Communication is provided in the most appropriate format to ensure service users carers etc. understand what the Trust is doing in respect of their care. This includes the provision of interpretation and translation services (Ujala) across the trust – Service is promoted on the Trust intranet and web site • Interpretation and translation volumetric data is analysed to determine trends and ongoing need	☐
	1.3	**Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ☐ Age; ☐ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ☐ Sex; ☐ Sexual orientation Evidence drawn upon for rating: • Information throughout the transition process is clear for the patient and the other service areas/providers. For example; clear communication of special needs/reasonable adjustments such as translation of documentation, contact needs, dietary requirements, etc. • Care pathways have been fully explained and patients understand the process and reason for changes;	☐

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Better health outcomes, continued	1.4	**When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ☐ Age ☐ Disability ☐ Gender reassignment ☐ Marriage and civil partnership ☐ Pregnancy and maternity ☐ Race ☐ Religion or belief ☐ Sex ☐ Sexual orientation Evidence drawn upon for rating: • Patients are treated with dignity and respect; Refer to Trust aims vision and equality diversity and human rights policy • Any mistakes are identified, rectified and a blame free culture; add relevant policies and procedures to evidence this • Staff are comfortable with reporting issues of abuse, mistreatment and inappropriate behaviour that impacts on the patients care; for example refer to raising concerns and whistle blowing policy.	☐
	1.5	**Screening, vaccination and other health promotion services reach and benefit all local communities** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ☐ Age ☐ Disability ☐ Gender reassignment ☐ Marriage and civil partnership ☐ Pregnancy and maternity ☐ Race ☐ Religion or belief ☐ Sex ☐ Sexual orientation Evidence drawn upon for rating: • Promotional material effectively targets the diverse communities in Leicester, Leicestershire and Rutland; (give examples of young, older, disabled, BME communities . Nasal flu application good example of targeting equality groups • Promotional material is communicated to local communities in a way that is understandable and easy to read; • Access to services are promoted internally effectively, so staff are	☐
Improved patient access and experience	2.1	**People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ☐ Age ☐ Disability ☐ Gender reassignment ☐ Marriage and civil partnership ☐ Pregnancy and maternity ☐ Race ☐ Religion or belief ☐ Sex ☐ Sexual orientation Evidence drawn upon for rating: • Communication of services are made available in different formats that clearly outline the service delivery in specific areas. For example; Bradgate Unit, Marlyn Vaz Centre, learning disabilities etc.; • Smoking prevalence's taking account of LGB & T people and targeting young people, BME communities etc. who are identified at high risk (documented in LGB & T Public Health Outcomes	☐

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Improved patient access and experience	2.2	**People are informed and supported to be as involved as they wish to be in decisions about their care** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ☐ Age ☐ Disability ☐ Gender reassignment ☐ Marriage and civil partnership ☐ Pregnancy and maternity ☐ Race ☐ Religion or belief ☐ Sex ☐ Sexual orientation Evidence drawn upon for rating: • Patients are involved in their care plans. For example: they understand the care pathway and agree with the delivery of care; • Reasonable Adjustment made to meet individual needs. For example; treatment/care takes into consideration individuals request (where applicable), BSL interpreters provided to support understanding, spiritual needs met in line with religious requirements, etc. The Trust has signed up to and delivering on the	☐
	2.3	**People report positive experiences of the NHS** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ☐ Age ☐ Disability ☐ Gender reassignment ☐ Marriage and civil partnership ☐ Pregnancy and maternity ☐ Race ☐ Religion or belief ☐ Sex ☐ Sexual orientation Evidence drawn upon for rating: • Staff promote and raise awareness of the feedback forms, format and accessibility • Information gathered is monitored by the nine protected characteristics;	☐
	2.4	**People's complaints about services are handled respectfully and efficiently** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ☐ Age ☐ Disability ☐ Gender reassignment ☐ Marriage and civil partnership ☐ Pregnancy and maternity ☐ Race ☐ Religion or belief ☐ Sex ☐ Sexual orientation Evidence drawn upon for rating: • Complaints are dealt with and issues addressed openly and transparently. • Complaints are monitored to address any patterns in issues arising by protected characteristics; Provide evidence to support this.	☐

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
A representative and supported workforce	3.1	**Fair NHS recruitment and selection processes lead to a more representative workforce at all levels** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation **Evidence drawn upon for rating:** The better retention of staff by promoting their health and well-being is favoured over using agency staff and international recruitment. The Trust monitors the workforce makeup to ensure we start to improve the representation across protected groups. We have a recruitment strategy that will focus our work to ensure we target areas which increases awareness among local population.	☐
	3.2	**The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation **Evidence drawn upon for rating:** The Trust has implemented the Agenda for Change terms and conditions. The provisions set out in this handbook are based on the need to ensure a fair system of pay for NHS employees which supports modernised working practices. The national partners have agreed to work together to meet the reasonable aspirations of all the parties to: • ensure that the pay system leads to more patients being treated,	☐
	3.3	**Training and development opportunities are taken up and positively evaluated by all staff** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation **Evidence drawn upon for rating:** The Trust has committed to develop its staff to be the best they can be. The Learning and Development team are available to support that commitment by providing training, organisational development and leadership development, quality improvement and innovation and multi-professional education and practice. All staff are required to attend the Trust induction and this is then followed up by mandatory training every 3 years.	☐

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
A representative and supported workforce	3.4	**When at work, staff are free from abuse, harassment, bullying and violence from any source** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ☑ Age; ☑ Disability; ☑ Gender reassignment; ☑ Marriage and civil partnership; ☑ Pregnancy and maternity; ☑ Race; ☑ Religion or belief; ☑ Sex; ☑ Sexual orientation Evidence drawn upon for rating: We also have specific policies that deal with individual circumstances such as gender-reassignment policy providing guidance for managers and staff to have appropriate consideration for individuals who require specific leave in this area. The Trust has formal procedures in place to deal with and tackle issues of inappropriate behaviour. Additionally, we have the anti-bullying and harassment advice service, which provide staff	☐
	3.5	**Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ☑ Age; ☑ Disability; ☑ Gender reassignment; ☑ Marriage and civil partnership; ☑ Pregnancy and maternity; ☑ Race; ☑ Religion or belief; ☑ Sex; ☑ Sexual orientation Evidence drawn upon for rating: The Trust has a number of policies that help staff to consider flexible options such as: • Flexible working practices; • Careers breaks • Term time only; • Part-time working; • Home working options;	☐
	3.6	**Staff report positive experiences of their membership of the workforce** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ☑ Age; ☑ Disability; ☑ Gender reassignment; ☑ Marriage and civil partnership; ☑ Pregnancy and maternity; ☑ Race; ☑ Religion or belief; ☑ Sex; ☑ Sexual orientation Evidence drawn upon for rating: The Trust acquires evidence of the staff experience through the annual National Staff Survey, Exit Interviews and the quarterly Pulse Survey. AMH & LD have an agreed staff survey action plan for 2015 to help address areas where the responses are not positive and of concern to the senior leadership team. All sources of feedback from staff are scrutinised by the AMH & LD Workforce Group with actions implemented to improve the staff experience.	☐

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Inclusive leadership	4.1	**Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ☑ Age; ☑ Disability; ☑ Gender reassignment; ☑ Marriage and civil partnership; ☑ Pregnancy and maternity; ☑ Race; ☑ Religion or belief; ☑ Sex; ☑ Sexual orientation Evidence drawn upon for rating: LPT Trust Board and senior leaders routinely receive and demonstrate commitment to the equality agenda. The area of work has entailed: • Bi-annual briefing papers to Trust Board • Bi-annual briefing papers to Strategic Workforce Group – Chaired by Chief Executive with attendance by Executive Teams; • Embedding the Equality Delivery System 2 into Trust Business	☐
	4.2	**Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ☑ Age; ☑ Disability; ☑ Gender reassignment; ☑ Marriage and civil partnership; ☑ Pregnancy and maternity; ☑ Race; ☑ Religion or belief; ☑ Sex; ☑ Sexual orientation Evidence drawn upon for rating: The Equality agenda is monitored through various avenue to ensure risks are managed. This will entail; • Through the Trust Business Plans and Service Plans; • The Quality Schedule, Clinical Quality Review Group, Quality Assurance Committee, Better Care Together, etc. • Management of Change processes that improve the service and employment practices;	☐
	4.3	**Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ☑ Age; ☑ Disability; ☑ Gender reassignment; ☑ Marriage and civil partnership; ☑ Pregnancy and maternity; ☑ Race; ☑ Religion or belief; ☑ Sex; ☑ Sexual orientation Evidence drawn upon for rating: • Equality Training for staff covering anti-bullying and harassment, general equality awareness, cultural awareness and due regard; • Equality being embedded with the training modules delivered by the learning and development centre; • Surveys undertake to identify issues, over and above the annual Staff Survey such as pilot survey in HR to assess whether discrimination was an issue, bullying and harassment survey, pulse	☐

Workforce Race Equality Standard

REPORTING TEMPLATE (Revised 2016)

Name of organisation: Leicestershire Partnership Trust

Date of report: July 2016

Name and title of Board lead for the Workforce Race Equality Standard: Alan Duffell

Name and contact details of lead manager compiling this report: Sandy Zavery (sandy.zavery@leicspart.nhs.uk)

Names of commissioners this report has been sent to (complete as applicable):

Name and contact details of co-ordinating commissioner this report has been sent to (complete as applicable): Dan Whalley

Unique URL link on which this Report and associated Action Plan will be found:

This report has been signed off by on behalf of the Board on (insert name and date):

DRAFT

1. Background narrative

a. Any issues of completeness of data

At March 2016, ethnicity was known for 97.76% of the substantive workforce.

b. Any matters relating to reliability of comparisons with previous years

Where the methods of calculating an indicator have changed since the previous year, the previous year's indicator has been recalculated to the latest standard to facilitate comparison.

