The theme of today's board is Learning Disabilities

Leicestershire Partnership NHS Trust

Public Meeting of the Trust Board
9.30 am Tuesday 3 December 2019
Venue: Premier Suite, Leicester Racecourse

Public meeting

Item No.	Timings	Item	Purpose	Paper Ref	Discussion to be led by
1	**09.30**	Apologies for absence: and welcome: • Ashiedu Joel, NHSI Next Director NED development scheme • Clare Hazeldine, Clinical Lead for Speech and Language Therapy • Brendan Daly, Community Development Worker • Staff Voice representatives: Gemma Clarke (LD Outreach Manager), Fran Bailey (Community LD Manager), Mo Henton (LD Outreach Support Worker), Jane Reynolds (LD Outreach Nurse) • Sarah Warmington Associate Director of Commissioning East Leics CCG • Dr Rohit Gumbar – Leardning Disability Service			Cathy Ellis
2	9.30 5 mins	Veterans' Gold Award	Celebration		Cathy Ellis
3	09.35 10 mins	Patient voice film	Quality Improvement		Helen Thompson
4	09.45 30 mins	Staff voice Attendees: Gemma Clarke – LD Outreach Manager Fran Bailey – Community LD Manager Mo Henton – LD Outreach Support Worker	Quality Improvement		Helen Thompson

		Jane Reynolds – LD Outreach Nurse			
5	10.15 20 mins	Declarations of interest in respect of items on the agenda			
6		Minutes of the previous meeting, 1 November 2019	Assurance	A	Cathy Ellis
7		Matters arising actions	Assurance	B	Cathy Ellis
8		Chairman's Report	Information	C	Cathy Ellis
9		Chief Executive's Report	Information	D	Angela Hillery
		Governance and Risk			
10	10.35 10 mins	Organisational Risk Register	Assurance	E	Anne-Maria Newham
11	10.45 5 mins	Standing Orders, Standing Financial Instruction and Scheme of delegation	Approval	F	Dani Cecchini
12	10.50 10 mins	Break			
Total for section = 80 minutes (excluding break)					
		Strategy and System Working			
13	11.00 20 mins	STP Workstream LLR LD and Autism Transforming Care Programme Update – Sarah Warmington Associate Director of Commissioning East Leics CCG	Assurance	Oral	Helen Thompson
Total for section = 20 minutes					
		Quality Improvement and Compliance			
14	11.20 30 mins	Service Presentation: Learning Disability Service Update – Supporting the system delivery plan – Dr Rohit Gumbar in attendance.	Information/ Assurance	Oral	Helen Thompson

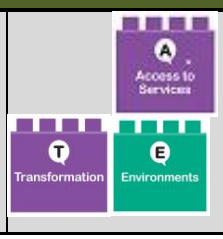
15	11.50 5 mins	Quality Assurance Committee Highlight report November 2019	Assurance	G	Liz Rowbotham
16	11.55 5 mins	Director of Nursing's Report including AHP report	Assurance	H	Anne-Maria Newham
17	12.00 10 mins	Care Quality Commission (CQC) progress Report	Assurance	I	Anne-Maria Newham
18	12.10 10 mins	Patient and Carer Experience and Involvement (including Complaints)	Information/ Assurance	J	Anne-Maria Newham
19	12.20 5 mins	Safer Staffing Report – October 2019	Assurance/ Compliance	K	Anne-Maria Newham
20	12.25 5 mins	Guardian of Safe Working Hours (Junior Doctors contract) Annual Report	Assurance and Compliance	L	Sue Elcock
Total for section = 70 minutes					
		Performance and Assurance			
21	12.30 5 mins	Finance and Performance Committee highlight report November 2019	Assurance	M	Geoff Rowbotham
22	12.35 10 mins	Finance monthly report – month 7	Performanc e	N	Dani Cecchini
23	12.45 10 mins	Integrated Quality and Performance monthly report Waiting Times Compliance AMH &LD	Performanc e	Oi Oii	Dani Cecchini
24	12.55 5 mins	Review of risk – any further risks as a result of board discussion?	Assurance	Oral	Cathy Ellis
Total for section = 30 minutes					
25		Information Pack (circulated to Board members only) containing: • LPT Annual Safeguarding Report 2018 – 2019 • Organisational Risk Register	Information		Cathy Ellis
26		Any other urgent business			Cathy Ellis

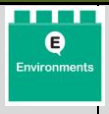
27		Public questions on agenda items			Cathy Ellis
28	1.00	**Date of next meeting:** The next public Trust Board meeting will be held on 14 January 2020			Cathy Ellis
It is recommended that, pursuant to Section 1 (2), Public Bodies (Admission to Meetings) Act l960, representatives of the press and other members of the public be excluded from the following meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.					

Leicestershire Partnership NHS Trust

Confidential Trust Board Meeting
1.30 pm on Tuesday 3 December 2019
Venue: Premier Suite, Leicester Racecourse

AGENDA

Item No.	Timings	Item	Purpose	Paper Ref	Discussion to be led by
1	1.30	Apologies for absence:			Cathy Ellis
2		Declarations of interest in respect of items on the agenda			Cathy Ellis
3	1.30 5 mins	Minutes of the Board Development 23 October 2019 Minutes of the previous confidential meeting, 1 November 2019	Assurance	AAi AAii	Cathy Ellis
4		Matters arising	Assurance	BB	Cathy Ellis
5	1.35 10 mins	Chief Executive's report	Assurance	Oral	Angela Hillery
Total for section = 15 minutes					
		Governance and Risk			
6	1.45 15 mins	Performance Management and Accountability Framework Integrated Performance Report Development	Assurance	Oral	Dani Cecchini
Total for section = 15 minutes					
		Strategy and System Working			

7	2.00 20 mins	All Age Mental Health Transformation	Approval	Oral	Gordon King
8	2.20 10 mins	East Midlands Mental Health Alliance MOU		CC	Angela Hillery
9	2.30 10 mins	Contract Model 2020/21	Assurance	Oral	Dani Cecchini
10	2.40 10 mins	Forensic New Care Model/Provider Collaborative/Partnership Agreement	Approval	DD	Dani Cecchini
Total for section = 50 minutes					
		Quality Improvement and Compliance  			
11	2.50 10 mins	Interagency Safeguarding Review update and oversight report	Approval	EE	Anne-Maria Newham
12	3.00 15 mins	Elimination of Dormitory Accommodation		FF	Dani Cecchini
13	3.15 10 mins	Break			
Total for section = 25 minutes (excluding Break)					
		Performance and Assurance 			
14	3.25 5 mins	Payroll Provider Update	Assurance	GG	Sarah Willis
15	3.30 10 mins	Financial Turnaround	Assurance	Oral	Dani Cecchini
16	3.40 5 mins	Review of risk – any further risks as a result of board discussion?	Assurance		Cathy Ellis
Total for section = 20 minutes					
17	3.45	Confidential Board information pack: • System Strategic Plan Self Certification • SUTG Mental Health Presentation • Board Development Action Tracker Draft			

18	3.45	Confirmed minutes available to Board members on request (matters have previously been highlighted in the Chairs' reports): • Quality Assurance Committee • Finance and Performance Committee	Assurance		Cathy Ellis
19	3.45 5 mins	Chair's Board Development Action Tracker on priorities	Assurance	Oral	Cathy Ellis
20	3.50 5 mins	Any Other Business	Assurance	Oral	Cathy Ellis
Total for section = 10 minutes					
21	3.55	Close			

UNCONFIRMED

Leicestershire Partnership NHS Trust

Trust Board

Minutes of the Meeting held in public on Friday 1st November 2019, 9.30 am

A

Leicestershire County Hall, Sparkenhoe Committee Room

Present:

Ms Cathy Ellis, Chair
Mr Geoff Rowbotham, Non-Executive Director/Deputy Chair
Ms Ruth Marchington, Non-Executive Director
Professor Kevin Harris, Non-Executive Director
Ms Elizabeth Rowbotham, Non-Executive Director
Mr Faisal Hussain, Non-Executive Director
Mr Darren Hickman, Non-Executive Director
Ms Angela Hillery, Chief Executive
Ms Dani Cecchini, Director of Finance
Ms Anne-Maria Newham, Director of Nursing
Dr Sue Elcock, Medical Director

In Attendance:

Ms Rachel Bilsborough, Director of Community Health Services
Ms Helen Thompson, Director, Families, Young People & Children Services & Learning Disabilities
Ms Sarah Willis, Director of Human Resources & Organisational Development
Ms Ashiedu Joel, NHS Improvement Next Director NED Development Scheme
Mr Frank Lusk, Trust Secretary
Ms Anna Pridmore, Interim Associate Director of Corporate Governance
Mr Paul Blakey, Healthwatch
Mrs Kay Rippin, Corporate Affairs Manager
Ms Michele Morton (minutes)

		ACTION
TB/19/182	Apologies and welcome Apologies for absence had been received from Mr Gordon King and Ms Cathy Geddes, NHSI Improvement Director The Chair welcomed Ms Michele Morton, Ashiedu Joel, Mrs Kay Rippin, Ms Tracy Ward, Head of Patient Safety (shadowing Ms Newham), Mr Paul Blakey, Healthwatch, Ms Nikki Beacher, Ms Jude Smith, Ms Michelle Law and Ms Zoe Harris and Mr	

	Fisher, member of the public.	
TB/19/183	Patient Voice	
	A patient voice film was shown that featured Mr John Lawlor who talked about his experience of the respiratory service. He was 72 years of age and in April 2014 he started to notice himself becoming breathless whilst playing with his grandsons. Over a period of 4 weeks his shortness of breath became more noticeable so he made an appointment with his doctor who sent him for a test to the practice nurse. The results showed he had COPD. He felt frustrated and had slowed down considerably.	
	He had a call from the surgery 6 weeks after diagnosis and visited a COPD nurse at the clinic. He had an assessment that lasted over an hour and during that time he learned everything there was to know about COPD; about chest infections, doing exercises, height, weight and how to use the inhalers. After the assessment he felt assured and confident.	
	Mr Lawlor saw the COPD nurse each month for things like problems with his inhaler. He added there was always something to talk about and she had a magical way of helping him out of the doldrums. She asked him if his feet were swollen and diagnosed fluid on the lungs and got that cleared and his breathing once again became normal.	
	Mr Lawlor said he had full respect for the COPD nurses as they had his best interests at heart. They were always at the end of the phone in an emergency which made him feel assured and comforted.	
	Ms Bilsborough said the service was becoming more integrated with providers such as the Leicester Royal Infirmary respiratory team and general practitioners.	
	Mr Rowbotham said he had visited the service recently and he was impressed, particularly as service provision was from local sites which saved patients having to travel.	
	Ms Rowbotham said the film was positive and she recognised the importance of people with a chronic disease having one professional to relate to which she felt was extremely important from the perspective of consistency.	
	Ms Hillery commented that she noticed how confident the patient felt following his appointment with the nurse and the recognition of the impact of patient centered care.	
	Mr Blakey said it was refreshing to hear that everything was well explained to Mr Lawlor and that he was given the opportunity to ask	

	questions and have things explained to him.	
	Professor Harris asked if Mr Lawlor's care was tested to check that he was receiving the right care and that it aligned with the many national guidelines around treatment. He added that the patient was usually the best witness to that. Ms Bilsborough replied that audits were carried out against NICE guidance, coupled with high impact interventions; however she agreed on the importance of testing out that patients were receiving the right kind of care.	
	Ms Cecchini suggested linking patient stories to outcomes and deliverables in order to get a broader picture and she asked if services were linked into the multi-disciplinary teams. Ms Law explained that integrated teams spanned the whole of the health economy.	
TB/19/184	Declarations of Interest All Board members confirmed that they had no conflicts of interest in relation to the agenda items. The Chair reminded all Board members to record any declarations, or a nil return, on the self-service LPT Declare.	
TB/19/185	Minutes of the previous public meeting, 1st October 2019 The minutes of the meeting held on Tuesday 1st October were approved and accepted as a correct record with the exception of: **TB/19/172 - Joint Quality Assurance Committee and Finance and Performance Committee, September –** 3rd paragraph, second sentence should read … she agreed the trust had shown some improvement but the trust remained an outlier on mortality reviews for audits of patients with learning disabilities.	
	Resolved: The minutes of the meeting held on Tuesday 1st October 2019 were confirmed subject to the above amendment.	
TB/19/186	Matters arising actions	
	Trust Board members reviewed the list of matters arising actions at Paper B. All green actions were agreed as closed and others were on track.	
	893: All-age mental health transformation – a business and delivery plan would be brought to the December Trust Board. **900 and 901**: Agreed as completed.	
	Resolved: The Matters Arising had been reviewed by the Board and status of actions agreed and minuted.	

TB/19/187	Chair's Report	
	The Chair presented paper C and highlighted the following:	
	• Gave the opening speech at two conferences where she focused on Step up to Great and Leadership: o Allied Health professional conference for approximately 100 staff. o Learning from Incidents conference for approximately 60 staff.	
	• Attended the long service awards ceremony, recognising 123 staff and 34 volunteers which was an opportunity to thank staff for their contribution to the NHS and the experience they brought to work each day.	
	• A reverse mentoring reflection session had been held with other leaders who were being mentored by BAME staff.	
	• A Board Development Session had been held on the 23rd October that focused on the well-led self-assessment and a workshop that defined the risk appetite statement.	
	Resolved: The Trust Board received the Chair's report.	
TB/19/188	Chief Executive's Report	
	Ms Hillery presented paper D and highlighted the following:	
	• NHS providers and the National Association of Primary Care would be working closer together to promote effective collaboration between primary care and trusts.	
	• The publication of the Mental Health five year forward view dashboard Q4 2018/19 by NHS England/Improvement.	
	• Arising from the Better Care Together Update, there would be a focus on the Long Term Plan and continued work on updates.	
	• Congratulations were extended to Haseeb Ahmad, the Equalities and Diversity Lead, named as one of the top 10 most influential people with a disability in the UK on the disability power list 100.	
	• Accreditation had been achieved for inpatient and outpatient eating disorders service that gave assurance around quality standards.	
	Ms Rowbotham asked if an update was available for the NICE quality standards for learning disability services. Dr Elcock said the Trust	

	was currently moving through that process and The Chair added that the Board focus for December would be learning disabilities. A progress update would form part of that.	
	Ms Marchington commented that it would be useful to include any implications for LPT in any of the items in the CEO's report if they were available. Ms Hillery agreed to signal where issues were being worked through.	
	Resolved: The Trust Board received the Chief Executive's Report	
	Governance and Risk	
TB/19/189	Organisational Risk Register (ORR)	
	Ms Newham presented paper E that provided a summary of the organisational risk register and included current and residual risk scores. She explained that the report was the first of its kind presented in the new template and cycle of risk review, and highlighted how the new ORR mapped against the 'step up to great' strategic framework.	
	Ms Newham reported that the Strategic Executive Board continued to review current information that related to local and internal changes which might impact on the ORR and she highlighted three areas of ongoing review:	
	• Shared CEO role	
	• Violence and aggression	
	• Climate change	
	Ms Newham said the former Board Assurance Framework would be closed down and superseded by the new risks. 11 risks had been closed and superseded by new risks and one risk had been closed completely.	
	Ms Newham agreed to clarify the scoring in relation to the waiting times risk (30a). Ms Marchington referred to concerns expressed in other papers over waiting times and she felt the risk scoring did not triangulate with data in these other reports. She sought reassurance that confidence existed on the mitigated action around the likelihood rating, and was happy for that to be considered by the Finance and Performance Committee. Dr Elcock replied that most of the services had mitigations in place to manage waiting lists. The Finance and Performance Committee had not been specifically assured about plans to reduce waiting lists however the process of the	

	management of waiting lists had provided more assurance. Ms Hillery added that feedback received from the intensive support team had shown that the CAMHs service had one of the best waiting times processes in the country.	
	Trust Board members acknowledged the timings were currently slightly out of kilter but Mr Rowbotham pointed out the ORR would gradually become a live document following the transitional period.	
	The Chair asked about the new payroll provider and the staffing risks. Ms Willis confirmed that risk 21 that related to payroll would remain for a further 2 months whilst backlog issues were being managed and risks 4 and 26 for staffing would become more closely linked.	
	Ms Newham agreed to update risk 22 and populate the scoring.	
	Resolved: The Trust Board: • **Noted the organisational risk profile** • **Noted the closure and de-escalation of risks from the former Board Assurance Framework /Corporate Risk Register**	
TB/19/190	EU Brexit Briefing	
	Ms Cecchini presented paper F that provided assurance regarding the risk of disruption to services and detrimental impact on patient safety as a result of EU exit. The following was noted:	
	• A further communication would be circulated in respect of the Brexit pause which would be based on national communications. She added that business as usual would continue to be maintained particularly around stock levels.	
	• Sitrep reports had been stood down in line with the national position.	
	Resolved: The Trust Board was assured on the Trust's EU exit preparedness.	
	Strategy and System Working	
TB/19/191	NHS Long Terms Plan (LTP) and LLR Integrated Community Board Update	
	Ms Bilsborough, together with Ms Harris and Ms Smith gave a presentation on the NHS Long Term Plan and LLR Integrated Community Board update that included the following:	
	• NHS Long Term Plan implementation framework (Ageing Well)	

	• LLR integrated respiratory services update • LLR integrated specialist palliative and End of Life care services update	
	The Long Term Plan ensured that patients received more options, better support and properly joined up care at the right time in the optimal care setting. Chapter One was a new service model for the 21st century and the Implementation Plan was driven by the Ageing Well Programme.	
	• The Ageing Well Programme is a national programme supporting the delivery of new models of care. Board was asked to note that LLR had expressed an interest in becoming a regional accelerator site; the outcome of this bid would be known by end November.	
	• A presentation ensued setting out transformation plans for both LLR Integrated Respiratory Service and Integrated Specialist Palliative and End of Life Care Service, covering progress to date, outcomes and key risks	
	Ms Bilsborough highlighted that one complexity was the integration of NHS and non NHS services and the anxiety that created with partners. A Memorandum of Understanding was under development that set out how activity was to be delivered in an integrated way and be of most benefit to patients.	
	In respect of end of life care Mr Hussain emphasised the importance of a good understanding of culture and the need to engage appropriately for improved service provision. Ms Smith explained that one of the Hospice at Home nurses was currently studying cultural differences and this research would be fed into the integrated programme.	
	Mr Hickman said the presentation was very good and illustrated the motivation of staff. He asked if sufficient coverage existed and whether services were integrated across the whole of LLR. Ms Harris replied there was full coverage, however different challenges were faced in the city and county in terms of COPD partnerships and non elective emergency admissions, which made it difficult to ensure areas were appropriated resourced. From data received the city was considered more of a hotspot in terms of trying to keep patients at home, though UHL were completely supportive of the integrated service.	
	Professor Harris raised the issue over the different funding models of NHS and non NHS organisations and the fact that LOROS required fund raising donations to operate, and he asked if that was a risk. Ms Bilsborough explained the potential impact of that was one	

	reason for the slow development of services. It had been necessary to agree contract terms with the commissioners and LOROS and recognition of those complexities. Ms Smith added that conversations had taken place on a monthly basis with LOROS who relied heavily on donations and were anxious about the reputational effect of changes even though they acknowledged the changes were the right thing for the patients. There was also a recognition of the benefits of economies of scale.	
	Professor Harris asked if a sufficient workforce was available in order to deliver the required service. Ms Smith replied collectively there were approximately 32 nurses. Some staff had chosen not to work in the new model however there were some amazing healthcare assistants who were excited at joining the team.	
	Speaking as an end of life champion for the last few years, Ms Rowbotham said on some of her visits to district nursing teams one of the issues often raised was patient assumptions when discharged from UHL around community service provision (patients expecting 24/7 support rather than 3-4 times per day visits). She asked how that was being addressed. Ms Smith explained that all patients, together with their family had an assessment by a specialist nurse to consider a plan of care, and that was organised through the integrated work with UHL.	
	Ms Hillery thanked the team for their presentation. She commended and supported the successful integration and said it was a step forward to improved population health management. She queried the role of carers and also how patient experience feedback was captured, both of which she felt were critical. Ms Bilsborough explained a work stream existed that focused on carers as part of the Integrated Community Board. By moving more towards 'experience led' commissioning to inform the programme, the capturing of service user voices was important. More locally Ms Smith explained feedback was gathered from the friends and family test and patients were invited to help shape services. An end of life volunteer had created a very positive impression and there would also be patient representation on the end of life group. Monitoring took place every month to determine service improvements and KPIs were used to measure impact. When meetings took place with complainants their views were sought on how they would like to help shape services in the future.	
	Ms Marchington made reference to the fact that often such partnership working, with charities and community groups, provides an ideal set of circumstances for joint external funding bids and she felt that was worthy of further consideration.	
	Resolved: The Trust Board received a presentation on the NHS	

	Long Term Plan and LLR Integrated Community Board Update	
	Quality Improvement and Compliance	
TB/19/192	Quality Assurance Committee Highlight Report 15 October 2019	
	Ms Rowbotham presented paper G that set out the key headlines, issues and levels of assurance from the meeting held on 15 October 2019. Key highlights were:	
	• Concerns were raised regarding the lack of consistency that related to CPA performance. Further work was being undertaken by the CPA working group. Revision of the IQPR was awaited in line with the revised performance management framework.	
	• A report was received confirming the replacement of self-regulation for inpatient areas with ward accreditation schemes. Concerns were expressed that the structure to be introduced for non-ward areas was not clear and further clarity was requested from the executive team.	
	• An update was received on quarterly progress against the Research and Development strategy with ratings of key milestones, the majority of which was progressing to plan. A brief was also received that related to the research related well led component of CQC inspections and dissemination of that would be progressed through the CQC progress group.	
	Resolved: The Trust Board received the Quality Assurance Committee Highlight Report from the meeting held on 15 October 2019.	
TB/19/193	Director of Nursing's Report including Allied Health Professional Report	
	Ms Newham presented paper H that provided an update in respect of quality and safety. She reported that flu vaccination uptake was currently at 22% and discussions had been held with the lead nurses on how to make more progress. The vaccinations for the 5.5 thousand staff had been ordered by UHL, however only 3 thousand vaccines were available and some vaccinations had been given to the Alliance. There were some concerns that insufficient vaccines would be available despite assurances from UHL that would not be the case. The situation had been escalated on a local level and would be escalated to a regional level if necessary. Priority was being given to clinical staff and several initiatives were occurring to encourage staff to be vaccinated. Further key highlights in the report included:	

	• LPT completion rates for the national staff survey would be reported on in the December Board report.	
	• Complaints - the 25 day response rate was in accordance with best practice. All neighboring trusts had confirmed that was the preferred target and 60 days would only be considered if complaints were revisited or being investigated by the Ombudsman. She added additional capacity had been introduced and an action plan developed to tackle the trajectories and she felt confident that this would progress rapidly. Ms Hillery said complaints were being monitored very closely that included adherence to the timelines.	
	• Health Oversight Scrutiny Committee - Mr Hussain said he felt reassured that officers were meeting political partners and he said it was important for people to build relationships with stakeholders by developing a more strategic approach. The Chair added discussions had taken place with Ms Hillery on formalising the stakeholder engagement strategy and that would be worthy of future board discussion.	**CE**
	• Safeguarding – Ms Marchington referred to the systemwide review of safeguarding and she asked if accountability for safeguarding (which was raised by the Healthy Together teams at the previous board) would be made clearer as part of that. Ms Newham replied that the safeguarding review was about the capacity of LPT to deliver safeguarding and related to the changes in contract, which was different to the accountability arrangements. Ms Thompson explained that once discussions were complete between public health and safeguarding nurses the results would be fed into contract discussions.	
	Resolved: The Trust Board noted the contents of the report.	
TB/19/194	Care Quality Commission (CQC) Progress Report	
	Ms Newham presented paper I that provided an update on CQC related activity that included delivery against the actions identified following the 2018/19 inspection findings and proactive work in readiness for the 2019/20 inspection regime. There were currently 89 actions on the CQC element of the action plan. Of those, 64 were classed as warning notice or must do actions; 25 were classed as should do actions.	
	Ms Newham reported that across the themes we were now developing a better understanding of what it meant to move from red to green areas. Currently there were 4 warning notice actions remaining out of an original 51; those were:	

	• The number of children and young people waiting for an assessment – reported to be in a sustainable position.	
	• The neuro-developmental waiting list had been escalated as it had not met the trajectory.	
	• Seclusion policy and update of paperwork on a second PDSA cycle for the use of seclusion documentation.	
	• Corporate governance arrangements –this is on track for completion in November.	
	The Chair emphasised the importance of carrying out spot checks and Ms Newham explained those were carried out in a variety of ways, for example, by the safety team, teams themselves, managers, and peer teams from a different service. Spot checks helped to provide an understanding of what was needed for sustainability. The Chair said it was heartening to see the number of staff who had engaged with the changes that LPT was being asked to deliver. She added the fortnightly progress meetings held by Ms Newham were supportive for staff and demonstrated what good progress was being made.	
	Resolved: The Trust Board received assurance over CQC related activity, including delivery against the actions identified following the 2018/19 inspection findings and proactive work in readiness for the 2019/20 inspection regime.	
TB/19/195	Safer Staffing Report – September 2019	
	Ms Newham presented paper J that provided an overview of the nursing safe staffing during the month of September 2019, triangulating productivity, workforce metrics, quality and outcomes linked to Nurse Sensitive Indicators (NSIs) and patient experience feedback. The report provided assurance that arrangements were in place to safely staff LPT services with the right number of staff, with the right skills at the right time. It included an overview of staffing hot spots, potential risks and actions to mitigate the risk, to ensure that safety and care quality were maintained. Key points of note included:	
	• Temporary worker utilisation decreased overall by 2.2% and was reported at 31.9%.	
	• 70 candidates were currently in the recruitment pipeline.	
	Ms Newham said a good opportunity existed at the induction sessions to see the number of starters, which was usually 35-40 people on a fortnightly basis, with a high percentage of people new to the NHS.	

	Ms Rowbotham agreed to discuss with Ms Newham how the report might be presented in a shorter version, and also whether it would be more appropriate for submission in the first instance to one of the sub committees.	
	Mr Rowbotham commended the report and felt it contained more clarity and focus than previously which he said was important. He particularly commended the right staff; right skills; right place concept that helped to provide a comprehensive understanding in a triangulated way and those improvements had started to show. He added there could be an opportunity to adopt a similar approach in quality improvement in respect of targets, by using information to identify hot spots.	
	Ms Bilsborough said local ownership was very important and as the accreditation process was rolled out teams had started to strive for a compliant position.	
	Mr Blakey said it was positive that hot spots had been identified and he asked how staff working within those environments were managed from the context of possible conversations with inspectors. Ms Newham replied that it was important to keep staff from feeling isolated. LPT directors regularly visited hot spot areas to ensure they were the first person to hear concerns. More work was also being carried out in the gathering of staff concerns and asking staff opinions on what they would like to see changed. Those visits helped staff to feel proud about what was being achieved rather than developing negative attitudes.	
	Ms Newham said the Freedom to Speak up Guardian was very active and staff felt comfortable approaching her directly, which encouraged an open and transparent culture. She added that when wards were visited staff were encouraged to communicate directly with directors which made a positive difference to how staff felt and it made them proud of their environment.	
	Board members noted the increased number of nursing associates who would be critical in relation to the future workforce, and was due to the strong collaboration with Demontfort University. Conversations were also being held on how to increase the workforce with initiatives such as apprenticeships.	
	Resolved: The Trust Board received assurance that processes were in place to monitor and ensure the inpatient and community staffing levels were safe and that patient safety and care quality were maintained.	
TB/19/196	Infection Prevention and Control (IPC) Report	

	Ms Newham presented paper K, a six monthly report that provided assurance from the Director of IPC that the Trust had a robust, effective and proactive infection prevention and control strategy and work programme in place, that demonstrated compliance with the Health and Social Care Act 2008 (updated in July 2015) also referred to as the Hygiene Code.	
	The report provided an update on actions identified following the NHS England and Improvement IPC visit to meet recommendations that included a GAP analysis against the Hygiene Code. Ms Newham added that the report outlined completion of the Healthcare worker flu vaccination best practice management checklist for public assurance via trust boards by December 2019.	
	Mr Hickman asked what had been carried out differently for IPC that would identify if any problems reoccurred and also provide assurance. Ms Newham replied with the following points:	
	• A huge communication exercise had taken place across the organisation that included a change to the website and staff access to key material documentation. Staff had also been notified of their responsibilities around IPC.	
	• Infection control was on each agenda of the CQC progress meetings.	
	• A piece of work had been carried out with the matrons so they better understood their responsibilities.	
	• IPC spot checks were carried out on a regular basis.	
	• The facilities management contract clearly reflected what it meant with respect to cleanliness and cleaning of all inpatient areas.	
	• The IPC committee reported directly to the quality forum that reported into the QAC, and that would be an assurance for the Board that standards were being maintained.	
	Ms Cecchini said it would be important that the threads between cleanliness, hygiene and standards linked in appropriately with the Finance and Performance Committee.	
	The Chair said she was pleased to see good progress on the action plan and the transparency on what remained outstanding.	
	Resolved: The Trust Board received assurance that processes were in place to monitor and ensure compliance against the Health and Social Care Act 2008 and actions were in place to address gaps in compliance.	

TB/19/197	'Learning from Incidents' Death of a patient under the care of the crisis team	
	Ms Ward presented paper L, accompanied by a short film that documented a patient story (by his sons), Mr S, from a serious incident investigation in 2019. Key points of note included:	
	• Mr S was referred to the crisis response and home treatment team in January 2019. His first language was Punjabi and an interpreter was present during his first full assessment. It was Mr S's first episode of mental ill health and first contact with mental health services. He took his own life on the 21st January.	
	• A key contributory factor identified was that no one person or the multi-disciplinary team had overall oversight of the case. Policies and procedures established were not always followed and as a result the patient's deterioration was not identified and appropriate action taken. Further issues were identified on continuity of care; interpreter services; medication review and communication issues.	
	One of the key failures in the treatment of the patient was lack of a translator and the constant change of nurses (9 different nurses over 12 visits). The patient had mentioned suicide to the nursing staff yet he was not seen as a serious case. The family was also not aware of the 'crisis house' facility. The family felt that treatment should be more personalised and less generic.	
	Trust Board members noted that there had been a thorough and transparent investigation that had involved the patient's family. Actions had been taken to listen and learn from the incident and careful consideration had been given to the recommendations. Work had begun to support the Crisis team to address the areas identified and that included additional funding. The funding did however have clearly defined deliverables not necessarily aligned to the areas identified in the serious incident report. Ms Hillery added that the crisis team model was an active topic of discussion at the Mental Health Programme Board.	
	The Chair said sincere apologies had been extended to the family for the failings in the service that had raised a number of issues, including a lack of continuity and oversight.	
	From the perspective of integration Ms Hillery informed the Board it would be important to work on the crisis service model and that would include appropriate support to carers who had experienced a difficult episode and were possibly at risk themselves.	
	Ms Newham said following a facilitated meeting with the Coventry and Warwickshire crisis team (for an external perspective) links were	

	being forged to identify areas of service improvement, for example, continuity of visits and electronic solutions to determine marginal gains. Having the same nurse to visit ensured that patients did not have to continually repeat information.	
	Dr Elcock reported that carer engagement was part of the suicide prevention work. She agreed on the importance of teams understanding the relevance of consistency. In previous action plans she felt the cultural elements had not been addressed and the clinical model needed a shift towards what was best for patients.	
	Ms Bilsborough said elements in the above conversation were relevant to share with service areas outside of the mental health arena in respect of continuity of care.	
	In terms of potential new investment Ms Thompson felt an opportunity existed to address the area of practitioners and better support for the mental health triage teams who dealt with significant turnover and volume of patients every month.	
	Ms Ward confirmed to Mr Hickman that patient experience groups were taking up the issue of the translator service. In the specific case of Mr S the staff had felt the patient, who was very reserved, had understood, without realising he was unable to explain his feelings. The diversity team would also be looking at the cultural components of care.	
	Mr Hussain emphasised the importance of demonstrating transparency with regard to serious incidents and was surprised that the learning and sharing of the incidents was not already embedded in service delivery, especially around the completion of forms.	
	Ms Ward explained to Professor Harris contact with families was dependent on the confidence and ability of the team conducting the investigation and she added the process had changed so that final draft reports were shared with families for any factual inaccuracies.	
	A brief conversation was held on the appropriate level of serious incident reports submitted to Board level and the use of non-executive director scrutiny and involvement in signing-off reports which would be considered as part of the review.	
	Ms Newham said the progress on the action plan in respect of the serious incident external review would be brought to a future Board meeting.	
	In respect of ongoing processes, Mr Hussain asked the executive directors to ensure the areas of work were adequately resourced.	
	Resolved: The Trust Board were assured that:	

	• **Robust and transparent serious incident investigations were undertaken and that patient's families' views were sought and listened to in order to identify lessons to be learned.** • **Further investigation was undertaken in a just way with an understanding of the system issues rather than those of individuals.** • **Areas were identified that required improvement wider than the crisis team, particularly in relation to culturally competent care. That area was being considered by the patient experience group.**	
	Performance and Assurance	
TB/19/198	Finance and Performance Committee highlight report 15 October 2019	
	Mr Rowbotham presented paper M and he highlighted the following key areas:	
	• Efficiency and Productivity Strategy **–** and the acknowledgement the Trust needed to take a more strategic approach to the delivery of financial sustainability to avoid previously utilised short term fixes, sometimes at the expense of long term sustainability.	
	• Estates and Facilities Management **–** discussion on the estates strategy and inpatient strategic outline case now progressing to outline business case. Also: o Detailed work on dormitory accommodation was progressing. o Assurance had been gained on cleanliness concerns raised at the last Board meeting. o CAMHS build was on schedule. o Limited assurance received for the Internal Audit Estates maintenance review – an expected outcome.	
	• Waiting Times Summary **–** update received on Trust performance against local and national waiting time targets and progress confirmed in relation to the 7 priority areas of work. Ms Rowbotham said she welcomed the inclusion of the 52 week treatment waits and Mr Rowbotham added that real progress was beginning to be made to identify the overall position. Ms Hillery referred to the CAMHs and said CCGs (through the contracting meetings) had endorsed the model that had capacity to meet patient needs.	
	• FPC Governance **–** assurance received on the proposal for a revised governance structure for FPC based on the three levels of assurance principles. Agreed it would address the concerns outlined in the CQC report in respect of clear lines of reporting	

	and improved alignment with the QAC.	
	Resolved: The Trust Board received the Finance and Performance Committee Highlight Report 15th October 2019.	
TB/19/199	Finance monthly report – month 6	
	Ms Cecchini presented paper N that provided assurance that the Trust financial position was closely monitored and managed, with any perceived adverse impact immediately and clearly highlighted to senior management. Key highlights included:	
	• The Trust was reporting a surplus of £696,000 at the end of September 2019, in line with the Trust plan. The worsening run-rate increased the risk to delivery of a year-end break-even.	
	• Better Payment Practice Code Compliance – the Trust was currently achieving 3 of the 4 targets at September.	
	• CIP schemes were currently under delivering, showing £1,345,000 achieved compared to a £1,660,000 year to date target. The year-end forecast for operating schemes currently showed 69% achievement by the end of the year.	
	• Delivery of the stretch target surplus by the year end was dependent on delivery of the Financial Turnaround Plan.	
	Resolved: The Trust Board accepted the reported financial position and supported any further actions designed to improve the year end forecast as agreed and discussed during the meeting.	
TB/19/200	Integrated Quality and Performance monthly report Waiting times compliance AMH & LD	
	Ms Cecchini presented paper Oi that provided the Trust with an integrated quality and performance report which showed levels of compliance with the NHS Improvement's Single Oversight Framework and CQC registration, together with detailed analysis for those areas requiring additional action to ensure achievement of targets.	
	Ms Cecchini reported that gatekeeping had shown a huge improvement and performance against national targets was now showing as green.	
	In respect of the out of area bed days Mr Hussain sought assurance that a solution had been found on the appropriate recording and monitoring of data and Ms Cecchini agreed to investigate that.	**DC**

	Ms Hillery said agency spend required more careful examination, particularly non clinical staff as it impacted on finance and quality.	
	Ms Marchington said she was pleased to see the improvements in waiting times but remained unsure that the evidence fully triangulated the whole picture. Ms Bilsborough confirmed that the situation was under consideration.	
	Resolved: The Trust Board: **Received assurance with regard to areas of quality and performance where performance improvement action was being undertaken.** **Received the NHSI compliance segment rating of three.**	
TB/19/201	Audit and Assurance Committee highlight report 4th October 2019	
	Mr Hickman presented paper P and reported on the following key highlights:	
	• Organisational Risk Register - and the acknowledgement that it was under development. Considerable progress had been made and next steps were clarified. Evidence for full assurance was anticipated.	
	• Internal Audit Progress Report - and adjustments to plan were noted. The poor rate of internal audit first follow-up completion of management risk actions was discussed. In future those actions would be captured in the corporate risk management processes.	
	Resolved: The Trust Board received the Audit and Assurance Committee highlight report 4th October 2019.	
TB/19/202	Review of risk – any further risks as a result of board discussion The Chair recapped to ensure all the risks highlighted through the meeting were reflected on the risk register: • Flu vaccinations for staff. • Facilities Management Service. • Financial position. • Waiting times for all waits, not just the priority areas. • Development of themes from patient stories such as translation services, cultural issues and workforce equality.	
TB/19/203	Receipt of Documents for Information	
	Resolved: The Trust Board confirmed receipt of: • Documents signed under seal.	