2. Total numbers of staff

a. Employed within this organisation at the date of the report

5574 substantive staff (including executive and non-executive board members)

b. Proportion of BME staff employed within this organisation at the date of the report

20.13%

DRAFT

3. Self reporting

a. The proportion of total staff who have self–reported their ethnicity

97.76%

b. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity

November / December 2015: “Listening into Action” roadshow across Trust sites to garner information on barriers to providing equality monitoring information; followed by a request to employees in March 2016 to update their equality monitoring information on the electronic staff record, giving assurances over confidentiality, the purposes for which the information will be used, and offering an example of a positive outcome related to the use of the information (a leadership mentoring programme for BME staff).

c. Are any steps planned during the current reporting period to improve the level of self reporting by ethnicity

Annual request to staff to update their equality monitoring information on the electronic staff record, supported by assurances over confidentiality, the purposes for which the information will be used, and offering examples of positive outcomes for staff related to the use of the information.

4. Workforce data

a. What period does the organisation’s workforce data refer to?

Staff in post at the end of March 2016
Recruitment in the 15/16 financial year
Disciplinary cases opened in the 14/15 and 15/16 financial years
Non-mandatory training undertaken in the 15/16 financial year
NHS Staff Survey undertaken in November and December 2015

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For each of these four workforce indicators, compare the data for White and BME staff

15/16	14/15	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective

1. Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.

Pay Band	Total n	% BME
Non Clinical - Apprentice	16	18.75%
Non Clinical - Band 2	245	29.80%
Non Clinical - Band 3	306	28.10%
Non Clinical - Band 4	208	24.04%
Non Clinical - Band 5	122	23.77%
Non Clinical - Band 6	102	24.51%
Non Clinical - Band 7	100	21.00%
Non Clinical - Band 8a	59	16.95%
Non Clinical - Very Senior Manager	89	7.87%
Clinical - Apprentice	5	20.00%
Clinical - Band 2	564	26.95%
Clinical - Band 3	460	11.74%
Clinical - Band 4	180	10.00%
Clinical - Band 5	989	20.22%
Clinical - Band 6	1129	12.84%
Clinical - Band 7	459	11.98%
Clinical - Band 8a	121	12.40%
Clinical - Band 8b	55	20.00%
Clinical - Band 8c	10	0.00%
Clinical - Band 8d	8	12.50%
Clinical - Very Senior Manager	17	35.29%
Clinical - Medical Training Grade	84	71.43%
Clinical - Medical Career Grade	121	61.98%
Overall	5449	20.13%

Explanatory note regarding the definition of Very Senior Managers (VSM):

The WRES technical guidance suggests defining VSM using the following methods (taken verbatim from the guidance):
- Occupational Codes starting 'G0' = AfC Band 8a and over, most commonly 8d and above in larger

Pay Band	Total n	% BME
Non Clinical - Apprentice	14	50.00%
Non Clinical - Band 2	211	28.44%
Non Clinical - Band 3	287	24.39%
Non Clinical - Band 4	204	22.06%
Non Clinical - Band 5	133	26.32%
Non Clinical - Band 6	112	27.68%
Non Clinical - Band 7	97	18.56%
Non Clinical - Band 8a	63	20.63%
Non Clinical - Very Senior Manager	86	10.47%
Clinical - Apprentice	13	7.69%
Clinical - Band 2	593	23.44%
Clinical - Band 3	447	12.75%
Clinical - Band 4	159	9.43%
Clinical - Band 5	1013	20.14%
Clinical - Band 6	1088	11.76%
Clinical - Band 7	463	12.31%
Clinical - Band 8a	121	12.40%
Clinical - Band 8b	52	17.31%
Clinical - Band 8c	12	8.33%
Clinical - Band 8d	9	11.11%
Clinical - Very Senior Manager	15	40.00%
Clinical - Medical Training Grade	87	59.77%
Clinical - Medical Career Grade	124	58.06%
Overall	5403	19.34%

At March 2016:

Non-clinical:

- BME staff were overrepresented at lower pay bands (2 and 3), with a tendency for lower levels of representation at bands 8a and above. This pattern largely reflects the distribution of Asian British staff in the non-clinical workforce who were especially overrepresented at band 2, but also at bands 3, 4, and 6.

Clinical:

- Unqualified roles (bands 2 to 4; essentially additional clinical services): BME people were overrepresented at the lowest pay band (2) and underrepresented at higher bands (3 and 4);
- Qualified roles (band 5 and above): BME people were underrepresented at middle pay bands (6 and 7). Specifically, Asian British staff were overrepresented in Medical roles and underrepresented in other qualified clinical roles (bands 5 to 7, essentially nursing roles). Whilst, Black British staff were overrepresented in the lowest

Action points:

In clinical and non-clinical roles:

Addressing the underrepresentation of BME staff at the higher pay bands;

- Positive action initiatives internally and externally that raise awareness of the recruitment and selection process;
- Mentoring, coaching and development programmes (e.g., outline career progress journey) targeted at Non Clinical Bands 2 and 3, and Clinical Band 2 and Band 5 (nurses), to support progression to higher pay bands, with an emphasis on promoting the participation of BME staff;
- Raise awareness at local and national level of the need to develop initiatives that encourage people into nursing roles, ensuring an approach that will engage Asian British people;

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organisations (such as acute trusts) and potentially from 8a in smaller organisations, and VSM. (See Occupational Code Manual for further guidance). - Occupation Code Z2E = Chair and Non-Exec Directors (Not necessary if identified using Job Roles as below.) - Job Roles: Chair, Chief Executive; Finance Director; Other Exec Director; Board Level Director; Non-Exec Director; Senior Manager (Reports to a Board Member) Based on this guidance, for LPT, everyone at band 8b and above in a non-clinical role has been defined as a Very Senior Manager. Defining Very Senior Managers amongst clinical staff was more difficult (ESR offers no clear indication regarding which clinicians have significant management responsibilities). Organisational charts have been used to identify clinical directors and the tier of clinical management below them.		unqualified pay band (2) and the lowest qualified pay band (5). Comparing the distribution of BME staff within the workforce at March 2015 with that at March 2016, the overrepresentation of BME staff at lower pay bands was more pronounced at March 2016.	• Provide support to assist unqualified clinical staff on low pay bands to gain the qualifications necessary for qualified clinical roles. Action taken: A specific, in-depth survey of discrimination and issues regarding career progression in the Adult Mental Health and Learning Disability division (AMH&LD) has been undertaken in conjunction with AMH&LD's senior leadership team (November / December 2015). A working group has been set up to deal with the issues arising. Action planned AMH&LD staff will be surveyed again (in November / December 2016, depending upon the progress of the working group) to determine if the identified issues have been addressed.
2. Relative likelihood of staff being appointed from shortlisting across all posts.			
Relative likelihood = 0.61	**Relative likelihood = 0.58**	BME people were less likely than White people to be appointed if	Encourage and promote applications from BME people to

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BME people were 0.61 times as likely as (i.e., less likely than†) White people to be appointed if shortlisted.	BME people were 0.58 times as likely as (i.e., less likely than†) White people to be appointed if shortlisted.	shortlisted. More detailed analysis of the recruitment process indicated that BME people were overrepresented amongst applicants (based on expectations derived from the local population; 2011 Census), but were underrepresented amongst those shortlisted and amongst those appointed. This might reflect that BME people were overrepresented in posts at lower pay bands – when advertised these posts attract greater numbers of candidates per post.	posts at higher pay bands. A particular area to target would be the promotion of qualified nursing roles to Asian British people. Offer support in making strong applications.
3. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year.			
Relative likelihood = 1.12 BME staff were 1.12 times as likely as (i.e., equally likely† compared to) White staff to enter a formal disciplinary process. (Cases opened in 14/15 and 15/16.)	**Relative likelihood = 1.63** BME staff were 1.63 times as likely as (i.e., more likely than†) White staff to enter a formal disciplinary process. (Cases opened in 13/14 and 14/15.)	BME and White staff were equally likely to enter a formal disciplinary process. (Cases opened in 14/15 and 15/16.) The greater likelihood of BME staff entering a formal disciplinary process seen in the 13/14 to 14/15 two-year window was not apparent in the 14/15 to 15/16 two-year window.	Continue to monitor the equality profile of those entering disciplinary proceedings (this is part of our wider workforce equality monitoring scheme).

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4. Relative likelihood of staff accessing non-mandatory training and CPD.			
Relative likelihood = 0.86 BME staff were 0.86 times as likely as (i.e., less likely than†) White staff to access non-mandatory training.	**Relative likelihood = 0.93** BME staff were 0.93 times as likely as (i.e., less likely than†) White staff to access non-mandatory training‡. ‡ The relative likelihood appears close to 1; however, both outcomes (BME and white accessing non-mandatory training) were common (86.1% and 92.7% respectively) – under these circumstances an odds ratio is a better indicator. The odds ratio was 0.49 – the odds of BME staff accessing non-mandatory training was less than half the odds of white staff accessing non-mandatory training.	BME staff were less likely than White staff to access non-mandatory training. Additional analysis indicated that Asian British people in particular were less likely to access non-mandatory training (relative likelihood vs White staff = 0.76). This might reflect occupational segregation. Qualified nursing staff (where Asian British people were underrepresented) were most likely to undertake non-mandatory training; whilst Medical and Administrative and Clerical staff (where Asian British people were overrepresented) were least likely to undertake non-mandatory training. The non-mandatory training included in this indicator covers only that logged on U-learn (the central electronic training record). Unfortunately, some training delivered locally or sourced externally is not recorded centrally and will not be reflected in this indicator; this issue will have affected Medical staff more than other groups. BME people are overrepresented amongst Medical Training Grade Staff; consequently the present figure may underestimate the likelihood of BME staff accessing non-mandatory training. Work is planned to log all training on U-learn.	Review the provision of non-mandatory training to Administrative and Clerical roles and assess its efficacy in supporting career development. Record all non-mandatory training centrally, on U-learn.

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National NHS Staff Survey indicators (or equivalent). For each of the four staff survey indicators, compare the outcomes of the responses for White and BME staff.			
15/16	**14/15**	**Narrative – the implications of the data and any additional background explanatory narrative**	**Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective**
5. KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.			
% **BME** **28.65%** **White** **27.46%** BME ≈ White	**%** **BME** **26.43%** **White** **28.38%** BME ≈ White	BME and White people were equally likely to experience harassment, bullying or abuse from patients, relatives or the public. Further analysis indicated a specific problem for Black British staff (46.99% of whom experienced harassment, bullying or abuse from patients, relatives or the public); this may reflect the overrepresentation of Black British staff in frontline, low band additional clinical services roles and low band qualified nursing roles.	The Trust continues to raise awareness of its anti-bullying and harassment policies and process to ensure that staff are aware of how to deal with inappropriate behaviour and how to report incidents. Training on dealing with abuse from service users is provided and is targeted to frontline staff. For instance, training in Management of Actual or Potential Aggression (MAPA) Disengagement Skills is mandatory for frontline staff in mental health services.

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6. KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.			
% **BME** **24.79%** **White** **20.64%** BME ≈ White	**%** **BME** **23.84%** **White** **20.30%** BME ≈ White	BME and White people were equally likely to experience harassment, bullying or abuse from staff. Further analysis indicated a specific problem for Black British staff in terms of harassment, bullying or abuse from colleagues (as opposed to from managers): 26.83% of Black British staff compared to 14.73% of White staff.	Action taken: An in-depth survey of bullying and harassment in AMH&LD has been undertaken in conjunction with AMH&LD's senior leadership team (November / December 2015). This survey identified particular issues around staff-on-staff bullying and harassment for Black British staff, and particular issues around staff-on-staff physical violence for bank staff (who were disproportionately more likely to be from a BME background, especially Black British). A working group has been set up to deal with the issues arising. Action planned: AMH&LD staff will be surveyed again (in November / December 2016, depending upon the progress of the working group) to determine if the identified issues have been addressed. The Trust continues to raise awareness of its anti-bullying and harassment policies and processes to ensure that staff are aware of how to deal with inappropriate behaviour and how to report incidents.
7. KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.			

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<table><tr><th></th><th>%</th></tr><tr><td>**BME**</td><td>**74.79%**</td></tr><tr><td>**White**</td><td>**92.45%**</td></tr></table> BME < White†	<table><tr><th></th><th>%</th></tr><tr><td>**BME**</td><td>**76.29%**</td></tr><tr><td>**White**</td><td>**90.62%**</td></tr></table> BME < White†	BME people were less likely to believe that the Trust provides equal opportunities for career progression or promotion. This finding may be linked to the finding that BME people are overrepresented at lower pay bands in Indicator 1 and may point to a specific issue around career development.	Action taken: A specific, in-depth survey of discrimination and issues regarding career progression in AMH&LD has been undertaken in conjunction with AMH&LD's senior leadership team (November / December 2015). A working group has been set up to deal with the issues arising. Action planned: AMH&LD staff will be surveyed again (in November / December 2016, depending upon the progress of the working group) to determine if the identified issues have been addressed. Measures to aid career progression for BME people are outlined against Indicator 1
8. Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues			

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<table><tr><th></th><th>%</th></tr><tr><td>**BME**</td><td>**12.92%**</td></tr><tr><td>**White**</td><td>**5.43%**</td></tr></table> BME > White†	<table><tr><th></th><th>%</th></tr><tr><td>**BME**</td><td>**14.29%**</td></tr><tr><td>**White**</td><td>**5.58%**</td></tr></table> BME > White†	BME people were more likely to have experienced discrimination at work from a manager, team leader or other colleagues. This finding may be linked to the finding that BME people are overrepresented at lower pay bands in Indicator 1 and may point to discrimination experienced in terms of career development.	Action taken: An in-depth survey of discrimination in AMH&LD has been undertaken in conjunction with AMH&LD's senior leadership team (November / December 2015). This survey identified particular issues around discrimination affecting career progression for BME staff. A working group has been set up to deal with the issues arising. Action planned: AMH&LD staff will be surveyed again (in November / December 2016, depending upon the progress of the working group) to determine if the identified issues have been addressed. Measures to aid career progression for BME people are outlined against Indicator 1

Board representation indicator. For this indicator, compare the difference for White and BME staff			
15/16	**14/15**	**Narrative – the implications of the data and any additional**	**Action taken and planned including e.g. does the**

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		background explanatory narrative	indicator link to EDS2 evidence and/or a corporate Equality Objective
9. Percentage difference between the organisations' Board voting membership and its overall workforce.			
-12.44%	-12.20%	BME people were underrepresented on the board relative to their level of representation in the workforce overall.	Promote the development of board-level skills amongst staff with an emphasis on developing and mentoring BME staff for such roles.

† Statistically significant (α = .05)

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Leicestershire Partnership NHS
NHS Trust

Equality and Human Rights Team

Appendix 4

Summary of Main Findings from the Equality Monitoring of Service Users in the 14/15 Financial Year

Table of Contents

1 Introduction

This report brings together a summary of findings from the equality monitoring of service users in the 2014/15 financial year. The summary is organised under headings that are derived from five separate reports that were published on our website at the end of January 2016, in accordance with the requirements of the Equality 2010 and the Public Sector Equality Duty:

- Leicestershire Partnership NHS Trust: Adult Mental Health and Learning Disability Services, Community Health Services, Families Young People and Children's Services: April 2014 to March 2015; A quantitative equality analysis of service users' access to mental health services, care episode events, and outcome scores
- Leicester City Increasing Access to Psychological Therapies Service: April 2014 to March 2015; Summary of a quantitative equality analysis of access, outcomes, and experience indicators for users of the Increasing Access to Psychological Therapies service
- Adult Mental Health Patient Discharge Questionnaire: April 2014 to March 2015; A quantitative equality analysis considering ward, age, gender, ethnicity, religion or belief, and sexual orientation
- Leicestershire Partnership NHS Trust: CQC Mental Health Community Service User Survey 2015; A quantitative equality analysis considering organisational unit, age, gender, and ethnicity: Summary of findings
- Leicestershire Partnership NHS Trust: Adult Mental Health and Learning Disability Services, Community Health Services, Families, Young People, and Children's Services: April 2014 to March 2015; A quantitative equality analysis of complainants

The published reports can be accessed at http://www.leicspart.nhs.uk/_Aboutus-EqualityandHumanRights-PublicationofEqualityInformation.aspx under the headings "Equality information for the 2014/15 financial year, published January 2016" and "Information about our service users." Information about the Leicester City Increasing Access to Psychological Therapies Service is included for completeness; however, the service has since moved to another provider.

The intention of the reports is to inform service delivery, planning, and decision-making. Some of the findings within the reports may reflect differences in need and the types of conditions treated for different groups of people. Other findings may reflect equality issues that can be addressed by the Trust. There will be a need to identify those areas where the Trust can make a difference and to prioritise actions to address these areas.

Suggested priority areas (other areas identified in the reports summarised below might also be addressed, there will be a need to review each report and determine priorities):

- Investigate and address the finding that Asian British people are underrepresented amongst those accessing mental health services; are there barriers to access that can be addressed by the Trust?

- Increase the number of service users who complete and return the Adult Mental Health Patient Discharge Questionnaire.

- The Adult Mental Health Patient Discharge Questionnaire identified that people of minority religions or beliefs (those other than Christianity or no religion)
    - give less positive ratings of their care on an adult mental health ward,
    - were less likely to understand the reasons for taking medication and the side effects of the medication taken,
    - were less likely to feel involved in decisions about their care and treatment and discharge from the ward,
    - and were less likely to recommend the ward to friends and family if they needed similar care or treatment.

- The CQC Mental Health Community Service User Survey 2015 identified that younger service users (aged 18 to 35 years old)
    - were less likely to feel that the person they saw listened to them carefully and were less likely to feel that they were given enough time to discuss their needs,
    - and were less likely to feel as involved as they wanted to be in discussing how their care was working and were less likely to feel that decisions were made together between them and the person they saw during this discussion.

- Increase the completeness of equality monitoring information held within our patient information systems by upgrading the systems to hold all equality monitoring information (Integrated Information Team) and asking equality monitoring questions of all service users.

Clinical Commissioning Groups expect that equality issues to be acted upon will be identified, that action plans will be developed and implemented to address these issues at service or Trust level as appropriate, and that progress against these actions plans will be monitored and reported back to the Clinical Commissioning Groups. It is the responsibility of services to develop, implement, and monitor action plans to address prioritised equality issues. It is the responsibility of the Equality and Human Rights Team to report back to Clinical Commissioning Groups on what equality issues are being addressed and on progress in addressing these issues.

2 Leicestershire Partnership NHS Trust: Adult Mental Health and Learning Disability Services, Community Health Services, Families Young People and Children's Services: April 2014 to March 2015; A quantitative equality analysis of service users' access to mental health services, care episode events, and outcome scores

Below, the main findings of the analyses are summarised under the headings of data quality, service use, care episode events, and Health of Nation Outcome Scores. Only service lines featured on the MARACIS and RiO databases are covered; consequently these analyses look primarily at the provision of mental health care.

2.1 Data quality

- At present, disability, gender reassignment, and pregnancy and maternity are not monitored on the RiO or MARACIS databases. (A "mobility index" is recorded on MARACIS, but not disability itself.)

- In data used for the present analyses, there were high levels of missing data for the protected characteristics of religion or belief and sexual orientation and potentially significant levels of missing data for the protected characteristics of ethnicity and marital status. There is also a possibility that those service users with missing data will be concentrated in certain subgroups. As such, analyses of ethnicity should be regarded as potentially flawed and should be interpreted with caution (analyses of the other protected characteristics with high levels of missing data were not undertaken).

- Assuming that the missing data codes have been used correctly during data entry, the missing data appear to be predominantly of the "NULL" or "not recorded" type (the service user was either not asked the equality monitoring question or their response was not recorded). Additionally, data on some protected characteristics are not available at all for the purposes of equality monitoring (pregnancy and maternity, gender reassignment).

- Data on service users within the prison service were not available at the time of undertaking the analyses reported.

- **Recommendation**: It is recommended that steps are taken to promote the collection of complete equality monitoring data across all protected characteristics, ensure that all equality monitoring questions are asked, and to make all necessary data available for analysis.