	• Seasonal Flu Vaccination Campaign 2019-20 Executive Team paper May 2019. • LPT IPC Strategy 2019-22.	
TB/19/204	Any Other Urgent Business No other urgent business.	
TB/19/205	Public Questions on agenda items Mr Fisher raised some issues with regard to his experiences with the mental health services and in particular the Bradgate Unit where he felt the service was short-staffed, and he had concerns about violence and aggression and fire safety. He added that it was very difficult for some patients since a smoking ban had been introduced and said when patients were in a fragile state the ability to smoke was a huge support for them. Mr Fisher informed the Board he would be moving from Leicestershire back to Lincolnshire shortly. The Chair thanked him for his comments and she agreed to look into the concerns raised by him.	
	Resolved: The Trust Board noted the above.	
TB/19/206	Date of Next Meeting	
	The next public meeting would be held at 9.30 am on Tuesday 3rd December 2019 at a venue to be confirmed.	

B

Leicestershire Partnership NHS Trust

TRUST BOARD 3 December 2019

MATTERS ARISING FROM THE PUBLIC TRUST BOARD MEETINGS

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

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

Action No	Meeting month and minute ref	Action/issue	Lead	Due date	Outcome/evidence (actions are not considered complete without evidence)
893	July TB/19/127	All-age mental health transformation: Clarity was needed for the pre-consultation business case timeline and this would be considered by the Executive Team. Confirmation of Commissioners buy-in was also key.	Gordon King	3 December 2019	Following further discussions on the timetable with Mr Gordon King the intention is now to bring a business plan and delivery plan to the December Trust Board. On agenda 3.12.19. Action CLOSED.
899	October TB/19/158	The joint Chief Executive Officer role had been highlighted as a risk at	Frank Lusk	3 December 2019	NHFT has been contacted for their risk description for consistency in approach. Once their risk has been finalised it will be

Action No	Meeting month and minute ref	Action/issue	Lead	Due date	Outcome/evidence (actions are not considered complete without evidence)
		NHFT so Chair suggested that the same risk be added to the LPT risk register.			shared with LPT for our review, amendment and addition to LPT's Organisational Risk Register.
902	November TB/19/193	Discussions had taken place with Ms Hillery on formalising the stakeholder engagement strategy and would be worthy of future board discussion.	Cathy Ellis	4 February 2020	To be considered at a future Board development session. February Board Development time is most likely timing at this stage. Action CLOSED.
903	November TB/19/200	Assurance sought that a solution had been found on the appropriate recording and monitoring of data for out of area beds.	Dani Cecchini	3 December 2019	.

C

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

Trust Board 3rd December 2019

The period covered by this report is from 1st November 2019 to 3rd December 2019

Hearing the patient and staff voice	• Chair boardwalk to the Bradgate Unit and the Involvement centre, including unannounced drop in visits to Ashby and Watermead wards. Ashiedu Joel accompanied me as part of her NHSI NED development programme.
	
	• Non-Executive Directors boardwalks to:
	  ○ FYPC – Health Visiting North Charnwood
	  ○ CHS- City Walk aid clinics, Mental Health Services for Older People Community Mental Health team in Melton Rutland and Harborough, District Nursing in Market Harbough/Kibworth
	  ○ AMH/LD – Liaison and Diversion team, Assertive Outreach team

Connecting for Quality improvement	• Gave opening speech at Therapeutics in Learning Disability conference for approx. 100 specialists from across the country. Focused on a patient story which highlighted learnings for LD and mental health services. • Attended learning forum "CQC progress meeting" for LPT staff which is led by the Director of Nursing, AHPs & Quality. Meeting focused on collaborative care planning, research and mixed sex accommodation • Attended LPT Quality Improvement conference held for 300 staff • Supported Listening into Action event for Let's Get Gardening at the Bradgate Unit working on increasing opportunities for patients to engage in therapeutic activity in the outdoor areas • LPT / NHFT Buddy forum sharing learning opportunities across both organisations
Promoting Equality Leadership & Culture	• Proud to support Brendan Daly and Rob Melling at the Ministry of Defence Employer Recognition Scheme award ceremony in London. LPT received a Gold Award for our support of the Armed Forces. We are one of 12 NHS trusts that have achieved this. • Gave opening speech at LPT's Health & Wellbeing conference for staff to highlight the work taking place across the trust • BAME Reverse Mentoring programme – 4th session with my mentor continuing to build on my learning.
Building strong Stakeholder relationships	• NHSI System Improvement & Assurance Meeting to review LPT performance • University of Leicester Council meeting and Finance Committee • East Midlands Mental Health Chairs and CEO meeting
Good Governance	• Observed Quality Assurance Committee and Finance & Performance Committee - both committees making progress on transition to the new governance structure • Completed 4 Mental Health Act (MHA) Managers 1:1 appraisals. Chaired the MHA Managers team meeting with presentation from Alison Kirk, Patient Experience and Improvement Lead on patient involvement in LPT. • Chaired interview panel for the appointment of a consultant in CAMHS/LD services

Abbreviations:

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

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board 3rd December 2019
Paper number	**D**

Name of Report CEO Report

For approval		For assurance		For information	X

Presented by	Angela Hillery, CEO	Author (s)	Sinead Ellis-Austin Business Manager

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

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

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

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

1. Introduction/Background

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

2. Aim

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

3. Recommendations

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

4. Discussion

National Developments

All inpatients with learning disability or autism to be given case reviews

The Department for Health and Social Care (DHSC) has announced all people with a learning disability or autism in a mental health inpatient setting will have their case reviewed over the next twelve months. The case reviews of those in long term segregation will be overseen by a newly established independent panel. There will be an associated training package for all health and social care staff. The trials of the new training package will begin in 2020 and run until March 2021. Data on inpatients in mental health settings that have a learning disability or autism will also be published through an information dashboard, which will include data on inpatient rates in different regions for bench marking purposes and shared good practice.

'We are the NHS' campaign shines light on nursing

NHS England and NHS Improvement have launched the next phase of 'We are the NHS'. The campaign aims to increase the number of people considering a career in nursing and support those currently working as NHS nurses by shining a light on the incredible work they do, and their contribution to delivering The NHS Long Term Plan and NHS People Plan, released earlier this year.

NHS England reviewing patient transport contracting

NHS England has ordered a review into the cost of patient transport services and the way they are commissioned. Chief Executive Simon Stevens recently told the Healthwatch annual conference that the probe, expected to last a year, would act on concerns raised by patients. A lead for the review has not yet been announced but NHS England said a governance board, involving a cross section of patient organisations, including Healthwatch England, Age Concern and Kidney Care UK, would oversee it.

NHS whistle-blower support scheme

The NHS in England is to roll out dedicated support for members of staff who raise the alarm on unsafe practice. Following successful pilots, the NHS will soon offer practical support to any doctor, nurse, or other worker across the country who needs additional support to build their career after

raising concerns at work, as part of the NHS Long Term Plan to improve care and treatment. The scheme will offer staff career coaching, shadowing opportunities, work experience, CV writing advice, interview skills practice and resilience training to former or current members of staff who have blown the whistle on poor practice. The move to ramp up support for whistle-blowers is part of a package of measures to put a renewed focus on the wellbeing of patients under NHS care and follows publication earlier this year of a world-first patient safety strategy, which included a requirement for every local health service to have a dedicated patient safety specialist.

Revised guidance to improve the Friends and Family Test

Revised guidance, to improve the Friends and Family Test (FFT) as a tool for listening to patient feedback, has been published. The guidance explains that a new question, asking patients to rate their overall experience of the NHS service they used, has been included in the FFT. Patients will also be able to provide feedback at any time instead of during discharge or within 48 hours of discharge only. The changes will take effect from 1 April 2020 and further information is available on the NHS England website.

Recent publications:

CQC and National Police Chiefs' Council

The CQC have signed a memorandum of understanding (MoU) with the National Police Chiefs' Council (NPCC). The MoU will see an established framework for the sharing of information where incidents of avoidable harm have occurred to people using health and social care services. The MoU between the CQC and NPCC will be applied across various health and social care settings and will ensure effective communication and liaison in the regulation, investigation and enforcement of health and safety for people using health and social care services.

Patient Safety Incident Statistics

The bi-annual patient safety incident statistics have been published by Trust for Oct 18 to Mar 19. National patterns and trends are also available

Local Developments

LLR Better Care Together Update

The latest edition of Partnership Update, the Leicester, Leicestershire and Rutland Health and Social Care Better Care Together (BCT) newsletter can be found in Appendix 1. Highlights of this report include:

- Development of the Better Care Together workforce plan continues. This plan is aligned to the NHS Long Term Plan and the Interim NHS People Plan. A local Long Term Plan workforce 'narrative' has been developed which details the strategic approach for Leicester, Leicestershire and Rutland (LLR). The plan is currently RAG-rated as 'amber' with a need to develop more of a focus on how the changes will be delivered and gaps will be addressed.

- The system has submitted a bid to NHS England and NHS Improvement for the Ageing Well programme, the national framework for delivering NHS Long Term Plan commitments in relation to community services. All STP areas will receive £145,000 in the current year to support Ageing Well. In addition, accelerator sites will receive extra funding from a national pot of £6 million in 2019-20 and £40 million in 2020-21. Ageing Well aims to expand urgent community response services to seven days-a-week 24/7, improve response times for services, and help people to

stay well in partnership with support from primary care networks. The LLR bid to become an accelerator site will be in relation to the urgent community response element.

- Whilst the system remains in escalation for Transforming Care Partnership, the stock take and recovery plan for care for people with learning disabilities and/or autism. The position in October is an improvement on September with only one area now rated as 'red' for not delivered/requiring escalation .

Recent events

Professor Sab Bhaumik (OBE)

Sadly, our colleague, Professor Sab Bhaumik OBE, recently passed away. Sab was well renowned locally, nationally and internationally and devoted his life to the Trust and learning disabilities' psychiatry. He was awarded the highest honour, an Honorary Fellow status in 2015 by the Royal College of Psychiatrists. He was a highly regarded colleague, teacher, mentor and friend – known for his compassionate leadership and commitment to putting people with learning disabilities and their families at the heart of what he did.

LD Nursing Centenary

Nursing colleagues from across our adult learning disabilities community service gathered in large numbers throughout November to celebrate LD nursing's centenary. The CAMHS learning disability team held an open afternoon to mark the occasion and were delighted to welcome Dr Agnes Hauck, Consultant Psychiatrist for Learning Disabilities, after whom our Agnes Unit is named.

Occupational Therapy Week (4th – 10th November)

It was great to see a number of events taking place across the Trust to raise awareness about the work of our OTs, with staff hosting OT team talks, videos, photos and information displays for patients and staff and plans to host an 'OT party'.

Purple Tuesday 2019

I was delighted to read about staff supporting "Purple Tuesday" 2019 (12th November 2019) an internationally recognised call to action, which aims to change and improve the experience for disabled people and help improve the awareness of the value and needs of disabled people.

Training for staff supporting forensic learning disability patients

Specialist practitioners from the Trust are pioneering new training to help health and care staff reduce the risk of people with learning disabilities becoming involved with the criminal justice system, and to improve support for people with a forensic history. LPT has brought together four experienced LD clinical practitioners who work across Leicester, Leicestershire and Rutland to develop an LD Forensic Network. This is an all-age pilot initiative, supported through investment from NHS England's Transforming Care programme. The programme will be rolled out to health and care staff working with two specific cohorts of people with learning disabilities. The one-day training programme was launched earlier this month for a group of 15 staff from LPT and other health and care providers. Feedback from this group is already being used to evolve and enhance the training. Over the next five months the team aims to deliver training sessions to 200 health and care staff.
In addition to the training programme, LPT's forensic network staff can provide advice and supervision for professionals managing patients from the at-risk group.

Re-Accreditation of Langley Ward

The Langley Ward at the Bennion Centre (adult eating disorders inpatient and day care patient ward) was re-accredited by the Royal College of Psychiatrists. Every three years a full review of wards is

carried out on its behalf by the Quality Network for Eating Disorders (QED), with an interim review after 18 months. LPT is delighted to have received confirmation from the QED that the high standards of patient care identified during the previous full visit in 2015 continue to be maintained, and the ward accreditation will remain in place.

The Royal College's accreditation programme involves assessment against some 300 standards categorised into five sections, with themes including safety, timely and purposeful admission, the environment and facilities and therapies and activities on offer.

Our Future Our Way
The design phase of "Our Future Our Way" has now started; work is taking place throughout the Trust through co-design of solutions to address the 9 priorities from staff feedback. Change Champions have begun to explore, with other staff, the first three priorities: leadership, valuing one another and no bullying.

QI Conference
It was brilliant to see so many of our staff attending and presenting at the recent QI conference held in partnership with De Montfort University (DMU) and I had the pleasure of opening the event alongside Dr Simon Oldroyd from DMU. It was a great opportunity to launch our new QI approach building on the strong foundations that are already in place.

Awards news
Gold Standard ERS Scheme
The Trust has been awarded 'gold standard' status by the Ministry of Defence's Employer Recognition Scheme (ERS) in recognition of their support for the Armed Forces community. Cathy Ellis (Chair), Armed Forces champion Brendan Daly and Rob Melling (Head of Community Development Rob attended the ceremony to accept the award. LPT has worked closely with the Armed Forces community to improve the understanding of the needs and priorities of Forces families and service leavers across the region and is one of just two gold ERS award winners from Leicestershire this year.

Health Service Journal (HSJ) Award - Leicestershire School of Nursing Associates
The Leicestershire School of Nursing Associates – a practice approach to developing a new workforce were nominated for the 'Workforce Initiative of the year' at the HSJ Awards 2019. This is a joint collaboration across UHL, DMU and LPT. I am very proud that the collaboration were HSJ finalists and achieved 'highly commended'.

Mental Health peer supporters first graduation
The peer support graduation was a celebration of how far people have come along their recovery journey to complete the peer support worker training. Fourteen people completed this course, and eleven of those have been offered paid roles within LPT across AMH and CAMHS, a fantastic outcome.

Cavell Award - Westcotes Planned Community Nursing Team
Following a nomination by a student nurse who worked with the team, the Westcotes Planned Community Nursing Team have received a Cavell Award. The Cavell Star Awards are given to staff who show exceptional care to colleagues, patients and their families.

Healthcare Financial Management Association (HFMA) Awards
The HFMA is the professional body for finance staff in healthcare. Each year, the local branches recognise the contribution that finance staff make to their organisations. I'm delighted that we continued our success this year with 2 awards for LPT staff this year, following on from previous

success in 2017/18. Congratulations to Imtiaaz Girach, who received the East Midlands Chairman's special recognition award and Matt White, winner of the East Midlands Outstanding Leadership Contribution award.

Relevant External Meetings attended since last Trust Board meeting

Service visits by Executive Directors since last Trust Board

Nov 2019
LAC Clinics
Langley Ward
Visit to PCT building (Melton Mowbray Hospital)
Staff Surgery and CMHT (Braunstone City West)
Cedars Centre
Bennion Centre
Evington Centre
Bradgate Wards
District Nursing Team
Podiatry service
Prayer Room at Bradgate Unit
Arts in Mental Health Team
PIER Team
St Lukes Treatment Centre

Executive Directors: external meetings since last Trust Board

Nov/Dec 2019	
Royal College of Psychiatrists – Divisional Meeting	Mental Health & Learning Disability Clinical Forum
Provider Collaboration Meeting	LLR Discharge Planning meeting
BAME co-mentoring Session NHS Leadership Academy	Workforce plan for Transforming Care Partnerships/Learning Disabilities
Mark Farmer - Healthwatch	TCP Trajectory Oversight meeting
Adult ED New Care Model Launch Event	LPT CQRG (Clinical Quality Review Group)
CAMHS T4 Services for LD/ASD Patients	Meeting with HR Director (NHFT)
Regional TCP Escalation Call	System Improvement & Assurance meeting
Future Focused Finance	2020/21 Contracting and Transformational Approach
Improving Health and Wellbeing Summit	360 Assurance Management Board
East Midlands HRD & SPF Meetings	Therapeutics in Intellectual Disability Symposium
LLR Workforce System Meetings	City Health & Wellbeing Board Scrutiny
SRO Interdependency Forum	Rutland All Council members
LLR TCP Executive Board	County Hall Council members
Chief Officers Meeting	LLR Local Workforce Action Board
COO Meeting	Regional UEC Escalation meeting
Extended System Sustainability Group Meeting	People's Plan Advisory Group
Meeting with Tamsin Hooton, West Leics CCG	LPT Trust Board Meeting with LSCPBs and LA
NHS Providers Board Meeting	*Integrated Community Board (ICB)
NHS Providers Mental Health Leaders Network	* UoI/LPT Strategic Partnership Meeting
NHSI – Additional Resources/Costings	* LLR STP System Review Meeting
Quality Improvement Conference	*Mark Andrews – Rutland County Council
Mids & East MH & LD CEO Meeting	A & E Delivery Board
East Midlands Alliance CEO Meeting	

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

Better Care Together Partnership update

A business update for partner boards, governing bodies and members

October/November 2019

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

Establishing a workforce fit for the future

The Workforce workstream of Better Care Together is supporting the development of a workforce plan. This plan is aligned to the NHS Long Term Plan and the Interim NHS People Plan. As part of this, a local Long Term Plan workforce 'narrative' has been developed setting out the strategic approach for Leicester, Leicestershire and Rutland (LLR). The plan has been assessed as having strengths in organisational development (leadership and culture) and is currently RAG-rated as 'amber' with a need to develop more of a focus on how the changes will be delivered and gaps will be addressed.

The workstream is currently seeking to set out priority areas, while capturing current and future workforce requirements across different care settings. Another key priority is to develop and share workforce analytics to monitor the impact of changes. The workstream is seeking to secure additional resource to support workforce modelling and strategic planning.

A number of achievements have been recorded by the workforce workstream. In mental health a workforce diagnostic has been undertaken by an independent expert and two stakeholder workshops (September 2018 and March 2019) held, with outputs reported into the mental health programme delivery board. Mapping of the workforce has taken place across a number of areas including the Home First workforce across health and social care which has considered the tasks that need to be delivered and the skills required. A five-year strategy for supporting apprenticeships and work experience has been developed, focused on ensuring a supply of new entrants into the health and care sector. The workstream has also been involved in helping develop new roles (such as physician associates) and extending roles (such as nursing associates and advanced practitioners).

There are two sub-groups to this workstream – organisational development (OD) and culture change, and primary care workforce. The OD sub-group has been involved in a wide variety of activities – this includes working with the National Leadership Centre to receive 30 days of support in our move towards establishing an integrated care system in LLR, and running a cohort in 2019 of the leadership programme, Leading Across Boundaries.

The primary care sub-group has been supporting LLR's efforts in international GP recruitment and has secured a full-time project lead for this from NHS England. To date, a total of 14 GP vacancies in local practices have been filled as a result of the international recruitment scheme, helping reduce reliance on locum doctors. Elsewhere in primary care, among other achievements, a pharmacist workforce development programme has helped develop a consistent approach to education, training and career pathways for pharmacists, two cohorts have been run of the Releasing Time to Care 'active signposting' initiative, and a LLR Practice Managers' Academy has been established.

SLT welcomed the update and recommended that a session dedicated to workforce be integrated into the BCT Interdependencies Forum comprising of responsible officers from each workstream.

Progressing plans to move the paediatric congenital heart service

The full business case for the planned move of the paediatric congenital heart service from Glenfield Hospital to the Leicester Royal Infirmary has now been approved by the University Hospitals of Leicester (UHL) board. Members of the Better Care Together system leadership team (SLT) were updated on the proposals at their October meeting.

Figure 1 Architect Impression of the Children's Hospital following Phase II

Plans for the move originated following the 2014 New Cardiac Review by NHS England which set out a series of national standards to which all such centres should comply. This included requirements for a minimum number of specialist surgeons, a minimum number of operations carried out by each surgeon, and the need for co-location with other paediatric services.

The East Midlands Congenital Heart Centre is a specialised service, commissioned by NHS England. The full business case outlines the capital and revenue investment required by UHL in order to meet NHS England standards. It also includes the income and expenditure required in order to increase surgical activity to the minimum levels outlined within the standards. Local clinical commissioning groups have been fully supportive of the campaign to keep the congenital heart service at UHL.

In order to meet the minimum levels of activity required by NHS England standards, the number of surgical procedures needs to increase from 418 in 2019-20 to 487 in 2021-22. This is entirely commissioned by NHS England. It is anticipated that the majority of increase in congenital heart surgical activity will be from outside of LLR.

Care for people with learning disabilities and/or autism

SLT has been updated on progress with the Transforming Care Partnership stocktake and recovery plan for care for people with learning disabilities and/or autism. The position in October is an improvement on September with only one area now rated as 'red' for not delivered/requiring escalation (the need to chase up from NHS England and NHS Improvement when the new care model is to be implemented.)

Risks in reconfiguration

A number of actions have been outlined to the UHL board in order to mitigate the clinical risk of delays in reconfiguring acute clinical services. The more time that elapses between the current configuration and where we need to be when fully reconfigured, the more the pressures and risks build in a small number of clinical services. Services particularly affected are maternity and neonatal, the quality of the environment in the Intensive Care Unit at the Leicester Royal Infirmary and renal services. Reports continue to be delivered to the UHL board monitoring progress.

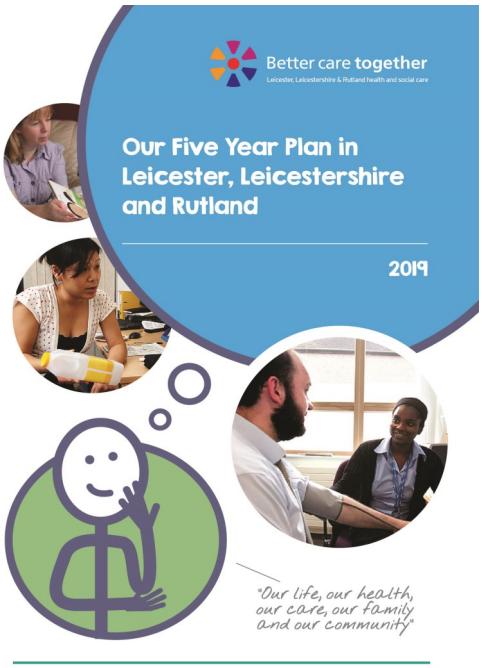
The Pre-consultation Business Case for the reconfiguration continues to go through national processes for approval and will be followed by consultation. During this time SLT confirmed the importance of conversations with the Local Authorities.

Bid for national funding

SLT was asked to support a bid to NHS England and NHS Improvement for their Ageing Well programme, the national framework for delivering NHS Long Term Plan commitments in relation to community services. All STP areas will receive £145,000 in the current year to support Ageing Well. In addition, accelerator sites will receive extra funding from a national pot of £6 million in 2019-20 and £40 million in 2020-21. Ageing Well aims to expand urgent community response services to seven days-a-week 24/7, improve response times for services, and help people to stay well in partnership with support from primary care networks. The LLR bid to become an accelerator site will be in relation to the urgent community response element.

Re-freshed plan produced

A refreshed Better Care Together five-year plan has been drafted in response to publication of the NHS Long Term Plan. As the plan states: "We know that we have more to do to improve outcomes, reduce inequalities and unwarranted clinical variation. This five-year plan has given us the opportunity to take stock of our progress to date, restate our priorities over the next few years and respond to the requirements of the NHS Long Term Plan. This plan is our strategic intent on how we will work together to improve outcomes for our population." The plan is still going through the process of sign-off with NHS England and is likely to be published during the next couple of months. A public-facing version will also be available at that time. In support of the five-year plan, operational plans will be produced each year setting out the detail of delivery in the coming year.



Financial recovery

The LLR system has a financial recovery plan in place, with regular submissions made to NHS England and NHS Improvement. The forecasted deficit in October was £13.2 million, but is being continually reviewed in light of the latest activity figures.

Estates update

The STP estates strategy 'checkpoint template' for LLR has been submitted to NHS England and NHS Improvement and at the time of producing the board paper, feedback was still awaited. In their review of estates plans, the LLR Estates Forum did not have any red RAG-ratings for projects. A One Public Estate workshop was held with partner organisations in July 2019 which considered issues of increasing efficiency, such as travel plans and low energy zones.

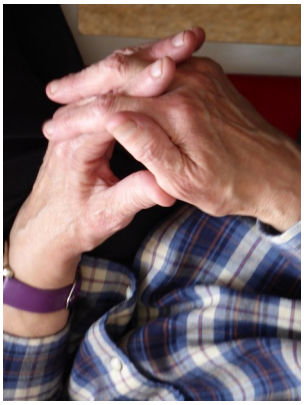
SLT confirmed a health representative to site on the One Public Estate Group going forward.

New research group

A new research and innovation group has been formed, chaired by Professor Azhar Farooqi, which SLT confirmed as a new BCT workstream. The LLR Academic Research and Innovation Liaison Group has representation from LLR clinical commissioning groups' research and development, three local universities and other research partners including the East Midlands Academic Health Science Network and East Midlands Applied Research Collaborative (formerly CLAHRC). The group aims to promote and support research and innovation in health and care across LLR, allied to the priorities of an integrated care system. The partners will discuss research and innovation issues and find ways of working together across a changing research and NHS landscape.

Update on end-of-life care

SLT has been updated on the progress made by the end-of-life programme and its key areas of focus. New analysis predicts a saving of more than £200,000 over the last half of 2019-20 through providing better, more efficient care to people at the end of their lives. The programme is also looking to strengthen its care planning offer for the group of patients identified with the highest mortality risk.



Meeting Name and date	Trust Board 3 December 2019
Paper number	E

Name of Report: Organisational Risk Register

For approval		For assurance	x	For information	

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

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

Report previously reviewed by	
Committee / Group	Date
Operational Executive Management Team	15 November 2019
Quality Assurance Committee	19 November 2019
Finance and Performance Committee	19 November 2019

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

Recommendations of the report
- To note the organisational risk profile, including changes since the last risk report. - To approve the risk appetite statement in appendix C

Organisational Risk Register

1 Introduction

1.1 The organisational risk register (ORR) is presented as part of an ongoing risk review process.

2 Discussion

2.1 Risk Review Cycle

Arrangements for implementing the revised risk management policy and the organisational risk register continue to develop and embed. The revised quality governance structure has been developed and committees / groups in levels 1 and 2 have been established. Further development work is planned with the governance structure for level 3 groups during quarter 4 in 2019/20. This work will provide clarity over the risk review cycle at this level, and remit of each group for providing assurance and escalation to level 2 groups. This will in turn provide assurance and escalation to the level 1 structure.

It is anticipated that the risk assurance and escalation process from level 3 to the level 1 and 2 committees/groups will start to embed during quarters 1 and 2 in 2020/21. In the intervening period, while the Board Committees are not receiving the flow of assurance, we are introducing an interim measure for prioritising risk review at the Board Committee level. Over the next three months (November 2019 to January 2020), the Head of Quality Governance will adopt the following approach to prioritise the top three risks for Committees to review;

- Top 3 risks with the highest residual risk score (where these are red)
- Where closure or re-scoring for risk is proposed
- Where current or residual risks scores have increased in the last month
- Where risk review should be rotated to ensure coverage.

3. Risk Appetite

3.1 The Trust Board has determined its current risk appetite in October 2019. The risk appetite matrix is available in appendix A. The Trust's risk appetite statement is available in appendix C and will be available within the Trust's risk policy and on the website in December 2019 once approved by the Trust Board in November 2019.

4. Revisions to the Organisational risk register - November 2019

4.1 The risk review cycle still transitioning towards the diagram presented in Appendix D. As a consequence, not all of the updates resulting from discussion at the October 2019 Board have been presented to the Strategic Executive Group. These are captured below, along with feedback from recent Committee and Executive Director review. All of these changes will be proposed to the Strategic Executive Group on the 6th December 2019 and presented to Board for approval in January 2019.

4.2 Committee, Group and Executive Director review

- A new risk reflecting the shared Chief Executive role will be drafted for consideration.
- Risk 32 PMO office to be closed. A Head of PMO is in post temporarily to support and introduce the mechanism to manage the quality improvement plan.
- Risk 21 Payroll: The Strategic Workforce Committee considered this risk as part of their meeting held on 13 November 2019 and agreed that the risk has been mitigated by the introduction of a new contractor. This was reported to the Quality Assurance Committee on 20 November 2019. Closure of this risk will be proposed to the Strategic Executive Board.
- Risk 7 Failure to implement the Community Service Redesign may result in loss of business opportunities. To be de-escalated to the Directorate risk register.

4.2.1 Committee updates

- The QAC requested the following updates;
  - Risk 11 regarding the estate configuration to be updated with dates for short, medium and long term work programmes.
  - Clarity over the distinction between the two staffing related risks (4 and 26). The Director of HR is considering with the Medical Director and the Director of CHS how the risk should be articulated to reflect the particular issues arising from the recruitment of staff in CHS and the recruitment of medical staff.
  - Risk 28 regarding timely access to assessment and treatment needs to reflect the harm review process.
  - To propose a recommendation that the three transformation risks move from QAC to FPC oversight (risks 6, 7 and 8)
- The FPC requested that the joint FPC and QAC meeting review those risks where there is a duel remit; for instance the two access risks (28 and 30).
- Scores have been included for risk 22 and the risk ownership has moved to the Director of Finance (as SIRO). Risk detail will be reviewed following work with the NHS Digital Cyber Team to evaluate the Trust's cyber risk profile on the 13 and 14 November 2019
- Scores for a number of risks have been updated to reflect the need to keep the current and residual consequence scores

the same. This has impacted on overall residual risk scores and applies to risks 4, 6, 8, 17 and 25

- There are six risks with the same current and residual scores. These will be evaluated with risk owners to address this and ensure that actions are in place to mitigate the risk and bring down the residual risk score.

4.3 Feedback from the October 2019 Board;

- Potential lack of supply of flu vaccine: There is a risk at Directorate level linked to non-achievement of the flu target (risk 3958). This is being monitored weekly by NHSE. Additional stock of the flu vaccine has been received by the Trust and therefore this risk is not currently recommended for escalation. There will be a recommendation made to the Strategic Executive Board on the 6 December 2019 to escalate the risk around not meeting the flu target.
- Residual risk score for Access: Two 'access to services' risks (28 and 30) have had residual risk scores revised from 12 (amber) to 16 (red) following further review of gaps in controls and assurances. Further mitigating action is currently being determined.
- Progress with the IQPR: The residual risk score for risk 20 – performance management framework, has been revised from 12 (amber) to 16 (red), this was in response to a delay in progress. Additional support has been put in place for the next month to ensure progress is made on the performance management framework. The risk will be kept under review by the Director of Finance and assessed again at the end of the month.
- In terms of risk 10, relating to the planned and reactive maintenance of the estate, the Board received an options paper at the October 2019 meeting. The Director of Finance continues to the keep the risk under review to ensure it is being addressed as part of the management work.
- Following a review of the Trust's action plan for the Health and Safety Executive after the recent inspection, it is proposed that the risk of violence and aggression continue to be managed at Directorate level with no current need for escalation.
- The risk has been reviewed by the key officers responsible for EPRR and it has been proposed that any climate change risk is kept under review during the year and a further fuller risk assessment is completed prior to the August 2020 EPRR annual self-assessment process to determine the level of risk.

5. Organisational risk register summary: November 2019

Risk ID	Risk Title	Risk Owner	Responsible Committee	Risk Level @ Oct 19	Current Risk Level	Residual Risk Level
1	The Trust's systems and processes for the management of patients may not be sufficiently effective and robust to provide harm free care on every occasion that the Trust provides care to a patient	DoN	QAC	16	16	12
2	The Trust's safeguarding systems do not fully safeguard patients	DoN	QAC	12	12	9
3	The Trust does not demonstrate learning from incidents and events and does not effectively share that learning across the whole organization	DoN	QAC	15	15	10
4	Services do not have the right number of staff with the right skills at the right time	DoN	QAC	12	12	8
5	Capacity and capability to deliver KLOEs	DoN	QAC	12	12	9
6	The co-produced future model for all age mental health services does not deliver the required transformation to meet population needs	DoMH	QAC	16	16	12
7	Failure to implement the Community Service Redesign may result in loss of business opportunities	DoCHS	QAC	9	9	6
8	Failure to deliver LPT's contribution to the LLR Transforming Care Plan will adversely impact on the quality of life and outcomes for people with a Learning Disability or Autism	DoMH	QAC	16	16	12
9	Failure to maintain the level of cleanliness required within the Hygiene Standards	DoF	QAC	12	12	8

10	Failure to implement planned and reactive maintenance of the estate leading to an unacceptable environment for patients to be treated in	DoF	FPC	16	16	12
11	The current estate configuration is not fit for the delivery of modern mental health, community and LD services	DoF	FPC	20	20	20
12	The Trust does not positively impact on the experience of service users, carers and families that use our services	DoN	QAC	12	12	6
13	The Trust does not increase the number of service users that are positively participating in their care, treatment and service improvement	DoN	QAC	12	12	9
14	Patients do not always find it easy to share their experiences and the Trust does not as a result receive feedback	DoN	QAC	12	12	9
15	Risk of disruption to service and detrimental impact on patient safety as a result of EU exit	DoN	FPC	15	15	12
16	The Leicester/Leicestershire/Rutland system is unable to work together to deliver an ICS by April 2020	CEO	FPC	16	16	12
17	Failure to meet financial plan and statutory breakeven duty	DoF	FPC	16	16	16
18	The Trust does not routinely achieve regulator standards which impacts on the achievement of the step up to great framework set by the Trust	CEO	QAC	12	12	8

19	There is a risk that inaction or failure to deliver on agreed plans results in a persistent and detrimental impact on LPT's reputation	CEO	QAC	12	12	12
20	Performance management framework is not fit for purpose	DoF	FPC	20	20	16
21	Operations are disrupted due to supplier failing to deliver their payroll contract	DoHR	FPC	15	15	10
22	Financial, reputational or service delivery harm or loss resulting from information breaches and attacks on information systems	DoF	FPC	16	16	12
23	Failure to deliver the EPR system and realise the benefits of the system	MD	FPC	16	16	8
24	Failure to deliver workforce equality, diversity and inclusion	DoHR	QAC	12	12	9
25	Failure to create a culture of collective leadership that empowers staff to improve the services we provide	DoHR	QAC	16	16	12
26	Insufficient staffing levels to meet capacity and demand, and provide quality services	DoHR	QAC	16	16	12
27	Failure to improve the health and well-being of our staff	DoHR	QAC	9	9	6
28	Failure to deliver timely access to assessment and treatment which could impact on patient safety and outcomes	Divisional Directors	QAC	16	16	16

29	Failure to achieve the out of area placement trajectory by the end of 20/21 will result in local people not having timely access to a local acute mental health bed	DoMH	FPC	20	20	15
30	Unmitigated demand may result in patients being unable to access services in clinically appropriate timescales	DoF / DDs	FPC	16	16	16
31	Projects will not deliver sufficiently to embed a consistent QI framework	MD	QAC	9	9	9
32	Failure to secure the resources and develop a PMO to support the delivery of the Trust QI plan	DoN	QAC	12	12	8

6. Heat Map

The heat maps below illustrate the current and residual risk levels of the corporate risk register.

Current risk levels given the existing set of controls.

This shows that currently, the majority of risks are likely to occur and will have a major impact. Of the 32 risks, 18 are high scoring. The elements of the strategic framework with the greatest scoring risk profile is 'Environment' (risk number 11), 'Well Governed' (15, 20) and 'Access to Services' (29).

Consequence						
	5			3, 21	29	
	4			4, 9, 18, 19, 32	1, 6, 8, 10, 16, 17, 22, 23, 25, 26, 28, 30	11, 20
	3			7, 27, 31	2, 5, 12, 13, 14, 24	15
	2					
	1					
		1	2	3	4	5
		Likelihood				

Residual risk levels remaining once additional controls are implemented.

There are six high residual risk scores; the estates configuration risk (11) scoring 20, four risks scoring 16, these include; financial

plan (17), performance management framework (20), timely access to services (28) and demand impacting on access to services (30). The risk around out of area (29) scores 15.

Consequence	5		3, 21	29		
	4		4, 9, 18, 23, 32	1, 6, 8, 10, 16, 19, 22, 25, 26	17, 20, 28, 30	11
	3		7, 12, 27	2, 5, 13, 14, 24, 31	15	
	2					
	1					
		1	2	3	4	5
		Likelihood				

Appendix A: LPT Risk Appetite Matrix

Risk levels ➤ **Key elements** ➘	**0** **Avoid** Avoidance of risk and uncertainty is a Key Organisational objective	**1** **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	**2** **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	**3** **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	**4** **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	**5** **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for exposure to risk. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/ Quality/Outcomes/ Patient Benefit	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems /technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems/ technology developments limited to improvements to protection of current operations.	Innovation supported with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery. Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	**NONE**	**LOW**	**MODERATE**	**HIGH**	**SIGNIFICANT**	

Appendix B: Risk Scoring Matrix

The following matrix is used to grade risk. Risk scoring = consequence x likelihood (C x L)

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

The scores obtained from the risk scoring matrix are assigned grades as follows;

1-3 Low (Low)
4-6 Moderate (Yellow)
8-12 High (Amber)
15-25 Significant (red)

Leicestershire Partnership NHS Trust

Board Risk Appetite Statement

The Trust Board is responsible for setting and monitoring a collective appetite for risk when pursuing its 'Step up to Great' strategic objectives. This appetite allows Board members to take a corporate view on each organisationsal risk, to determine what additional assurance it requires. It reduces the likelihood of any inopportune risk taking which could expose the Trust to any risk it cannot tolerate, or to an overly cautious approach which may stifle growth and development. The level of risk that it is willing to accept is based on what it considers to be justifiable and proportionate to the impact for patients, carers, the public, members of staff, the wider health economy and the sustainability of the Trust.