2.2 Service use

- When comparing observed levels of service use with that expected based on representations in the local population, there was evidence that some groups of people were underrepresented amongst service users (please refer to Table 1 for a summary). This underrepresentation may reflect differing patterns of need in different sections of the local population, or it may reflect unmet need for some groups of people. Leicestershire Partnership NHS Trust is principally a provider of secondary care mental health services – underrepresentations in service use may potentially arise from barriers to seeking treatment (e.g., unwillingness, inability, lack of knowledge) or barriers and difficulties in gaining referral from primary care.

- The analyses were compartmentalised by age, ethnicity, and gender to isolate associations between service use and any one of these factors at a time.

- **Adult Mental Health and Learning Disability Services: Community, Prisons, and Learning Disabilities:**
  - there were underrepresentations of younger BME adults (especially "other" White, Asian or Asian British, and Chinese people), with variations by age band and gender, but especially for women.

- **Adult Mental Health and Learning Disability Services: Inpatient, Crisis, and Liaison:**
  - there were underrepresentations of younger BME adults (especially "other" White, Asian or Asian British, Black or Black British, and Chinese people), with variations by age band and gender, and more markedly for women.

- **Community Health Services:**
  - there was an underrepresentation of older, White British men in CHS; the underrepresentation of men probably reflects that the older demographic served by CHS is disproportionately female due to the greater longevity of women and that compartmentalisation in a "75 years old and over" age band may not have adequately controlled for this influence.

- **Families, Young People and Children's Services:**
  - there was an underrepresentation of girls;
  - there was an underrepresentation of Asian or Asian British children;
  - there were underrepresentations of younger Asian or Asian British and Chinese adults (varying across age bands);
  - there was an underrepresentation of young, White British men.

- **Recommendation**: It is recommended that further investigation is undertaken into these areas to ensure that access to services is equitable and in line with need for the groups outlined above (please refer to Table 1 for a summary).

Table 1: A summary of areas of underrepresentation and thus potential unmet need, broken down by demographic group and service

Group	AMH LD: CPLD	AMH LD: ICL	CHS	FYPC
Asian or Asian British children				X
Girls				X
Young, Asian or Asian British and Chinese adults	X	X		X
Young BME adults in general, especially women	X	X		
Young White British Men				X
Older White British men			X	

2.3 Care episode events

- Variations in the experience of adverse care episode events were noted by age, gender, ethnicity, and service (please refer to Table 2 for a summary). These differences may reflect differences in the nature and severity of the conditions treated, and contribute to our understanding of the experiences of different groups.

- **Assault, mental health act use, restraint, and seclusion**: In AMH LD: CPLD, AMH LD: ICL, and FYPC some BME groups (especially Black or Black British and Asian or Asian British people) were more likely to experience being involved in assault, mental health act use, restraint, and seclusion, with patterns varying by event type, age, and gender.

- **Self-harm**: Various groups were identified as being at heightened risk of self-harm, with variations across services: Young White British women in AMH LD: CPLD and AMH LD: ICL; people aged 75 years old and over in AMH LD: ICL; people aged 50 to 74 years old in CHS; and people aged 16 to 29 and 30 to 49 years old in FYPC.

- **Seclusion**: Men were at a heightened risk of seclusion in AMH LD: CPLD and AMH LD: ICL.

- **Assault and restraint**: In CHS, men were at a heightened risk of being involved in assault and restraint, especially amongst White British people aged 75 years old and over.

- **Mental health act usage**: In CHS, those aged 50 to 74 years old were at a heightened risk of mental health act usage.

- **Delayed discharge**: Various groups were identified as being at heightened risk of delayed discharge, with variations across services: people from a White background other than British or Irish, especially amongst women aged 50 to 74 years old in AMH LD: CPLD; men, those aged 50 to 74 years old, Asian or Asian British people, and people from “other” ethnic groups in AMH LD: ICL; women from amongst White Irish people aged 75 years old and over, and men in general in CHS; Asian or Asian British people and people from a White background other than British or Irish in FYPC.

- **Recommendation**: It is recommended that further investigation is undertaken into the above areas to assess whether care episode events experienced by service users reflect need or the conditions being treated, rather than any systematic bias or other form of discrimination (please refer to Table 2 for a summary).

Table 2: Services where certain groups experienced a greater likelihood of experiencing an adverse care episode event by age, gender, ethnicity, and event type

		Assault, Restraint	Mental health act use	Seclusion	Self-harm	Delayed discharge
Some BME groups (especially Black or Black British and Asian or Asian British people)		AMH LD: CPLD AMH LD: ICL FYPC	AMH LD: CPLD AMH LD: ICL FYPC	AMH LD: CPLD AMH LD: ICL FYPC		
Men				AMH LD: CPLD AMH LD: ICL		AMH LD: ICL CHS
Young White British women					AMH LD: CPLD AMH LD: ICL	
People aged 75 years old and over					AMH LD: ICL	
People aged 50 to 74 years old			CHS		CHS	AMH LD: ICL
People aged 16 to 29 and 30 to 49 years old					FYPC	
Men, especially amongst White British people aged 75 years old and over		CHS				
Various ethnic groups, varying by service	People from a White background other than British or Irish (especially amongst women aged 50 to 74 years old in AMH LD: CPLD)					AMH LD: CPLD FYPC
	People from "other" ethnic groups					AMH LD: ICL
	Asian or Asian British people					AMH LD: ICL FYPC
	Women from amongst White Irish people aged 75 years old and over					CHS

2.4 Health of Nation Outcome Scores

- Variations in the prevalence of conditions requiring formal action (summary in Table 3), recovery from these conditions in the year (summary in Table 4), and improvement in these conditions in the year (summary in Table 5) were noted by age, gender, ethnicity, and service. Again, these differences may reflect differences in the nature and severity of the conditions treated, and contribute to our understanding of the experiences of different groups.

Overactive, aggressive, disruptive or agitated behaviour:

- Men were at a greater risk in AMH LD: CPLD, AMH LD: ICL, CHS, and FYPC; and over the year men were less likely to recover on this measure in CHS and FYPC or to improve on this measure in CHS.
- Those aged 16 to 29 years old were at a greater risk in AMH LD: CPLD.

Non-accidental self-injury:

- Those aged 16 to 29 years old, women, and White British people were at a greater risk in AMH LD: CPLD and AMH LD: ICL; and over the year women were less likely to recover on this measure in AMH LD: CPLD and AMH LD: ICL or to improve on this measure in AMH LD: ICL.
- Those aged 50 to 74 years old and White Irish people were at a greater risk in CHS.
- Women and White British people were at a greater risk in FYPC.

Problem drinking or drug-taking:

- Men were at a greater risk in AMH LD: CPLD, AMH LD: ICL, CHS, and FYPC.
- Patterns varied by age group across services with greater risk amongst those age 16 to 29 in AMH LD: CPLD, those aged 30 to 49 years old in AMH LD: CPLD, AMH LD: ICL, and FYPC, and those aged 50 to 74 years old in CHS.
- White British people were at a greater risk in AMH LD: CPLD and AMH LD: ICL; and over the year White British people were less likely to improve on this measure in AMH LD: CPLD.

Cognitive problems:

- Those aged 50 to 74 and 75 years old and over, and men were at a greater risk in AMH LD: CPLD and AMH LD: ICL; and over the year those aged 50 to 74 years old were less likely to recover on this measure in AMH LD: CPLD and AMH LD: ICL.
- Those aged 75 years old and over were at a greater risk in CHS; and over the year those aged 75 years old and over were less likely to recover on this measure in CHS.

Physical illness or disability problems:

- Those aged 50 to 74 years old and women were at a greater risk in AMH LD: CPLD, AMH LD: ICL, and FYPC; and over the year those aged 50 to 74 years old were less likely to recover on this measure in AMH LD: CPLD and AMH LD: ICL.
- Those aged 75 years old and over were at a greater risk in AMH LD: CPLD, AMH LD: ICL, and CHS.

Problems associated with hallucinations and delusions:

- Men were at a greater risk in AMH LD: CPLD, AMH LD: ICL, CHS, and FYPC; and over the year men were less likely to recover on this measure in AMH LD: CPLD and CHS or to improve on this measure in AMH LD: CPLD.
- Asian or Asian British people were at a greater risk in AMH LD: CPLD, AMH LD: ICL and FYPC.
- Black or Black British people were at a greater risk in AMH LD: CPLD and AMH LD: ICL.
- Those age 16 to 29 years old were at greater risk in FYPC; and over the year those aged 50 to 74 years old were less likely to recover or to improve on this measure in AMH LD: CPLD.

Problems with depressed mood:

- Women were at a greater risk in AMH LD: CPLD, AMH LD: ICL, and FYPC.
- White British people were at a greater risk in AMH LD: CPLD and AMH LD: ICL.
- Those aged 50 to 74 years old were at a greater risk in CHS.

Other mental and behavioural problems:

- Women were at a greater risk in AMH LD: CPLD, AMH LD: ICL, and FYPC; and over the year women were less likely to recover on this measure in AMH LD: CPLD, AMH LD: ICL, and FYPC.
- White British people were at a greater risk in AMH LD: CPLD, AMH LD: ICL, and FYPC; and over the year White British people were less likely to improve on this measure in AMH LD: CPLD or to recover on this measure in AMH LD: CPLD and FYPC.
- Those aged 50 to 74 years old were at a greater risk in CHS; and over the year those aged 50 to 74 years old were less likely to recover or to improve on this measure in CHS.

Problems with relationships:

- Those aged 16 to 29 years old were at a greater risk in AMH LD: CPLD and AMH LD: ICL and those aged 50 to 74 years old were at a greater risk in CHS.
- Over the year White British people were less likely to improve on this measure in AMH LD: ICL.
- Men were at a greater risk in CHS.

Problems with activities of daily living:

- Men were at a greater risk in AMH LD: CPLD.
- Those aged 50 to 74 years old were at a greater risk in AMH LD: ICL and those aged 75 years old and over were at a greater risk in CHS; and over the year those aged 75 years old and over were less likely to improve on this measure in CHS.

Problems with living conditions:

- Men were at a greater risk in AMH LD: CPLD and AMH LD: ICL.
- Those aged 16 to 29 years old were at a greater risk in AMH LD: CPLD.