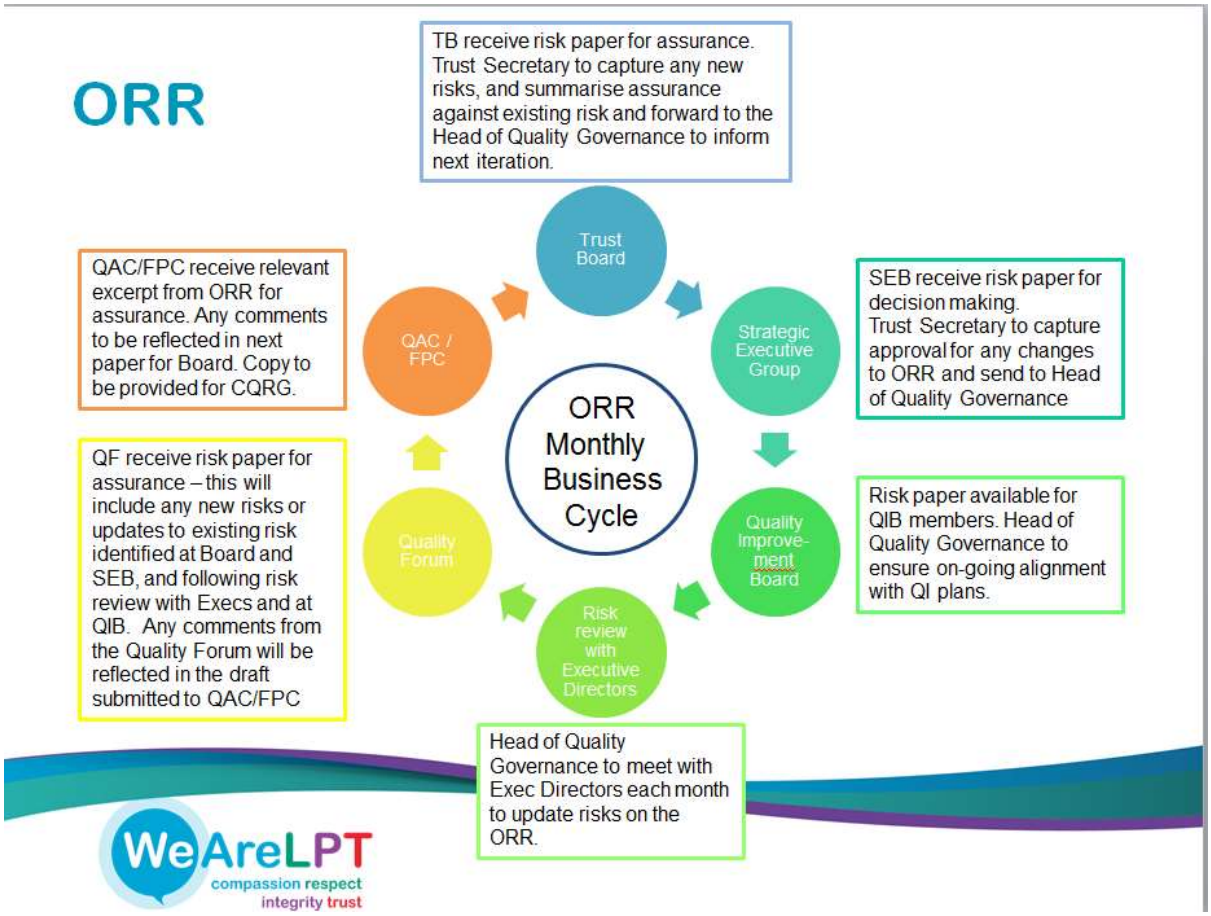
The Board's approach to and appetite for risk was last reviewed and approved in October 2019 and is summarised below.

Risk Element	Risk Appetite	Appetite Descriptor
Financial / VFM	Moderate Appetite Cautious Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.
Compliance / Regulatory	Moderate Appetite Cautious Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward	Limited tolerance for exposure to risk. Want to be reasonably sure we would win any challenge.
Innovation / Quality / Outcomes / Patient Benefit	Significant Appetite Seek Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management

		by trust rather than tight control.
Reputation	Moderate Appetite Cautious Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.

Matrix based on Good Governance Institute Risk Appetite Matrix for NHS organisations.

Appendix D Risk Review Cycle



Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board - 3rd December 2019
Paper number	F

Name of Report: Annual Refresh of Standing Financial Instructions (SFIs) including Scheme of Reservation and Delegation (SORD) and Standing Orders (SOs)

For approval	x	**For assurance**		**For information**	

Presented by	Dani Cecchini Director of Finance	**Author (s)**	Jackie Moore Financial Controller

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

Report previously reviewed by	
Committee / Group	Date
Strategic Executive Board	05/11/2019

Assurance: What assurance does this report provide in respect of the Organisational Risk Register?	**Links to ORR risk numbers**
Provides assurance that the Trust reviews its governance requirements regularly and incorporates any required changes at least annually, to support achievement of statutory financial requirements. These were last updated and approved in April 2019.	17-4264 Failure to meet financial plan and statutory breakeven duty

Recommendations of the report

The Trust Board is recommended to approve the changes made to the Trust's SFIs, SORD and SOs.

These changes have previously been reviewed by the Strategic Executive Board. Due to the timing of December's meeting, this report will be presented to the Audit & Assurance Committee on 6th December, as an adequacy check post Trust Board approval.

A summary of changes is shown at Appendix 1. If you would like copies of the full documents please email Jackie.Moore@leicspart.nhs.uk

APPENDIX 1: SUMMARY OF SFI, SORD & SO CHANGES (DECEMBER 2019)

Ref	Document	Detail of change	SO, SORD & SFI Ref
1	All documents	Change in job titles: i. Chief nurse to Director of Nursing ii. Director of Human Resources and Organisational Development (consistent)	All documents
2	SO	Change of principal place of business from Riverside House to Trust HQ	SO: 1.1i)
3	SO	Any interests or changes in interest should now be declared on-line, using LPTDeclare (No longer required to be recorded in minutes of Trust Board meeting)	SO: 7.1.4
4	SFI	Change of security management responsibility from Director of HR to Director of Finance	SFI: 3.6.4
5	SFI	Losses and special payments to be reported annually to the A&AC in March (previously FPC)	SFI: 15.2.10
6	SORD	Budgetary virement limits were previously not defined separately for Executive Directors. Now includes limit of £250k, in line with tenders and competitive quotations, authorisation of revenue requisitions and invoice approval	SORD: 4.2.2

Ref	Document	Detail of change	SO, SORD & SFI Ref
7	SFI / SORD	For authorisation purposes (e.g. budget virements, requisitions, payment of invoices etc.), clarification that Executive Director includes Chief Executive	SFI / SORD: 4.2.2 SFI / SORD: 9.8.1 SFI / SORD: 12.1.2 SORD: 12.5.1.6
8	SFI	An independent examination of the charitable funds annual accounts and annual report is now undertaken by Internal Audit; previously a full audit was undertaken by External Auditors.	SFI: 18.11.4 & 18.11.5
9	SORD	Align capital authorisation limits with new capital investment process: Increase Capital Management Committee's authorisation limit to £1m (previously £150k) and include authorisation route for emergency capital £5k to £150k.	SORD: 13.1.1
10	SORD	Align capital documentation templates with new capital investment process	SORD: 13.1.2

G

Leicestershire Partnership NHS Trust

QUALITY ASSURANCE COMMITTEE – DATE 19/11/19

HIGHLIGHT REPORT

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

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

Report	Assurance level*	Committee escalation	ORR Risk Reference
Update of New Governance Structure: TORS & workplans	High	QAC to move from bi-monthly meetings from December 2019 with FPC planning to move to bi monthly meetings from April 2020. The joint QAC/FPC Meeting will be retained with meetings three times a year. QAC: Subject to changes to membership, quoracy and equality & diversity recognition, TOR approved **Trust Board to review revised QAC TORs (Annex) and approve.** Health & Safety: Subject to amendments to workplan, reporting and risk section TOR approved Quality Forum: Final version TOR to be approved at December QAC QIB Meeting : Final version TOR to be approved at December QAC Meeting Buddy Forum: TOR acknowledged Strategic Workforce Group: Subject to minor amendments, TOR approved. Trust Policy Committee: TOR approved.	20

Report	Assurance level*	Committee escalation	ORR Risk Reference
ORR	Medium	Risks 4, 26 and 28 were reviewed in detail. 4 and 26 appear similar in the risk descriptor but are significantly different. The actions were all deemed to be appropriate to mitigate risk and were underway. Advised that risk descriptor is revised for greater clarity. Risk 28 requires updates re action and whether these will mitigate risk score. Update on harm process to be brought to joint FPC/QAC in December 2019 Risk 6,7,8 are related to transformation . Clarity requested by chair as to whether these were better owned by FPC Wider review of risk showed that some actions required updates	All
IQPR	Medium	No improvements in CPA 7 day performance. More work being undertaken to sort out 'ground floor' issues and the appointment of designated personnel. Further feedback expected at December 2019 CEG Meeting. There were no identified NHS triggers for HR as at October 2019. New IQPR format expected in draft form in December 2019 SI numbers appear different in 2 reports, work required to understand the difference for reporting to Board	20
Director of Nursing, AHPs and Quality Update.	High	Verbal report. There has been a lot of work on CQC progress (see later paper). Assistance for staff to understand most difficult problems needed such as dormitories, seclusion etc. Large contingency of staff have now done quality improvement training. Take up on flu vaccination is lower in comparison to other trusts.(see additional risks section)	18 31 19
Health & Safety committee including assurance around HSE inspection	Low	Lack of assurance on compliance with fire regulations and health and safety regulations with respect to sub contractors. These require urgent escalation and actions. Issue to be raised directly with responsible Director. Update on health and safety action plan at December 2019 QAC	18
Strategic Workforce	High	Committee reported on more work around recruitment.	26,

Report	Assurance level*	Committee escalation	ORR Risk Reference
Committee		Staff survey running at 39% with target of 60%. In relation to temporary staff, reduction in use of agency staff and increase in bank staff utilisation ongoing. Meeting appraised of celebratory workforce achievements.	25, 27 17,4
Trust Policy Group	High	Update on the establishment of the group. Request made for colour coding including words for low, medium and high risk areas. Update from next meeting onwards on policy status. Discussion around the role of the group to be further explored at Executive Board.	18
Quality Forum	Medium	Patient safety group reported reduced capacity related to SI investigations plus the implementation of the external review recommendations now forms a bigger piece of work to report to the Executive in December 2019. QAC to be updated on this at February 2020 meeting. Medicines Management Group highlighted the use of Esketamine – NICE guidance not yet published. Medicines management group reported concerns re the use of FP10 – further work to be undertaken and reported. Patient Experience group described further work required around how to improve FFT rates and this may require additional funding. Report to go to the Executive Clarity required around appropriate membership for the groups reporting to the QF as currently this is an issue related to capacity of some key staff Proposal regarding integration on Equality & Diversity into terms of reference and working practice of committees to be taken forward by Board Secretary.	1 3 18 13 14 24
QIB	Medium	Verbal report. No specific concerns raised. Further work to be done around the standards brick and the facilities brick. Project Management now in place, working on KPI's for more meaningful plans.	18 32
Buddy Forum	High	Update on structure and progress of buddy relationship.	18

Report	Assurance level*	Committee escalation	ORR Risk Reference
CQC report	Medium	This is 97% for warning notice and must do actions with two actions outstanding and these are linked to pieces of work scheduled in phase 2. Recognition given for progress made.	18
Patient experience quarterly report	Medium	Full report in board papers. Reduction of number of complaints achieved with better triage of issues, but only 26% of complaints investigated in a timely manner although capacity has been increased. Closer work required with nominated clinicians. Community Health Survey revealed improved results but still low performance. Full report to be circulated to Board members	12 13 14
Quality Account Indicators.	Low	Paper received and assurance lacking on the accuracy of the quality of the data. Significant concerns expressed re the outcome of the external review of indicators for the Quality account. Concerns also raised whether this was not confined to these indicators. To be discussed at joint QAC/FPC Meeting in December 2019.	18
Sexual Safety Report	High	Membership established of a national collaborative. Phase 1 includes baseline data gathering plus changes to monitoring systems. In future to report through legislative committee with annual report to QAC.	1 2 3
Clarification of earlier papers and any further risks	Low	QAC asked that consideration be given to risk in items raised in the Health & Safety Committee report Additional risks identified re flu vaccination rates, CPA performance and Quality account indicators. QAC asked that these are reviewed for consideration of inclusion in the ORR.	
AOB	High	Clinical Director or representative no longer required to attend QAC meetings. The input from the directorates over the past years was acknowledged and thanks given	

Chair	Liz Rowbotham, Non-Executive Director

G

Annex

Leicestershire Partnership NHS Trust

Quality Assurance Committee

Terms of Reference

References to "the Committee" shall mean the Quality Assurance Committee

1.0 Purpose of Committee

1.1 The role of the Committee is to provide assurance to the Trust Board, that the Trust is properly governed and well managed across the full range of activities and to provide internal and external assurance relating to quality and to monitor the Trust's Quality strategies and plans and to provide the Trust Board with assurance on Quality Key Performance Indicators (KPIs) and deliverables.

1.2 The Trust Board has created three key committees, the Finance and Performance Committee, the Audit and Assurance Committee and the Quality Assurance Committee. Each committee works with the other committees to ensure there is consistency between understanding joint agenda items. This Quality Assurance Committee achieves this by ensuring the Chair of the Committee is a member of the Audit and Assurance Committee and the Quality Assurance Committee and the Finance and Performance Committee meet on a regular basis to discuss joint agenda topics.

2.0 Clinical Focus and Engagement

2.1 The Trust considers clinical engagement and involvement in Board decisions to be an essential element of its governance arrangements and as such the Trust's integrated governance approach aims to mainstream clinical governance into all planning, decision-making and monitoring activity undertaken by the Board.

3.0 Authority

3.1 The Committee is authorised by the Trust Board to conduct its activities in accordance with its terms of reference.

3.2 The Committee is authorised by the Trust Board to seek any information it requires from any employee of the Trust in order to perform its duties.

3.3 The Committee is authorised by the Trust Board to obtain, at the Trust's expense, any outside legal or other independent professional advice.

4.0 Membership

4.1 The members and in attendance membership of the Committee is listed in Appendix 1

4.2 Only members of the Committee have the right to attend Committee meetings. However, other individuals and officers of the Trust may be invited to attend for all or part of any meeting as deemed appropriate.

4.3 Membership of the Committee will be reviewed and agreed annually with the Trust Board.

4.4 The Chair of the Committee shall be one of the independent Non-Executive Directors selected by the Chair of the Trust Board. In their absence their place will be taken by another independent Non-Executive Director.

4.5 In the situation of a prolonged absence of the Chair or a member of the Committee, the Trust Board will determine a replacement Chair. The Chair of the Trust Board will determine replacement of independent Non-Executive Director membership and the Chief Executive in consultation with the Chair of the Trust will determine replacement Directors. All replacement members will hold full membership authority unless otherwise agreed

5.0 Secretary

5.1 The Personal Assistant to the Director of Nursing, AHP and Quality will act as secretary of the Committee.

5.2 The agenda will be agreed with the Chair following consultation with the Director of Nursing, AHP & Quality.

5.3 The Personal Assistant to the Director of Nursing, AHP & Quality will support the production of the Committee information pack and ensure the pack is circulated within the required timeline of 7 days prior to the meeting, attend the meetings to take the minutes, keep a record of matters arsing and issues to be carried forward and generally provide support to the Chair and members of the Committee.

6.0 Quorum

6.1 The quorum necessary for the transaction of business shall be three, and must include a Non-executive Director and clinical Executive Director. A duly convened meeting of the Committee at which a quorum is present sell be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

7.0 Frequency of Meetings

7.1 The Committee shall meet not less than 6 times a year and at such other times as the Chairman of the Committee shall require at the exigency of the business.

7.2 Members will be expected to attend at least three-quarters (75%) of all meetings.

8.0 Agenda/Notice of Meetings

8.1 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Committee, and any other person required to attend, no later than 5 working days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

8.2 The agenda for each meeting will include an item "Declarations of interest in respect of items on the agenda". Any declarations made will be recorded in the minutes of the meeting.

9.0 Minutes of Meetings

9.1 Minutes of Committee meetings shall be circulated promptly to all members of the Committee. The Committee's minutes will be open to scrutiny by the Trust's auditors.

9.2 The Chair of the Committee shall draw to the attention of the Board any issues that require executive action

10.0 Duties

10.1 The Committee shall support the work of the Trust Board in ensuring a balanced and integrated approach to

- clinical focus, engagement and governance; clinical audit
- patient/stakeholder involvement
- performance management
- strategic management

10.2 The reporting groups within the governance structure includes receiving information from:-

- Health and Safety Committee
- Strategy Workforce Committee
- Trust Policy Committee
- Quality Forum
- Quality Improvement Board

10.3 The Committee is responsible for providing assurance to the Trust Board, on the effectiveness of the Trust's arrangements for quality, staffing, health and safety and policy management and ensuring there is a consistent approach throughout the Trust:

- The underlying assurance processes that support achievement of the corporate objectives and the management of clinical principle risks specific to quality including:

    - Organisational Risk Register
    - Aspects of the Annual Governance Statement related to quality
    - Clinical audit programme
    - Policies and procedures
    - Quality Improvement Strategy
    - Complaints report
    - Pressure ulcer/infection control reports
    - Privacy and Dignity Annual Declaration
    - Safeguarding report
    - Research and Development quarterly performance report
    - Professional Revalidation reviews
    - Clinical Excellence Awards
    - Quality related items from the IQPR
    - Workforce issues
    - EDS
    - Workforce Planning
    - Culture and Leadership programme
    - Assurance reports against SI investigations
    - highlight reports and trend analysis of clinical incidents, and assurance of associated action plans where risks have been identified reports summarising feedback from service users and carers on their experience and involvement, with identified areas for improvement
    - Health and Safety management

- The Committee will also report to the Trust Board on the assurances received from the buddy forum set up with Northamptonshire Healthcare NHS Foundation Trust

- Assurance that the Trust is compliant with all applicable legal and regulatory requirements in particular those of the CQC and NHS Improvement, and including:

    - Patient involvement and information (including complaints, compliments and claims)
    - Personalised care, treatment and support
    - Safeguarding and safety (including infection control)
    - Statutory reports
    - Compliance with quality national and local mandatory targets
    - All other aspects of patient experience, safety and effectiveness including waiting times and outcomes

10.5 In carrying out this work the Committee will seek reports and assurance from Directors and Managers as appropriate, concentrating on the over-arching

systems of quality governance and clinical risk management together with indicators of their effectiveness.

10.6 To oversee, review and update the development and publication of an annual Quality Account, (which identifies the improvement priorities for the coming year). Scrutinise performance against quality indicators set out in the Quality Account.

10.7 Ensure there is an understanding of the key issues being identified by internal audit reports associated to work of the Committee and receive assurance from other reporting groups (through highlight reports) on reports from such bodies as Internal Audit, Audit Commission, National Confidential Inquiries, etc., and to review reports itself as appropriate.

10.8 To provide assurance to the Trust Board that the necessary steps are being taken to deal with any issues raised and that action plans are being implemented and reviewed.

10.9 To initiate and monitor investigation of areas of serious concern as necessary, and ensure resulting action plans are implemented. To receive assurance from reporting groups on any investigations areas initiated and any outcome from those investigations.

10.10 To receive exception reports from the reporting groups on the outcomes of **external** reviews, inquiries, surveys and investigations, with assurance that any lessons learnt have been implemented to ensure delivery of the highest quality of services, and to capture any risks to Patient Safety and Care outcomes.

10.11 To receive exception reports from the reporting groups on the outcomes of **internal** activity, e.g. from clinical audits, site visits and other clinical governance activities, and to capture any risks to Patient Safety and Care outcomes. To provide assurance and challenge around clinical audits across the organisation.

10.12 To receive assurance from the reporting groups on compliance with agreed best practice, e.g. NICE guidance, guidance that emerges from national confidential enquiries, high level enquiries and other nationally agreed guidance, and to ensure the capture of any risks to Patient Safety and Care outcomes. To ensure appropriate performance and focus of its reporting groups and to receive an annual report from each.

10.13 To ensure appropriate performance and focus of its reporting groups and to receive an annual report from each reporting group.

10.14 To maintain timely awareness of visits by external agencies, and to review these periodically.

10.15 To oversee the implementation of the Quality Improvement Strategy, and to keep this under review.

11.0 Reporting Responsibilities:

11.1 The Committee shall make whatever recommendations to the Trust Board it deems appropriate on any area within its remit where action or improvement is needed.

11.2 The Committee will produce a Highlight report from each meeting for the Trust Board describing levels of assurance for agenda items. Any immediate high risk concerns raised during the meeting will be shared directly with all Board members.

11.3 The Committee shall produce for the Trust Board an annual report on the work it has undertaken during the course of the year.

12.0 Annual Review

12.1 The Committee shall, at least once a year, review its own performance, constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the (Parent Committee) for approval.

13.0 Risk Responsibility

13.1 The risk areas the Committee has special responsibility for will be those that fall within the remit of this Committee.

Appendix 1 – Membership of the Committee

	Quality and Assurance Committee
Membership	• NED **(chair)** • NED x 2 • Director of Nursing, AHP & Quality **(Executive Lead)** • Medical Director • A Service Director • Director of Human Resources & OD • Director of Finance
In attendance	• Deputy Director of Nursing, AHP & Quality • Trust Secretary • Head of Quality Governance • Clinical Commissioning Group Representative • Other managers will be invited to attend as and when required
Frequency	Not less than 6 times per 12 months
Day and times	9.00 am on Tuesday of third week

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board – 3 December 2019
Paper number	**H**

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

For approval		For assurance		For information	x

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

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

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

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

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

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

Welcome

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

9th October – Opening of the Bradgate prayer room

I had the pleasure of opening the re-furbished Bradgate prayer room. This was made possible with thanks to both charitable funds and also the support of managers at the Bradgate Unit.

Discussion to develop the Quality Account

We have agreed to use a very good template from NHFT in relation to the development of the Quality Account. For the last five years we have failed to meet our indicator set, and as such we have had a limited assurance review from our external auditors (KPMG). We discussed adopting the foundation trust indictors as they are more sensitive to current provision which are 'out of area and early intervention in psychosis'. We will look to adopt these in the future.

22nd October 2019 -Strategic Improvement and Assurance Meeting (SIAM)

The deep dive for this meeting was on the 2 external reviews conducted in September 2018 on Serious Incidents and April 2019 on Governance structures. We shared the latest Quality and Finance Performance Governance structures. NHSi have offered to support the trust in observing our committees and Board. They will observe committees in December 2019 and the Board in January 2020. They've asked for a deep dive at the next meeting on patient involvement and experience.

Agency spend Task and Finish group

Myself and Rachel Bilsborough are joint SRO for this programme of work to reduce agency spend and utilise temporary staffing in a more effective way. This meeting takes place fortnightly and explores all aspects to rostering, unused hours, use of bank, and processes for requesting temporary staff. Whilst we have made some real in-roads to the use of agency in nursing staff we are now looking to explore efficiencies in Health Informatics and Medical.

FLU

Week commencing 14th October 2019 we have received communication from NHSi that's states **'**your trust has been identified as being in the lowest quartile for 2018/19 and the National Team are now asking that you begin reporting flu vaccination uptake'. We have submitted our data 16th October. Our forms are inputted by the Occupational Health Team at UHL. We have been asked to buddy with another trust to help improve our uptake to see if they are doing anything new/innovative.

31st October 2019 – High level QIA for financial recovery plan

Myself and Dr Elcock attended this meeting with all Directors of Nursing and Medical Directors across LLR. This is a challenging forum to assess whether system wide cost improvement programmes should progress to the next stage after having been reviewed from a quality impact perspective.

Privacy and dignity relating to dormitories

The dormitories are not on the 2 purpose built mixed sex wards which are watermead and Beaumont, which we can make mixed or single sex, they are on the older wards and how we allocate beds in dormitories to support privacy and dignity is outlined below. The dormitories in reality offer very little patient privacy or dignity as the they are 2 or 4 bedded with the only dividers being curtains (mainly based on risk/ ligature issues) – patients can see each other under curtains if they wanted too or if they waft around when doors or windows are open and can obviously hear everything another patient is saying or doing. In reality what we are trying to do in the interim of changes to reduce the number of beds in the rooms is ensure we consider the issues below.

There is consideration of previous risk issues – sexual/ offending behaviour, violence to others and we review who was in dormitories following patients complaints regarding being in a dormitory (there aren't that many) and incidents related to patient on patient physical or sexual abuse (there's been no sexual abuse incident related to dormitories).

MHSOP have developed a shared room risk assessment which is going to be adopted by AMH.

Sexual Safety national collaborative

LPT have been accepted into the national collaborative to improve our understanding and implementation of sexual safety on all wards. With thanks to Michelle Churchard Smith for driving this very important agenda.

18th November 2019 – Buddy Forum

This forum is well attended by senior staff from NHFT and LPT. I continue to be the executive lead for LPT in the buddy relationship working very closely with my peer Julie Shepherd at NHFT. Comms have taken a lead on promoting the buddy relationship with our new #Buddy up which strengthens our organisations understanding of the benefits.

18th November 2019 – Meeting with Leicester University senior lecturers

This is a relationship building meeting which works really well. It's an open and honest conversation about how students are experiencing their placements in LPT. Changes to the NMC standards mean that students are only meant to be 50% in practice. We need to consider this when organising our placement planners.

18th November 2019 - Discussion on centralising corporate functions.

Meeting with the three operational directors and the three governance leads for the clinical directorates. This was to discuss the recommendations made by external reviewers and the CQC re; centralisation and governance structures. Action agreed for Governance leads and interim corporate governance director to work on mapping functions across all directorates, and accountabilities by end Dec 2019. A second piece of work to map all level three meetings to the agreed level one and two structures, for the end of Jan 2020.

Serious Incidents

Going forward we have agreed with the QAC Chair and Head of patient safety to report Serious Incidents in the following way:
1. All SI executive summaries will come to QAC from February 2020.
2. QAC will decide which ones need to escalate to the Board.
3. There will be SIs that used to be called level 2 which are for example, homicides they will go in their entirety to Board.
4.NEDs will continue to sit on panels as agreed due to complexity and severity but this will not be all SIs, and therefore rare.

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board 3 December 2019
Paper number	I

Name of Report: Care Quality Commission Report

For approval		For assurance	x	For information	

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

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

Report previously reviewed by	
Committee / Group	Date
Operational Executive Team	15 November 2019
Quality Assurance Committee	19 November 2019

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

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

Leicestershire Partnership NHS Trust

Care Quality Commission Report

1. Aim

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

2. Introduction / Background

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

3. Discussion

3.1 There are currently 90 actions on the CQC element of the regulatory action plan. Of these, 64 are classed as warning notice or must do actions; 26 are classed as should do actions.

% actions complete – November 2019

- Warning notice and must do actions are 97% complete (last month was 92%). There are 2 outstanding actions.
- Should do actions are 62% complete (last month was 56%). There are ten outstanding actions.

% spot checks complete where the corresponding action has been completed and a spot check is applicable – November 2019

- Warning notice and must do spot checks 68% complete.
- Should do spot checks are 27% complete.

3.2 Summary of progress against each phase of delivery.

The table below highlights the level of completion for warning notice, must and should do actions. It also provides a breakdown of completed spot checks where the corresponding action has been completed and a spot check is applicable.

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

Step up to Great	Theme	Warning Notice and Must Do % Completion		Should Do % Completion		Escalated (section 3.3)
		Action	**Spot Check**	**Action**	**Spot Check**	
	Privacy and dignity	100%	100%			
	Risk assessments	100%	67%			
	Infection Control	100%	100%			
	Seclusion environments/ paperwork	100%	50%			
	Fire safety	100%	50%	50%	0%	
	Physical healthcare	100%	75%	0%		
	Medicines mgt / medical devices	100%	88%	100%	50%	
	CTO (S11)			0%		
	Safeguarding			0%		
	Workforce			50%	13%	
	Environmental / estates	80%	50%	100%	100%	✓
	Patient Involvement			100%	0%	
	Care planning	100%	50%	100%	n/a	
	Governance	100%	0%	100%	0%	
	Meet diverse need			100%	0%	
	Access	83%	33%	33%	n/a	✓
	Total number (%)	62 / 64 (97%)	30 / 44 (68%)	16/26 (62%)	3/11 (27%)	

NB: Fire safety completion has dropped from 100% last month to 50% this month due to the addition of a new action (S25).

3.3 Escalation

There are two warning notice actions which remain outstanding. These have been escalated below and relate to the 'Environment' and 'Access' components of the Trust's strategic framework.

Table 2: Outstanding warning notice actions for escalation

	**Dormitory Accommodation** M3 Dormitory accommodation to be reviewed as part of the work to look at the re-provision of the four older wards This action is rated red. The long term plan for dormitory accommodation is for resolution through the Inpatient re-provision SOC. The Estates and Medical Equipment Strategy Group (EMESG) has formed a sub-group to look at scope of works and possible impact on bed numbers for an interim solution. Scope and outline costs to be finalised by Dec 2019 to ensure works reflected in 2020/21 capital plan. This has been escalated because, while work continues to determine a short and longer term solution, the Trust needs a clear plan mitigate privacy and dignity in the meantime and clarity around how the board is sighted on the impact of dormitory accommodation. Organisational Risk Register: Risk 4260 - The current estate configuration is not fit for the delivery of modern mental health, community and LD services. Current and residual risk score 20. Quality Improvement Plan: **We will improve the quality of our buildings and ensure they are safe clean and welcoming by:** •Eliminating all dormitory style accommodation in our acute and older peoples mental health inpatient and replace with en-suite single rooms by 2030. •Developing a business case for an interim solution •Ensuring mitigations are in place to manage privacy, dignity and safety in the existing dormitory accommodation **To progress these priorities in 2019/20 we will:** •Refresh our estates strategy to ensure it meets the current and future needs of our patients •Develop the Strategic Outline Business Case for the replacement of our adult and older peoples mental health beds

ND assessment and treatment waiting times

Warning Notice ref. W1, W3

The Neuro-Developmental Waiting List is not meeting the trajectory. This has been escalated because achievement of this action is dependent on the success of the Trust's recovery plan. This includes;

- Regular validation of waiting lists
- Diversion of cases to Community Paediatrics
- Scheduled ND focussed weeks
- Continue to monitor productivity through twice weekly ND focussed PTL
- 'Go live' of new CAMHS referral form to include supporting school information for ND assessments

Corporate Risk Register: Risk 4273 - Failure to deliver timely access to assessment and treatment which could impact on patient safety and outcomes. Current risk score 16, residual risk score 12.
Quality Improvement Plan:

We will make it easier for people to access our services by reducing our waiting times through:
•Determining our priority services for waiting time improvements using a risk based approach
•Developing demand and capacity capability and a schedule of demand and capacity reviews across our services
•Engaging with our commissioners to review access targets to ensure they are safe, appropriate and deliverable
•Reviewing, amending and publishing a revised LPT Patient Access Policy
•A relentless focus on data quality improvements
•Providing the services with performance dashboards to support service level performance management
•Executive oversight through our revised performance management processes

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

4. Preparing for the 2019/20 Inspection

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

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

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

See Appendix B for the latest CQC ratings poster which displays the Trust's compliance with fundamental standards.

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

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

6. Conclusion

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

Appendix 1 – Excerpts from the CQC Action Plan as at 1st November 2019.

Table 1: 12 outstanding actions (1 warning notice, 1 must do and 10 should do actions)

Ref No:	Action type	Theme	Improvement/ Objective	Action	Action Taken
W1	Warning Notice	Access to treatment for specialist community mental health services for children and young people	Ensure patient waiting times for assessment and treatment meet commissioned targets and the NHS constitution for children and young people.	Agree a trajectory and resourcing model to deliver significant improvement and increase capacity for assessment and treatment including neurodevelopmental specialist assessment	Access Waiting List: - Number of Patients Waiting for Assessment as at 23/09/19: 103 (target for sustainable position achieved - now managed within tolerances 80 to 150) - Treatment (excluding ND) Waiting List as at 14/10/19 is 420 (trajectory target of 481) - Neurodevelopmental Waiting List as at 14/10/19: 545 (trajectory target of 408) - Access- 4 week urgent performance. September - 100% - Access-13 week routine performance. June 74.7%. July 97.2%. August 97.2%, Sept 98.1% IST follow up review providing strong assurance on the approach to waiting list management. Trust Board presentation completed on 1st October 2019 and confirmation of financial support for Year 2 (2020/21)

M3	Must Do	Estates and premises	The trust must ensure it reviews arrangements of dormitory accommodation with a view to eliminating this in line with national guidance.	Dormitory accommodation to be reviewed as part of the work to look at the re-provision of the four older wards	A paper was discussed at ET on Monday 27 May 2019 and will be going to FPC/QAC meeting on the 18th June 2019. Following discussion at ET/FPC was agreed to progress the viable interim options. Long term plan is for resolution through the Inpatient re-provision SOC. (The SOC was 'approved in principle' at Trust Board - 01 Oct 2019) Timeline for interim estates solution to be agreed 6 August at the Strategic Estates Management Group. The Estates and Medical Equipment Strategy Group (EMESG) has formed a sub-group to look at scope of works and possible impact on bed numbers for an interim solution - sub group to report back to EMESG in Oct 2019 - scope and outline costs to be finalised by Dec 2019 to ensure works reflected in 2020/21 capital plan.
S1	Should Do	Access to services	The trust should ensure patients have access to psychological therapy and this is delivered and recorded in line with best practice	1.To review psychological therapies provision, i.e. offering different therapies to meet the needs of the patient group. 2.To recruit to Band 8c Directorate Head of Psychology post after which other psychology staff will be recruited for the Bradgate Unit.	1, Northumberland Tyne and Wear Foundation Trust (NTW) have completed an independent review of psychological interventions provided in the Directorate. The report has now been received and the recommendations being considered by the Directorate Management Team. 2. Recruitment to Band 8c Directorate Head of Psychology post agreed by

			guidance		SMT and funding identified. Job description has been written and banded and this has now been sent for consistency checking. Post to be advertised before the end of November 2019.
S4	Should Do	Bed Management	The trust should ensure bed management arrangements are more robust in order that patients have access to an acute bed within their area	To review the bed management processes, patient flow and availability of beds in conjunction with Commissioners to reduce the number of inappropriate Out of Area Placements (OAP's)to local trajectory, eliminating all OAPs by end of March 2021.	As at 01.11.19 There are 9 OOA, this includes 3 acute male patients, 2 male PICU and 4 female PICU. This is reviewed fortnightly and has oversight from Executive Team. Work around Red to Green, Housing, EDP and other initiatives are ongoing as part of the Quality Improvement work to reduce the length of stay. Revised bed management SOP. Progress beds, Out of Area Recovery Plan in place as agreed with NHS England (this includes the elimination of progress beds).
S25	Should Do	Fire Safety Issues	Trust to provide clear guidance to staff regarding the escorting of patients who want to smoke whilst on escorted leave.	To review the Trust Smoke Free Policy to ensure that there is clear guidance to staff regarding the escorting of patients who want to smoke whilst on escorted leave.	Smoke Free Group to nominate a lead and review by end of November 2019.

S11	Should Do	CTO (Community Treatment Order)	To ensure that all patients who are subject to a CTO receive their 132 section rights.	To jointly develop with assertive outreach a bite size training programme to support staffs knowledge and understanding of CTO and the implications for care delivery.	A CTO SOP has also been written and approved by MHAAC and has been circulated Trust wide. An online CTO census has also been approved and is currently in the design phase. This will go live on the 01/11/20. The census will be completed by an identified clinical staff member in all community teams and will be submitted monthly. Bite size Training for staff in conjunction with the Assertive Outreach Team has been developed. CTO training has now been held with 28 staff attending out of 50 who had booked onto this. CTO online audit questions just being amended and still on trajectory to start on 01/11/19.
S12	Should Do	Physical Healthcare	The Trust should review how they assess and monitor patient's physical health needs in children and young people.	Ensure that the requirements for undertaking physical health checks on children and young people in mental health services are met.	Steps taken within CAMHS to ensure compliance with NICE Guidelines: * All clinicians to record past medical history/allergies as part of the core mental health assessment if there are any current physical health concerns. Then to take appropriate actions in partnership of other providers. * All patients on ADHD/antipsychotic medications have their clinical observations (height, weight and BP pulse done) as per NICE

					recommendations by clinicians within the service. Currently in the process of ensuring it is recorded systematically in SystmOne so that it is easily accessible to all when required. Training for relevant clinicians 03/12/19. * Currently not compliant with metabolic monitoring for patients on antipsychotics. Directorate Pharmacist collecting baseline data regarding demand and capacity. There is a set centralised process in place within AMH and are looking at the option of CAMHS being part of this.
S14	Should Do	Safeguarding / incident reporting	The Trust should review their safeguarding children and incident reporting policies to reflect staff practice	Confirmation of policy review and timeline for completion of updated policy.	Requested update from Central Safeguarding Team 03.06.19. The Trust incident reporting policy is currently under review. The Head of Patient Safety and the Safeguarding Lead are writing a section for safeguarding children to be inserted within the main incident reporting policy. The Trust Safeguarding policy is also under review and both policies will be completed by 30th September 2019 deadline within the trust governance agreed process (via the safeguarding committee).

S15	Should Do	Workforce	The trust should ensure staffing requirements of 136 services do not adversely affect those of acute wards for adults of working age	The rostering team will work with operational managers to review the rosters and staffing requirements.	Additional funding identified of £160K for Band 5 RGN 24/7. Job description is being updated and then recruiting in November. In the interim, a member of staff from the wards is covering PSAU on a rota basis and their post will be backfilled by bank or agency staff.
S19	Should Do	Workforce	The trust should ensure that staff have access to regular team meetings	Wards to have at least monthly team meetings chaired by the Charge Nurse / Sister or deputy, which will be supplemented by a weekly information sharing email. Information from the meeting will be cascaded to all staff and be available for all staff to see Standardised agenda linked to STEP up to GREAT to be developed and shared across team leader meetings including lessons learned discussion The frequency and cancellation rates of scheduled team meetings to be reviewed by service managers and action taken where meetings do not take place	All team meetings are using the standard meeting agenda not all staff currently attending, in the interim minutes and newsletter are being circulated.

S21	Should Do	Workforce	The trust should ensure that the senior executive team are present and visible to staff	• Increase the number of Executive Team Boardwalks and ensure that there is a programme of visits in place. • Photos and job titles of the senior executive team and local senior managers are to be made freely available in public and staff areas of the service. • To plan a regular programme of Q&A sessions for staff within the unit with the Executive and Service Manager team to increase leadership visibility.	We are launching the culture and leadership programme which is an NHSi programme and will support strengthening this area We are launching the culture and leadership programme which is an NHSi programme and will support strengthening this area Personal call to action from all board by way of a letter to the home addresses of all staff with pictures included. More focus board walks in areas of concern underway. Board meeting are moving to clinical sites to ensure visibility Senior teams attended the step up to great launch sessions Step up to great launched posters out across the Trust Photo Board and leadership quotes are on display in the BMHU reception

S22	Should Do	Workforce	The Trust should ensure all staff are supported to raise concerns about bullying	• HR team will to review with operational managers to ensure staff are supported and aware of support systems in place. Staff side and freedom to speak up guardian to be connected also. • FTSU Guardian to arrange drop in sessions • Ward Sisters to implement 'Stress Tool' on their wards. • Ward Sisters to publicise any staff 'resilience' training available for staff to access • LPT Equalities Lead to arrange sessions in April and re-visit in May	• Anti-Bullying and Harassment service available for staff. Poster updated to include Freedom to Speak Up Guardian. • Positively supporting your mental health document produced to include all sources of mental health support for staff including emotional resilience workshops. This has been shared with managers through the newsletter and included in Team Brief (April 2018) • Stress risk assessment tool included in Stress Management policy and HR teams have been working with managers to ensure that this is undertaken in a supportive way. • Freedom to Speak up Guardian has visited areas where issues were identified around bullying to remind staff of routes for raising issues. • Working group meets regularly to discuss Trust approach to bullying and will be looking to learn from good practice in other organisations to focus on civility and resolution – linked to the culture, leadership and inclusion work. Evidence being submitted to the strategic workforce group for sign off on the 13 November 2019

Table 2: 22 Outstanding spot checks where corresponding action has been completed (11 warning notice, 3 must do's and 8 should do spot checks)

Ref No:	Action type	Theme	Improvement/ Objective	Action	Action Taken (phase 1 or 2)	Spot Check / Audit (phase 3)
W3	Warning Notice	Access to treatment for specialist community mental health services for children and young people	Ensure patient waiting times for assessment and treatment meet commissioned targets and the NHS constitution for children and young people.	Ensure staffing establishment is sufficient to meet trajectory requirements in regard to specialist skills and capacity	Staffing establishment in place to meet the required trajectory for assessment and treatment. The following have been put into place to ensure that we reduce the number of c&yp waiting for ND assessment. • A review of the pathway model to be more systematic regarding the assessments – e.g. working in pairs of clinicians • A plan to incorporate the requirement for GP's to acquire and submit supporting school information for a referral which is primarily a request for a neurodevelopmental assessment • A plan to start to align clinicians with ND experience to complete access assessments for CYP	Waiting for achievement of ND trajectory, and for Healios to fully establish before completing spot check. Audit tool is being designed and will be completed throughout December. Results and report will be completed January 2020.

					primarily referred for neurodevelopmental assessment - this is more realistic now that access waits are low • Community paediatrics continuing to take cases from referral who are solely referred for neurodevelopmental assessment • Starting our partnership work with our online provider, 'Healios', to undertake neurodevelopmental assessments • Undertaking a piece of work to understand the capacity required for ADHD post diagnosis support and out of that our future workforce requirements • Incorporating 'Neurodevelopmental weeks' into our schedule.	
W5	Warning Notice	Access to treatment for specialist community mental health	Ensure patient waiting times for assessment and treatment meet commissioned	Progress large scale change programme to maximise longer term sustainability of service.	CAMHS Improvement Board 2018/19 project end report completed and signed off by FYPC Sustainability meeting 18/4/19.	Scope of spot check being determined.

		services for children and young people	targets and the NHS constitution for children and young people.		2019/20 improvement priorities agreed at FYPC Sustainability Meeting 18/4/19 for CAMHS operational management team to take forward alongside senior leadership team support for access work. CAMHS Improvement Team meeting report went to FYPC Business Day 19th September 2019. Focussed weeks for ND assessment commencing October 2019. Key areas of progress evidenced as: 1. peer supporters recruited and trained 2. care navigator support established for transition to adult services/discharge 3. waiting times escalation process and management responsibilities documented 4. Dialectical Behavioural Therapy (DBT) training scheduled for21/23rd Oct 5. additional anxiety group work capacity in place.	

W6	Warning Notice	Access to treatment for specialist community mental health services for children and young people	The specialist community mental health services for children and young people crisis team to meet their commissioned target to telephone patients within two hours and assess them within 24 hours	Review of existing systems and processes to identify opportunities for improvement and implement changes	Improvement plan in place led by Head of Service including action progressed on; increasing staffing with locum and recruitment, change in leadership, scheduling, review of KPIs with commissioners and improved data validation, process redesign and protocols to support staff for 2 hour and 24 hour contacts. New processes being implemented to help Crisis Team meet 2 hour and 24 hour KPI targets. Structured scheduling of appointments to have sufficient assessment slots available each day and coverage on telephone triage at all times. New referral script has been reviewed and agreed by team when receiving referrals. The script is being used to allow the service to receive sufficient information on all referrals and ascertain whether the referral is appropriate for the service. Additional locum support to	Scope of spot check being determined.

					increase capacity to offer assessments. Additional Locum support to offer 2 assessments per day on top of teams current capacity. Report to FYPC Business Day 19th September 2019. Focussed weeks for ND assessment commencing October 2019. Ongoing CAMHS Improvement plan is being progressed and governed through the CAMHS Improvement Group.	
W38	Warning Notice	Seclusion environments and seclusion paper work	Seclusion paperwork/ process Ensure compliance with the Seclusion Policy and the Mental Health Act Code of Practice	Matrons to complete a review of all seclusions and documentation 1 month after the implementation of the new policy and documentation	The service has completed the second PDSA cycle and the new paperwork has been launched 15.10.19	Spot check for revised paperwork planned for November 2019

W16	Warning Notice	Environmental Issues	Establish a co-ordinated and responsive repairs and maintenance process to quickly address and resolve issues promptly	To strengthen our internal governance arrangements and clarify the escalation process for unsatisfactory delays Re-issue the new process for reporting and logging repairs and maintenance requests to the ward clerks/ administrators Include process in new ward clerk induction pack Ensure that the new process loop is closed with the job number being shared by reception with the ward clerk	This is managed by the Buildings and Security Manager (BSM) for acute, forensic and rehab until recruitment completed for substantive property managers in all areas. Escalation will be either directly to the on-site maintenance staff or to the Property Officer. • Confirmed current maintenance reporting route into Helpdesk with cc to BSM to ensure oversight and tracking. • BSM oversees a maintenance log for each ward and keeps track on response (escalation) and completion in conjunction with Estates Manager. • BSM receives updates on local improvement works / new works each ward area is progressing. • BSM is planning an AMH Inpatients 2019/2020 Programme of New Works in conjunction with Estates.	The Trust undertook a comprehensive FM provider review and a report was presented to the board on the 1st November 2019.The Board approved action to investigate and cost an option that better meets the needs of the trust

					Rehab: Locally agreed process of a log being held by receptionists at each area. Staff report any estates or works issues to the receptionist who will log it as a job, obtain a job number and will update when completed. Admin manager reviews every week and chases outstanding issues as well as bringing to monthly admin meeting. As a next step, there is further quality improvement work taking place to address roles and responsibilities for identifying and reporting issues. There is also a recognition that the responsiveness of estates needs further improvement. An escalation process has been implemented and embedded within the service.	

W19	Warning Notice	Risk Assessment	Ligature risk assessments to be tailored and include actions. To ensure that systems and processes are in place to enable timely and adequate response to actions	Ward sister / charge nurses will ensure that the ligature risks for each individual patient is assessed through the risk assessment process and where required a person centred ligature care plan is in place	MDT's have reviewed individual risk assessments identifying if individual ligature care plans are required and completing ligature care plans as required. . Environmental ligature risk assessments completed as well.	Initial spot checks undertaken to ensure that MDT are reviewing individual patients and creating ligature care plans if required. Further spot check arranged. Cycle 2 of the collaborative care planning work and will be completed by end of September 19. Cycle 2 completed. Gaps still remain out of eight sets of notes four stated in the Care Plans that the patient was a risk of ligature and how this would be managed and four did not. Further work with staff being undertaken by Senior Matron. Cycle three will commence December 19.

W22	Warning Notice	Risk assessment of patients	To ensure risk assessments are robust and completed and updated following incidents.	To ensure risk assessments are robust and completed and updated following incidents.	Risk assessments have been subject to a one off review and updated where necessary. On-going updates completed in response to incidents and significant changes in presentation using PDSA methodology. The work has been completed and evidence has been uploaded to the evidence folder. Spot checks to commence in November 19.	Spot checks commenced in November 19 the results will be available early December 19.
S8	Should Do	Fire Safety Issues	The trust should ensure a review of the management and implementation of its smoke free policy at the Bradgate Unit	Review the on-going provision of vaping material and NRT for patients.	Successful implementation of the Smoke Free Policy and provision of vapes and NRT to be routinely reviewed by the Smoke Free Group. Meeting minutes requested for evidence.	Spot check will commence on 15th November 19. Results will be available December 19.
W27	Warning Notice	Fire Safety Issues	Safe evacuation in the event of a fire. Disabled patients will have a personal emergency escape plan in the event of fire	Ward Sister to send AMH PEEP and guidance sheet to all Ward Sister/charge nurses and to be point of contact for any queries. To flag those patients with a PEEP	The need for a PEEP has been added to the admission check list and handover agenda. Email and attachment sent to all AMH/LD Ward Sisters/Charge Nurses. Spot checks show that patients requiring a PEEP have one and there is good	Spot checks found 100% compliance. New round of spot checks to commence in November 2019 to ensure on-going compliance before being signed off.

				on nursing handover	staff knowledge.	
W28	Warning Notice	Fire Safety Issues	Safe evacuation in the event of a fire. Disabled patients will have a personal emergency escape plan in the event of fire	An alert flag to be introduced into RiO to identify patients who require a PEEP.	There is a 'patient at a glance board' on wards, which demonstrates in red if a patient requires a PEEP. Not possible to add an alert flag onto RiO due to imminent changes to EPR systems. Processes are in place and robust regarding the use of PEEPS. It is on the admission checklist for all patients to be assessed for a PEEP and paperwork is completed if they need one. A care plan is then written on RiO and it is recorded on the patient status board in the nursing office in red.	Random spot checks are in place to ensure compliance. Results to be reviewed and formally signed off November 19.
M5	Must Do	Fire Safety Issues	The trust must ensure that weekly fire checks of environments are completed	Weekly fire checks of the environment to be carried out.	Fire checks being completed each week.	Spot checks being undertaken by the Team Manager. Results to be reviewed and formally signed off November 19.

S9	Should Do	Medicines Management	Strengthen medicines management systems and processes to comply with standards and policy	Confirm the process for medication incident reporting with all staff at the homes team meetings. Review all medication error incidents that are reported for learning and share with staff in team meetings	All medication incidents are reported on Ulysses as an eIRF and considered under the Trust Medication Error Policy. All Ward Matrons/Charge Nurses receive information about medication incidents in their areas and these are reviewed monthly by them Matron for shared learning with their staff teams. A quarterly report about medication incidents is being collated for Quarter 2.	Scope of spot check being determined
M6	Must Do	Medical Devices	The trust must ensure that medical equipment used by staff is regularly and accurately checked	Establish that all of the medical equipment is on the Medical Devices database. To ensure all medical equipment is checked annually in accordance	All medical equipment in use is recorded on the Trust Medical Devices database. There is a robust and clear process in place for the management and servicing of medical devices. There is a	Scope of spot check being determined

				with the Medical Devices Policy. To review the process for locally checking equipment in between the annual checks.	link person in each service who is responsible for ensuring that equipment is available for servicing at the appropriate time (date given a month in advance) and for reporting when equipment is faulty or has been removed from use. The Medical Devices Team undertake site visits to undertake spot checks of equipment in use and locate any missing equipment.	
M7	Must Do	Seclusion environments and seclusion paper work	Ensure seclusion policy includes adequate seclusion room checks	Seclusion room checks will be completed after patient seclusion is terminated.	The seclusion room checklist is in place and checks are happening routinely as part of the process when seclusion is terminated	Spot checks have shown that seclusion room checks are mostly embedded although there has been occasional inconsistency. Spot checks to be repeated to check for full compliance.
W42	Warning Notice	Physical Healthcare	All patients admitted to Rehabilitation Wards will have a physical health examination	Matrons to confirm the correct checking process is in place for equipment and the Trust calibration schedule includes the	Equipment is held on the Trust central database and there is an annual service check of this equipment by a specialist company.	Ward staff complete weekly checks outside of this annual check. The checks are signed off by the Ward Sister/ Charge Nurse weekly and a brief

				equipment		compliance report with any actions go to the Inpatient Governance meeting.
W51	Warning Notice	Governance	Objective Governance - Not always focussed on the most important aspects of quality / issues	To implement a revised BAF and a Quality Improvement Plan for 2019/20	The Trust Board has received regular updates on the revisions to the BAF/CRR including a deep dive workshop at Board on the 30th August 2019. A final version was presented to the Audit Committee workshop on 23th September 2019 and the Board 1st October 2019. The quality improvement plan has been presented to both July and August 2019 Trust Boards for assurance and is now the central topic for the new quality improvement board.	Spot check to review the monthly business cycle for the revised BAF and QI plan to undertaken in November 2019
S17	Should Do	Workforce	The trust should ensure the use of bank staff does not impact on the delivery of consistent patient care	The trust should ensure the use of bank staff does not impact on the delivery of consistent patient care	The Trust safer staffing report provides oversight of use of Temporary staff and increased utilisation due to RN vacancies, sickness and increased levels of patient acuity requiring observation support. Regular block	Spot check on content of safer staffing report and bank staff training compliance (to see evidence of an increase) planned for November 2019

					booking of bank and agency RNs continues to manage the impact of the increase in RN vacancies across the acute inpatient wards. A triangulated approach to the impact of staffing to patient outcomes and experience is reviewed in the monthly papers. Bank staff are subject to the same mandatory and role essential training as substantive staff to ensure they have the right skills, a programme of work is in place to improve bank staff training compliance.	
S18	Should Do	Workforce	The trust should ensure the use of bank staff does not impact on the delivery of consistent patient care	Ensure that bank staff have the skills to provide safe and effective care	Bank staff attend core induction and are provided with the same mandatory training and competencies expected of substantive staff.CSS, in conjunction with the Lead Nurse and Therapy group and Learning and Organisational Development Group, have actions in place to improve compliance rates with all mandatory training topics with a particular focus on Adult Immediate Life	As at the end of September 2019 there remain two RAG rated red topics Management and Prevention of Falls - 2 Years increased from 25% to 36.7% and SCIP-UK - 1 Year at 40%. Compliance with Adult Immediate Life Support increased from 61% to

					Support. Ward Matrons/charge nurses to develop a cohort of regular bank staff if possible and ensure that they are inducted to the individual ward • From 1st July, a rule will be in place on Health Roster preventing bank workers from self-booking shifts if non-compliant with Adult Immediate Life Support (agreed by Lead Nurses). Bank workers who are non-responsive to requests to book on will go through the training non-compliance process which can result in restriction from working or sanction as agreed by the Temporary Staffing Panel. • At the Lead Nurse and Therapy meeting in June we will agree a phased plan to implement rules for other mandatory topics. • Progress to date and next steps will be received by SWG for assurance in July.	68%.in September 2019.

S20	Should Do	Workforce	The trust should ensure that staff have access to regular team meetings	• Establish a programme of regular team development days across the service. • Encourage regular meetings and team work, team meetings. • Provide additional OD support and training on teams. • HR to review with operational managers to ensure there are opportunities for team meetings.	In response to the action we held a team development training sessions for line managers Further training in our OD portfolio for attendance. Ran a communication importance of team working and support available, that we will rerun every quarter for the rest of the year (embedding message) Inclusion in Leadership Matter newsletter – in all ways that we can include in team brief We have commenced an audit within mental health services on how often management supervision is undertaken which includes one to ones and team meetings	The 2018 Staff Survey shows that 71.3% of respondents say that the team they work in often meets to discuss effectiveness. This has shown a gradual increase from 66% in 2015 and is above the national average of 69.3%'. Results of 2019 staff survey to be reviewed before sign off.

S23	Should Do	Patient Involvement	The Trust should ensure patients are provided with food of their choice	To ensure patient feedback on menu choice is fed into the menu service reviews with the dieticians and local food group.	Work has been undertaken with patients at Stewart House. This work has involved had food focus meetings to understand patients experience of the food provided and what they would like to see. This is evidenced through the food focus meeting minutes. However we do not have evidence of the changes in food provision as a result of these discussions. Evidence has been requested. A meeting took on 7th November 2019 with the patient involvement facilitator at Stewart House to ascertain the evidence of how the feedback from discussion with patients has informed the menu choice.	There is a quarterly food focus group session, attendance is patient rep from each ward, OT, Food company rep, and dietician. The meeting is to discuss larger changes for example changing the menu and meal choices, including taster sessions. The menus are on a two week rotation with a six monthly change of the two week menu. Monthly community ward forums are held on each ward to discuss lots of things and food is on the agenda for all patients to feedback any comments.

S24	Should Do	Patient Involvement	Ensure there are clear systems to gather feedback from patients and carers and use it to make improvements to the service	Review the current systems for gathering patient and carer feedback – Ward/ home patient meetings, complaints, service user forums, friends and family tests, patient stories and feed into service reviews and service quality improvement plans	A Patient and Carer Experience/Involvement lead has been appointed at the Agnes Unit. This role has created a detailed work plan in regards to plans around experience and involvement at the unit, and creating processes/systems to regular gather feedback and turn this into improvements. The involvement of patients in Experienced based co-design is already taking place, involving patients in shaping when and how they would like to feedback, and involved in planning activities on the unit. A feedback tree has been created for patients and carers to leave feedback comments to. The team have also been working with patients to create an experience journal of the things they have been involved with whilst staying on the unit and will also include any service improvements they have been instrumental	Scope of spot check commenced on the 4 November 19. Patient care facilitator is gathering feedback form patients at the Agnes unit on a weekly basis This is evidenced in the weekly team meeting and discussed and any concerns /improvements that patients have are actioned. There has been a positive increase in returns of FFTs.

					in	
S26	Should Do	meet diverse need	The Trust should review their processes for meeting patient's diverse needs	• Implement a quality improvement project for the collation and utilisation of protected characteristics information including EIA's for services. • Ensure care planning represents the diverse needs of our patient group. • Include in records audit programme.	There has been considerable work to facilitate the collection and recording of protected characteristics and other mandated information with RiO and AMH along with PIER and ED. After consideration of the optimum method to facilitate collection and consideration of what neighbouring trusts do, a paper collection form was devised. This is now being sent\given out at first appointment. Once returned, staff then record the information within the patient record to ensure not only an accurate record but enable reporting. Plan for initial rollout of recording and reporting of protected	Ensure care planning represents the diverse needs of our patient group and include in records audit programme. Monitoring of delivery of the action plan via IG & Record Keeping Group. Long term monitoring via the audit programme. Results to be reviewed and signed off November 2019

					characteristics has now been completed.	

Appendix B - Compliance with fundamental standards: Ratings poster as at 1st November 2019

	Safe	Effective	Caring	Responsive	Well led	Overall
Long stay or rehabilitation mental health wards for working age adults	Inadequate	Inadequate	Requires improvement	Good	Inadequate	Inadequate
Community-based mental health services for older people	Good	Good	Good	Good	Good	Good
Wards for people with a learning disability or autism	Requires improvement	Good	Good	Good	Not rated	Requires improvement
Acute wards for adults of working age and psychiatric intensive care units	Inadequate	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate
Specialist community mental health services for children and young people	Requires improvement	Good	Good	Inadequate	Requires improvement	Requires improvement
Community health services for adults	Good	Good	Good	Good	Requires improvement	Good
Mental health crisis services and health-based places of safety	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Community-based mental health services for adults of working age	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Wards for older people with mental health problems	Good	Requires improvement	Good	Good	Good	Good
Community health services for children, young people and families	Good	Good	Outstanding ☆	Good	Good	Good

	Safe	Effective	Caring	Responsive	Well led	Overall
Community health inpatient services	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Child and adolescent mental health wards	Good	Good	Good	Good	Good	Good
End of life care	Good	Requires improvement	Good	Good	Good	Good
Forensic inpatient/secure wards	Good	Requires improvement	Good	Good	Good	Good
Community mental health services with learning disabilities or autism	Good	Good	Good	Requires improvement	Good	Good

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board – 3 December 2019
Paper number	J

Name of Report: Patient and Carer Experience and Involvement (PCEI) Quarterly Report (including Complaints) Quarter 2, year-end 2019/20

For approval		For assurance	X	For information	

Presented by	Anne-Maria Newham, Director of Nursing, AHPs and Quality	Author (s)	Alison Kirk, Patient Experience and Involvement Lead

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

Report previously reviewed by	
Patient and Carer Experience Group	5 November 2019
Quality Assurance Committee	20 November 2019

Assurance :	Links to ORR risk numbers
• There is a risk that the Trust does not positively impact on the experiences of service users, carers and families that use our service	4257
• Patient do not always find it easy to share their experiences and the Trust does not as a result received feedback	4281
• We have a developing Patient Experience & Involvement Framework and until fully embedded there is a risk of not being able to evidence the delivery of quality patient experience	4280

Recommendations of the report
• Receive assurance that work is being undertaken to improve how the Trust hears the voices and improves the experience of those who use our services, and their carers. • Receive assurance that robust systems and processes are in place to ensure that complaints are being managed effectively in accordance with both the Trust and regulatory requirements.

Leicestershire Partnership NHS Trust

Trust Board

Patient and Carer Experience and Involvement (PCEI) Quarterly Report (including Complaints) Quarter 2, year-end 2019/20

1. Introduction

The Patient Experience Report aims to present a rounded picture of patient experience and, as such, provides information on all aspects of experience, good and less positive. Where poor experience is reported, actions are then taken to ensure improvements are made and featured in future reports.

The reports present a wide range of information from different sources. Including the following:

- Frequent Feedback – comments, enquiries and concerns
- NHS Choices Feedback
- Friends and Family Test (FFT)
- Complaints
- Compliments
- Service Improvement Projects
- Boardwalks
- Patient Stories

It is understood that each method of feedback has its strengths and weaknesses. Using all methods of information available enables the Trust to better understand the patient's experience of the services offered and delivered, and is beneficial to help prioritise where to focus efforts on action planning.

2. Aim

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

3. Recommendations

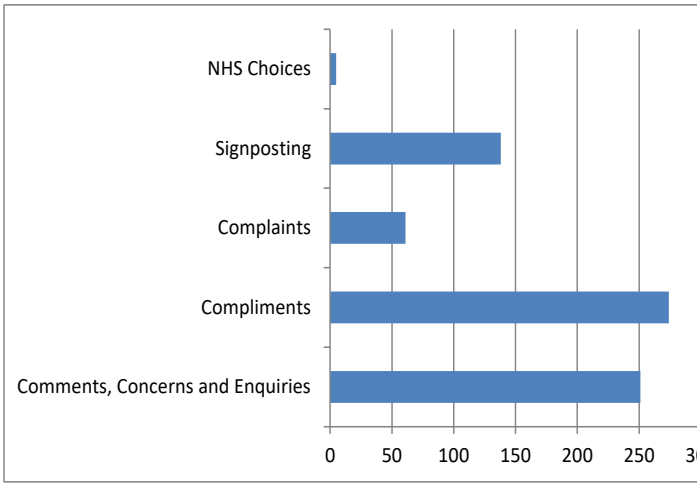
The Trust Board is recommended to:-

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

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

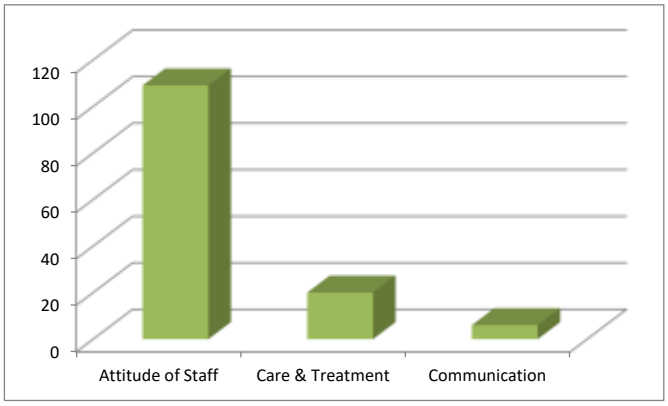
4. Key highlights from the Patient Experience Report are as follows:

Feedback Overview shows that the Trust received 724 individual pieces of feedback in relation to complaints, comments, enquires, concerns, signposting and compliments. This is compared to 758 in Quarter 1. 38% (n=272) were to provide positive feedback captured through compliments, which is in line with Quarter 1. The remaining 62% of feedback received related to comments, concerns and enquiries (35%), complaints (7%) and the remaining 20% in relation to signposting to services both internal and external to the Trust.



A full breakdown of feedback received for Quarter 2 is available in Appendix 1.

The most reported concern across complaints and concerns, comments and enquiries was in relation to appointments. This covered a range of issues including cancelled and delayed appointments as well as waiting times. A programme of work has commenced to understand the harm that may be being caused to patients who are currently on the waiting list for a follow up appointment. This work will firstly focus on those patients who are waiting for adult mental health and learning disability service follow-up appointments. The work includes co-designing a questionnaire with service users who have experience of long waiting times which will be used to understand the experience of those who are currently on the waiting list as to ascertain any potential areas of harm that this wait may have caused to individuals. Once agreed the survey will be piloted with a small number of patients, using different approaches this will inform the further roll out of the survey and to ensure that those who are surveyed are able to access further advice and support whilst on the waiting list.



Positive feedback in the form of compliments demonstrated that patients and carers were mainly happy with the attitude of staff towards them with 40% (n=109) compliments received. 20% (n=52) of compliments received related to good customer service with care and treatment receiving the third highest number of compliments 7% (n=20).

This feedback demonstrates that patients and carers reported the highest satisfaction on the emotional elements of their care, whereas those who reported poor experience in relation to appointments demonstrated dissatisfaction with the rational elements of care e.g. processes and systems that impacted on their care.

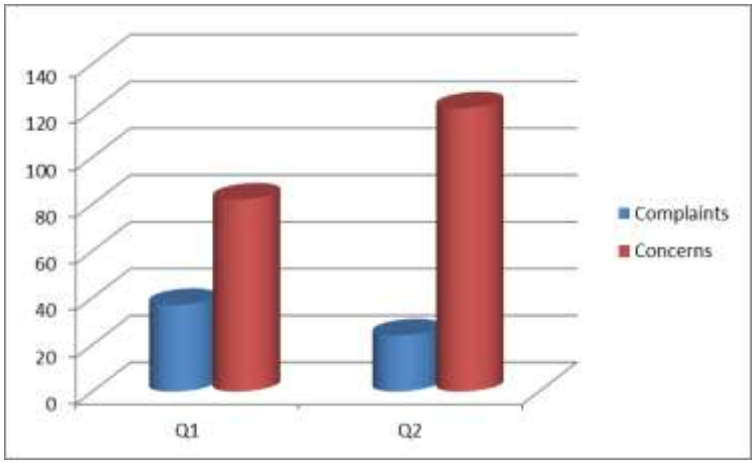
NHS Choices patient feedback

During the period 3 comments were received through NHS Choices, all of which related to Adult Mental Health Services, specifically the Bradgate Unit. All three comments were in relation to reported poor care that was not joined up and provided by staff with poor patient attitudes. Each piece of feedback has been shared with the service involved with the Patient Experience Team offering further support and advice to the individual who has posted the comment. On the time of writing this report no response has been received back from the service involved,

Complaints

The Trust received 61 new complaints between 1 July and 30 September 2019 which included multi-agency complaints where we were asked to investigate specific elements of the complaint that relates to a person's care and treatment. This is a reduction of 24 complaints compared to Quarter 1 and a reduction of 80 complaints received in the same Quarter last year.

The reduction in the number of complaints is in direct correlation with the introduction of better triaging of the issues that are being raised with the Patient Experience Team and complaints leads within directorates. This is in addition to a better understanding of the different informal approaches and processes for resolution that can be explored prior to the formal complaints process. Staff are now increasingly looking to exhaust informal pathways in the first instance in an attempt to resolve issues swiftly without defaulting to a formal complaints process. This is coupled with greater communication between the Patient Experience Team to gain opinions of their colleagues on how the issues could be best handled.



This is evidenced by comparing Adult Mental Health and Learning Disability figures for concerns and complaints for Quarter 1 and Quarter 2, where there has been a decrease in formal complaints but an increase in the number of concerns reported where issues are dealt with informally.

For this quarter 100% of complaints were acknowledged within 3 working days; 26% (n=16) complaints were investigated within 25 working days, in addition to this 23 complaints were investigated within the timescale negotiated with the complainant, the

negotiation may be impacted by a number of things including the complexity of the complaint which may require longer than 25 days for investigation or the fact that the complainant as requested that the investigation is paused for a personal reason. However it is noted that in some services complaints investigations have regularly taken longer than 25 days due to staff setting these timescales not in negotiation with the complainant. A full breakdown for Q2 is provided in Appendix 2.

In August a paper was provided to the Strategic Executive Board on the current position of complaints across the Trust along with proposed changes to the current complaints procedure and structure. The changes adopt and embed best practice from the Parliamentary and Health Service Ombudsmen - My Expectations report and NHS England guidance. This work was well received and approved providing a pathway for work to commence on a revised procedure. The Complaints Policy is currently undergoing a review and will be revised in accordance with the new complaints process.

From 1 October 2019 the Trust has agreed all complaints must be investigated within 25 working days unless the complaint is complex and requires a longer investigation or if the complainant requests a longer timescale. In all circumstances this will be in agreement with the complainant and the complaints manager.

To build capacity in complaints management across the Trust additional resource is being sourced with the Adult Mental and Learning Disabilities Directorate with support for investigations and for managing the increasing number of concerns coming into the directorate. Adult Mental Health and Learning Disabilities have the highest number of complaints which are also the most complex so additional capacity will focus on reducing the backlog with current complaints and to provide quicker informal resolution to concerns. Within the Corporate Complaints Team recruitment to the current vacant post is now in progress following a capability review. It is envisaged that all roles will be filled by December 2019.

The Complaints Service is working in cooperation with a nominated clinician to update complaints training material for medical staff. This is with a view to delivering sessions to clinicians on their role in the complaints process with particular emphasis on supporting and addressing service user concerns at the point of service delivery. This worked is aimed at reducing the number of clinical complaints received as clinicians will be empowered to help address concerns with them locally. The Complaints Team are also devising a regular Trust wide training program to provide staff with a better understanding of the different stages of the complaints process and the importance of trying to address any concerns directly with the service user in the first instance.

The Complaints Team have enhanced its working relationship with our complaints counterparts across Northamptonshire with a number of visits completed to gain valuable insight into their complaints process. The sharing of best practice has taken place over the last period and has contributed to the work started on the revision of the complaints process.

Friends and Family Test

3,234 responses to the Friends and Family Test (FFT) were received in Quarter 2. This is an increase of 9% across the Trust compared to Quarter 1 but is still significantly below the national average. The current response rates for FFT across Mental Health Services in England is 3%, the Trust is currently reporting a 1% response rate. In relation to

Community Health Services the national average across England is 4% with the Trust achieving a 2% response rate.

Of the responses received the average recommendation score for each Directorate are as follows, a full breakdown is shown in Appendix 3:

Adult Mental Health and Learning Disabilities	91%
Community Health Services	96%
Families, Children and Young People	98%

In order to address the low response rate across the Trust and to understand what front line staff and services are currently doing to capture and use patient feedback a Listening into Action event took place on 19 September 2019. The event, which had 50 participants in attendance, provided a rich insight into the challenges and opportunities to improving how patient feedback can be captured and used within frontline services. The themes from this event have now been finalised by the Sponsor Group and will be followed up through a 20 week improvement programme. The themes that the Sponsor Group will focus on are:

- Releasing time for involvement and feedback
- Turning feedback into action
- Creating a network where staff and services can exchange ideas and experiences

In addition to this work a review of the current FFT provision across the Trust has been undertaken with a specific focus on the IT system and infrastructure that supports the implementation of FFT, this was informed by the feedback from staff on the poor experience of using the current system.

The system, which was developed in-house by the Health Informatics Service, relies mainly on paper-based capture which is inputted either by the Directorate or the Patient Experience Team. In addition to the cards, IPads were provided to allow real-time FFT feedback to be captured. However due to connectivity issues across a majority of the services where the IPads were provided the number of feedback captured via this route is low, with many services reporting that they have given up with the IPads and are now only using cards for feedback. This has also been compounded by the current system where staff can download data and display it through 'You said we did' posters. Staff have reported challenges with the current system saying is it timely and doesn't always give them useful information that they can use, this has also been evident through the feedback received by Wards who have taken part in the Community Health Services Ward Accreditation process, where FFT feedback is a key element of the patient experience metric.

In order to address these issues a review of current systems that are available for FFT has been undertaken, looking at alternative approaches to capturing feedback through automated texting and call systems through to developing patient feedback volunteers who could work alongside clinics and wards to capture feedback. This review has resulted in the development of a capital bid for an IT infrastructure to support a new system across the Trust, alongside work with the Volunteer Team on creating a feedback volunteer role which will be piloted in services during the remainder of 2019/20.

NHS England/Improvement have been invited to deliver a workshop on 14 November 2019 on the new FFT guidance which will commence in April 2020. The aim of the workshop is to set out the new guidance and to provide an opportunity to discuss with NHS England/Improvement opportunities to increase the update of FFT across the Trust in the run up to the commencement of the new guidance and to ensure that the Trust is ready to implement the new guidance in April 2020.

Service improvements – Ellistown (Ward 2), Coalville Hospital

In Quarter 1 Ellistown Ward at Coalville Hospital received the highest number of compliments in relation to Nursing Care. In order to understand more about what the team are doing we visited the ward. On talking to the team they told us that things had not always been good, they had struggled for some time with staff turnover and instability of leadership. They had poor FFT responses and patient experience on the ward was not positive.

However with the introduction of a new Matron and Sister thing's had started to improve. New structures and processes had been put into place focusing on getting the basics right. These processes were now being implemented with the philosophy we are one team and we want to have pride in the care that we deliver to our patients. The teams ethos is that everyone is as important as the next with every uniform being as important as each other. The health care assistants, nurses and allied staff have stepped up over and above their roles with everyone wanting to be the best they can be. This alongside the confidence the Matron has in allowing the team to problem solve as a team and make the changes that matter to patients has allowed them to respond to what patients and their families are telling them is important.

"We are a ward family" Ellistown Team

The role of the meaningful activities co-ordinator on the ward as released time for staff to care and spend time with those patients who have increased need whilst providing patients with a range of activities that enables them to interact with each other.

Board Walks

During Q2 25 Board Walks were undertaken by Trust Non-Executives, our Chair, Chief Executive and Directors. The boardwalks covered a wide range of services including District Nursing Services, Volunteer Services, Community Inpatient Wards and Learning Disability Outreach Services.

Board Walks are an opportunity for our non-executive directors to gain an invaluable insight into the work and people across the Trust. Through discussions and observations it is an opportunity to discuss with staff what is working well and what isn't working well for both staff and patients.

During one visit staff had highlighted the issue with FFT collection, there were issues with IPad connectivity and as a result the staff on the ward were having to revert to using paper. It was also mentioned that the ward had seen a dip in FFT responses recently due

to housekeeper change and not having anyone on the ward prompting completion of cards.

On a visit to one of the community District Nursing Teams the staff had decided that they wanted to proactively obtain feedback so were utilising the admin team to identify and capture feedback from patients which was working well.

Patient Stories

Patient Stories continue to be presented at each Trust Board meeting, ensuring that the patient is central to all discussions. Following the investigation of a serious incident where a patient in the care of the Trust had committed suicide, the family had asked to tell their story about their experience.