Problems with occupation and activities:

- Men were at a greater risk in AMH LD: CPLD and AMH LD: ICL; and over the year men were less likely to recover on this measure in AMH LD: CPLD.
- Those aged 50 to 74 years old were at a greater risk in CHS.
- White British people were at a greater risk in CHS.

Recommendation:

- It is recommended that further investigation is undertaken into the above areas.
    - Knowledge of differing patterns of risk by age, ethnicity, gender, and service across the HoNOS domains may help with service planning (please refer to Table 3 for a summary).
    - Differing patterns in likelihoods of recovery (please refer to Table 4 for a summary) or improvement (please refer to Table 5 for a summary) from a problem requiring formal action by age, ethnicity, gender, and service across the HoNOS domains may reflect differences in need or the severity of the conditions being treated, but could potentially reflect differences in the efficacy of treatment by protected group.

Table 3: Summary of groups with a greater likelihood of exhibiting a problem requiring formal action across the HoNOS domains by age, gender, ethnicity, and service

	Overactive, aggressive, disruptive or agitated behaviour	Non-accidental self-injury	Problem drinking or drug-taking	Cognitive problems	Physical illness or disability problems	Problems associated with hallucinations and delusions	Problems with depressed mood	Other mental and behavioural problems	Problems with relationships	Problems with activities of daily living	Problems with living conditions	Problems with occupation and activities
Men	AMH LD: CPLD AMH LD: ICL CHS FYPC		AMH LD: CPLD AMH LD: ICL CHS FYPC	AMH LD: CPLD AMH LD: ICL		AMH LD: CPLD AMH LD: ICL CHS FYPC			CHS	AMH LD: CPLD	AMH LD: CPLD AMH LD: ICL	AMH LD: CPLD AMH LD: ICL
Women		AMH LD: CPLD AMH LD: ICL FYPC			AMH LD: CPLD AMH LD: ICL FYPC		AMH LD: CPLD AMH LD: ICL FYPC	AMH LD: CPLD AMH LD: ICL FYPC				
16 to 29 years old	AMH LD: CPLD	AMH LD: CPLD AMH LD: ICL	AMH LD: CPLD			FYPC			AMH LD: CPLD AMH LD: ICL		AMH LD: CPLD	
30 to 49 years old			AMH LD: CPLD, AMH LD: ICL, and FYPC									
50 to 74 years old		CHS	CHS	AMH LD: CPLD AMH LD: ICL	AMH LD: CPLD AMH LD: ICL FYPC		CHS	CHS	CHS	AMH LD: ICL		CHS
75 years old +				AMH LD: CPLD AMH LD: ICL CHS	AMH LD: CPLD AMH LD: ICL CHS					CHS		
White British		AMH LD: CPLD AMH LD: ICL FYPC	AMH LD: CPLD AMH LD: ICL				AMH LD: CPLD AMH LD: ICL	AMH LD: CPLD AMH LD: ICL FYPC				CHS
White Irish		CHS										
Asian British						AMH LD: CPLD AMH LD: ICL FYPC						
Black British						AMH LD: CPLD AMH LD: ICL						

Table 4: Summary of groups with a lower likelihood of recovering from a problem requiring formal action across the HoNOS domains by age, gender, ethnicity, and service

	Overactive, aggressive, disruptive or agitated behaviour	Non-accidental self-injury	Problem drinking or drug-taking	Cognitive problems	Physical illness or disability problems	Problems associated with hallucinations and delusions	Problems with depressed mood	Other mental and behavioural problems	Problems with relationships	Problems with activities of daily living	Problems with living conditions	Problems with occupation and activities
Men	CHS FYPC					AMH LD: CPLD CHS						AMH LD: CPLD
Women		AMH LD: CPLD AMH LD: ICL						AMH LD: CPLD AMH LD: ICL FYPC				
50 to 74 years old				AMH LD: CPLD AMH LD: ICL	AMH LD: CPLD AMH LD: ICL	AMH LD: CPLD		CHS				
75 years old +				CHS								
White British								AMH LD: CPLD FYPC				

Table 5: Summary of groups with a lower likelihood of improving with a problem requiring formal action across the HoNOS domains by age, gender, ethnicity, and service

	Overactive, aggressive, disruptive or agitated behaviour	Non-accidental self-injury	Problem drinking or drug-taking	Cognitive problems	Physical illness or disability problems	Problems associated with hallucinations and delusions	Problems with depressed mood	Other mental and behavioural problems	Problems with relationships	Problems with activities of daily living	Problems with living conditions	Problems with occupation and activities
Men	CHS					AMH LD: CPLD						
Women		AMH LD: ICL										
50 to 74 years old						AMH LD: CPLD		CHS				
75 years old +										CHS		
White British			AMH LD: CPLD					AMH LD: CPLD	AMH LD: ICL			

3 Leicester City Increasing Access to Psychological Therapies Service: April 2014 to March 2015; Summary of a quantitative equality analysis of access, outcomes, and experience indicators for users of the Increasing Access to Psychological Therapies service

In the period April 2014 to March 2015 inclusive, 8950 people were referred to the IAPT service, 4982 of whom (55.7%) entered treatment. This represents a statistically significant increase in the number of people referred compared to the previous financial year, but a statistically significant decrease in the number of people entering treatment compared to the previous financial year. In the financial year ending March 2014, 8741 people were referred to the IAPT service, 5251 of whom (60.1%) entered treatment. In the financial year ending March 2015, the vast majority of referrals came from Primary Health Care (97.32%). Below, the main findings of the equality analyses are summarised.

3.1 Data quality: there were high levels of missing data in terms of ethnicity, religion or belief, sexual orientation, and carer status

In the data used for the present analysis, there were high levels of missing data for the protected characteristics of ethnicity, religion or belief, and sexual orientation, and also for carer status (in terms of those who entered treatment: 16.7%, 45.4%, 41.6%, and 65.4% missing, respectively). There was also a possibility that those service users with missing data would be concentrated in certain subgroups. As such, analyses of ethnicity, religion or belief, sexual orientation, and carer status should be regarded as potentially flawed and should be interpreted with caution.

Assuming that the missing data codes have been used correctly during data entry, for religion or belief, sexual orientation, and carer status the missing data appear to be almost exclusively of the “not recorded” type (the service user was either not asked the equality monitoring question or their response was not recorded). For ethnicity, about two-thirds of the missing data were of the “not recorded” type, whilst the remaining third were of the “not disclosed” type (the service user chose not to disclose the information and this decision was recorded).

There may be a need to promote the collection of equality monitoring data by ensuring that equality monitoring questions are asked of service users, especially with regard to religion or belief, sexual orientation, and carer status, but also with regard to ethnicity. For the protected characteristic of ethnicity, there may also be a need to investigate why some service users do not wish to disclose this information and to address any concerns identified. In terms of the percentages of missing data, religion or belief, sexual orientation, and carer status are priority areas. The degree of missing data for carer status was especially high and statistical analyses of this factor will have been underpowered. There may well be equality issues affecting those who provide unpaid care; however, the present analyses are unlikely to have been sensitive enough to detect such issues.

3.2 The protected characteristics of disability, gender reassignment, marital status, and pregnancy and maternity are not routinely monitored at present

The protected characteristics of disability, gender reassignment, marital status, and pregnancy and maternity are not routinely monitored at present. Consideration should be given to monitoring these factors; for instance, mental health and disability are clearly pertinent to the IAPT service, whilst comorbidity and physical disability could also potentially have a large impact on access to services and treatment outcomes. It is noted that routine monitoring of the protected characteristic of gender reassignment would need to have regard to Section 22 of the Gender Recognition Act 2004 on the "prohibition of disclosure of information," which may preclude routine monitoring of this protected characteristic.

3.3 Teenagers were underrepresented amongst IAPT service users, whilst young adults were more likely to drop out of treatment

Compared to the age profile of the population of Leicester City aged 16 years old and over, teenagers were underrepresented amongst referrals and those who entered treatment with the IAPT service. From amongst those referred, young adults (under 29 years old) were less likely to enter treatment, were more likely to drop out of treatment through an unscheduled discontinuation or through the patient declining treatment (18 to 29 year olds), and were overrepresented amongst those who did not attend their second appointment (18 to 29 year olds). Lower than expected access to IAPT services for teenagers may reflect that some teenagers will access psychological therapies through child and adolescent mental health services elsewhere. However, there appears to be a need to address a low uptake of referred young adults into the IAPT service and a high drop-out rate amongst young adults.

3.4 Older adults were underrepresented amongst IAPT service users

Compared to the age profile of the population of Leicester City aged 16 years old and over, older adults (aged 60 years and over) were underrepresented amongst referrals and those who entered treatment with the IAPT service. Nonetheless, if referred, those aged 40 to 79 years old were more likely to enter treatment; and from amongst those who entered treatment, older adults (50 to 74 years old) where more likely to complete treatment and were less likely to drop out of treatment. The underrepresentation of older people in LPT's IAPT service may reflect that the IAPT service for older people in Leicester is delivered by Nottinghamshire Healthcare NHS Trust; these people will therefore not appear in the data held by Leicestershire Partnership NHS Trust.

3.5 Asian or Asian British people were underrepresented amongst IAPT service users

Compared to the ethnicity profile of the population of Leicester City aged 16 years old and over, Asian or Asian British people were underrepresented amongst all referrals and amongst those who entered treatment with the IAPT service. There may be a need to encourage or improve access to the IAPT service for Asian or Asian British people, especially at the referral stage.

3.6 Black or Black British and Mixed race people were less likely than other ethnic groups to enter the IAPT service after referral

Black or Black British people were proportionately represented and Mixed race people were overrepresented amongst IAPT service users when compared to representations in the population of Leicester City aged 16 years old and over. However, if referred to the IAPT service, Black or Black British and Mixed race people were less likely than other ethnic groups to enter treatment with the service. There may be a need to investigate whether unfair barriers exist in moving from referral to treatment for Black or Black British and Mixed race people.