The story which was told by the two sons of the deceased described their experience of the investigation process and what lessons should be learnt for future investigations, these included:

- *The Trust seemed compassionate in the beginning; we were told about the investigation but heard nothing after that first meeting, no communication, no updates.*

- *Could not contact the person leading the investigation so ended up calling the Crisis Team to find out what was happening, only to be told the investigation was completed.*

- *Being informed that the report was to be published without the family having sight of the report or being told of the outcomes of the investigation first.*

- *We cannot say that the NHS and learnt anything from our father's death, we have not yet seen any improvements.*

- *The Trust does not want to take any blame for what happened or accept any responsibility, however if it did, this could have made a big difference.*

The story was shown at the recent Learning Organisation Conference to set out the importance of learning organisations for patients and staff. The story is also being used by the Patient Safety Team to understand what learning the organisation needs to undertake to improve how it manages its incident investigations for patients and families.

You can access the story here https://youtu.be/ScOwNQZyhtE

Local and National Surveys

Work is progressing in relation to the development of an organisation-wide patient experience survey. The review of all current patient experience surveys in place across the Trust has now been completed. The results of the review will now be shared with a group of patients and carers to discuss and review, this was scheduled for September 2019 but has been moved back to November 2019 due to availability of our patient and carer group. The work will focus on designing a set of patient experience questions with patients and carers that will be piloted in March 2020 and then rolled out across the Trust

from April 2020 alongside the new FFT question. It is envisaged there will be a specific question in relation to access to services, this will used to measure the impact of Access to Services priorities set out in the Trust's Step Up to Great quality improvement strategy and to measure the satisfaction in accessing the Trust's services.

The Community Mental Health Survey results were published in October 2019. The key headlines from this year's survey are as follows:

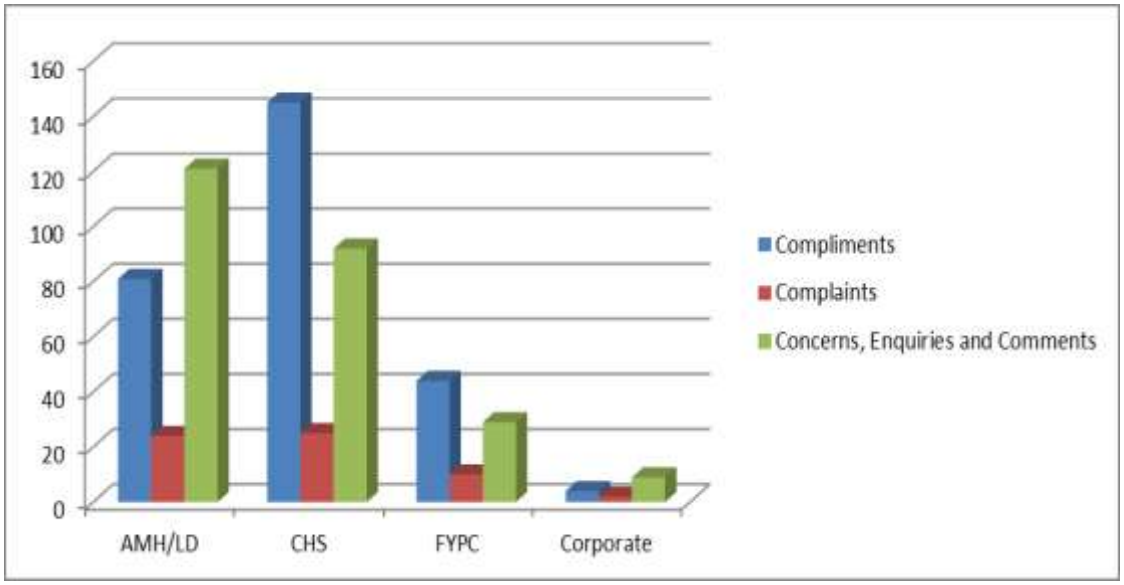
- The sample for the survey was generated at random on the agreed national protocol from all clients on the CPA and Non CPA Register seen between 1st September and 30th November 2018.
- The Survey was undertaken between February and June 2019.
- There has been a general improvement in results since 2018, although many scores are still in the lower range of Trusts surveyed by Quality Health.
- Older People's Mental Health (OPMH) generally scores better than Adult Mental Health (AMH).
- The overall rating of care has improved, but is still just in the lower range of Trusts surveyed by Quality Health.
- Lowest score achieved for agreement of care taking service users' personal circumstances into account.

Following the dissemination of the results to all services involved in the survey it was felt that a number of improvements that have been implemented over the last year will address a number of areas in the survey where poor experience was reported, this included the introduction of Peer Support Workers and the Collaborative Care Planning work current underway. A meeting to agree and finalise an improvement plan will be held in mid-November and a full report with an accompanying improvement plan will be produced in early 2020.

Directorate Feedback Breakdown

Appendix 1

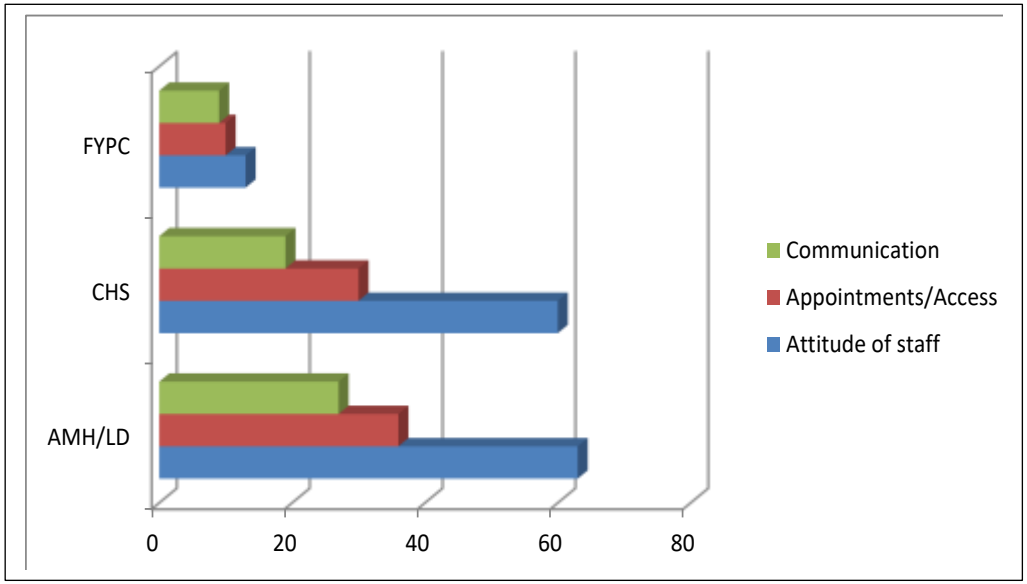
Individual Feedback Received Across All Directorates



During Q2 734 individual pieces were captured and recorded, of this feedback 38% was positive and 68% related to comments, concerns, enquiries and signposting.

Both graphs show all feedback received through website feedback and comments, concerns, enquiries received by directorate. Each comment can cover a range of themes and the analysis below is based on the themes covered in individual comments. During the period July 2019 to September 2019, 312 comments, concerns, enquiries were received.

Feedback broken down by each Directorate for each of the top three feedback themes for concerns, enquiries and comments



What did patients say was good?

What did patients wasn't good?

The nurse was excellent. She took the time to understand my problems and concerns and explained everything sufficiently. We made a plan.

Quick access to the service. Great support in keeping my daughter at home. We like the virtual clinic set up, everyone is really friendly.

As I have had arthritis for many years, I had booklets on arthritis exercises etc., no new help at all was given really so felt very disappointed having to wait two weeks and not getting any new help with pain.

I found your staff extremely helpful and really listened to what I had to say. Thank you

I would like there to be better continuity of care. I see different nurses each time and then have to explain things over and over again.

The staff attitude to me was very good. The level to which I was expected to achieve in my session was very clear.

The waiting list is too long and it takes months to get an appointment.

We wanted to write and thank you for the excellent care provided by Anita Kilroy-Findley, I have had severe leg ulcers since the age of 37; I am now 62 and for the first time have some hope of my condition being stabilised and discomfort reduced. This is due to the excellent care provided by Anita.

Anita is not only a wonderful clinician but is extremely caring and patient. Despite what must be a demanding job Anita explains the care pathway and options which I feel has given me a number of treatment options that are already healing some of the ulcers. Anita's expertise has not only been excellent for me both physically and mentally but also for my family as they can see the excellent care Anita is giving.

Please pass on our grateful thanks to Anita who tenaciously and expertly helps me manage my condition in a way that eases the pain and gives me hope that there are options that were not previously available; this is only due to the high level of expertise and care from Anita.

With our grateful thanks to you and Anita.

Recognition of Positive Experiences delivered by our staff

I saw a chap at LOROS yesterday morning who came to clinic in a wheelchair, in pain, vomiting, confused and imminently dying. He had been discharged from hospital that morning to see me. He had no authorisations, end of life meds, DNA CPR form, equipment or POC.

Some straight talking and he wanted to die at home.

I rang the hospice at home team from clinic and having sorted all the necessary paperwork and meds – I could get him home yesterday confident he would be assessed and supported by the team later that day.

He died this morning within 24 hours of being at home.

I spoke to his son today - he required 2 prns overnight and died peacefully this morning holding his sons hand. His son couldn't have been more grateful to all those involved.

I have spoken to the team today and expressed my huge thanks for the team's support – for being so willing to respond at short notice and for facilitating not creating barriers which enabled this man to die at home.

I want to make sure these moments of excellent patient care are celebrated and not lost in all that we do day to day. We strive to do our best at all times but sometimes we do even better than that :)

Well done team.

Complaints

Appendix 2

During Q2 61 complaints were received into the Trust. The dashboard below breaks down the complaint by directorate as well as the timescales, to which complaints were acknowledged, investigated and responded to.

	Q1	July 2019	Aug 2019	Sept 2019	**Total Q2**	Total 19/20
Adult Mental Health and Learning Disabilities	35	8	9	7	**24**	59
Community Health Services	28	9	9	7	**25**	53
Families, Young People and Children	21	1	7	2	**10**	31
Corporate/Facilities	0	1	0	1	**2**	2
Total Received	**84**	19	25	17	**61**	145
Complaints vs Patient Activity (Complaints Rate as a %)*	0.04	0.03	0.04	0.02	**0.03**	0.04
% of complaints acknowledged within three working days	99.3	100	100	100	**100**	99.6
Number of complaints responded to within the negotiated timescale****	37	9	9	5	**23**	60
Number of complaints responded to in 25 days	26	7	5	4	**16**	42
Number of complaints upheld or partly upheld in quarter	51	13	16	8	**37**	88
Number of complaints ongoing after 3 months**	19	6	7	10		
Number of complaints ongoing after 6 months***	3	0	0	0		
Number of reopened complaints	14	5	5	1	**11**	25
Number of complaints reported to the PHSO	2	0	0	1	**1**	3
Number of complaints upheld or partly upheld by the PHSO	0	0	0	1	**1**	1

*Patients attended and seen

**Complaints ongoing after 3 months at the end of Q1

***Complaints ongoing after 6 months at the end of Q1. These include those also included in the ongoing after 3 months section.

****Position statement as responses still under investigation.

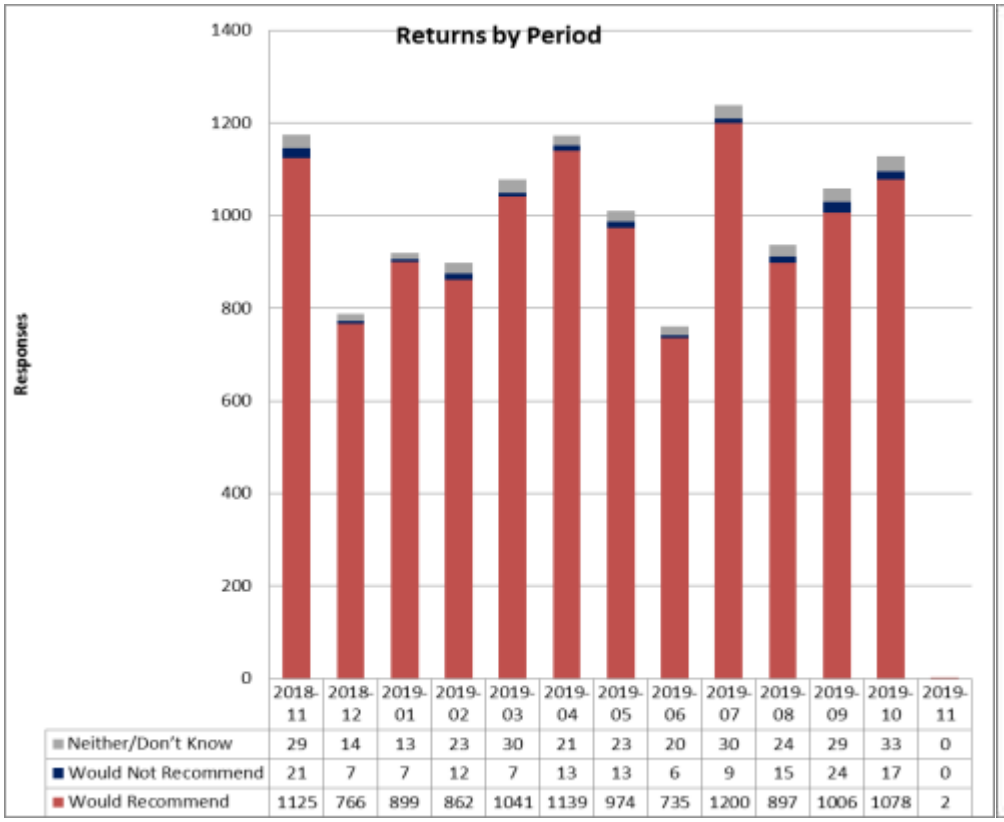
Learning from Complaints

Community Health Services have undertaken a learning review of a re-opened complaint which was not completed within 25 days. The review was undertaking by the lead investigator which found a number of process issues that has resulted in delays within the investigation and the subsequent delay. These findings have now resulted in a number of recommendations to the complaints process for both the Complaints Team and the investigators within Directorates and Services which have been agreed and are now being adopted.

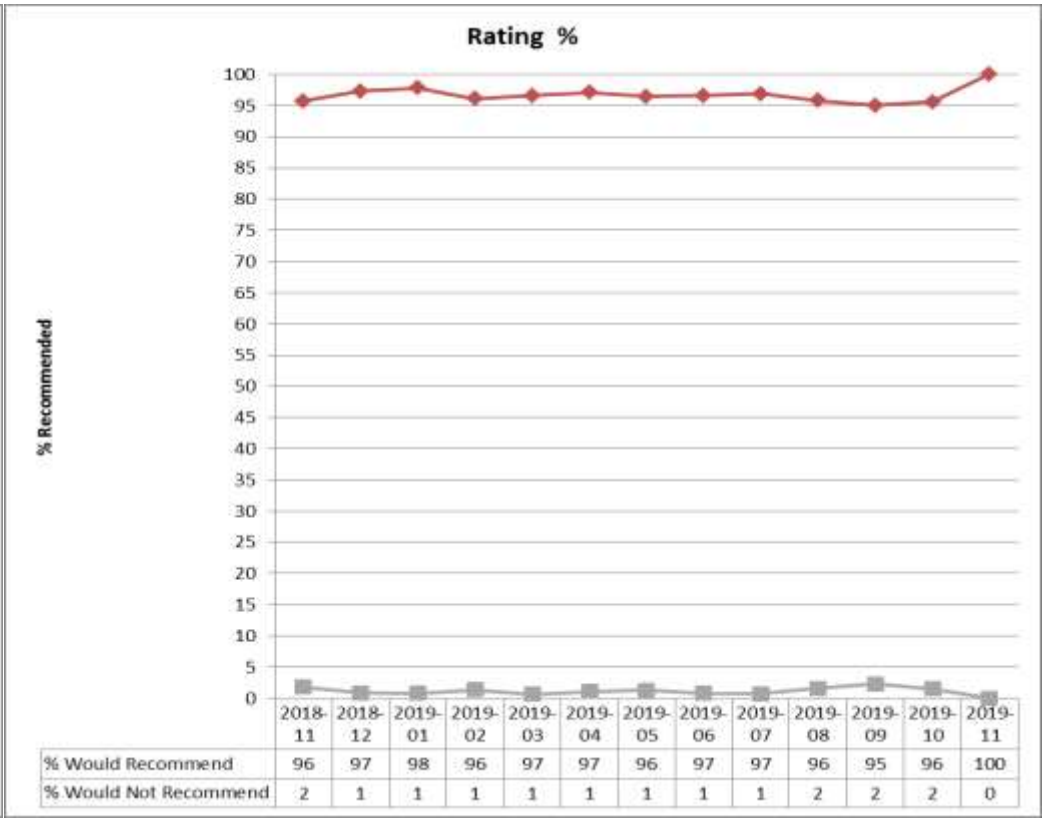
These are:

Recommendation	Actions	By whom	By when
Clear plan of actions to be developed	Clear plan to developed and recorded on CMD by that ensures the 15 days real time frame is met	Complaint Lead	On receipt on the complaint
Identify on receipt the support required	Any support required to investigate and / or write the response must be clearly identified	Complaint Lead	On receipt of the complaint
If the complaint is initially unable to be contacted do not delay the investigation	Investigation starts as soon as the complaint is received	Complaint Lead	On receipt of the complaint in line with the investigation plan
All staff involved and supporting the complaints process to be fully versed in the systems and processes	New staff brought in the support the complaints process must be given the new complaints process and informed of their role within it	The commissioning/recruiting person	Prior to commencement of role
Need for robust handover processes when any staff members involved in the complaint processes go on planned leave.	Each service to review existing handover processes to ensure that they are robust and include the learning from this investigation	All CHS services – via OMT	Service specific

Trust-Wide Returns trend analysis



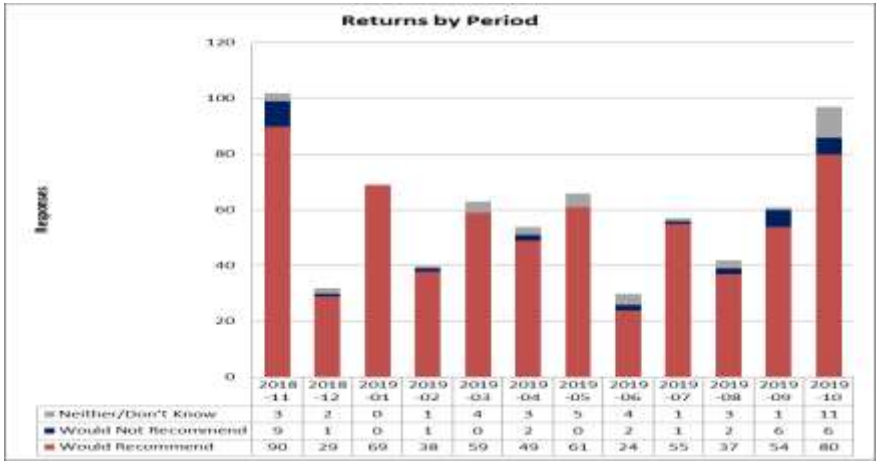
	2018-11	2018-12	2019-01	2019-02	2019-03	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11
Neither/Don't Know	29	14	13	23	30	21	23	20	30	24	29	33	0
Would Not Recommend	21	7	7	12	7	13	13	6	9	15	24	17	0
Would Recommend	1125	766	899	862	1041	1139	974	735	1200	897	1006	1078	2



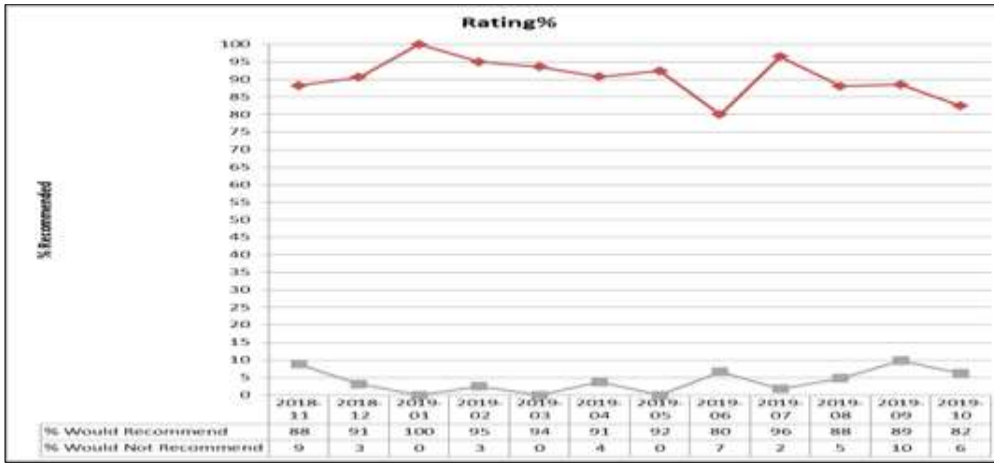
	2018-11	2018-12	2019-01	2019-02	2019-03	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11
% Would Recommend	96	97	98	96	97	97	96	97	97	96	95	96	100
% Would Not Recommend	2	1	1	1	1	1	1	1	1	2	2	2	0

Friends and Family Test (FFT) Comparable Data

Adult Mental Health and Learning Disabilities

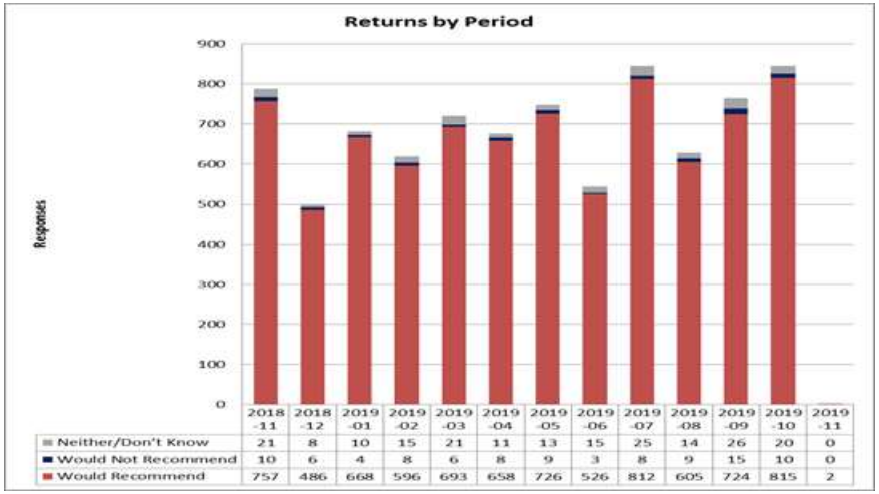


	2018-11	2018-12	2019-01	2019-02	2019-03	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10
Neither/Don't Know	3	2	0	1	4	3	5	4	1	3	1	11
Would Not Recomenend	9	1	0	1	0	2	0	2	1	2	6	6
Would Recommend	90	29	69	38	59	49	61	24	55	37	54	80

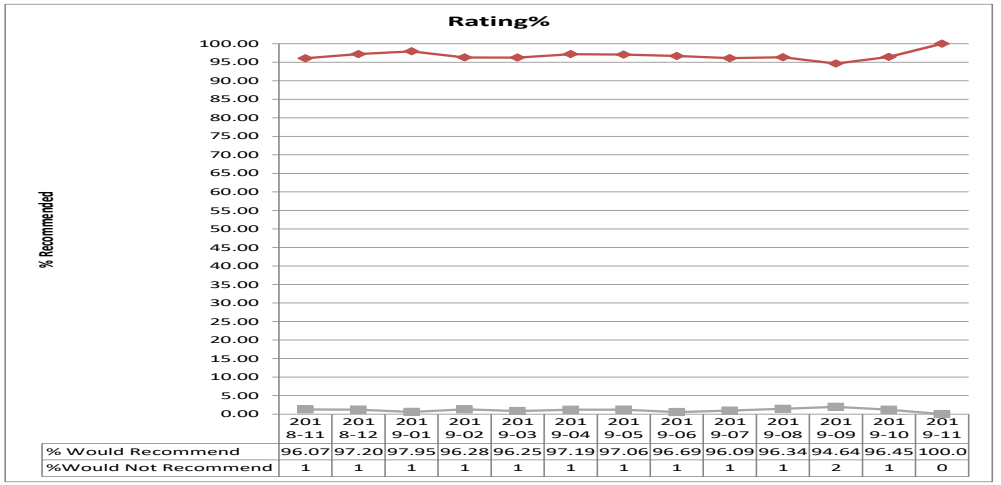


	2018-11	2018-12	2019-01	2019-02	2019-03	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10
% Would Recommend	88	91	100	95	94	91	92	80	96	88	89	82
% Would Not Recommend	9	3	0	3	0	4	0	7	2	5	10	6

Community Health Services

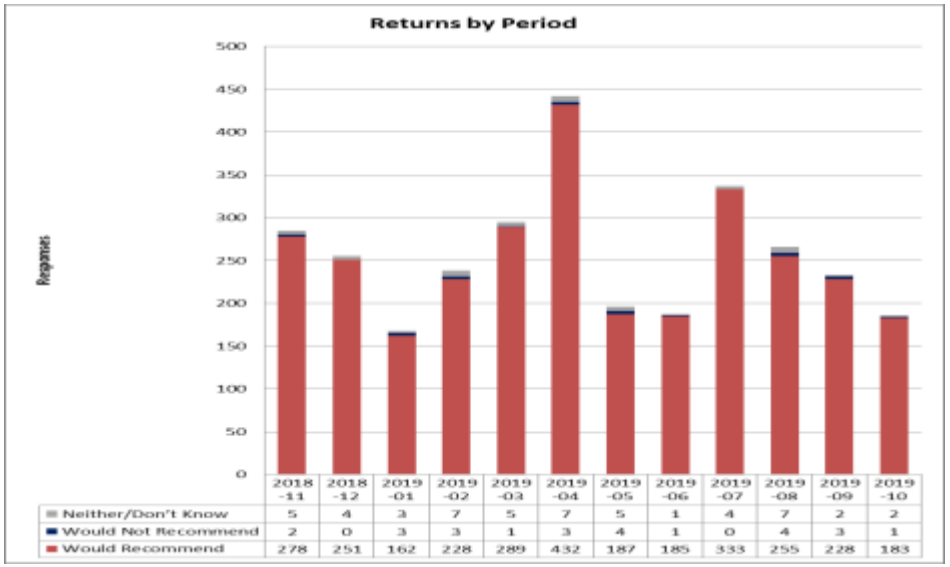


	2018-11	2018-12	2019-01	2019-02	2019-03	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11
Neither/Don't Know	21	8	10	15	21	11	13	15	25	14	26	20	0
Would Not Recommend	10	6	4	8	6	8	9	3	8	9	15	10	0
Would Recommend	757	486	668	596	693	658	726	526	812	605	724	815	2

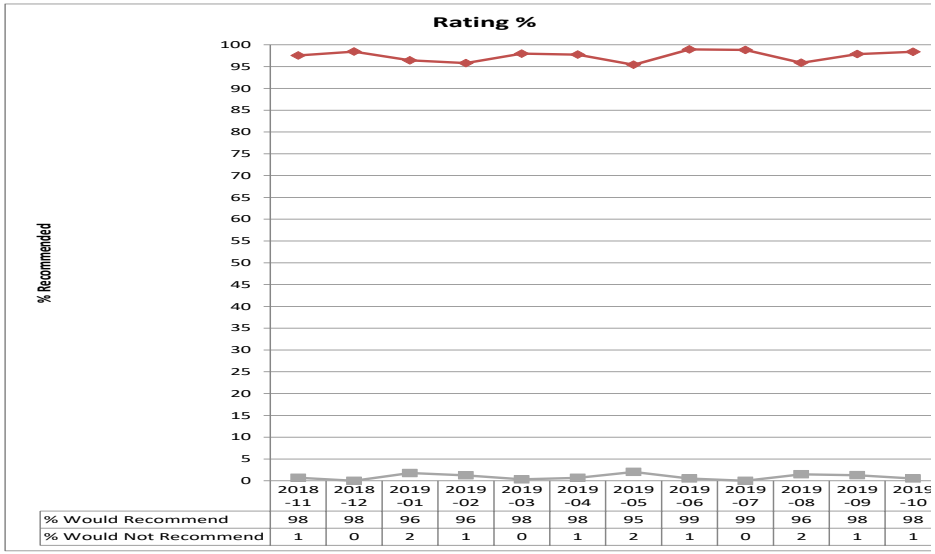


	2018-11	2018-12	2019-01	2019-02	2019-03	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11
% Would Recommend	96.07	97.20	97.95	96.28	96.25	97.19	97.06	96.69	96.09	96.34	94.64	96.45	100.0
%Would Not Recommend	1	1	1	1	1	1	1	1	1	1	2	1	0

Families, Children and Young People



	2018-11	2018-12	2019-01	2019-02	2019-03	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10
Neither/Don't Know	5	4	3	7	5	7	5	1	4	7	2	2
Would Not Recommend	2	0	3	3	1	3	4	1	0	4	3	1
Would Recommend	278	251	162	228	289	432	187	185	333	255	228	183



	2018-11	2018-12	2019-01	2019-02	2019-03	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10
% Would Recommend	98	98	96	96	98	98	95	99	99	96	98	98
% Would Not Recommend	1	0	2	1	0	1	2	1	0	2	1	1

Service Improvement – Patient & Carer Involvement

Appendix 4

Patient Experience and Involvement Three Year Delivery Plan

We held two patient and carer sessions during late September and early October to engage on our Patient Experience and Involvement Three Year Delivery Plan. Participants including patients, carers, voluntary and CCG partner organisations who all contributed their thoughts and ideas on what our plans should focus on and how patients, carers and partners should be involved in our work moving forward.

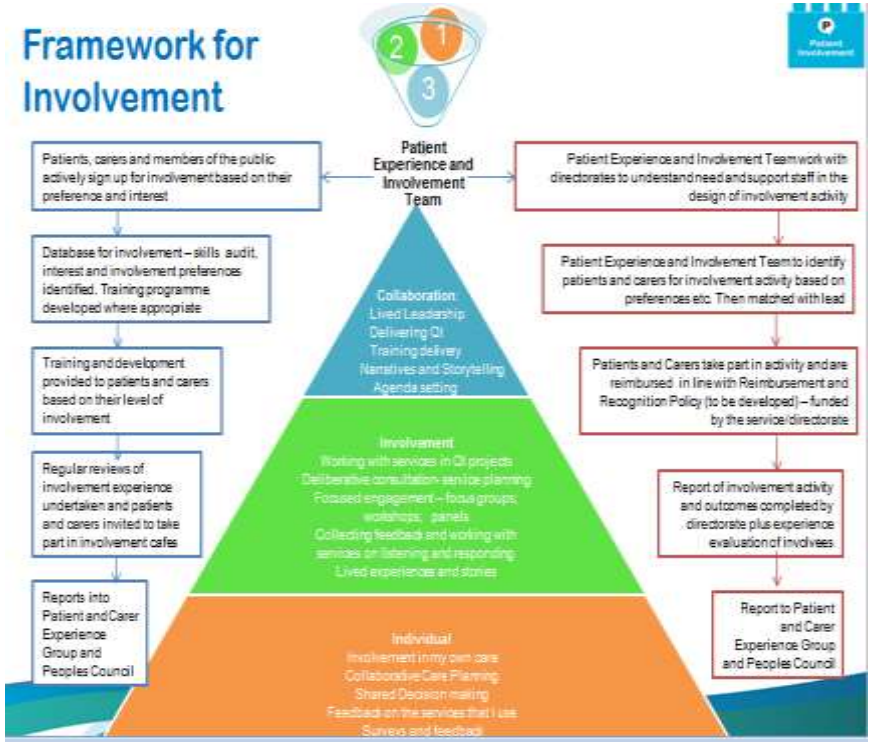
The feedback from both events have now been analysed and shared with participants, key elements have now also been incorporated into our delivery plan and include:

- Acknowledge and recognise involvement of patients and carers by professionals and not to be taken for granted.
- Create opportunities to get involved from individual care planning, to service improvement initiatives, up to policy setting
- Do not have one size fits all approach to involvement - involve me in the way I choose and on the issues that are important to me
- Recognise my involvement and provide support that allows me to get involved
- Being listened to when I share my experience and feedback to me when something has been done as a result
- Recognise my skills, not just my condition
- Provide me with the training and support that enables me to participate fully
- Develop involvement cafes in the community – come to us
- Work more effectively with the Voluntary and Community Sector

of

Patient Involvement

Our Patient Involvement Framework



Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board – 3 December 2019
Paper number	**K**

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

For approval		For assurance	X	For information	

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

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

Report previously reviewed by		
Committee / Group	Date	
Direct report to Trust Board	3.12.19	

Assurance: What level of assurance does this report provide in respect of the Organisational Risk Registers?	Links to ORR risk numbers
Significant Assurance Processes are in place to monitor and ensure staffing levels are safe and that patient safety and care quality is maintained.	4,26

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

Leicestershire Partnership NHS Trust

TRUST BOARD – 3 DECEMBER 2019

SAFE STAFFING – OCTOBER 2019 REVIEW

Introduction/Background

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

2 Actual staff numbers compared to planned staff numbers are collated for each inpatient area, CHPPD and temporary worker utilisation. A summary is available in Annex 1.

3 Quality Schedule methods of measurement are RAG rated in Annex 1;
- A – Each shift achieves the safe staffing level 100%
- B – Less than 6% of clinical posts to be filled by agency staff

Aim

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

Recommendations

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

Discussion

Trust level highlights for October 2019

Right Staff

- Overall the planned staffing levels were achieved across the Trust.
- Temporary worker utilisation rate decreased overall this month a further 2.3%; reported at 29.6% and Trust wide agency usage decreased this month by 0.3% to 3.9% overall.
- There are nine hotspot inpatient areas, hotspots have been identified either by; exception to planned fill rates, high percentage of temporary worker/agency utilisation or by the Lead Nurse due to concerns relating to increased acuity, high risk patients, staff sickness, ability to fill additional shifts and the impact to safe and effective care.
- There are nine community hot spots teams. Staffing and case-loads are reviewed and risk assessed across service teams using patient prioritisation models to ensure appropriate action is taken.

- A review of the Trust's NSIs and patient feedback has not identified any correlation between staffing and impact to quality and safety of patient care/outcomes.

Right Skills

- In consideration of ensuring staff have the 'right skills', a high level overview of clinical training, appraisal and supervision for triangulation is presented. As of 1 November 2019 Trust wide;
    - Appraisal sustained GREEN at 93.5%
    - Clinical supervision turned GREEN increased from 84.5% to 86%
    - Substantive staff; of the 30 core and clinical mandatory compliance subjects; most are GREEN with the exception of eight topics; one new topic RED; MAPA disengagement and seven at AMBER. Drop in compliance for MAPA training is due to additional CHS Community Hospital staff (482 substantive and 48 bank) that now require MAPA training following a review of training in response to violence and aggression incidents. To try to meet demand additional training courses are running between now and March 2019.
    - Bank staff; there is continued improvement in bank staff compliance most are GREEN with the exception of seven topics; three at RED including MAPA and four at AMBER.

Right Place

- Fill rates for actual HCSWs over 100% reflects the high utilisation and deployment of additional temporary staff due to increased levels of therapeutic observation to maintain safety of all patients.
- The total Trust CHPPD average (including ward based AHPs) is reported at 11.12 CHPPD in October 2019, with a range between 5.2 (Skye Wing) and 38.4 (Agnes Unit) CHPPD. Variation reflects the diversity of services, complex and specialist care provided across the Trust.
- Analysis of CHPPD has not identified any significant variation at service level, indicating that staff are being deployed productively across services.

In-patient Staffing

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

	DAY		NIGHT		
	% of actual vs total planned shifts RN	% of actual vs total planned shifts care HCSW	% of actual vs total planned shifts RN	% of actual vs total planned shifts care HCSW	Temp Workers%
Aug 19	103.0%	200.2%	110.3%	193.8%	34.1%
Sept 19	100.2%	201.9%	107.0%	179.6%	31.9%
Oct 19	**102.1%**	**199.4%**	**108.7%**	**186.4%**	**29.6%**

Table 1 - Trust level safer staffing

7 Temporary worker utilisation rate decreased overall this month a further 2.3%; reported at 29.6% and Trust wide agency usage decreased this month by 0.3% to 3.9% overall. The following wards utilised above 6% agency staff; Heather, Griffin, Beechwood, Clarendon, Feilding Palmer, St Lukes Ward 3, Coalville Ward 3 (CAMHS).

Summary of staffing hotspots – Inpatients

Hot spot wards	Aug 2019	Sept 2019	Oct 2019
Hinckley and Bosworth - East Ward	X	X	
Beechwood	X	X	X
Clarendon			X
Feilding Palmer	X	X	X
St Lukes Ward 3	X	X	X
Short Breaks - The Gillivers	X	X	X
Mill Lodge	X		
Coleman	X	X	X
Gwendolen	X		
Belvoir	X	X	
Heather		X	X
Griffin	X	X	X
Watermead	X	X	
Agnes Unit			
Langley	X	X	
Ward 3 Coalville (CAMHS)			X

Table 2 – In-patient staffing hotspots

8 Coleman and Gillivers are hot spot areas as they did not meet the threshold for planned staffing across all shifts, on these occasions staffing was reported to be within safe parameters for all areas.

9 Heather, Griffin, Beechwood, Clarendon, Feilding Palmer, St Lukes Ward 3 and Coalville Ward 3 CAMHS Wards are hot spots due to utilising over 6% agency staff.

10 Heather and Griffin wards are hotspots also due to increased patient acuity and risk, staff sickness and vacancies and high use of bank and agency staff.

11 Number of occupied beds, vacancy factor, planned staffing levels versus actual staffing levels and percentage of temporary staff utilised is presented in the tables per in-patient area by service and directorate in Annex 2, triangulated with the NSIs that capture outcomes most affected by nurse staffing levels.

Community Teams

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

Community team hot spots	August 2019	Sept 2019	Oct 2019
City East Hub- Community Nursing	X	X	X
City West Hub- Community Nursing	X	X	X
East Central Hub – Community Nursing	X	X	X
Hinckley and Bosworth – Community Nursing	X	X	X
Healthy Together – City (School Nursing)	X	X	X
Healthy Together – East	X	X	X
Health Together - West	X	X	X

Looked After Children team	X		
CAMHS County - FYPC	X	X	X
CAMHS Crisis - FYPC	X	X	
City West CMHT - MHSOP	X		X

Table 11 – Community Hot Spot areas

14 There remain a number of vacancies across the community planned care nursing hubs with City East, West and East Central carrying the largest number. Hinckley and Bosworth Hub remains a hotspot as they have four registered nurses on maternity leave while East Central is due to both staff vacancies and sickness.

15 Healthy Together City (School Nursing only), East and West Healthy Together and County Outpatient and teams are hot spot areas within FYPC Community; they are rated to be at Amber escalation level due to only 70% of the established team being available to work. Mitigation plans are in place within the service for moving staff internally where possible, overtime offered and vacant posts are being proactively advertised. Locum support recruited to and additional hours in place for existing substantive staff where possible to increase capacity. Risks continue to be monitored internally on a weekly basis.

16 City West CMHT is a hot spot due to vacancies and sickness, an additional Band 7 has been recruited on induction and internal moves have been secured to support the clinical risk and activity.

17 There are no hot spots in October 2019 for AMH/LD.

Recruitment and Retention

18 Rolling adverts for all RN posts including implementation of Trust incentivised schemes for hard to recruit areas. Accessing recruitment fairs at local universities, schools and colleges. Increased work experience placements and increased recruitment of clinical apprentices.

19 Cohort 4 of trainee Nursing Associates commence December 2019, LPT services are finalising trainee placements.

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

Conclusion

21 The Trust continues to demonstrate compliance with the National Quality Board (NQB) expectations to publish safe staffing information monthly. The safe staffing data is reported to NHS England (NHSE) via mandatory national returns on a site-by-site basis.

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

Presenting Director: Anne-Maria Newham – Director of Nursing, AHPs and Quality
Author: Emma Wallis – Associate Director of Nursing and Professional Practice

Annexe 1: October 2019

Ward Group	Ward name	Average no. of Beds on Ward	Average no. of Occupied Beds	Fill Rate Analysis (National Return) – Actual Hours Worked divided by Planned Hours: Nurse Day (Early & Late Shift) – Average % fill rate registered nurses	Nurse Day – Average % fill rate care staff	Nurse Night – Average % fill rate registered nurses	Nurse Night – Average % fill rate care staff	AHP Day – Average % fill rate registered AHP	AHP Day – Average % fill rate non-registered AHP	Skill Mix Met (NURSING ONLY)	% Temporary Workers (NURSING ONLY) – Total	Bank	Agency	Overall CHPPD (Nursing and AHP)
				>= 100%	>= 100%	>= 100%	>= 100%	-	-	>= 80%	<20%	-	-	
AMH Bradgate	Ashby	21	20	96.2%	136.3%	95.2%	196.8%			81.7%	27.8%	26.9%	0.9%	5.5
	Aston	19	18	90.2%	187.1%	90.3%	248.4%			65.6%	31.3%	28.7%	2.6%	7.0
	Beaumont	22	21	95.2%	154.8%	98.4%	371.0%			89.2%	34.1%	32.5%	1.7%	6.2
	Belvoir Unit	10	10	91.9%	216.9%	112.9%	204.8%			86.0%	30.6%	27.7%	2.9%	13.2
	Bosworth	20	20	84.9%	186.3%	95.2%	151.6%			61.3%	28.7%	25.9%	2.8%	6.0
	Heather	17	16	88.6%	186.3%	95.2%	303.2%			72.0%	51.0%	40.1%	10.9%	7.4
	Thornton	20	19	96.0%	179.8%	96.8%	109.7%			76.3%	41.3%	40.7%	0.6%	6.7
	Watermead	20	19	88.2%	225.0%	87.1%	325.8%			67.7%	45.5%	41.3%	4.2%	7.5
	Griffin Female PICU	6	6	192.1%	325.0%	193.5%	138.7%			100.0%	29.9%	13.9%	16.0%	17.4
AMH Other	HP Phoenix	12	11	103.2%	150.0%	100.0%	150.0%			97.8%	15.8%	14.8%	0.9%	9.6
	SH Skye Wing	30	28	118.5%	167.0%	200.0%	137.1%			100.0%	42.3%	41.6%	0.7%	5.2
	Willows Unit	27	26	127.4%	163.1%	120.2%	250.8%			89.2%	21.7%	20.7%	1.0%	9.1
	ML Mill Lodge (New Site)	14	12	92.7%	246.0%	85.5%	167.7%			77.4%	40.0%	35.0%	5.0%	11.3
CHS City	BC Kirby	24	19	82.6%	212.1%	95.2%	104.8%			61.3%	26.8%	25.0%	1.7%	6.6
	BC Welford	24	18	90.1%	200.0%	87.1%	125.8%			67.7%	25.4%	24.2%	1.2%	6.8
	CB Beechwood	22	20	81.9%	216.2%	100.0%	137.1%	99.7%	97.3%	63.4%	29.2%	20.1%	9.2%	8.7
	CB Clarendon	23	20	80.6%	212.9%	98.4%	137.1%			66.7%	19.6%	12.0%	7.7%	6.3
	EC Coleman	21	19	62.4%	300.0%	91.9%	177.4%			29.0%	33.9%	33.7%	0.2%	8.3
	EC Gwendolen	20	15	87.0%	272.6%	91.9%	180.6%			73.1%	28.8%	27.5%	1.3%	9.8
CHS East	FP General	9	7	143.2%	84.3%	133.3%	-	100.0%	100.0%	72.0%	24.7%	11.8%	12.9%	9.4
	MM Dalgleish	17	14	108.6%	132.8%	96.7%	496.8%	93.3%	99.9%	96.8%	3.3%	3.3%	0.0%	10.9
	Rutland	16	13	100.0%	118.5%	96.8%	96.8%			96.8%	14.4%	8.6%	5.8%	6.6
	SL Ward 1 Stroke	16	13	102.4%	191.1%	100.0%	100.0%	94.8%	94.2%	100.0%	22.1%	16.9%	5.2%	11.6
	SL Ward 3	12	10	97.6%	133.1%	196.8%	154.8%	101.6%	102.0%	86.0%	39.0%	25.8%	13.2%	9.7
CHS West	CV Ellistown 2	18	14	101.6%	184.7%	200.0%	101.6%	99.0%	100.0%	98.9%	9.0%	5.6%	3.3%	10.2
	CV Snibston 1	13	11	101.4%	143.8%	101.6%	109.8%	95.1%	95.8%	87.1%	11.7%	9.6%	2.1%	12.5
	HB East Ward	20	18	91.4%	200.8%	103.2%	133.9%	100.3%	100.0%	75.3%	18.6%	10.6%	7.9%	8.9
	HB North Ward	19	17	115.3%	172.6%	100.0%	106.5%			95.7%	28.2%	22.3%	6.0%	6.9
	Lough Swithland	24	21	100.0%	208.9%	100.0%	200.0%	99.7%	100.0%	100.0%	10.7%	8.5%	2.2%	7.6
FYPC	Langley	15	12	96.8%	182.3%	100.0%	109.7%	100.5%		94.6%	45.8%	44.5%	1.3%	9.1
	CV Ward 3	10	6	191.3%	331.9%	190.9%	369.7%			98.9%	44.1%	37.1%	7.0%	21.0
LD	3 Rubicon Close	4	3	108.1%	146.8%	100.0%	119.4%			87.1%	26.5%	26.1%	0.4%	20.4
	Agnes Unit	12	7	237.5%	946.4%	209.4%	859.4%			100.0%	50.5%	46.8%	3.7%	38.4
	The Gillivers	5	2	96.8%	152.2%	54.8%	154.8%			73.1%	17.8%	17.8%	0.0%	26.5
	The Grange	5	3	-	175.0%	-	209.7%			94.6%	23.0%	23.0%	0.0%	21.2
Trust Total				**102.1%**	**199.4%**	**108.7%**	**186.4%**			**82.4%**	**29.6%**	**25.7%**	**3.9%**	

Annexe 2: Inpatient Ward triangulation staffing, CHPPD, vacancy factor and NSIs.

Trust thresholds are indicated below;

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

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

Acute Inpatient Wards

Ward	Occupied beds	DAY % of actual vs total planned shifts RN	DAY % of actual vs total planned shifts care HCSW	NIGHT % of actual vs total planned shifts RN	NIGHT % of actual vs total planned shifts care HCSW	Temp Workers%	CHPPD Care Hours Per Patient Day	Vacancy Factor	Medication errors	Falls	Complaints	FFT Promoter % (arrears)
Ashby	20	96.2%	136.3%	95.2%	196.8%	27.8%	5.5	13.1%↓	0↓	1↑	0	80%
Aston	18	90.2%	187.1%	90.3%	248.4%	31.3%	7.0	10.4%↓	0↓	1↓	0	66.7%
Beaumont	21	95.2%	154.8%	98.4%	371.0%	34.1%	6.2	19.8%↑	1↑	3↑	1↑	nil
Belvoir Unit	10	91.9%	216.9%	112.9%	204.8%	30.6%	13.2	42.2%	0↓	0	0	nil
Bosworth	20	84.9%	186.3%	95.2%	151.6%	28.7%	6.0	8.3%↓	0	1↑	0↓	100%
Heather	16	88.6%	186.3%	95.2%	303.2%	51.0%	7.4	17.7%↑	0↓	0↓	0↓	nil
Thornton	19	96.0%	179.8%	96.8%	109.7%	41.3%	6.7	16.9%↓	1↓	2↓	0	100%
Watermead	19	88.2%	225.0%	87.1%	325.8%	45.5%	7.5	9.8%↑	3↓	2	0↓	nil
Griffin F PICU	6	192.1%	325.0%	193.5%	138.7%	29.9%	17.4	18.6%↓	2↓	0↓	0↓	nil
TOTALS									**7↓**	**10↓**	**1↓**	

Table 3 - Acute inpatient ward safe staffing

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

Temporary worker utilisation is Red for Heather Wards at 51.0%. The high utilisation is associated with both vacancies and increased patient acuity and higher levels of staffing required to meet enhanced levels of observation.

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

Learning Disabilities (LD) Services

Ward	Occupied beds	DAY % of actual vs total planned shifts RN	DAY % of actual vs total planned shifts care HCSW	NIGHT % of actual vs total planned shifts RN	NIGHT % of actual vs total planned shifts care HCSW	Temp Workers %	CHPPD Care Hours Per Patient Day	Vacancy Factor	Medication errors	Falls	Complaints	FFT Promoter % (arrears)
3 Rubicon Close	3	108.1%	146.8%	100.0%	119.4%	26.5%	20.4	20.61↑	0	0↓	0	100%
Agnes Unit	7	237.5%	946.4%	209.4%	859.4%	50.5%	38.4	14.5%↓	0	3↑	0	100%
The Gillivers	2	96.8%	152.2%	54.8%	154.8%	17.8%	26.5	13.7%	0	0	0	100%
The Grange	3	-	175.0%	-	209.7%	23.0%	21.2	21.9%↓	0	0↓	0	100%
TOTALS									**0**	**3↓**	**0**	

Table 4 - Learning disabilities safe staffing

Short breaks met the planned staffing levels with the exception of Gillivers that only met the planned RN level on nights 54.8% of the time. Patients do not always require RN support and skill mix is adjusted according to patient needs utilising HCSWs who are trained to administer medication and carry out delegated health care tasks. Night RN cover can be shared across the site as the homes are situated next to each other.

The Agnes Unit has seen an increase in patient acuity, higher levels of therapeutic observations resulting in increased utilisation of HCSWs; the increase is also associated with providing staff to escort a patient whilst at UHL.

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

Low Secure Services – Herschel Prins

Ward	Occupied beds	DAY % of actual vs total planned shifts RN	DAY % of actual vs total planned shifts care HCSW	NIGHT % of actual vs total planned shifts RN	NIGHT % of actual vs total planned shifts care HCSW	Temp Workers%	CHPPD Care Hours Per Patient Day	Vacancy Factor	Medication errors	Falls	Complaints	FFT Promoter % (arrears)
HP Phoenix	11	103.2%	150.0%	100.0%	150.0%	15.8%	9.6	-0.2%↓	0	0	1↑	42.90%

Table 5- Low secure safe staffing

Phoenix Ward achieved the planned staffing thresholds for all shifts.

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

Rehabilitation Services

Ward	Occupied beds	DAY % of actual vs total planned shifts RN	DAY % of actual vs total planned shifts care HCSW	NIGHT % of actual vs total planned shifts RN	NIGHT % of actual vs total planned shifts care HCSW	Temp Workers%	CHPPD Care Hours Per Patient Day	Vacancy Factor	Medication errors	Falls	Complaints	FFT Promoter % (arrears)
Skye Wing	28	118.5%	167.0%	200.0%	137.1%	42.3%	5.2	-1.6%	0↓	0↓	0	50%
Willows Unit	26	127.4%	163.1%	120.2%	250.8%	21.7%	9.1	-0.1%↓	0	3↑	1↑	50%
Mill Lodge	12	92.7%	246.0%	85.5%	167.7%	40.0%	11.3	6.2%↓	0	1↓	0	nil
TOTALS									**0↓**	**4↓**	**1↑**	

Table 6 - Rehabilitation service safe staffing

All ward/units met the planned staffing thresholds for all shifts.

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

Community Health Services (CHS)

Community Hospitals

Ward	Occupied beds	DAY % of actual vs total planned shifts RN	DAY % of actual vs total planned shifts care HCSW	NIGHT % of actual vs total planned shifts RN	NIGHT % of actual vs total planned shifts care HCSW	Temp Workers%	CHPPD Care Hours Per Patient Day	Vacancy Factor	Medication errors	Falls	Complaints	FFT Promoter % (arrears)
FP General	7	143.2%	84.3%	133.3%	-	24.7%	9.4	44.5%↑	0↓	1↓	0	100%
MM Dalgliesh	14	108.6%	132.8%	96.7%	496.8%	3.3%	10.9	-0.8%	0	4↑	1↑	nil
Rutland	13	100.0%	118.5%	96.8%	96.8%	14.4%	6.6	16.5%	0	0↓	0	100%
SL Ward 1	13	102.4%	191.1%	100.0%	100.0%	22.1%	11.6	18.3%↓	2↑	2↑	0	100%
SL Ward 3	10	97.6%	133.1%	196.8%	154.8%	39.0%	9.7	31.3%↓	2↑	1↓	0	100%
CV Ellistown 2	14	101.6%	184.7%	200.0%	101.6%	9.0%	10.2	0.2%↓	0↓	3↓	0	100%
CV Snibston 1	11	101.4%	143.8%	101.6%	109.8%	11.7%	12.5	12.9%	0	3↑	0	100%
HB East Ward	18	91.4%	200.8%	103.2%	133.9%	18.6%	8.9	5.0%↓	2↓	2↓	1↑	100%
HB North Ward	17	115.3%	172.6%	100.0%	106.5%	28.2%	6.9	16.3%↓	0	3↓	0	94.7%
Swithland	21	100.0%	208.9%	100.0%	200.0%	10.7%	7.6	22.6%↓	0	2↓	1↑	91.3%
CB Beechwood	20	81.9%	216.2%	100.0%	137.1%	29.2%	8.7	11.3%↓	0	8↑	1↑	100%
CB Clarendon	20	80.6%	212.9%	98.4%	137.1%	19.6%	6.3	10.5%↓	0↓	5↓	0↓	100%
TOTALS									**6↓**	**34↓**	**4↑**	

Table 7 - Community hospital safe staffing

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

Feilding Palmer, St Lukes Ward 1 are hot spots associated with increased temporary workforce usage due to vacancies, maternity leave and sickness.

Ward 3 St Luke's is a hotspot associated with increased temporary workforce due to vacancies, sickness, maternity leave and also Jury service. In addition there is increased acuity of patients with additional staff to support specialing and management.

North Ward and Beechwood Ward are hotspots associated with increased temporary workforce usage due to vacancies, maternity leave, sickness and increased acuity of patients requiring additional staff to support specialing and management.

A review of the NSIs for the community hospital wards has identified that there was an increase in falls incidents on Beechwood Ward, Dalgliesh Ward and Snibston Ward and an increase in medication errors which were prescribing and procedural errors in relation to returning of medications to pharmacy, these were on St Lukes Ward 1 and Ward 3. Review of the increased incidences has not identified any direct correlation between staffing and the impact to quality and safety of patient care/outcomes.

A review of the NSIs for the community hospital wards has identified that for Ellistown Ward Coalville Community Hospital there was one major harm incident, however the review has not identified any direct correlation between staffing and the impact to quality and safety of patient care/outcomes.

Mental Health Services for Older People (MHSOP)

Ward	Occupied beds	DAY % of actual vs total planned shifts RN	DAY % of actual vs total planned shifts care HCSW	NIGHT % of actual vs total planned shifts RN	NIGHT % of actual vs total planned shifts care HCSW	Temp Workers%	CHPPD Care Hours Per Patient Day	Vacancy Factor	Medication errors	Falls	Complaints	FFT Promoter % (arrears)
BC Kirby	19	82.6%	212.1%	95.2%	104.8%	26.8%	6.6	27.5%↑	0↓	9↑	0	88.9%
BC Welford	18	90.1%	200.0%	87.1%	125.8%	25.4%	6.8	19.2%	2↑	6↑	0	nil
Coleman	19	62.4%	300.0%	91.9%	177.4%	33.9%	8.3	13.8%↑	0	5↓	0	nil
Gwendolen	15	87.0%	272.6%	91.9%	180.6%	28.8%	9.8	14.3%↓	0	11↑	0	50%
TOTALS									**2↓**	**31↑**	**0**	

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

Coleman is a hotspot as they only met the threshold for planned staffing on days 62.4% of the time. Analysis has shown that there were 10 shifts that had one registered nursing staff. The ward was supported by the charge nurse, Medicines Administration Technician MAT and quailed staff from Gwendolen ward.

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

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

Ward	Occupied beds	DAY % of actual vs total planned shifts RN	DAY % of actual vs total planned shifts care HCSW	NIGHT % of actual vs total planned shifts RN	NIGHT % of actual vs total planned shifts care HCSW	Temp Workers%	CHPPD Care Hours Per Patient Day	Vacancy Factor	Medication errors	Falls	Complaints	FFT Promoter % (arrears)
Langley	12	96.8%	182.3%	100.0%	109.7%	45.8%	9.1	-8.1%	0↓	4↑	0	nil
CV Ward 3 - CAMHS	6	191.3%	331.9%	190.9%	369.7%	44.1%	21.0	13.6%	0	0	0	nil
TOTALS									**0↓**	**4↑**	**0**	

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

Both wards met the thresholds for RN and HCSW planned staffing in October 2019

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

A review of the falls on Langley has not identified any staffing impact on the quality and safety of patient care/outcomes. There was no harm as an outcome of the falls.

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board Public 3rd December 2019
Paper number	**L**

Name of Report **:**
Guardian of Safe Working Hours Quarterly Report
August 2019 to October 2019

For approval		For assurance	X	For information	

Presented by	Dr Sue Elcock, Medical Director	Author (s)	Dr Amala Maria Jesu, Guardian of Safe Working Hours Angela Salmen, Medical Staffing Manager

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

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

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

Recommendations of the report

The Report provides assurance to the Trust Board that doctors in training in LPT are safely rostered and have safe working hours that comply with the Terms and Conditions of Service.

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Leicestershire Partnership NHS Trust

TRUST BOARD – 3rd December 2019

Guardian of Safe Working Hours Quarterly Report
August 2019 to October 2019

1. Introduction

The Report:

i) Provides assurance to the Trust Board that doctors in training in LPT are safely rostered and have safe working hours that comply with the Terms and Conditions of Service

ii) Shows that seven exception reports have been raised in this period

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

iv) Provides information on the implementation of changes to the 2016 TCS as implemented in August 2019

2. Recommendations

The Report is to provide assurance to the Board.

3. Transfers to the 2016 TCS

Implementation of the new TCS for Junior Doctors is well established after beginning in December 2016. There are 90 trainees employed on the 2016 contract. The remaining 3 trainees are likely to remain on their existing 2002 TCS until they complete training.

4. Work Schedules

As required under the TCS, generic and personalised work schedules continue to be provided to trainees in accordance with the code of practice and outline the working pattern; pay; training opportunities; key contacts and time for education, handovers, breaks and rest periods.

5. Exception Reports

Exception reporting is the mechanism for all doctors employed on the 2016 Junior Doctors Contract to inform the Trust when their day to day work varies significantly and/or regularly from the agreed work schedule. The reports are raised electronically using the "Allocate" rostering system and there is a robust system in place to manage exception reporting.

Seven exception reports have been received in this quarter. The majority (4 of 7) of the exception reports raised were in relation to the hours worked and lack of rest on CDR rota covering the A&E department at LRI. One report was about the lack of equipment. There

has also been one exception report each on the StR and Evington rotas, again with regards to hours worked. One exception report is waiting to be resolved and the delay has been due to a system problem which is being closely monitored by medical staffing.

As resolution, an engagement event, led by the Medical Director, has recently taken place with medical trainees. Working patterns, particularly for doctors working on the Central Duty Rota in A&E and Specialty Registrars are being reviewed to ensure compliance with rest requirements. The exception report about equipment has been resolved through the provision of equipment (laptop and mobile telephone)

6. Rota Gaps and re-design

Gaps in the current rotation (August 2019 – December 2019);

- CT1-3 x 1 One post covered by LAS
- StR Adult x 6 no cover
- StR OA x2 no cover
- StR CAMHS x2 no cover
- StR LD x 2 no cover

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

7. Implementation of changes to the TCS from August 2019

A number of changes have been introduced nationally to the TCS, some of which are to be phased in over the next 12 months. The changes relate to working patterns, exception reporting, pay and allowances. Changes have been made in ESR to pay,

An engagement event, led by the Medical Director, has recently taken place with medical trainees. Working patterns, particularly for doctors working on the Central Duty Rota in A&E and Specialty Registrars are being reviewed to ensure compliance with rest requirements.

We have recently received £60k to improve the working conditions of junior doctors. Discussions have taken place with trainees to develop a list of priorities and following consultation, laptops have been purchased for Core Trainees and the Bradgate on call room will be refurbished.

8. Engagement

- The last JDF had reasonable turn out of trainees and was led by Dr Elcock as an initial consultation meeting looking into the current on calls and whether they are in line with meeting the rest requirements indicated in the new contract changes. Trainees will also complete a monitoring exercise which will give an objective account of the intensity of on calls.

Presenting Director: Dr Sue Elcock, Medical Director

Authors: Dr Amala Maria Jesu, Guardian of Safe Working Hours
Angela Salmen, Medical Staffing Manager

Appendices

Appendix A	Locum Hours – Internal Bank and Agency (1st August 2019 – 31st October 2019)
Appendix B	12 month summary data Exception reports

Appendix A

Locum Hours (Internal Bank and Agency)
1st August 2019 – 31st October 2019

Locum bookings by Rota				
Rota	Number of shifts vacant	Number of shifts filled by Internal Bank	Number of shifts given to agency	Number of shifts filled by agency
Bradgate / Bennion	33	33	Nil	
Evington	10	10		
Central Duty Rota	12	12		
StR East	1	1		
StR West	10	10		
Total	66	66		

Locum bookings by reason				
Reason	Number of shifts vacant	Number of shifts filled by Internal Bank	Number of shifts given to agency	Number of shifts filled by agency
Vacancy *	29	29	Nil	
Sickness	7	7		
Maternity	6	6		
Special Leave	1	1		
Temporary removal of trainee from rota**	23	23		
Total	65	65		

* includes Less Than Full Time (LTFT)

** may be due to reasonable adjustments recommended by Occupational Health or Heath Education East Midlands/Associate Director for Medical Education

Appendix B

Summary Data

Exception Reports

Reason for exception report	Aug'18 – Dec'18	Jan'19 – Apr'19	May'19 – July'19	Aug'19 – Oct'19
Working Hours	0	1 (rest, TOIL)	2	6
Training issue	0	0	0	0
Other reason	0	0	1	1
Total	0	1	3	7

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Leicestershire Partnership NHS Trust

FINANCE AND PERFORMANCE COMMITTEE – 19 NOVEMBER 2019

HIGHLIGHT REPORT

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

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

Report	Assurance level*	Committee escalation	ORR/Risk Reference
Director of Finance Report G Well-governed	**High**	The biggest issue currently for LPT was delivery of the 2019/20 plan and setting control totals for each clinical and corporate directorate. Discussions were still taking place on delivery of the 2019/20 and 2020/21 system financial plans. The Committee acknowledged the restrictions in place because of Purdah. At the East Midlands HFMA awards evening, Matt White, Head of Finance AMH/LD won the Outstanding Leadership Award and Imtiaz Girach, Financial Developments Manager won the Chairman's special recognition award. Good progress was being made on the establishment of LPT's PMO arrangements led by Attain. The Committee agreed an action plan would be presented to FPC at a future date to be agreed.	
LPT 2020/21 Planning and Contracting Update G Well-governed	**Medium**	Key points to note with regard to planning were; • LPT had submitted its revised 2019/20 figures to the STP which could mean there was an impact on the current bottom line of £43m gap across the system next year. • The draft position, based on all assumptions in the STP plan, was total LPT income next year would be c£300m. Potentially £233m would come from CCGs however, it included the investment sums which may be held centrally at STP level initially. • Key elements of the LPT financial plan included development of the three year CIP plan, the current target assumption was a target of £4.7m, 1.6%. • The cash plan would follow the development of the I & E and capital plans. Future cash plans would need to be built around LPT's ability to generate income, following the removal of PSF funding. • Capital bids had been collated by the IM&T and Estates	17

Report	Assurance level*	Committee escalation	ORR/Risk Reference
		Committees and submitted to the Capital Committee for prioritisation. • The LLR draft financial plan included a forecast of £8.9m for LPT agency spend in 2020/21. • Concern was raised that the financial position as a system was deteriorating and this could raise reputational issues. The key points to note in terms of contracting were; • Next steps included reconciling the financial plan to LTP narrative and deliverables for LPT; ensuring LPT Step up to Great priorities could be delivered within the financial envelope; agreement of contract approach and value for 2020/21; and understanding the system control total approach and what that meant for LPT • The new contracting approach was expected to support fixed, cost based contracts aligned to a system plan; strong shared governance to manage risks; risk/gain share based on organisational turnover; single savings programme and single operational plan; and resources aligned to delivery. • Assurance was received that all organisations had agreed in principle to a LLR revised contracting approach Memorandum of Understanding. The Committee had a reasonable level of assurance based on there being a process in place which was supported by the LLR system but outcomes were still to be agreed.	
LLR Integrated Therapy Services 	**Medium**	As an example of the STP approach, the Committee received for information, an update on the engagement taking place around the potential design of a new clinical service model and management structure for the provision of therapies. The Committee noted the proposal was a LLR trailblazer in terms of its ability to work together across the system to deliver integrated services and improved outcomes for service users. From an LPT perspective, clinically and contractually the risk was low. From a reputational perspective it was important the Trust continued to be actively involved in this work and secured best outcomes for LLR residents and the system. FPC agreed the Audit and Assurance Committee would be informed how proposed new arrangements would be managed. An update on progress would be provided to FPC in spring 2020.	16
Waiting Times Summary Report 	**Low**	FPC received an update detailing Trust performance against local and national waiting time targets, confirmed progress in relation to the eight targets over seven priority services and work to address over 52 week waiters as at 30 September 2019. **Priority Services** • With regard to how Adult CMHT performance could be improved. FPC noted transformation would not be achieved quickly but recent changes to staffing could	29

Report	Assurance level*	Committee escalation	ORR/Risk Reference
		make small improvements to the first wait position. • The Committee noted the improvement in the CAMHS position and that the Adult ADHD position was consistently positive. It was not assured around the delivery of improvement plans covering other services. **52 week waits** • External resource had been secured to support services in developing performance improvement plans focusing on long waiters over target but under 52 weeks. The work was expected to be completed in November and an update on proposals to be received at FPC in December. **National Targets** All had been met for the first time however, the Committee was not assured the position was sustainable.	
Data Quality Improvement Plan 	**Low**	Assurance was received the Trust was on track to implement a data quality kite mark tool to assess against priority waits and KPIs against the six data quality domains. However, QAC had raised concern at its meeting earlier about the quality of the KPIs to be tested in the external limited assurance review for the Quality Account, as the quality of the data for the national submission did not provide assurance on the end to end data quality process that LPT was expected to have knowledge of. The Committee agreed there would be in-depth discussion at the next joint FPC/QAC meeting in December. The Committee was not assured due to the fundamental issue around data quality that needed to be resolved although it acknowledged there was assurance around the kite mark work.	20
IQPR and Performance Management 	**Low**	The IQPR end of October 2019 position was presented for information. The Committee noted that the CPA 7 day target was not being met and the CDiff position had deteriorated. Good progress was being made on out of area placements and a significant improvement in gatekeeping was noted. An update on progress to develop a performance management framework was received from Graeme Jones. A draft proposal would be received at the next FPC and Trust Board in December. FPC recognised the progress made. It was not assured due to the slippage in implementation.	
Partnership Agreement for Forensic Provider Collaborative	**High**	The Committee received an update on the programme of work LPT had been engaged in led by Nottinghamshire Healthcare, to develop a New Care Model / Provider Collaborative for secure services in the East Midlands. FPC supported continued engagement and recommended agreement by Trust Board at its meeting on 3 December.	19

Report	Assurance level*	Committee escalation	ORR/Risk Reference
Organisational Risk Register 	**Low**	FPC received the organisational risk profile. The Committee agreed the approach to manage key risks during the implementation period and proposed implementation plans for tiers 2/3. It reviewed the 3 key risks; Estates, Performance Management, and access to services and new risks from Trust Board and operational reviews. Key actions were agreed. The Committee maintained a level of not assured due to the gap in review by tier 2 committees and tier 3 engagement.	All
Finance Report Month 7 2019/20  Financial Turnaround Plan	**Low**	• The run-rate overspend for month 7 was £278k which was a reduction from the month 6 position. Central reserves were still able to offset the operational overspend in order to deliver the year to date planned surplus. However, central reserves would not be sufficient to cover the operational overspend until the end of the financial year and there was a risk the Trust would start to lose PSF funding and slip into deficit if the turnaround plan did not deliver. • All areas with the exception of Estates slowed their rate of overspend or increased their underspend however, the overall level of recovery required was still c£2.2m. • A control total setting approach was being taken to the recovery plan and work was taking place with directorate leads to review current forecasts and consider actions to be taken to reduce the financial gap. This was a positive move in terms of having a better understanding of directorate financial positions and delivery of financial turnaround actions. The Committee received an update on progress to date with delivery of the Financial Turnaround Plan. Whilst the turnaround approach had been very positive in generating debate around how the Trust spent money and made savings, it had been less successful in generating robust saving values and run rates. A change in approach to the FTP meetings had been implemented to ensure better attendance and focus on key items. CIP monitoring and planning would be included in the meetings and vacancy control would be separately undertaken weekly. The Committee acknowledged progress was being made to reduce the financial gap but also the consequences of the Trust not delivering its financial plan at year end.	17, 22
Estates and Facilities Management Update 	**Low**	An update on progress was presented, key issues were; • The next stage of work on the Strategic Outline Case had recommenced following approval at Trust Board. • With regard to the facilities management services review, an initial meeting had been held with UHL and a task and finish group was being set up to work on implementation. • PLACE audits had been completed and relatively good feedback had been received. • An update on dormitory accommodation would be	9, 10, 11

Report	Assurance level*	Committee escalation	ORR/Risk Reference
		presented to the next Trust Board meeting. • The estates workstream had started on the Community Services Redesign, feeding into this work were the plans for the Evington Centre and move of stroke services from UHL. • Progress was being made on a solution for Westcotes, specifically the clinical aspects. Two concerns raised at QAC were highlighted, FPC was assured a formal response was going to be provided by the Chair of the Health and Safety Committee. The Committee acknowledged a significant amount of work was taking place but was not assured due to the substantial gaps around maintenance. FPC requested a plan was presented for managing the interim maintenance position.	
Committee Governance 	**Medium**	The Committee received and approved the governance implementation plan, updated terms of reference for FPC and three of the level two sub-committees reporting into FPC under the new governance structure; Data Privacy, IM&T and the Financial Turnaround Committees. **The revised TORs are at the Annex for Board approval.** Highlight reports would be presented to the December FPC meeting from those sub-committees with approved ToR that met prior to the next FPC meeting. ToR for the remaining sub-committees would be presented to FPC in December 2019 for approval. The Committee was reasonably assured based on it having a programme of work but it not being fully implemented at this time.	11
IM&T Strategy and Review of the Health Informatics Service 	**Medium**	The Committee received assurance on delivery of the 2018 – 2020 LPT IM&T Strategy, the key points to note were; • Work to consolidate down to a single EPR by 2020 was progressing, 'go-live' was likely to be May/June 2020. • With regard to the digital offer, the handover to LHIS from external sub-contractors originally anticipated in March 2019 was currently taking place. An IM&T Strategy for 2020/24 was being developed and would include the roll out of NerveCentre and the digital dictation using a product called Big Hand. The new strategy was likely to be presented to Trust Board April 2020. An update on LHIS performance for the last six months of 2019/20 financial year was provided. • A £0.3m deficit position had been expected at year end but this had now changed to c£0.5m, LHIS felt this was mainly due to a £1m gap between the budgets LPT held for their services and the actual cost of provision of those services. • Key business risks were highlighted which included; o The formation of the new ICS by March 2021.	

Report	Assurance level*	Committee escalation	ORR/Risk Reference
		○ The PCN risk previously highlighted had improved ○ The 20% Teckal compliancy limit. ○ Cyber security. • Performance figures continued to be largely stable or slightly improving. Based on the financial position reported and changes outlined the Committee was reasonably assured. It requested assurance on a sustainable business model for LHIS going forward.	
Income Distribution Policy	**High**	Key changes made during the review of the policy were highlighted, they included a significantly more detailed explanation of the operation of the R&D cost centres and the prioritisation framework for utilising this income. Other changes included a more detailed explanation of the operation of cost attribution in research. FPC approved the revised policy.	
Purchasing Card and Internet Policy	**High**	Key changes made to the policy since its last review included the strengthening of guidelines for use of purchasing cards for specific websites. Assurance was received that regular discussion took place on use of purchasing cards. FPC approved the revised policy.	

Chair	Geoff Rowbotham, Non-Executive Director

Annex: Revised FPC TORs

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Annex

Leicestershire Partnership NHS Trust

Finance and Performance Committee

Terms of Reference

References to "the Committee" shall mean the Finance and Performance Committee

1.0 Purpose of Committee

1.1 The role of the Committee is to provide assurance to the Trust Board, that the Trust is properly governed and well managed across the full range of activities within the scope of the terms of reference and to seek internal and external assurance relating to the delivery of key financial strategies, key financial indicators, business development and investment and performance management, estate management and IT management.

2.0 Clinical Focus and Engagement

2.1 The Trust considers clinical engagement and involvement in Board decisions to be an essential element of its governance arrangements and as such the Trust's integrated governance approach aims to mainstream clinical governance into all planning, decision-making and monitoring activity undertaken by the Board.

2.2 The Committee will therefore ensure appropriate clinical attendance at its meetings.

3.0 Authority

3.1 The Committee is authorised by Trust Board to investigate any activities within its terms of reference.

3.2 The Committee is authorised by Trust Board to seek any information it requires from any employee of the Trust in order to perform its duties. All employees are directed to co-operate with any request made by the Committee.

3.3 The Committee is authorised by the Trust Board to obtain, at the Trust's expense, any outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience or expertise, if it considers this to be necessary.

4.0 Membership

4.1 Only members of the Committee have the right to attend Committee meetings. However, other individuals and officers of the Trust may be invited to attend for all or part of any meeting as deemed appropriate. The membership comprises:

- Two independent Non-Executive Directors.
- The Director of Finance who will hold executive responsibility for the Committee
- A Service Director
- The Medical Director or Director of Nursing, AHPs and Quality

4.2 The Chair of the Committee shall be one of the independent Non-Executive Directors selected by the Chair of the Trust Board. In their absence their place will be taken by another independent Non-Executive Director.

4.3 Membership of the Committee will be reviewed and agreed annually by the Board.

4.4 In the situation of a prolonged absence of the Chair or a member of the Committee, the Trust Board will determine a replacement Chair. The Chair of the Trust Board will determine replacement of independent Non-Executive Director membership and the Chief Executive in consultation with the Chair of the Trust will determine replacement Directors. All replacement members will hold full membership authority unless otherwise agreed. .