3.7 Men were underrepresented amongst IAPT service users

Compared to the gender profile of the population of Leicester City aged 16 years old and over, men were underrepresented amongst all referrals and amongst those who entered treatment with the IAPT service. There may be a need to encourage or improve access to the IAPT service for men, especially at the referral stage.

3.8 Christians, Hindus, and Muslims were underrepresented amongst IAPT service users

Compared to the religion or belief profile of the population of Leicester City aged 16 years old and over, Christians, Hindus, and Muslims were underrepresented amongst all referrals and amongst those who entered treatment. Thus, some religion or belief groups are not accessing services at expected levels. The pattern observed for religion or belief groups follows that observed for ethnicity to some degree. There may be a need to encourage or improve access to the IAPT service for some religion or belief groups, especially at the referral stage.

3.9 People who were not heterosexual were overrepresented amongst IAPT service users and were more likely to use the self-referral route

Compared to a national estimate for the sexual orientation profile of the population, people who were not heterosexual were overrepresented amongst all referrals and amongst those who entered treatment, indicating good access to IAPT services. In terms of referral routes to the IAPT service, people who were not heterosexual were overrepresented amongst self-referrals; this pattern applied almost exclusively to Gay Men.

Thus, there appears to be a disproportionately high level of need for IAPT services amongst local LGB communities; with associated higher levels of service access. The self-referral route of access has been promoted to LGB communities using the "Open Mind" branding, with associated high levels of use of this route by Gay Men in particular. There may be a need to fine-tune the self-referral route of the IAPT service to better reach all LGB communities.

3.10 Recovery rates were equitable by age, ethnicity, gender, religion or belief, sexual orientation, and carer status

In the period April 2014 to March 2015 inclusive, there were 2325 clinical cases with a recovery result, of whom 705 recovered (30.3%). Recovery rates for clinical cases were equitable by age, ethnicity, gender, religion or belief, sexual orientation, and carer status.

3.11 Response rate to the patient experience questionnaire was low

In the period April 2014 to March 2015 inclusive, the response rate to the patient experience questionnaire was low (just 207 of the 2103 people who completed their scheduled treatment in the financial year ending March 2015; 9.84%). It is not possible to judge whether or not those who responded to the questionnaire were representative of all service users who completed their treatment.

It is recommended to take steps to increase the number of people who complete and return the patient experience questionnaire on completion of their treatment, with an additional emphasis on collecting equality monitoring information alongside the questionnaire, in order to gain a more complete view of the experiences of different groups using the IAPT service. For instance, the questionnaire indicated that Black or Black British people were less likely to be satisfied with the therapist that treated them (Question 5), but this finding was based on the responses of a small number of people from this ethnic group (fewer than 10)—it will be important to monitor this trend and determine if the trend remains apparent in a larger sample of people.

3.12 The Leicester City IAPT service records information on service users' experience of violence that has affected health and service users' experience of hate crime

Of those for whom information on violence that has affected health was available (n=1742), 23.5% had experienced violence that has affected their health and of those for whom information on the experience of hate crime was available (n=1586), 9.8% had experienced hate crime. The patterns of violence that has affected health and experience of hate crime varied across protected characteristic subgroups and this information may help in service planning and evaluation.

Of the 4982 service users who entered treatment with the IAPT service in the period 1st April 2014 to 30th March 2015, information on violence that has affected health was available for 35.0% and information on the experience of hate crime was available for 31.8%. As such, there is uncertainty regarding how well the information on violence that has affected health and the experience of hate crime reflects the experiences of all IAPT service users. The missing data were almost exclusively of the "not recorded" type (the service user was either not asked the question or their response was not recorded). There is a need to ask the monitoring questions around violence that has affected health and the experience of hate crime of more service users in order to gain a more reliable picture of the needs of those who use IAPT services in these respects.

4 Adult Mental Health Patient Discharge Questionnaire: April 2014 to March 2015; A quantitative equality analysis considering ward, age, gender, ethnicity, religion or belief, and sexual orientation

4.1 Data quality

- A total of 142 Adult Mental Health Patient Discharge Questionnaires were returned in the period April 2014 to March 2015 for a total of 1558 patients discharged (9.1% of discharges).

- Amongst discharged patients who returned the questionnaire, data quality for each of the protected characteristics covered by the questionnaire (age, disability, gender, ethnicity, religion or belief, and sexual orientation) varied between 76.06% (age and religion or belief) and 83.10% (gender) complete.

- In order to obtain a reliable measure of patient experience amongst those discharged, it is recommended to take steps to increase the percentage of discharged patients who complete and return the Adult Mental Health Patient Discharge Questionnaire; and to encourage a greater percentage of respondents to disclose their equality monitoring information. This may involve ensuring that all those patients discharged receive the questionnaire, emphasising the importance of returning the questionnaire with all parts completed, and perhaps giving patients an opportunity to complete the questionnaire prior to leaving the care environment (whilst maintaining confidentiality). At present, the questionnaire is administered in paper form and is returned by post (freepost). Participation rates might be increased by offering alternative methods for completing and returning the questionnaire, perhaps including an online option.

4.2 Overview of the questionnaire

- The area receiving the highest ratings overall related to patients feeling that staff were kind and caring (Q5: Do you feel the staff were kind and caring towards you while you were on the ward?).

- The area receiving the lowest ratings overall related to how well patients understood the side effects of their medication (Q6b: How well did you understand the side effects of the medication you were taking?). This finding related especially to people of “other” religions or beliefs (other than Christianity or No Religion – specifically Buddhists, Jews, Hindus, Muslims, and Sikhs); please see below "Understanding of the reasons for taking medication and the side effects of the medication taken."

- The vast majority of respondents (88.3%) were either likely or extremely likely to recommend the ward to friends and family if they needed similar care or treatment (Q10: How likely are you to recommend our ward to friends and family if they needed similar care or treatment?).

- There were several areas where ratings differed across the protected characteristic subgroups covered. Broadly, patients of religions or beliefs other than Christianity or No Religion tended to rate the various measured aspects of their patient experience less positively. Please see the points outlined below for further details. It is noted that there were relatively few respondents of religions or beliefs other than Christianity or No Religion (19 people of "other" religions or beliefs), so it is difficult to assess how well their views reflect those of the wider groups that they represent in the analysis; increasing the percentage of those discharged who return the questionnaire will help to gain a more robust picture of the issues highlighted here.

4.3 Care on the ward

- Questions 1, 2, 4, and 5: people of religions or beliefs other than Christianity or No Religion gave less positive ratings in terms of
    - feeling welcome when they arrived on the ward,
    - feeling that staff knew about their condition and fully understood their needs,
    - the ease of finding a nurse or another member of staff on the ward that they could talk to about any worries or fears,
    - feeling the staff were kind and caring towards them while they were on the ward.

- It is recommended to investigate why people of religions or beliefs other than Christianity or No Religion tended to rate the noted aspects of their care more negatively. It may be necessary to ensure that services are delivered in a culturally appropriate manner, with special consideration for the needs of certain groups.

4.4 Feeling safe on the ward

- Question 3: people who were not heterosexual felt less safe on the ward.

  (There were relatively few respondents to the questionnaire who were not heterosexual, less than 10, so it is difficult to assess how well their views reflect those of the wider group that they represent in the analysis; increasing the percentage of those discharged who return the questionnaire will help to gain a more robust picture of the issue highlighted here.)

- It is recommended to take steps to make people who are not heterosexual feel safer on the wards. This may involve determining why this group feels less safe; tackling both perceptions of a lack of safety and any areas where there are material security and safeguarding issues.

4.5 Understanding of the reasons for taking medication and the side effects of the medication taken

- Questions 6a and 6b: BME people and people of religions or beliefs other than Christianity or No Religion understood less well why they were taking medication, whilst people of religions or beliefs other than Christianity or No Religion also understood less well the side effects of the medication they were taking.

- It is recommended to take steps to ensure that patients from minority ethnic groups and minority religions understand why they are taking medication. Additionally, care should be taken to ensure that all patients understand the side effects of their medication (this area was rated least positively within the questionnaire overall), with special regard to understanding amongst patients of minority religions or beliefs. It may be necessary to determine any reasons for a lack of understanding amongst patients around the medication they are taking and its side effects; for instance, it may be that language in verbal and written communication is a barrier to understanding amongst patients of minority religions or beliefs.

4.6 Patient involvement in decisions about care and treatment, and discharge from the ward

- Questions 8 and 9: People of religions or beliefs other than Christianity or No Religion felt that they were less involved than they wanted to be in decisions about their care and treatment, and were less involved than they wanted to be in the planning of their discharge from the ward.

- It is recommended to ensure that all patients, including people of religions or beliefs other than Christianity or No Religion, are as involved as they want to be in decisions about their care and treatment, and in the planning of their discharge from the ward. This may involve, for instance, providing a culturally appropriate service and taking into account the communication needs of those for whom English is not their first language. Further investigation may be required to hone in on the exact barriers to involvement to be overcome.

4.7 The likelihood of recommending the ward to friends and family if they needed similar care or treatment

- Question 10: People of religions or beliefs other than Christianity or No Religion were less likely to recommend the ward to friends or family if they needed similar care or treatment.

- It is recommended to further investigate why those of minority religions were less likely to recommend their ward to friends or family. Such an investigation could inform any steps to be taken in order to ensure the experiences of services users are as positive as possible across all religious groups. Some potential reasons why those of minority religions may be less likely to recommend their ward to friends or family have been identified in the present analyses:
    - care on the ward,
    - understanding of the reasons for taking medication and the side effects of the medication taken,
    - involvement in decisions about care and treatment, and discharge from the ward.

- Further investigation into these issues for people of minority religions may help to inform and target actions to be taken to make the experience of receiving treatment and care more positive for these groups of people. Additionally, given that there were just 19 respondents of “other” religions or beliefs to the questionnaire, increasing the numbers returning the questionnaire will help to gain a more robust picture of the issues highlighted.

5 Leicestershire Partnership NHS Trust: CQC Mental Health Community Service User Survey 2015; A quantitative equality analysis considering organisational unit, age, gender, and ethnicity: Summary of findings

5.1 Younger service users felt that they were given insufficient time and attention during consultations, and insufficient involvement in their care

- Younger service users (aged 18 to 35 years old) were less likely to feel that the person they saw listened to them carefully and were less likely to feel that they were given enough time to discuss their needs.