5.0 Secretary

5.1 The Committee shall be supported administratively by The Personal Assistant to the Director of Finance.

5.2 The agenda will be agreed with the Chair following consultation with the Director of Finance.

5.3 The Personal Assistant to the Director of Finance will support the production of the Committee pack and ensure the pack is circulated within the required timeline of five working days prior to the meeting, attend the meetings to take the minutes, keep a record of matters arsing and issues to be carried forward and provide support to the Chair and members of the Committee. .

6.0 Quorum

6.1 The quorum shall be three members of the Committee and must include an Non-Executive Director. A duly convened meeting of the Committee which is quorate shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

7.0 Frequency of Meetings

7.1 The Committee shall meet not less than 6 times a year and at such other times as the Chairman of the Committee shall require at the exigency of the business.

7.2 The Finance and Performance Committee and the Quality Assurance Committee will additionally hold quarterly joint meetings to discuss key joint agenda issues and report jointly to the Board. Separate governance arrangements are in place for the management of the joint meeting.

7.3 Members will be expected to attend at least three-quarters (75%) of all meetings.

8.0 Agenda / Notice of Meetings

8.1 Unless otherwise agreed, notice of each Committee meeting will confirm the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Committee, and any other person required to attend, no later than five working days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

8.2 The agenda for each meeting will include an item “declarations of interest in respect of items on the agenda”.

9.0 Minutes of Meetings

9.1 Minutes of Committee meetings shall be circulated promptly to all members of the Committee. The Committee’s minutes will be open to scrutiny by the Trust’s auditors.

9.2 The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

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10.0 Duties

10.1 The Committee supports the work of the Trust Board in ensuring a balanced and integrated approach to

- clinical focus, engagement and governance;
- patient/stakeholder involvement
- performance management
- financial oversight
- strategic management
- business management
- estates management
- IT management

10.2 The Committee is responsible for providing assurance to the Trust Board, on the effectiveness of the Trust’s arrangements for finance, business and performance, ensuring there is a consistent approach throughout the Trust,

specifically in the areas of financial management, business management, performance management and contract management, the Committee will review the adequacy and effectiveness of:

- The underlying assurance processes that support achievement of the corporate objectives and the management of principle risks specific to finance, business and performance including:
    - Assurance Framework
    - Aspects of the Annual Governance Statement related to finance, business and performance
    - Financial risks assigned to the Committee in line with the Risk Management Strategy

10.3 The Committee will seek assurance and undertake the following actions:

Finance

10.4 To review and make recommendations to Board on budgets, strategic plans and long-term investment strategy. This review will include reviewing the Long Term Financial Model (or equivalent planning model) and associated strategies; Cost Improvement Programmes; capital programmes; activity and capacity plans, and Annual Business Plan, and any financial/budgetary arrangements with partners.

10.5 To review and monitor performance against all statutory and organisational financial targets including financial risk.

10.6 To review and make recommendations to Board on all significant investment and divestment proposals under the Trust's Scheme of Reservation and Delegation, and in line with best practice investment appraisal techniques, the five-year Long Term Financial Model and agreed strategies; and to approve any financing or use of financial instruments within its delegation.

10.7 To ensure there are robust arrangements for overview and scrutiny of the estates and IT strategies, and their delivery.

10.8 To ensure there are robust arrangements for overview and scrutiny of the treasury management function, and to regularly review the operation of those arrangements.

10.9 To ensure there are robust arrangements in place for the identification and management of financial risk, and to undertake a regular review of the financial risk register.

10.10 To approve the accounting policies and treasury management policy.

10.11 To review the reference costs on an annual basis.

Business Development and Contracting

10.12 To ensure an appropriate and robust business development framework is in place and to regularly review its operation.

10.13 To scrutinise new business opportunities and tender proposals and to provide assurance to the Trust Board.

10.14 To ensure an appropriate and robust response is in place for contracting, and that the Trust has timely and accurate costing and activity information to support the process.

Performance

10.15 To scrutinise the performance of operational and corporate services in their contribution to the achievement of strategic objectives, KPIs and contractual targets.

10.16 To ensure that an effective performance management and data quality system is in place.

10.17 To ensure that there are effective emergency and business continuity arrangements in place for the Trust.

10.18 To ensure alignment to and utilisation of, the Performance and Accountability Framework for each service based on established performance measures.

10.19 To ensure the arrangements and performance of the shared facilities management services are adequate and monitored regularly throughout the financial year.

10.20 To review the performance, business plans and value added contribution from hosted services on a regular basis.

10.21 To oversee the assessment of benefits realisation and achievement of value for money for areas of delegated responsibility

General

10.22 To be empowered to delegate its authority to the Chairman or the Chief Executive Officer within the limits contained in the Trust's Scheme of Reservation and Delegation. The Board delegates responsibility for analysing and evaluating contract awards over £500k to the Committee. After such consideration, the Committee will make a recommendation to the Board for contracts where approval and award of the contract is proposed.

10.23 To receive on behalf of Trust Board and provide the Trust Board with assurance on the following:-

- Information Governance Toolkit Declaration

- Annual Business Plan (draft)
- Emergency and Business Continuity Annual Report
- LPT Major incident plan
- LLR Operating Plan
- Premises Assurance Model
- Reference Costs

10.25 To receive exception reports of outcomes of **external** reviews, inquiries, surveys and investigations, with assurance that any lessons learnt have been implemented to ensure delivery of the highest quality of services, and to capture any risks to finance, business or performance.

10.26 To receive exception reports of outcomes of **internal** activity, e.g. from internal audit, site visits and other activities, and to capture any risks to finance, business or performance outcomes.

10.27 To receive assurance of compliance with agreed best practice, e.g. national guidance, and to ensure the capture of any risks to finance, business and performance.

11.0 Reporting Responsibilities

11.1 The Committee shall make whatever recommendations to the Trust Board that it deems appropriate on any area within its remit where action or improvement is needed.

11.2 The Committee will produce a Highlight report from each meeting for the Trust Board describing levels of assurance for agenda items. Any immediate high risk concerns raised during the meeting will be shared directly with all Board members.

11.3 The Committee shall produce for the Trust Board an annual report on the work it has undertaken during the course of the year.

12.0 Annual Review

12.1 The Committee shall, at least once a year, review its own performance, constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Trust Board for approval.

13.0 Risk Responsibility

13.1 The risk areas the Committee has special responsibility for will be those that fall within the remit of this Committee.

Leicestershire Partnership NHS Trust

Meeting Name and date	**Trust Board meeting, 3rd December 2019**
Paper Reference	**N**

Name of Report:	**Month 7 Trust Finance Report**

For approval		For assurance	X	For information	X

Presented by	Danielle Cecchini, Director of Finance	Author (s)	Chris Poyser, Head of Corporate Finance; Jackie Moore, Financial Controller

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

Report previously reviewed by	
Committee / Group	Date
Finance & Performance Committee	19 November 2019

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

Recommendations of the report

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

Leicestershire Partnership NHS
NHS Trust

Finance Report for the period ended
31 October 2019

For presentation at the
Trust Board meeting
3 December 2019

Leicestershire Partnership NHS Trust

Contents

Executive Summary and overall performance against targets

Introduction

1. This report presents the financial position for the period ended 31 October 2019 (month 7). The report shows a £983k surplus, which is in line with plan.

2. Operational budgets are currently overspending by £2,850k. The run-rate overspend for month 7 was £278k, a reduction from £495k in month 6. Central reserves are still able to offset the operational overspend in order to deliver the year to date planned surplus. However, as forecast in previous months, central reserves will not be sufficient to cover the operational overspend until the end of the financial year if the current rate of overspend is maintained. It therefore remains imperative that the net directorate overspend is eliminated as soon as possible.

3. Adult Mental Health Services budgets show the highest level of overspend (£1,478k) followed by Estates services (£910k), FYPC Services (£337k) and Community Health Services (£215k). Enabling is the only directorate which is reporting an underspend (£281k).

4. Closing cash for October stood at £10.8m. This equates to 14.6 days' operating costs, and is above the planned cash level of £7.0m for October.

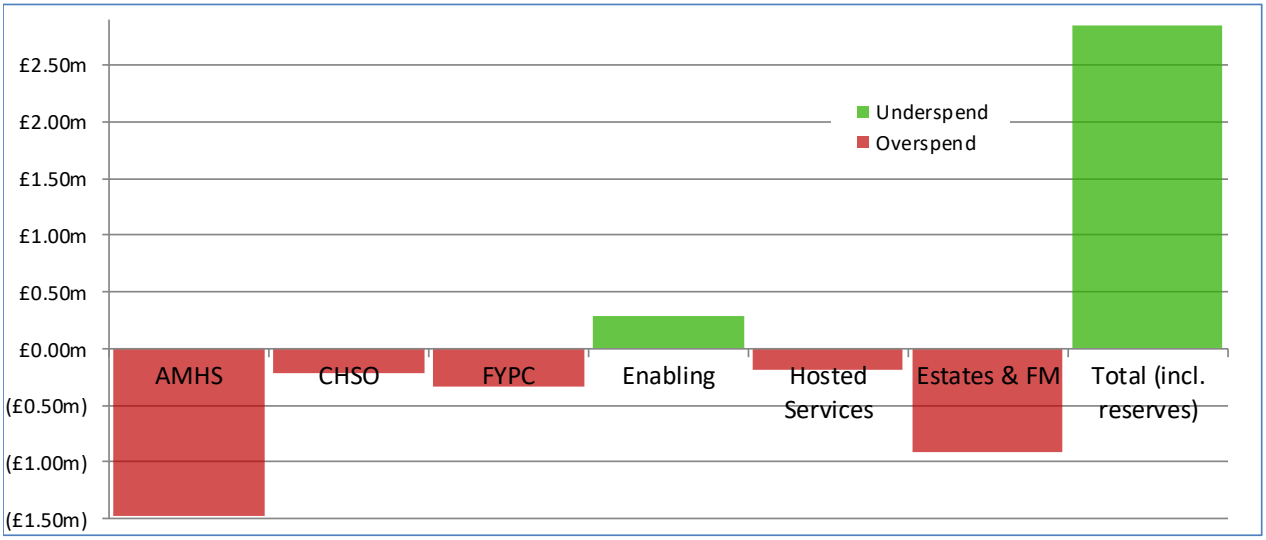
NHS Trust Statutory Duties	Year to date	Year end f'cast	Comments
1. Income and Expenditure break-even.	G	A	The Trust is reporting a surplus of £983k at the end of October 2019. This is in line with the Trust plan. The cumulative run-rate increases the risk to delivery of a year end break-even, particularly as PSF funding is at risk if the control total surplus is not achieved **[see 'Service I&E position' and *Appendix A*]**.
2. Remain within Capital Resource Limit (CRL).	G	G	The capital spend for October is £4.3m, which is within limits.
3. Achieve the Capital Cost Absorption Duty (Return on Capital).	G	G	The dividend payable is based on the actual average relevant net assets; therefore the capital cost absorption rate will automatically be 3.5%.
4. Remain within External Financing Limit (EFL).		G	Cash levels of £10.8m are currently above target. The forecast year end cash balance will deliver the EFL requirement.

Secondary targets	Year to date	Year end f'cast	Comments
5. Comply with Better Payment Practice Code (BPPC).	R	G	The target is to pay 95% of invoices within 30 days. Cumulatively the Trust achieved 3 of the 4 BPPC targets in October.
6. Achieve Cost Improvement Programme (CIP) targets.	R	R	CIP schemes are currently under delivering, showing £1,575k achieved compared to a £2,061k year to date target (equating to 76.4% delivery) at the end of month 7. The year end forecast (for operational schemes) currently shows 68% achievement by the end of the year. **[See 'Efficiency Savings Programme' + *Appendix B*].**
7. Deliver financial plan surplus	G	R	(Also see target 1 above). A surplus of £983k has been reported in month 7, in line with plan. The Trust plan for the year assumes a £0.5m LPT generated surplus, plus £2.1m PSF funding dependant on delivery of the NHSI breakeven control total. Delivery of the stretch target surplus by the year end is dependent on delivery of the Financial Turnaround Plan or other recovery actions.
Internal targets	**Year to date**	**Year end f'cast**	**Comments**
8. Achieve a Financial & Use of Resources metric score of 2 (or better)	G	G	The Trust is currently scoring 2 for year-to-date performance. Despite the potential risks to the year end I&E surplus stretch target, the strong cash position means that a score of 2 overall for the year is still likely.
9. Achieve retained cash balances in line with plan	G	G	A cash balance of £10.8m was achieved at the end of October 2019. Delivery of the year end cash forecast is expected to exceed target due to notification (after plan submission) of the 2018/19 incentive PSF. **[See 'cash and working capital']**
10. Deliver capital investment in line with plan (within +/- 15% YTD planned spend levels)	G	G	Capital expenditure totals £4,279k at the end of month 7; £217k below plan. **[See 'Capital Programme 2019/20']**

Income and Expenditure position

The month 7 position includes a significant operational overspend that is currently offset by the release of all central reserves.

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



Income and expenditure forecast

The month 7 operational overspend of £2,850k represents a negative movement of £278k compared to month 6 (£2,572k). Whilst the in-month movement in month 7 improved compared to month 6, the rate of overspend still needs to reduce considerably if the Trust is to achieve its year end financial targets. Central reserves budgets have been fully committed since month 6 – the Trust is now only managing to deliver the plan each month through unplanned fortuitous additional gains. This is clearly not a sustainable strategy, and means that if the operational position doesn't improve, there is a high risk that the Trust could fail to deliver the planned year-to-date financial position at any point from now until the end of the financial year.

Appendix F (risks, pressures and mitigations) provides details of the risk-adjusted year end forecast. Owing to the ongoing pressures within Adult Mental Health, and the recognition of further risk on the UHL Estates and FM contract value, the operational year end forecast has worsened by almost £0.6m since month 6. This adverse movement in the forecast position has been partially offset by the impact of several gains within central reserves (gains which also helped to secure the month 7 year-to-date position). These include unexpected VAT reclaims, and the release of several provisions from 2018/19 for which the corresponding expenditure is no longer anticipated.

The forecast also includes c. £2.2m benefit attributed to other recovery actions. This is expected to include financial turnaround savings as well as other technical adjustments (a.g asset revaluations resulting in reduced capital charges). To date, the current financial turnaround plan has not resulted in significant savings. The adoption of more challenging financial control total targets per directorate is now being implemented (detail of which is included in the Financial Turnaround paper).

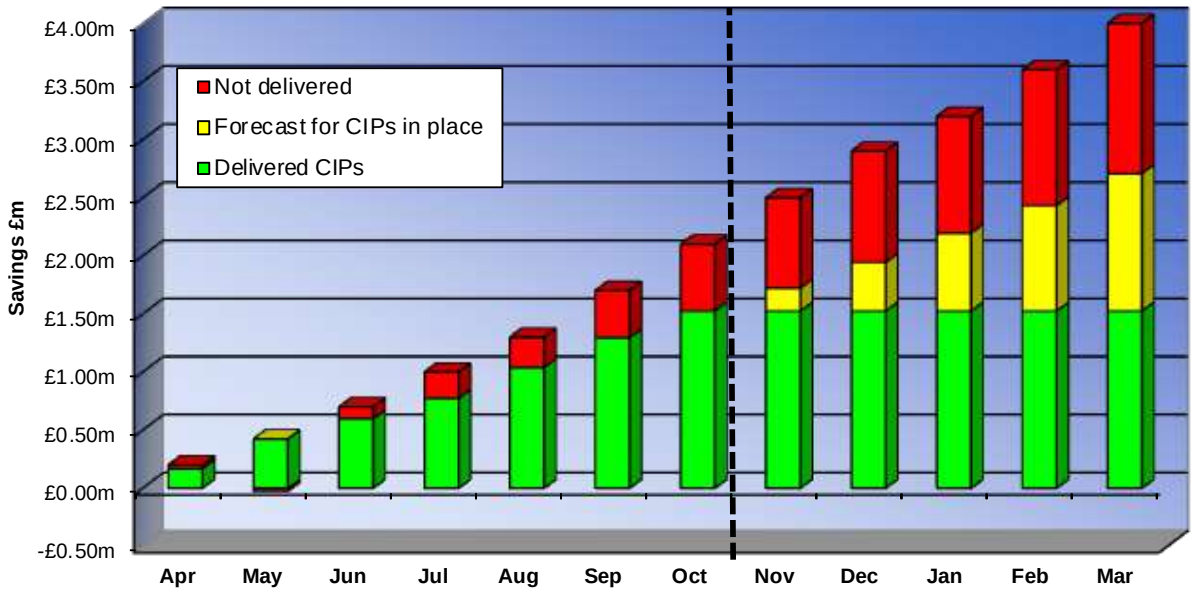
Run-rate variances

The usual graph to show run-rate performance by directorate has this month been replaced with a more detailed analysis shown in ***Appendix G.*** This analysis is based on the forecast excluding any additional recovery gains (i.e a £2.2m shortfall compared to plan).

This analysis also models the potential impact on our expected Provider Sustainability Funding (PSF) should the £2.2m shortfall be realised.

Directorate Efficiency Savings Programme

CIP performance (directorate schemes) as at month 7



	Apr £000	May £000	Jun £000	Jul £000	Aug £000	Sep £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	Mar £000
Monthly plan total:	**212**	**427**	**672**	**967**	**1,307**	**1,666**	**2,061**	**2,456**	**2,852**	**3,249**	**3,648**	**4,047**
Actual performance to date												
Achieved	169	474	648	824	1,089	1,345	1,575	1,575	1,575	1,575	1,575	1,575
Forecast achieved	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*196*	*418*	*670*	*907*	*1,183*
Total savings:	**169**	**474**	**648**	**824**	**1,089**	**1,345**	**1,575**	**1,772**	**1,993**	**2,245**	**2,482**	**2,758**
Variance:	**(43)**	**47**	**(24)**	**(143)**	**(217)**	**(321)**	**(485)**	**(685)**	**(858)**	**(1,004)**	**(1,165)**	**(1,290)**

At the end of October, CIP delivery amounted to £1,575k, against an overall year to date target of £2,061k. This equates to 76.4% delivery.

The year end forecast predicts performance significantly lower than plan by the end of March 2020 (68% delivery). This includes the additional £500k CIP required to deliver the higher surplus target set for the Trust by NHS Improvement.

Statement of Financial Position (SoFP)

PERIOD: October 2020	2018/19 31/03/19 Audited £'000's	2019/20 31/10/19 October £'000's
NON CURRENT ASSETS		
Property, Plant and Equipment	200,260	200,254
Intangible assets	1,909	1,740
Trade and other receivables	653	652
Total Non Current Assets	**202,822**	**202,646**
CURRENT ASSETS		
Inventories	319	406
Trade and other receivables	13,802	17,030
Cash and Cash Equivalents	8,357	10,758
Total Current Assets	**22,478**	**28,194**
Non current assets held for sale	**0**	**0**
TOTAL ASSETS	**225,300**	**230,840**
CURRENT LIABILITIES		
Trade and other payables	(14,856)	(17,988)
Borrowings	(220)	(220)
Capital Investment Loan - Current	(190)	(190)
Provisions	(1,202)	(1,120)
Total Current Liabilities	**(16,468)**	**(19,518)**
NET CURRENT ASSETS (LIABILITIES)	**6,010**	**8,676**
NON CURRENT LIABILITIES		
Borrowings	(8,025)	(8,024)
Capital Investment Loan - Non Current	(3,510)	(3,429)
Provisions	(1,129)	(1,129)
Total Non Current Liabilities	**(12,664)**	**(12,582)**
TOTAL ASSETS EMPLOYED	**196,168**	**198,740**
TAXPAYERS' EQUITY		
Public Dividend Capital	83,675	85,263
Retained Earnings	48,288	49,271
Revaluation reserve	64,205	64,205
TOTAL TAXPAYERS EQUITY	**196,168**	**198,740**

Non-current assets

- Property, plant and equipment (PPE) amounts to £200.3m. This balance will continue to increase as capital spend accelerates in the latter months of the financial year.

Current assets

- Current assets of £28.2m include cash of £10.8m and receivables of £17.0m.

Current Liabilities

- Current liabilities amount to £19.5m and mainly relate to payables of £18m
- Net current assets / (liabilities) show net assets of £8.7m.

Working capital

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

Taxpayers' Equity

- October's year to date surplus of £983k is reflected within retained earnings.

Cash and Working Capital

12 Months Cash Analysis Apr 18 to Mar 19

Cash – Key Points

October's closing cash balance is £10.8m and equates to 14.6 days' operating expenses - this is £3.7m above the planned cash balance of £7.0m.

The £3.7m cash over-achievement against plan relates to the following:

- The receipt of £3m relating to last year's PSF funding was received earlier than expected (planned PSF is phased equally over 12 months):

- Working capital balances are having a favourable impact on cash. Actual payables, receivables and provisions balances have resulted in the cash position exceeding planned levels. As at M7, the amount owed to the Trust from customers is less than expected and the amount the Trust owes to its suppliers is higher than planned. Invoice disputes with NHS Property Services and UHL are contributing towards the increased payables balance.

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

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

Receivables

Current receivables (debtors) total £17m.

Receivables	Current Month (October 2019)					
	NHS	Non NHS	Emp's	Total	% Total	% Sales Ledger
	£'000	£'000	£'000	£'000		
Sales Ledger						
30 days or less	2,255	1,380	8	**3,643**	**20.9%**	**43.6%**
31 - 60 days	233	153	6	**392**	**2.3%**	**4.7%**
61 - 90 days	416	20	1	**437**	**2.5%**	**5.2%**
Over 90 days	3,026	683	165	**3,874**	**22.3%**	**46.4%**
	5,930	2,236	180	**8,346**	**48.0%**	**100.0%**
Non sales ledger	5,557	3,127	0	**8,684**	**49.9%**	
Total receivables current	**11,487**	**5,363**	**180**	**17,030**	**97.9%**	
Total receivables non current		360		360	**2.1%**	
Total	**11,487**	**5,723**	**180**	**17,390**	**100.0%**	**0.0%**

Debt greater than 90 days amounts to £3.9m, an increase of £444k since last month. Outstanding contract recharges with UHL are responsible for the monthly increase. Receivables over 90 days should not account for more than 5% of the overall total receivables balance. The proportion at Month 7 is 22% (last month: 19.2%).

Aged debts > 90 days

Based on the RAG ratings below (see key), £3.9m (487 invoices) are greater than 90 days old. 44 of these invoices totalling £564k are deemed to be red (no movement since last month). The Accounts Receivable (AR) team focus on the green and amber debts, whilst the red debts are passed to Service areas once all general debt recovery processes have been exhausted. The majority of 'red' invoices relate to disputed AMH out-of-area recharges. Work continues to resolve these debts.

RAG	M5		M6		M7		Diff	
	£000	No	£000	No	£000	No	£000	No
Green	1,489	341	1,733	325	2,039	331	306	6
Amber	1,095	100	1,134	105	1,271	112	137	7
Red	565	45	564	45	564	44	0	(1)
Total	**3,149**	**486**	**3,431**	**475**	**3,874**	**487**	**443**	**12**

Key:

Green – invoice is in early stage of being chased by AR team, no queries or issues
Amber – invoice query raised by customer; AR team & invoice requester trying to resolve
Red * – AR team cannot resolve therefore passed to invoice requester to either resolve or agree write-off

* If debts are red rated, this does not imply that they all need to be written-off, just that more work is required to get disputes/queries resolved. There has not been any movement in the general bad debt provision of £374k since the start of the financial year, however several debts are in the process of write-off and will be included in next month's report.

Payables

The current payables position in Month 7 is £18m, an increase of £1.02m during the month. £0.5m of this increase relates to October's monthly PDC payment which will be paid to the Department of Health in March. The over 90 days supplier debt of £2.3m continues to relate to two suppliers - UHL (£0.5m) and NHS Property Services disputed invoices (£1.8m). Work is ongoing to resolve specific old year invoice disputes.

Payables	Current Month October 2019				
	NHS £'000	Non NHS £'000	Total £'000	% Total	% Purchase Ledger
Purchase Ledger					
30 days or less	2,635	2,035	**4,670**	**26.0%**	**66.6%**
31 - 60 days	4	43	**47**	**0.3%**	**0.7%**
61 - 90 days	2	24	**26**	**0.1%**	**0.4%**
Over 90 days	2,258	9	**2,267**	**12.6%**	**32.3%**
	4,899	2,111	**7,010**	**39.0%**	**100.0%**
Non purchase ledger	1,384	9,594	**10,978**	**61.0%**	
Total Payables Current	**6,283**	**11,705**	**17,988**	**100.0%**	
Total Payables Non Current	0	0	**0**		
Total	6,283	11,705	17,988	**100.0%**	

Better Payment Practice Code (BPPC)

The specific target is to pay 95% of invoices within 30 days. Cumulatively the Trust achieved 3 of the 4 BPPC targets in October. The one cumulative target not met relates to the number of NHS invoices paid within 30 days (94.4%).

From November, the Finance team will be introducing additional invoice monitoring processes to support delivery of all cumulative BPPC targets by the end of the financial year, with specific focus on NHS invoices as currently this is the area of non-compliance.

In addition to this the Finance team will continue to meet with any non-complying departments to help improve the position.

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

Capital Programme 2019/20

Capital expenditure totals £4.28m at the end of month 7, £200k (or 5%) below plan. Month on month spend continues to increase, with October's spend of c£1m being the highest so far this year (c£1m). The monthly spend will continue to increase from now until the end of the financial year due to planned payment of Interserve invoices for the construction of the CAMHS unit, Bradgate ward refurbishments, final costs relating to the Riverside office relocation and IM&T expenditure.

Following last month's confirmation from NHSI to spend to original plan, the Capital Management Committee has reviewed the progress of all schemes and identified expenditure slippage of c£1m. New schemes to be funded from this slippage include additional investment in site maintenance (inc. boilers), agile working, several minor refurbishments and additional EPR support. However, at this point, final confirmation that our CRL has been approved has not yet been received from NHSI.

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

	Annual Plan	Oct YTD Plan	Oct YTD Actual	Oct YTD Variance	Year End Forecast	Revision to Plan
Sources of Funds	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Depreciation	7,179	3,538	3,321	(217)	7,179	0
PDC capital for CAMHS	5,102	958	958	0	5,102	0
PFI Agnes Unit capital lifecycle replacement	100	0	0	0	100	0
I&E Surplus (CRL adjustment not confirmed)	1,576	0	0	0	1,576	0
Asset Sales	0	0	0	0	0	0
Total Capital funds	**13,957**	**4,496**	**4,279**	**(217)**	**13,957**	**0**
Application of Funds	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Estates & Innovation						
Service Improvements	(7,138)	(2,431)	(2,442)	(11)	(7,578)	(440)
Estates & Equipment	(2,911)	(973)	(309)	664	(2,233)	678
Sub-total:	**(10,049)**	**(3,404)**	**(2,751)**	**653**	**(9,811)**	**238**
IT Programme	**(3,908)**	**(1,092)**	**(1,528)**	**(436)**	**(4,146)**	**(238)**
Total Capital Expenditure	**(13,957)**	**(4,496)**	**(4,279)**	**217**	**(13,957)**	**0**
(Over)/underspend against resource available	**0**	**0**	**0**	**0**	**0**	**0**

APPENDIX A - Statement of Comprehensive Income (SoCI)

Statement of Comprehensive Income for the period ended 31st October 2019	YTD Actual M7 £000	YTD Plan M7 £000	YTD Var. M7 £000	Year end forecast £000
Revenue				
Total income	166,004	162,544	3,460	278,567
Operating expenses	(160,873)	(157,412)	(3,461)	(268,805)
Operating surplus (deficit)	**5,132**	**5,132**	**(0)**	**9,762**
Investment revenue	21	21	(0)	36
Other gains and (losses)	0	0	0	0
Finance costs	(581)	(581)	0	(996)
Surplus/(deficit) for the period	**4,572**	**4,572**	**(0)**	**8,802**
Public dividend capital dividends payable	(3,589)	(3,589)	0	(6,154)
I&E surplus/(deficit) for the period (before tech. adjs)	**983**	**983**	**0**	**2,648**
IFRIC 12 adjustments	0	0	0	0
Donated/government grant asset reserve adj	0	0	0	0
Technical adjustment for impairments	0	0	0	0
NHSI I&E control total surplus	**983**	**983**	**0**	**2,648**
Other comprehensive income (Exc. Technical Adjs)				
Impairments and reversals	0	0	0	0
Gains on revaluations	0	0	0	0
Total comprehensive income for the period:	**983**	**983**	**0**	**2,648**
Trust EBITDA £000	**9,549**	**9,549**	**(0)**	**17,336**
Trust EBITDA margin %	**5.8%**	**5.9%**	**-0.1%**	**6.2%**

APPENDIX B – Monthly Operational CIP performance by Service

CIP performance by Directorate		2019/20 Financial Year													
		1 Apr £'000	2 May £'000	3 June £'000	4 July £'000	5 Aug £'000	6 Sept £'000	7 Oct £'000	8 Nov £'000	9 Dec £'000	10 Jan £'000	11 Feb £'000	12 March £'000	19/20 YTD £'000	19/20 yr/end plan £'000
AMH & LD	Plan	25	25	56	61	61	61	63	63	63	64	65	65	353	674
	Actual / Forecast	0	141	10	12	48	18	-40	-73	18	48	34	68	188	283
	Variance	-25	116	-47	-49	-13	-43	-103	-136	-46	-16	-31	3	-165	-391
	Cumulative Variance	-25	91	44	-5	-18	-62	-165	-301	-347	-363	-394	-391		
	Cuml. % delivered	0%	280%	141%	97%	92%	79%	53%	28%	28%	33%	35%	42%	53%	42%
FYPC	Plan	49	49	49	49	49	49	49	49	49	49	49	49	342	586
	Actual / Forecast	49	49	49	49	49	49	49	49	49	49	49	49	342	586
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Cumulative Variance	0	0	0	0	0	0	0	0	0	0	0	0		
	Cuml. % delivered	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Community H/S	Plan	73	73	73	73	73	73	73	73	73	73	73	73	508	870
	Actual / Forecast	73	73	73	73	73	73	73	73	73	73	73	73	508	870
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Cumulative Variance	0	0	0	0	0	0	0	0	0	0	0	0		
	Cuml. % delivered	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Enabling	Plan	46	46	46	46	46	46	46	46	46	46	46	46	324	555
	Actual / Forecast	45	38	38	38	46	46	46	45	45	44	44	46	297	521
	Variance	-1	-8	-8	-8	0	0	0	-1	-1	-2	-2	0	-26	-34
	Cumulative Variance	-1	-9	-17	-26	-26	-26	-26	-28	-29	-31	-33	-34		
	Cuml. % delivered	98%	90%	87%	86%	89%	91%	92%	93%	93%	93%	93%	94%	92%	94%
Estates Services	Plan	19	22	22	66	66	66	99	100	100	100	101	102	359	862
	Actual / Forecast	2	5	5	5	5	5	38	38	38	38	38	40	65	257
	Variance	-17	-17	-17	-61	-61	-61	-61	-62	-62	-62	-63	-62	-294	-605
	Cumulative Variance	-17	-34	-51	-112	-173	-234	-294	-356	-418	-480	-543	-605		
	Cuml. % delivered	0%	0%	0%	13%	11%	10%	18%	22%	25%	27%	29%	30%	18%	30%
Trust-wide savings	Plan	0	0	0	0	45	65	65	65	65	65	65	65	175	500
	Actual / Forecast	0	0	0	0	45	65	65	65	0	0	0	0	175	240
	Variance	0	0	0	0	0	0	0	0	-65	-65	-65	-65	0	-260
	Cumulative Variance	0	0	0	0	0	0	0	0	-65	-130	-195	-260		
	Cuml. % delivered	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	100%	48%
Total	Plan	212	215	246	295	340	360	394	396	396	397	399	400	2,061	4,047
	Actual / Forecast	169	305	174	176	265	255	230	196	222	251	237	276	1,575	2,758
	Variance	-43	91	-72	-118	-74	-104	-164	-199	-174	-146	-161	-124	-485	-1,290
	Cumulative Variance	-43	47	-24	-143	-217	-321	-485	-685	-858	-1,004	-1,165	-1,290		
														76%	68%
Cumulative Delivered		80%	111%	96%	85%	83%	81%	76%	72%	70%	69%	68%	68%		

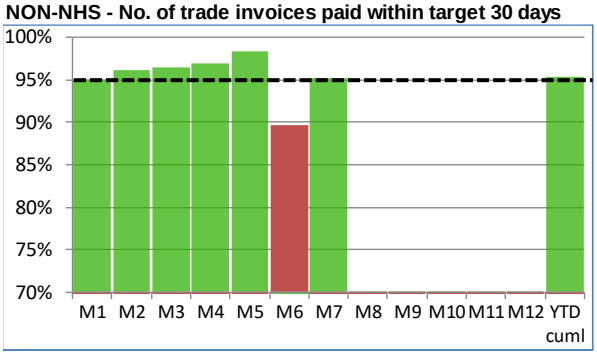
APPENDIX C – BPPC performance

Trust performance – current month (cumulative) v previous

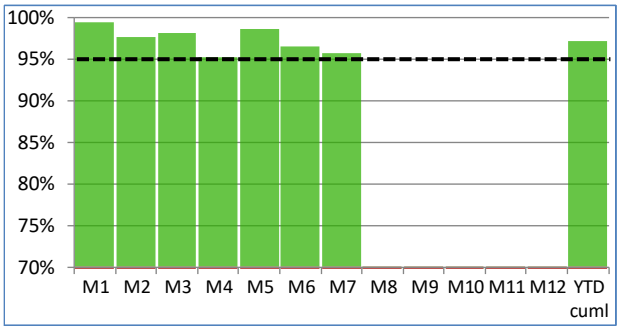
Better Payment Practice Code	October (Cumulative)		September (Cumulative)	
	Number	£000's	Number	£000's
Total Non-NHS trade invoices paid in the year	16,290	59,127	14,124	50,626
Total Non-NHS trade invoices paid within target	15,532	57,511	13,468	49,372
% of Non-NHS trade invoices paid within target	**95.3%**	**97.3%**	**95.4%**	**97.5%**
Total NHS trade invoices paid in the year	486	30,097	406	25,781
Total NHS trade invoices paid within target	459	29,893	385	25,578
% of NHS trade invoices paid within target	**94.4%**	**99.3%**	**94.8%**	**99.2%**
Grand total trade invoices paid in the year	16,776	89,224	14,530	76,407
Grand total trade invoices paid within target	15,991	87,404	13,853	74,950
% of total trade invoices paid within target	**95.3%**	**98.0%**	**95.3%**	**98.1%**

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

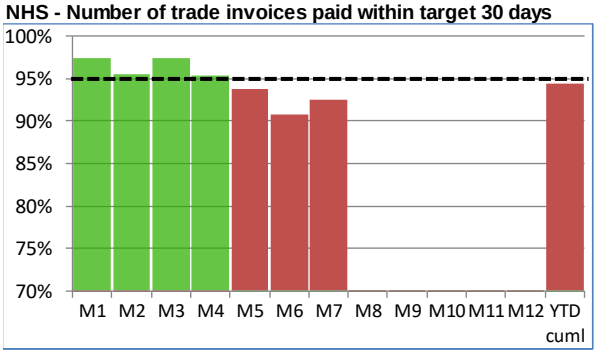
NON-NHS - No. of trade invoices paid within target 30 days



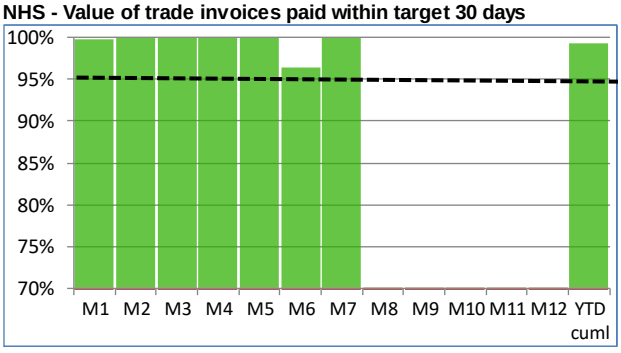
NON-NHS - Value of trade invoices paid within target 30 days



NHS - Number of trade invoices paid within target 30 days



NHS - Value of trade invoices paid within target 30 days



APPENDIX D – Agency staff expenditure

2019/20 Agency Expenditure (includes prior yr comparators)	2018/19 Outturn £000s Actual	2018/19 Avg. £000s Actual	2019/20 M1 £000s Actual	2019/20 M2 £000s Actual	2019/20 M3 £000s Actual	2019/20 M4 £000s Actual	2019/20 M5 £000s Actual	2019/20 M6 £000s Actual	2019/20 M7 £000s Actual	2019/20 M8 £000s F'Cast	2019/20 M9 £000s F'Cast	2019/20 M10 £000s F'Cast	2019/20 M11 £000s F'Cast	2019/20 M12 £000s F'Cast	19/20 YTD £000s Actual	19/20 Year End £000s F'cast
AMH/LD																
Agency Consultant Costs	-609	-51	-60	-64	-94	-59	-75	-86	-119	-90	-75	-65	-45	-45	-557	-877
Agency Nursing	-1,528	-127	-122	-142	-158	-173	-157	-214	-144	-155	-155	-150	-140	-135	-1,109	-1,844
Agency Scient, Therap. & Tech	-232	-19	-33	-18	-21	-26	-23	-12	-22	-25	-25	-25	-25	-25	-156	-281
Agency Non clinical staff costs	-409	-34	-48	-43	-31	-14	-25	-38	-7	-10	-10	-10	-10	-5	-206	-251
Sub-total	**-2,778**	**-231**	**-264**	**-267**	**-303**	**-273**	**-280**	**-350**	**-292**	**-280**	**-265**	**-250**	**-220**	**-210**	-2,029	**-3,254**
CHS																
Agency Consultant Costs	-182	-15	-15	-15	-12	-13	-11	-15	-18	-15	-15	-7	-7	-7	-98	-149
Agency Nursing	-3,579	-298	-306	-243	-305	-332	-302	-279	-298	-290	-320	-290	-270	-270	-2,066	-3,506
Agency Scient, Therap. & Tech	-644	-54	-54	-41	-47	-53	-49	-39	-30	-40	-40	-40	-40	-40	-313	-513
Agency Non clinical staff costs	-43	-4	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sub-total	**-4,447**	**-371**	**-375**	**-299**	**-365**	**-398**	**-362**	**-333**	**-345**	**-345**	**-375**	**-337**	**-317**	**-317**	-2,477	**-4,167**
FYPC																
Agency Consultant Costs	-429	-36	-42	-12	-29	-30	-41	-28	-37	-35	-35	-35	-35	-35	-220	-395
Agency Nursing	-521	-43	-118	-160	-163	-94	-96	-160	-132	-70	-50	-30	-20	-20	-923	-1,113
Agency Scient, Therap. & Tech	-26	-2	-4	-7	-11	-16	-5	-9	-10	-5	-5	-5	0	0	-63	-78
Agency Non clinical staff costs	-32	-3	-8	-15	-15	-28	-3	-8	-5	-5	0	0	0	0	-83	-88
Sub-total	**-1,007**	**-84**	**-172**	**-194**	**-218**	**-168**	**-145**	**-205**	**-185**	**-115**	**-90**	**-70**	**-55**	**-55**	-1,288	**-1,673**
Enabling, Hosted & reserves																
Agency Consultant Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Agency Nursing	-49	-4	0	29	0	0	0	0	0	0	0	0	0	0	29	29
Agency Scient, Therap. & Tech	-42	-4	-7	-4	-8	-10	-8	-5	-10	-9	-9	-9	-9	-9	-52	-97
Agency Non clinical staff costs	-623	-52	-22	-31	-24	-27	-19	-33	-36	-30	-30	-25	-25	-25	-191	-326
Sub-total	**-714**	**-60**	**-28**	**-6**	**-32**	**-38**	**-27**	**-38**	**-46**	**-39**	**-39**	**-34**	**-34**	**-34**	-214	**-394**
TOTAL TRUST															0	
Agency Consultant Costs	-1,220	-102	-117	-90	-136	-103	-126	-130	-174	-140	-125	-107	-87	-87	-875	-1,421
Agency Nursing	-5,676	-473	-546	-516	-626	-599	-556	-653	-574	-515	-525	-470	-430	-425	-4,069	-6,434
Agency Scient, Therap. & Tech	-944	-79	-99	-71	-87	-105	-85	-65	-72	-79	-79	-79	-74	-74	-583	-968
Agency Non clinical staff costs	-1,107	-92	-78	-89	-70	-70	-47	-79	-48	-45	-40	-35	-35	-30	-481	-666
Total	**-8,946**	**-746**	**-839**	**-766**	**-918**	**-877**	**-814**	**-926**	**-868**	**-779**	**-769**	**-691**	**-626**	**-616**	-6,008	**-9,488**
Agency ceiling (£8,122k)			-675	-677	-677	-677	-677	-677	-677	-677	-677	-677	-677	-677	-4,737	-8,122
Variance (+better/-worse)			**-164**	**-89**	**-241**	**-200**	**-137**	**-249**	**-191**	**-102**	**-92**	**-14**	**51**	**61**	-1,271	**-1,366**
Trust financial plan			-710	-681	-680	-678	-677	-675	-674	-670	-673	-675	-673	-656	-4,775	-8,122
Variance (+better/-worse)			**-129**	**-85**	**-238**	**-199**	**-137**	**-251**	**-194**	**-109**	**-96**	**-16**	**47**	**40**	-1,233	**-1,366**

At month 7, total Trust agency costs were £6,008k. This is higher than year-to-date planned spend of £4,775k, and also higher than the year-to-date agency spend ceiling of £4,737k set by NHS Improvement.