- Younger service users (aged 18 to 35 years old) were less likely to feel as involved as they wanted to be in discussing how their care was working and were less likely to feel that decisions were made together between them and the person they saw during this discussion.

6 Leicestershire Partnership NHS Trust: Adult Mental Health and Learning Disability Services, Community Health Services, Families, Young People, and Children's Services: April 2014 to March 2015; A quantitative equality analysis of complainants

There were 349 complaints recorded for the period April 2014 to March 2015. Below, the main findings of the equality analyses of complainants are summarised.

6.1 Data quality

- In the data used for the present analyses, there were very high levels of missing data amongst complainants for the protected characteristics of disability, ethnicity, marital status, pregnancy and maternity, religion or belief, sexual orientation, and transgender status. There is also a possibility that those complainants with missing data will be concentrated in certain subgroups. As such, analyses of these protected characteristics should be regarded as flawed and should be interpreted with caution.

- The Safeguard database, which stores details of complaints, can only store information on the protected characteristics of age, gender, and ethnicity; for these protected characteristics (especially for ethnicity) the missing data appear to be predominantly of the "NULL" or "not recorded" type.

- For the protected characteristics of disability, marital status, pregnancy and maternity, religion or belief, sexual orientation, and transgender status equality monitoring is dependent on the complainant returning a paper equality monitoring form; in the period of interest, just 15.8% of the 349 complainants returned a paper equality monitoring form.

- It is recommended to take steps to improve the completeness of equality monitoring data; it may be necessary to revisit and redesign the process for, and means of, collecting and recording equality monitoring data on complainants:
    - the equality monitoring of complainants relies largely upon complainants returning a paper equality monitoring form-this procedure is not working well;
    - it is recommended to upgrade the Safeguard database so that the system for recording complaints is capable of monitoring all the protected characteristics, or to collect an NHS number from complainants that can be used to link them to their demographic information held on other systems (although this information may be incomplete, too).

6.2 Variations in the pattern of complaints across services and age groups

- The age profile of complainants varied across LPT overall and within Community Health Services when compared to the overall age profile of service users within that division:
    - in particular, within Community Health Services older service users (75 years old and over) were less likely to complain, whilst younger service users were more likely to complain;
    - these variations in the age profile of complainants within Community Health Services may reflect differences by age group in satisfaction with the services supplied, treatment outcomes, and experience, or differences in levels of engagement with the complaints process-it is recommended to investigate whether these factors are equitable by age. (For instance, are older people within Community Health Services sufficiently able, encouraged, and helped to access the complaints process if the need arises? Or are younger advocates raising complaints for older service users and the advocates' equality monitoring information is being captured in error?)

Summary Integrated CRR/BAF

Risk No.	Description	Change	Current	Residual	Owner	Ctte	Age (mo)	Rev
BAF/2 /1043	Delivery of our financial plan may not be achieved without adequately embedded financial ownership, controls and monitoring arrangements. Non delivery of our planned core mandatory financial duties would put the Trust into a formal turnaround position with direct intervention from NHSI. All planned investments would be jeopardised. This 'umbrella' corporate finance risk is directly affected by a number of other individual risks as follows: Risk 311 (failure to achieve CIPs). Risk 367 (financial impact of UHL deficit/LHE financial failure). Risk 312 (insufficient transformational funding - where this could lead to a financial deficit). Risk 314 (insufficient capital funding). Risk 321 (risk of growth costs exceeding available funding). Risk 320 (risk of income loss through contract underperformance). Risk 1238 (absence of robust performance framework) NOTE THAT THE INDIVIDUAL FINANCE RISKS THAT FEED INTO THIS 'UMBRELLA' RISK SHOULD BE VIEWED TO OBTAIN FURTHER DETAILS OF CONTROLS, ASSURANCES, GAPS AND THE FORMAL ASSIGNED ACTIONS.	↔	High (Red) 25	High (Red) 20	DoF	FPC	23	✔
BAF/4 /1036	Without recruiting adequate staff we may be unable to run safe and efficient services as our services transform.	↑	High (Red) 20	High (Red) 16	DoHR/OD	SWG	23	✔
BAF/1 /1028	The Trust is at risk of non-compliance with regulatory requirements without a fully integrated self-regulation system	↑	High (Red) 20	High (Red) 16	CN/DepCEO	QAC	23	✔
BAF/2 /640	If we lose market share then we risk compromising our financial viability. Risk reflects significant increase in volume of upcoming tenders, the threat of competition from other organisations and the impact of the development of new models of care (Dalton Review). Risk also reflects the difficulties of producing winning bids and the significant resource (human and financial) required to achieve these.	↑	High (Red) 20	High (Red) 16	DoF	FPC	46	✔
CRR/1 /1356	Within Adult Mental Health when bed demand outstrips capacity, there can be a time delay in identifying/accessing an acute bed at point of need. The delay impacts on both patient safety and patient experience. Informal patients who refuse an out of area placement are offered home treatment options, potentially increasing the imminent risk for those individuals.	↔	High (Red) 20	High (Red) 16	DD	AMH.LD	6	✔
CRR/1 /909	Failure to address the 2015 CQC Comprehensive Inspection Actions will result in regulatory action against the Trust	↔	High (Red) 16	Moderate 12	CN/DepCEO	QAC	32	✔
CRR/2 /1119	We cannot assure ourselves of the accuracy and validity of the information we provide from our patient information systems without a full review of all stages of the information life cycle and implementation of a remedial action plan. Systems include: EPR - RiO and SystmOne; PAS - Clinicom, Tiara, Maracis This 'umbrella' corporate data quality risk is directly affected by a number of other individual risks as follows: Risk 1269 T1 Inability to report the minimum CYPHS data set Risk 702 T1 Lack of adequate national change control for key information systems Risk 992 T1 Unavailability of UHL Clinicom PAS data Risk 1103 T2 Non achievement of MSK waiting time targets Risk 1144 T2 Non achievement of Therapy waiting time targets Risk 1149 T2 Non achievement of Podiatry waiting time targets Risk 288 T2 Untimely data entry in clinical systems NOTE THAT THE INDIVIDUAL DATA, INFORMATION AND PERFORMANCE RISKS THAT FEED INTO THIS 'UMBRELLA' RISK SHOULD BE VIEWED TO OBTAIN FURTHER DETAILS OF CONTROLS, ASSURANCES, GAPS AND THE FORMAL ASSIGNED ACTIONS.	↔	High (Red) 16	Moderate 12	CN/DepCEO	QAC	17	✔
CRR/2 /314	Delivery of our strategic objectives could be jeopardised if planned capital funding is not available due to the worsening financial climate. In addition, the shift to greater IT capital investment is significantly increasing depreciation charges to revenue, as IT assets have much shorter lifespans than traditional investment in buildings.	↔	High (Red) 16	Moderate 12	DoF	FPC	59	✔
BAF/2 /1040	Failure to deliver an appropriate Estates Strategy and associated benefits (service transformations and appropriate environments) could impair our ability to deliver efficient and effective care	↔	High (Red) 16	Moderate 12	DoF	FPC	23	✔

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Leicestershire Partnership NHS Trust

Summary Integrated CRR/BAF

Risk No.	Description	Change	Current	Residual	Owner	Ctte	Age (mo)	Rev
CRR/2/311	Efficiency savings are an integral part of our Service Development Initiatives. If we fail to deliver a sufficient level of efficiency savings (CIPs) then we may not be able to complete the transformation of our clinical services or deliver our financial plans.	↓	High (Red) 16	Moderate 12	DoF	FPC	59	✔
CRR/2/312	Risk of not having sufficient non recurrent funds to support transformation. This would inhibit service development or result in an adverse financial position.	↑	High (Red) 16	Moderate 12	DoF	FPC	59	✔
CRR/2/367	Risk to LPT financial position of Local Health Economy financial failure. Includes impact of the Better Care Together programme.	↑	High (Red) 16	Moderate 12	DoF	FPC	56	✔
CRR/2/858	Without sufficiently embedded processes in the Trust to ensure high quality facilities management services are provided the quality and suitability of the healthcare Estate may be at risk. Includes risks of non compliance with statutory standards and NHS regulations (e.g. CQC). Reflects initial uncertainty relating to the reprovision of services by UHL, as KPIs are further developed. This uncertainty is partially mitigated through the 'co-operative agreement' that will be in place (in contrast to the traditionally more adversarial commercial contract with Interserve).	↔	High (Red) 16	Moderate 12	DoF	FPC	35	✔
CRR/2/321	Overall risk of population growth costs, inflation costs and volume increases exceeding current resources, leading to Financial Pressures. Includes risk of excess costs of safer staffing, access and waiting times	↑	High (Red) 16	Moderate 12	DoF	FPC	59	✔
CRR/2/320	Risk of contribution loss due to inability to accurately cost services and identify profitable or loss-making service lines. Incorporates potential future income/contribution loss through increased use of Payment by Results/activity based contract mechanisms and data quality issues. Also includes risk of other contract financial penalties (including waiting list related issues) - this risk has increased significantly from April 2015/16.	↔	High (Red) 16	Moderate 12	DoF	FPC	59	✔
CRR/3/1403	Due to the impact of the increased safeguarding agenda and its subsequent pressure on clinical and safeguarding teams there is a risk that the trust will not learn from lessons identified or be able to ensure that a high quality of safeguarding service is delivered. This may result in future harm not being prevented or unsafe services not being identified which would have a detrimental impact on the Trust's reputation.	↓	High (Red) 15	High (Red) 15	CN/DepCEO	QAC	3	✔
CRR/2/729	Insufficient capacity and capability within the Information Team to deal with the existing and emerging reporting and information requirements for Trust/ local/ national projects and data submissions. Lack of timely information could affect patient outcomes where decisions are made on information and trend data.	↓	Moderate 12	Moderate 12	CN/DepCEO	QAC	43	✔
BAF/4/1037	Without effectively engaging and supporting our staff we may be unable to deliver high quality services and support transformational change.	↑	Moderate 12	Moderate 9	DoHR/OD	SWG	23	✔
CRR/2/966	Unsigned contracts or non-enforceable agreements pose financial and service delivery risk eg. non-payment for services provided, unenforceable KPIs (including Quality) and increased risk of reduced notice periods. Expected increase in risk at the start of the year as number of unsigned contracts increases significantly.	↔	Moderate 12	Moderate 9	DoF	FPC	29	✔
CRR/1/1336	Failure to sustain improvements made as a result of learning could compromise our ability to improve outcomes for people who use our services; maintain compliance with our statutory obligations; and evidence a learning culture	↔	Moderate 12	Moderate 9	CN/DepCEO		7	✔
CRR/1/623	LPT has received limited assurance of robust arrangements for the safe management, maintenance, calibration, training and use of medical devices; this creates multiple risks and gaps with legislative and best practice requirements and increases the potential for patient harm and/or injury.	↓	Moderate 12	Moderate 8	DoHR/OD	QAC	47	✔
CRR/1/1238	Without a robust Performance Framework the Trust cannot receive assurance that it is achieving Key Performance Indicators (KPIs) and Targets. This could lead to impact of financial loss and reputational damage and may impact on patient outcomes.	↓	Moderate 12	Moderate 8	CN/DepCEO	FPC	12	✔
BAF/4/366	If we do not meet mandatory training compliance rates there may be an adverse impact on care delivery.	↔	Moderate 12	Moderate 8	DoHR/OD	SWG	56	✔
BAF/4/1039	Without developing our approach to change we place at risk the delivery of all our Strategic Objectives	↓	Moderate 12	Low 6	DoF	FPC	23	✔
CRR/4/1260	Nursing staff levels across the Trust are below establishment.. This is having an impact on the ability to deliver high quality effective care on a consistent basis	↔	Moderate 9	Low 6	CN/DepCEO	QAC	6	✔

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Summary Integrated CRR/BAF

Risk No.	Description	Change	Current	Residual	Owner	Ctte	Age (mo)	Rev
	.(Linkage with risk 1036 for workforce actions)							
CRR/3 /1033	Co-ordinated care may not be successfully delivered without developing effective service models.	↔	Moderate 9	Low 6	MD	QAC	23	✓
BAF/1 /1038	Inability to create high quality management and leadership capabilities may impact on the delivery of efficient and effective services.	↔	Moderate 9	Low 6	DoHR/OD	SWG	23	✓
CRR/2 /1133	Financial risk - uncertainty over the future cost of the provision of Estates and Facilities services, with the potential for significantly increased LPT costs, reputational impact and adverse effect on service quality. 12 months cost protection is provided in the arrangement with UHL, so cost uncertainty will become more relevant for future years. [NOTE: THIS RISK CHIEFLY RELATED TO THE PERIOD OF UNCERTAINTY PRIOR TO CONFIRMING THE NEW ARRANGEMENTS WITH UHL FOR ESTATES SERVICES PROVISION. ANY RESIDUAL RISK IS NOW INTENDED TO BE REFLECTED AS PART OF THE OVERALL OPERATIONAL ESTATES RISK 858, AND IT IS RECOMMENDED THAT RISK 1133 BE CLOSED].	↓	Moderate 9	Low 6	DoF	FPC	16	✓
BAF/3 /1030	Without alignment of our plans for integration and service transformation with the wider health and social care economy plans there is a risk that we will not deliver our strategic objectives.	↑	Moderate 8	Low 4	CEO	FPC	23	✗
CRR/1 /1029	We will be unable to assure progress with the patient experience agenda without adequate patient experience feedback mechanisms and associated work programs	↓	Low 6	Low 6	CN/DepCEO	QAC	23	✓
BAF/2 /1041	Without effective and timely delivery of our IM&T Strategy delivery of our SDI's, on-going care delivery, and stakeholder engagement are at risk	↓	Low 6	Low 6	CN/DepCEO	FPC	23	✓
CRR/1 /1086	There is a risk that staff will not be able access clinical systems due to server failure caused by inappropriate storage of servers within the Bradgate Unit. This could lead to untimely updates of patient information.	↓	Low 5	Low 5	CN/DepCEO	QAC	19	✓
CRR/2 /1024	There is a risk that the ending of the national IT contracts in June 2016 will adversely impact the finances of the Trust to a significant degree and lead to the unavailability/removal of TPP SystmOne access within the Trust, affecting CHS and FYPC Divisions.	↓	Low 4	Low 4	CN/DepCEO	FPC	23	✓

Total Number of Corporate Risks: 33

Key to acronyms

FPC	Finance & Performance Committee
QAC	Quality Assurance Committee
SWG	Strategic Workforce Group
CEO	Chief Executive
CN/Dep CEO	Chief Nurse / Deputy Chief Executive
DoF	Director of Finance
MD	Medical Director
DoHR/OD	Director of Human Resources / Operations Dept
DD AMH.LD	Divisional Director - Adult Mental Health & Learning Disabilities
DD FYPC	Divisional Director - Families, Young People & Children
DD CHS	Divisional Director - Community Health Services

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Leicestershire Partnership NHS Trust

Appendix 4: Top 5 risks per service

Risk No.	Description	Change	Current	Residual	Owner	Age (mo)	Rev
FYPC							
T1/1199	There is a risk that the Division's IT infrastructure and systems are unable to provide the level and quality of service data required. This lack of data affects the delivery of service targets, is causing reputational damage to the Trust and compromises our sustainability as a viable provider.	↑	High (Red) 20	High (Red) 16	Helen Thompson	14	✗
T1/785	There is a risk to patient safety due to waiting times in the CAMHS Service. As of March 2016 - 85 children have waited more than 13 weeks for their first appointment.	↑	High (Red) 16	Moderate 12	Adam Mckeown	39	✗
T1/953	If insufficient action is taken by LPT the contracts for Health Visiting and School Nursing, Family Nurse Partnership and National Childhood Measurement Programme will leave the organisation on the 1st April 2017. The contract value is circa £20m; the risks are therefore reputational and financial. The new contract is for a 0-19 Healthy Child Programme. (Links to Risk 1199)	↑	High (Red) 15	High (Red) 15	Mark Roberts	24	✗
T1/1421	If Continuing Health Care (CHC) is not fully implemented then young people at the point of Transition with complex health needs may not be effectively transferred from children to adult services. Potential delays in funding decisions could result in delays in the quality of care provided to LPT patients in all directorates. This could affect approximately 20 young people in the City. The number of young people in the County this could affect is unknown.	↔	Moderate 12	Moderate 12	Helen Burchnall	2	✓
T1/840	LPT's contract for Leicester Recovery Partnership will be ending on the 30.06.16. There is a financial risk that the PbR targets will not be achieved, and that the monies will not be released to LPT for up to six months after the end of the contact. The value of this is 15% of the total contract for Year 3 (£554,886).	↔	Moderate 12	Moderate 12	Helen Perfect	36	✓
				Total number of risks for FYPC returned		**5**	
CHS							
T1/818	Insufficient substantive staffing due to an inability to recruit and retain staff across all CHS services, is impacting on staffs ability to deliver safe and consistent patient care.	↑	High (Red) 15	Moderate 9	Judith Smith	37	✓
T1/767	Continuing high level of sickness absence within the division may potentially have an adverse impact on service delivery and quality of patient care.	↑	High (Red) 15	Moderate 8	Rachel Bilsborough	41	✓
T1/1208	Inaccurate data currently informs senior management team and commissioners due to data quality issues, which results in CHS being unable to report in regards to the Key Performance Indicators (KPI) for its Service Lines.	↑	Moderate 12	Moderate 9	Mark Dewick	13	✓
T1/1241	There is a risk to the safe and adequate provision of alternative patient care in the community following the left shift of 250 beds of activity from an acute to community setting	↔	Moderate 12	Moderate 9	Noel O'Kelly	12	✓
T1/1259	CHS continues to rely upon agency supplied nursing and AHP workers to supplement its staffing resource in times of peak demand, high vacancies and high sickness. Both the poor availability of this workforce and the TDA rules in regard to price caps and non-framework suppliers, is negatively impacting upon this strategy to support the divisions ambition to achieve safe staffing.	↔	Moderate 12	Moderate 8	Rachel Bilsborough	11	✓
				Total number of risks for CHS returned		**5**	
AMHLD							
T1/1188	The Inpatient Services (Bradgate wards - Heather, Aston, Ashby, Beaumont, Thornton, Waremead and Bosworth, Belvoir Unit, HPC - Phoenix and Griffin wards and the	↑	High (Red) 20	High (Red) 16	Michelle Churchard-S	14	✓

Leicestershire Partnership NHS Trust

Appendix 4: Top 5 risks per service

Risk No.	Description	Change	Current	Residual	Owner	Age (mo)	Rev
	rehabilitation wards bat Stewart House and Mill Lodge) are experiencing reduced staffing availability, due to vacancies and sickness and the skill mix does not meet the required 60:40 qualified to health care support worker ratio on all shifts and 1 registered nurse to 8 patients. Approximately 20% of the qualified staff are newly qualified staff undertaking preceptorship.This could be detrimental to patient care and safety. This risk does not include the Willows.						
T1/1111	Failure to deliver AMHLD planned financial target	↔	High (Red) 20	High (Red) 15	Teresa Smith	17	✗
T1/1419	Potential for the sustained increase in deaths amongst patients under the care of AMHLD in the community	↑	High (Red) 16	High (Red) 16	Mohammed Al-Uzri	2	✓
T1/1431	Failure to be able to implement strategies to reduce restrictive practices.	↑	High (Red) 16	High (Red) 16	Michelle Churchard-S	1	✓
T1/754	Risk of patients self harming or attempting suicide via ligature	↓	High (Red) 15	Moderate 10	Rachel Dawson	41	✓
	Total number of risks for AMHLD returned					**5**	
T1/1432	Several GP practices are disengaging from the shared care process for handling medications across the interface	↑	Moderate 12	Moderate 9	Satheesh Kumar	1	✓
	Total number of risks for returned					**1**	
	Total Number of Service					**16**	