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

After month 7, the revised forecast for the year is £9.5m against the plan / NHSI ceiling of £8.1m. This does not factor in the planned Financial Turnaround plan agency costs reduction

APPENDIX E – Cash flow forecast

APPENDIX E: 2019/20 CASH-FLOW FORECAST	OCT	OCT	OCT	NOV	DEC	JAN	FEB	MAR	YTD	19/20
	FORECAST	ACTUAL	VARIANCE	FORECAST	FORECAST	FORECAST	FORECAST	FORECAST	ACTUAL	FORECAST
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
OPENING BALANCE	**9,332**	**9,332**	**0**	**10,758**	**9,482**	**8,916**	**10,359**	**8,893**	**8,356**	**8,356**
INCOME										
CCG Block Contracts	18,172	18,172	**0**	18,078	18,078	18,078	18,078	18,078	125,878	216,268
NHS England Specialist Commissioning Contracts	626	626	**0**	623	623	623	623	623	4,589	7,704
Health Education England Medical Training Contracts	976	976	**0**	710	716	710	708	715	5,416	8,975
Local Authorities	1,437	1,437	**0**	1,437	1,437	1,437	1,437	2,157	8,734	16,639
UHL Contracts	787	787	**0**	200	200	200	200	400	1,200	2,400
Non Contract Activity (NCA) re service provision for Non- Leicester patients	325	156	**(169)**	325	311	325	325	574	1,437	3,297
Health Informatics Service (HIS)	1,027	832	**(195)**	928	1,033	740	850	1,049	1,800	6,400
360 Assurance Audit Services	521	243	**(278)**	342	342	420	242	323	1,000	2,669
Property income for rents and service charges	882	0	**(882)**	1,008	126	126	126	126	0	1,512
STP Funding 19/20	322	0	**(322)**	322	0	465	0	608	322	1,717
STP Funding 18/19 - Q4 plus incentive and bonus allocation	0	0	**0**	0	0	0	0	0	3,180	3,180
HMRC Mill Lodge VAT refund for construction works	0	0	**0**	0	0	0	0	0	0	0
HMRC VAT reclaims	266	266	**0**	323	259	259	259	259	1,954	3,313
Property disposals	0	0	**0**	0	0	0	0	0	0	0
Capital Loan	0	0	**0**	0	0	0	0	0	0	0
Other income receipts and recharges (including PDC)	1,118	813	**(305)**	615	830	2,397	673	2,092	4,395	11,000
PDC capital funding support	0	0	**0**	0	1,476	0	0	2,037	1,589	5,102
Income receipts relating to previous year	150	165	**15**	712	98	98	98	98	5,519	6,623
Total Receipts	**26,609**	**24,473**	**(2,136)**	**25,623**	**25,529**	**25,878**	**23,619**	**29,139**	**167,013**	**296,799**
PAYMENTS										
Payroll	16,940	16,984	**44**	16,990	16,990	16,990	16,990	16,990	119,457	204,407
Capital	1,614	829	**(785)**	1,738	2,419	1,213	1,263	421	3,403	10,457
Non pay general expenditure	4,685	3,191	**(1,494)**	4,875	4,653	4,200	4,700	5,136	26,527	50,091
UHL - Estates & FM Services	827	827	**0**	827	827	827	827	827	4,962	9,097
UHL - Other contracts	176	0	**(176)**	352	176	176	176	176	1,060	2,116
Rents and Service Charges (NHS Properties & Community Health Partnership)	1,252	284	**(968)**	1,297	329	329	329	330	1,335	3,949
HCL Agency Nursing Costs	250	449	**199**	400	400	400	500	531	2,723	4,954
Out of Area (OOA) costs for patients placed in private hospitals	200	483	**283**	300	300	300	300	300	2,227	3,727
Public dividend capital payment (PDC)	0	0	**0**	0	0	0	0	3,077	2,798	5,875
Other finance costs (inc loan interest and principal repayments)	0	0	**0**	120	0	0	0	0	119	239
Total Payments	**25,944**	**23,047**	**(2,897)**	**26,899**	**26,094**	**24,435**	**25,085**	**27,788**	**164,611**	**294,912**
CLOSING CASH BOOK BALANCE	**9,997**	**10,758**	**762**	**9,482**	**8,916**	**10,359**	**8,893**	**10,243**	**10,758**	**10,243**
Plan	**7,014**	**7,014**	**0**	**6,681**	**6,436**	**7,383**	**8,711**	**8,000**	**7,216**	**8,000**
Variance to plan	**2,983**	**3,744**	**762**	**2,801**	**2,480**	**2,976**	**182**	**2,243**	**3,542**	**2,243**

APPENDIX F – Risks, Pressures and Mitigations

Risk adjusted estimated year end position as at month 7

Likely Scenario					Scenario Analysis		
Description	Risk £000	Pressure £000	Mitigation £000	Net Total £000	Best £000	Likely £000	Worst £000
Opening 2018/19 budgets - break-even assumption	-	-	-	**0**	**0**	**0**	**0**
Operational positions							
Adult Mental Health	(833)	(1,552)	833	**(1,552)**	(1,207)	(1,552)	(2,350)
Learning Disabilities	(91)	(574)	91	**(574)**	(528)	(574)	(665)
Community Health Services	(950)	0	600	**(350)**	100	(350)	(850)
Families, Young People and Childrens Services	0	(1,890)	1,430	**(460)**	(350)	(460)	(890)
Enabling Services	0	(267)	645	**378**	500	378	250
Estates	0	(2,106)	293	**(1,813)**	(1,700)	(1,813)	(2,000)
Hosted Services	0	(1,000)	500	**(500)**	(350)	(500)	(600)
Service Delivery - total	**(1,874)**	**(7,389)**	**4,392**	**(4,871)**	**(3,535)**	**(4,871)**	**(7,105)**
Trustwide/Corporate							
Reserves contingency release (includes release of unused 18/19 provisions and further 19/20 VAT reclaims)	**0**	0	1,923	**1,923**	2,000	1,923	1,600
Risk of loss of income due to 'fixed' 19/20 cost based contract with Commissioners. Mitigation is early identification of issues and witholding of budget where funding is not forthcoming	(250)	0	250	**0**	0	0	(125)
Opening contract value risk. £0.9m is within LPT position and is covered by additional CIP (albeit CIPs are unidentified). Remaining £2.0m rests with CCGs - the mitigation for this is that it will only be reflected in the contract if definite QIPP/cost reduction can be agreed by both parties.	(2,000)		2,000	**0**	0	0	(892)
Additional £500k CIP linked to the increased NHSI surplus expectation (stretch target). Potential mitigation will be allocation/identification of additional CIP target (tbc)		(500)	0	**(500)**	(500)	(500)	(500)
Capital charges: £270k in-year pressure identified against budget. Opportunity to adopt new valuation method could realise additional savings - £500k estimate included pending further work		(270)	500	**230**	730	230	(270)
Risk that previous IT software VAT reclaims will be rescinded due to a change in HMRC approach. Mitigation is further unrelated VAT reclaims not yet reported.	(240)		240	**0**	167	0	(240)
Potential Recovery Actions Mill Lodge VAT reclaim - HMRC have initially rejected our claim, but independent VAT advisers suggest that the Trust still has a strong case and should pursue via Tax Tribunal. 50% of total relfected here as in previous months. Further 50% balance considered in 'additional financial recovery options' below			365	**365**	730	365	0
Freeze Invest to Save reserve in 2019/20			550	**550**	550	550	550
Cap 2019/20 redundancy costs at £200k			100	**100**	100	100	0
Additional financial recovery options - tbc			2,203	**2,203**	1,838	2,203	700
Trustwide/Corporate total:	**(2,490)**	**(770)**	**8,131**	**4,871**	**5,615**	**4,871**	**823**
Budget variance after net risks, pressures and mitigations	**(4,364)**	**(8,159)**	**12,523**	**0**	**2,080**	**0**	**(6,282)**
Trust plan surplus (includes additional £500k NHSI target)				**2,648**	**2,648**	**2,648**	**2,648**
Net I&E performance				**2,648**	**4,728**	**2,648**	**(3,634)**

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

APPENDIX G – Directorate financial run-rate analysis

DIRECTORATE RUN-RATE PERFORMANCE		2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2019/20	2019/20	2019/20	2019/20	2019/20	2019/20	2019/20	2019/20	2019/20	2019/20	2019/20	2019/20	2019/20	2019/20
		M1-9	M10	M11	M12			M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M7 YTD	
		ACTUAL	ACTUAL	ACTUAL	ACTUAL	AVG.	TOTAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	F'CAST	F'CAST	F'CAST	F'CAST	F'CAST	ACTUAL	AVG.	F'CAST
		£000 YTD	£000 run-rate	£000 run-rate	£000 run-rate	£000 run-rate	£000	£000 run-rate	£000 run-rate	£000 run-rate	£000 run-rate	£000 run-rate	£000 run-rate	£000 run-rate	£000 run-rate	£000 run-rate	£000 run-rate	£000 run-rate	£000 run-rate	£000	£000 run-rate	£000
ADULT MENTAL HEALTH SERVICES	PAY (actual)	-42,232	-4,800	-4,696	-4,672	-4,700	**-56,399**	-3,789	-4,062	-4,087	-4,133	-4,119	-4,285	-4,263	*-4,200*	*-4,194*	*-4,202*	*-4,227*	*-4,218*	**-28,737**	**-4,148**	***-49,778***
	NON-PAY (actual)	-4,707	-479	-655	-712	-546	**-6,553**	-498	-427	-449	-518	-687	-493	-565	*-501*	*-470*	*-448*	*-442*	*-442*	**-3,637**	**-495**	***-5,940***
	INCOME (actual)	57,388	6,411	6,472	6,438	6,392	**76,709**	6,562	6,688	6,605	6,670	6,755	6,627	6,722	*6,708*	*6,708*	*6,708*	*6,708*	*6,708*	**46,628**	**6,681**	***80,168***
	TOTAL NET (actual):	**10,449**	**1,132**	**1,122**	**1,055**	**1,146**	**13,757**	**2,275**	**2,200**	**2,068**	**2,019**	**1,949**	**1,849**	**1,894**	***2,007***	***2,044***	***2,058***	***2,039***	***2,048***	**14,254**	**2,037**	***24,450***
	TOTAL NET BUDGET:	10,907	1,212	1,212	1,213	**1,212**	**14,544**	2,208	2,181	2,181	2,181	2,181	2,181	2,148	*2,148*	*2,148*	*2,148*	*2,148*	*2,148*	**15,262**	**2,167**	***26,002***
	TOTAL VARIANCE:	**-458**	**-80**	**-90**	**-158**	**-66**	**-787**	**67**	**19**	**-113**	**-162**	**-232**	**-333**	**-254**	***-141***	***-104***	***-90***	***-109***	***-100***	**-1,008**	**-129**	***-1,552***
	OAPs **overspend** included in above	**-280**	**18**	**-103**	**-167**	-44	**-532**	**-60**	**26**	**-28**	**-73**	**-188**	**-71**	**-115**	***-59***	***-56***	***-6***	***0***	***0***	**-509**	**-53**	***-630***
	TOTAL VARIANCE EXCLUDING OAPs:	**-178**	**-98**	**13**	**9**	**-21**	**-255**	**127**	**-7**	**-85**	**-89**	**-44**	**-262**	**-139**	***-82***	***-48***	***-84***	***-109***	***-100***	**-499**	**-77**	***-922***
LEARNING DISABILITIES	PAY (actual)	[note: AMH / LD split not applied to prior year]						-937	-895	-869	-821	-894	-805	-848	*-844*	*-824*	*-814*	*-809*	*-809*	**-6,069**	**-848**	***-10,170***
	NON-PAY (actual)							-31	-35	-40	-25	-32	-44	-27	*-34*	*-34*	*-34*	*-34*	*-34*	**-235**	**-34**	***-403***
	INCOME (actual)							-97	-75	-120	-95	-61	-97	-75	*-91*	*-91*	*-91*	*-91*	*-91*	**-620**	**-90**	***-1,074***
	TOTAL NET (actual):							**-1,066**	**-1,006**	**-1,030**	**-942**	**-987**	**-945**	**-950**	***-969***	***-949***	***-939***	***-934***	***-934***	**-6,924**	**-971**	***-11,647***
	TOTAL NET BUDGET:							-923	-923	-923	-923	-923	-923	-923	*-923*	*-923*	*-923*	*-923*	*-923*	**-6,460**	**-923**	***-11,074***
	TOTAL VARIANCE:							**-143**	**-83**	**-107**	**-19**	**-64**	**-22**	**-27**	***-46***	***-26***	***-16***	***-11***	***-11***	**-465**	**-48**	***-574***
COMMUNITY HEALTH SERVICES	PAY (actual)	-54,427	-5,920	-6,016	-6,608	-6,081	**-72,971**	-6,252	-6,184	-6,346	-6,135	-6,151	-6,116	-6,050	*-6,188*	*-6,238*	*-6,198*	*-6,198*	*-6,259*	**-43,234**	**-6,193**	***-74,315***
	NON-PAY (actual)	-6,128	-698	-781	-742	-696	**-8,349**	-647	-537	-617	-623	-678	-647	-613	*-677*	*-676*	*-676*	*-676*	*-676*	**-4,362**	**-645**	***-7,743***
	INCOME (actual)	78,251	8,832	8,781	8,955	8,735	**104,819**	8,690	8,878	8,786	8,836	8,884	8,772	8,872	*8,767*	*8,767*	*8,767*	*8,767*	*8,768*	**61,718**	**8,796**	***105,554***
	TOTAL NET (actual):	**17,696**	**2,214**	**1,984**	**1,605**	**1,958**	**23,499**	**1,791**	**2,157**	**1,823**	**2,078**	**2,055**	**2,009**	**2,209**	***1,902***	***1,853***	***1,893***	***1,893***	***1,833***	**14,122**	**1,958**	***23,496***
	TOTAL NET BUDGET:	17,841	2,240	1,881	1,346	**1,942**	**23,308**	1,856	2,158	1,927	2,128	2,100	2,022	2,149	*1,925*	*1,905*	*1,916*	*1,913*	*1,848*	**14,340**	**1,987**	***23,847***
	TOTAL VARIANCE:	**-145**	**-26**	**103**	**259**	**16**	**191**	**-65**	**-1**	**-104**	**-50**	**-45**	**-13**	**60**	***-23***	***-52***	***-23***	***-20***	***-15***	**-218**	**-29**	***-351***
FAMILIES, YOUNG PEOPLE AND CHILDREN'S SERVICES	PAY (actual)	-33,146	-4,128	-3,869	-3,752	-3,741	**-44,895**	-3,664	-3,971	-4,000	-3,912	-4,173	-3,850	-3,931	*-3,824*	*-3,821*	*-3,824*	*-3,820*	*-3,812*	**-27,503**	**-3,884**	***-46,604***
	NON-PAY (actual)	-2,731	-322	-341	-593	-332	**-3,987**	-284	-263	-294	-312	-338	-294	-302	*-295*	*-298*	*-299*	*-302*	*-308*	**-2,087**	**-299**	***-3,589***
	INCOME (actual)	41,952	4,919	5,283	5,359	4,793	**57,513**	4,570	4,887	4,835	4,836	5,003	4,790	4,844	*4,775*	*4,777*	*4,775*	*4,776*	*4,765*	**33,764**	**4,803**	***57,632***
	TOTAL NET (actual):	**6,075**	**469**	**1,073**	**1,014**	**719**	**8,631**	**621**	**652**	**540**	**612**	**492**	**646**	**611**	***656***	***658***	***652***	***654***	***645***	**4,174**	**620**	***7,439***
	TOTAL NET BUDGET:	6,123	726	763	807	**701**	**8,418**	668	668	668	668	528	688	620	*680*	*680*	*680*	*680*	*670*	**4,509**	**658**	***7,899***
	TOTAL VARIANCE:	**-48**	**-257**	**310**	**207**	**18**	**213**	**-47**	**-16**	**-128**	**-57**	**-36**	**-42**	**-9**	***-24***	***-22***	***-28***	***-26***	***-25***	**-335**	**-38**	***-460***
ESTATES SERVICES	PAY (actual)	-136	-14	-14	-15	-15	**-179**	-26	-29	-30	3	-25	-27	-24	*-27*	*-27*	*-27*	*-27*	*-27*	**-158**	**-24**	***-293***
	NON-PAY (actual)	-23,085	-2,604	-2,605	-2,752	-2,587	**-31,046**	-2,572	-2,574	-2,613	-2,777	-2,653	-2,641	-2,579	*-2,655*	*-2,665*	*-2,656*	*-2,672*	*-2,667*	**-18,409**	**-2,644**	***-31,724***
	INCOME (actual)	1,649	183	182	208	185	**2,222**	219	230	242	300	263	261	218	*263*	*263*	*263*	*263*	*263*	**1,733**	**254**	***3,048***
	TOTAL NET (actual):	**-21,572**	**-2,435**	**-2,437**	**-2,559**	**-2,417**	**-29,003**	**-2,379**	**-2,373**	**-2,401**	**-2,474**	**-2,415**	**-2,407**	**-2,385**	***-2,419***	***-2,429***	***-2,420***	***-2,436***	***-2,431***	**-16,834**	**-2,414**	***-28,969***
	TOTAL NET BUDGET:	-21,010	-2,331	-2,332	-2,331	**-2,334**	**-28,004**	-2,263	-2,263	-2,263	-2,328	-2,281	-2,279	-2,247	*-2,251*	*-2,245*	*-2,245*	*-2,245*	*-2,246*	**-15,924**	**-2,263**	***-27,156***
	TOTAL VARIANCE:	**-562**	**-104**	**-105**	**-228**	**-83**	**-999**	**-116**	**-110**	**-138**	**-146**	**-134**	**-128**	**-138**	***-168***	***-184***	***-175***	***-191***	***-185***	**-910**	**-151**	***-1,813***
HOSTED SERVICES	PAY (actual)	-6,931	-769	-820	-700	-768	**-9,220**	-872	-747	-802	-812	-791	-803	-786	*-813*	*-813*	*-813*	*-813*	*-813*	**-5,613**	**-807**	***-9,678***
	NON-PAY (actual)	-4,209	-576	-760	203	-445	**-5,342**	-301	-342	-705	-330	-292	-371	-514	*-290*	*-300*	*-300*	*-300*	*-299*	**-2,855**	**-362**	***-4,344***
	INCOME (actual)	10,846	1,346	1,543	530	1,189	**14,265**	1,151	1,089	1,502	1,133	1,074	1,150	1,268	*1,059*	*1,062*	*1,062*	*1,062*	*1,062*	**8,367**	**1,140**	***13,674***
	TOTAL NET (actual):	**-294**	**1**	**-37**	**33**	**-25**	**-297**	**-21**	**-1**	**-5**	**-9**	**-9**	**-24**	**-32**	***-44***	***-51***	***-51***	***-51***	***-50***	**-101**	**-29**	***-348***
	TOTAL NET BUDGET:	-26	21	21	-20	**0**	**-4**	13	12	13	13	12	13	13	*13*	*13*	*13*	*12*	*12*	**89**	**13**	***152***
	TOTAL VARIANCE:	**-268**	**-20**	**-58**	**53**	**-24**	**-293**	**-34**	**-13**	**-18**	**-22**	**-21**	**-37**	**-45**	***-57***	***-64***	***-64***	***-63***	***-62***	**-190**	**-42**	***-500***
ENABLING SERVICES	PAY (actual)	-16,615	-1,845	-1,818	-1,676	-1,830	**-21,954**	-1,961	-1,894	-1,906	-1,925	-1,873	-1,952	-1,920	*-1,912*	*-1,909*	*-1,902*	*-1,893*	*-1,883*	**-13,431**	**-1,911**	***-22,930***
	NON-PAY (actual)	-6,375	-654	-674	-585	-691	**-8,288**	-630	-660	-607	-635	-759	-647	-582	*-635*	*-635*	*-634*	*-617*	*-617*	**-4,520**	**-638**	***-7,658***
	INCOME (actual)	8,293	964	1,057	1,163	956	**11,477**	893	916	877	948	918	955	980	*922*	*922*	*922*	*922*	*924*	**6,487**	**925**	***11,099***
	TOTAL NET (actual):	**-14,697**	**-1,535**	**-1,435**	**-1,098**	**-1,564**	**-18,765**	**-1,698**	**-1,638**	**-1,636**	**-1,612**	**-1,714**	**-1,644**	**-1,522**	***-1,625***	***-1,622***	***-1,614***	***-1,588***	***-1,576***	**-11,464**	**-1,624**	***-19,489***
	TOTAL NET BUDGET:	-14,992	-1,591	-1,482	-1,441	**-1,626**	**-19,506**	-1,710	-1,628	-1,630	-1,629	-1,763	-1,719	-1,666	*-1,624*	*-1,624*	*-1,624*	*-1,624*	*-1,625*	**-11,745**	**-1,656**	***-19,866***
	TOTAL VARIANCE:	**295**	**56**	**47**	**343**	**62**	**741**	**12**	**-10**	**-6**	**17**	**49**	**75**	**144**	***-1***	***2***	***10***	***36***	***49***	**281**	**31**	***377***
CENTRAL RESERVES	PAY (actual)	3,362	-150	77	-4,327	-87	**-1,038**	133	-79	411	-150	267	331	-188	*-210*	*-248*	*-285*	*-320*	*-321*	**725**	**-55**	***-659***
	NON-PAY (actual)	-2,559	-232	-340	-1,277	-367	**-4,408**	-832	-743	-689	-544	-611	-684	-618	*-505*	*-475*	*-460*	*-460*	*-453*	**-4,721**	**-590**	***-7,074***
	INCOME (actual)	3,757	605	684	5,862	909	**10,908**	1,162	1,132	985	1,134	996	1,082	1,261	*1,110*	*1,110*	*1,110*	*1,086*	*1,078*	**7,753**	**1,104**	***13,247***
	TOTAL NET (actual):	**4,560**	**223**	**421**	**258**	**455**	**5,462**	**463**	**310**	**707**	**440**	**652**	**729**	**455**	***395***	***387***	***365***	***306***	***304***	**3,757**	**459**	***5,514***
	TOTAL NET BUDGET:	3,467	257	391	401	**376**	**4,516**	137	96	93	1	169	230	186	*330*	*350*	*372*	*386*	*495*	**912**	**237**	***2,844***
	TOTAL VARIANCE:	**1,093**	**-34**	**30**	**-143**	**79**	**946**	**326**	**214**	**614**	**439**	**483**	**499**	**269**	**65**	**37**	**-7**	**-80**	**-191**	**2,845**	**222**	***2,670***

APPENDIX G (cont'd) – Financial run-rate analysis and SOF modelling

TOTAL RUN-RATE PERFORMANCE		2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2019/20	2019/20	2019/20	2019/20	2019/20	2019/20	2019/20	2019/20	2019/20	2019/20	2019/20	2019/20	2019/20	2019/20
		M1-9	M10	M11	M12			M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M0 YTD	
		ACTUAL	ACTUAL	ACTUAL	ACTUAL	AVERAGE	TOTAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	F'CAST	F'CAST	F'CAST	F'CAST	F'CAST	ACTUAL	AVERAGE	F'CAST
		£000 YTD	£000 run-rate	£000 run-rate	£000 run-rate	£000 run-rate	£000	£000 run-rate	£000 run-rate	£000 run-rate	£000 run-rate	£000 run-rate	£000 run-rate	£000 run-rate	£000 run-rate	£000 run-rate	£000 run-rate	£000 run-rate	£000 run-rate	£000	£000 run-rate	£000
OPERATIONAL TOTAL	PAY (actual)	-153,487	-17,476	-17,233	-17,423	-17,135	**-205,618**	-17,501	-17,783	-18,041	-17,736	-18,026	-17,838	-17,821	*-17,809*	*-17,826*	*-17,780*	*-17,787*	*-17,821*	**-124,745**	**-17,814**	***-213,768***
	NON-PAY (actual)	-47,235	-5,333	-5,816	-5,181	-5,297	**-63,565**	-4,963	-4,839	-5,325	-5,220	-5,439	-5,137	-5,182	*-5,086*	*-5,077*	*-5,046*	*-5,043*	*-5,043*	**-36,105**	**-5,117**	***-61,401***
	INCOME (actual)	198,379	22,655	23,318	22,653	22,250	**267,005**	21,987	22,613	22,726	22,627	22,837	22,458	22,829	*22,403*	*22,408*	*22,406*	*22,407*	*22,399*	**158,076**	**22,508**	***270,101***
	TOTAL NET (actual):	**-2,343**	**-154**	**270**	**50**	**-181**	**-2,178**	**-476**	**-9**	**-641**	**-328**	**-628**	**-516**	**-175**	***-492***	***-496***	***-420***	***-423***	***-464***	**-2,774**	**-422**	***-5,069***
	TOTAL NET BUDGET:	**-1,157**	**277**	**63**	**-426**	**-104**	**-1,244**	**-151**	**206**	**-26**	**111**	**-146**	**-17**	**94**	***-32***	***-46***	***-35***	***-39***	***-116***	**71**	**-16**	***-196***
	TOTAL VARIANCE:	**-1,186**	**-431**	**207**	**476**	**-78**	**-934**	**-326**	**-214**	**-614**	**-439**	**-483**	**-500**	**-269**	***-460***	***-450***	***-386***	***-384***	***-349***	**-2,845**	**-406**	***-4,873***
TRUST TOTAL	PAY (actual)	-150,125	-17,626	-17,156	-21,750	-17,221	**-206,656**	-17,368	-17,862	-17,630	-17,886	-17,759	-17,507	-18,009	*-18,019*	*-18,074*	*-18,065*	*-18,107*	*-18,142*	**-124,020**	**-17,869**	***-214,427***
	NON-PAY (actual)	-49,794	-5,565	-6,156	-6,458	-5,664	**-67,973**	-5,795	-5,582	-6,014	-5,764	-6,050	-5,821	-5,800	*-5,591*	*-5,552*	*-5,506*	*-5,503*	*-5,496*	**-40,826**	**-5,706**	***-68,475***
	INCOME (actual)	202,136	23,260	24,002	28,515	23,159	**277,913**	23,149	23,745	23,711	23,761	23,833	23,540	24,090	*23,513*	*23,518*	*23,516*	*23,493*	*23,477*	**165,829**	**23,612**	***283,347***
	TOTAL NET (actual):	**2,217**	**69**	**691**	**308**	**274**	**3,284**	**-13**	**301**	**67**	**112**	**24**	**213**	**280**	***-97***	***-109***	***-55***	***-117***	***-160***	**983**	**37**	***445***
	TOTAL NET BUDGET:	**2,310**	**534**	**454**	**-25**	**273**	**3,272**	**-14**	**302**	**67**	**112**	**23**	**213**	**280**	***298***	***304***	***337***	***347***	***379***	**983**	**221**	***2,648***
	TOTAL VARIANCE:	**-93**	**-465**	**237**	**333**	**1**	**12**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	***-395***	***-413***	***-392***	***-464***	***-539***	**0**	**-184**	***-2,203***
	CUMULATIVE VARIANCE							**0**	**0**	**0**	**0**	**0**	**0**	**0**	***-395***	***-807***	***-1,200***	***-1,664***	***-2,203***			

PSF MODELLING - IMPACT OF LOST PSF ON I&E POSITION	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2019/20	2019/20	2019/20	2019/20	2019/20	2019/20	2019/20	2019/20	2019/20	2019/20	2019/20	2019/20	2019/20	2019/20
	M1-9	M10	M11	M12			M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M0 YTD	
	ACTUAL	ACTUAL	ACTUAL	ACTUAL	AVERAGE	TOTAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	F'CAST	F'CAST	F'CAST	F'CAST	F'CAST	ACTUAL	AVERAGE	F'CAST
	£000 YTD	£000 run-rate	£000 run-rate	£000 run-rate	£000 run-rate	£000	£000 run-rate	£000 run-rate	£000 run-rate	£000 run-rate	£000 run-rate	£000 run-rate	£000 run-rate	£000 run-rate	£000 run-rate	£000 run-rate	£000 run-rate	£000 run-rate	£000	£000 run-rate	£000
Cumulative YTD variance (from above) by quarter									**0**			**0**			***-807***			***-2,203***			***-2,203***
PSF income by month							107	107	108	143	143	144	215	215	214	251	251	250			**2,148**
PSF income by quarter									**322**			**430**			**644**			**752**			**2,148**
PSF income lost based on above forecast									**0**			**0**			**-644**			**-752**			***-1,396***
Forecast run-rate variance, including lost PSF income							**0**	**0**	**0**	**0**	**0**	**0**	**0**	***-395***	***-1,057***	***-392***	***-464***	***-1,291***			***-3,599***
Forecast cumulative variance, including lost PSF income							**0**	**0**	**0**	**0**	**0**	**0**	**0**	***-395***	***-1,451***	***-1,844***	***-2,308***	***-3,599***			***-3,599***
Forecast cumulative I&E surplus/deficit, including lost PSF income							**1**	**82**	**168**	**298**	**482**	**696**	**983**	***886***	***134***	***78***	***-39***	***-951***			***-951***
SOF MODELLING (based on cuml YTD position building in loss of PSF income Q3 and Q4):																					
Capital service cover rating							**2**	**2**	**2**	**2**	**2**	**2**	**2**	***2***	***2***	***2***	***2***	***2***			
Liquidity rating							**1**	**1**	**1**	**1**	**1**	**1**	**1**	***1***	***1***	***1***	***1***	***1***			
I&E margin rating							**2**	**2**	**2**	**2**	**2**	**2**	**2**	***2***	***2***	***2***	***2***	***3***			
I&E margin: distance from financial plan							**1**	**1**	**1**	**1**	**1**	**1**	**1**	***2***	***2***	***2***	***2***	***2***			
Agency rating							**3**	**3**	**3**	**3**	**3**	**3**	**3**	***3***	***3***	***3***	***3***	***3***			
TOTAL RATING:							**2**	**2**	**2**	**2**	**2**	**2**	**2**	***2***	***2***	***2***	***2***	***2***			
							1.80	1.80	1.80	1.80	1.80	1.80	1.80	*2.00*	*2.00*	*2.00*	*2.00*	*2.20*			

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board – 3 December 2019
Paper number	Oi

Name of Report Integrated Quality and Performance Report

For approval		For assurance	X	For information	

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

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

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

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

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

1 Introduction/ Background

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

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

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

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

Segment Rating	3 - Providers receiving mandated support for significant concerns

2 Aim

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

3 Discussion

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

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

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

4 Quality Assurance Committee (QAC)

NHS Improvement (NHSI) quality of care indicators

4.1 There is two identified NHSI trigger(s) in 2019/20 quarter three relating to the care programme approach seven day (CPA seven day) and clostridium difficile occurrence indicator.

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

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

4.3 Performance for patients discharged on CPA during September 2019 is 91.2% against a national lower limit target of 95% (reported one month in arrears).

4.4 The performance for all patients discharged on CPA and on non-CPA during September 2019 is 89.2% against a national lower limit target of 95% (reported one month in arrears). Based on the SPC chart, there is special cause improvement of CPA 7 Day rates since July 2018; however the Trust will inconsistently meet the target of >=95% unless further improvements are made.

4.5 In September 2019, there were seventeen (17) patients recorded who breached the CPA seven day standard – of which, six were not contacted with attempts made; one not contacted with no attempt made; ten data quality issues identified classifying it as breaches in the month. A record of year to date data quality errors affecting this indicator are retained to support the audit for this Quality Account indicator.

4.6 The 2019/20 trajectory for clostridium difficile (C. Diff) has been set by the Leicester, Leicestershire and Rutland (LLR) clinical commissioning groups (CCGs) as an upper limit of twelve cases per annum. There has been one (1) reported case for Clostridium difficile during the month of October 2019 at East Ward, Hinckley and Bosworth Hospital. The year to date total occurrences of C.Diff is four (4). If this level of quality is sustained, the Trust can receive assurance of meeting this year-end target. Based on the SPC chart, there is no significant change to the number of reported cases since April 2018; and the Trust will consistently meet the trajectory. (See Annex A - detailed exception report – clostridium difficile (C Diff) cases).

Trust quality of care indicators

4.7 The CPA 12 month standard performance as at October 2019 is 92.4% against a lower limit threshold of 95%. The performance continues to improve following the implementation of patient level reporting and reminders to care co-ordinator. As per the new process, the circumstances leading to patients not receiving their 12 month review in a timely manner will be investigated following escalation to the appropriate manager(s). Based on the SPC chart, there is special cause improvement of CPA 12 month rates since December 2018; however the Trust will consistently fail the target of >=95% unless further improvements are made. (See Annex A - detailed exception report – CPA 12 month review).

NHS Improvement (NHSI) organisational health indicators

4.8 There are zero (0) identified NHSI trigger in October 2019.

4.9 Staff sickness absence remains above target at 4.9% in September 2019 (reported one month in arrears) – of which, 2.9% is long term sickness and 2.0% is short term sickness. Support to manage staff sickness absence is pro-actively offered to managers by the human resources department.

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

4.11 Staff turnover (normalised) was 8.8% for October 2019, which meets the Trust threshold of performing at less than 10% for a rolling twelve month period.

Trust human resources – workforce performance indicators

4.12 The Trust vacancy rate in October 2019 remains at 8.8%, which is above the upper limit threshold of 7%.

4.13 Cumulative year-to-date Trust agency costs were £6,008K as at 31 October 2019 (month 7). This is above the planned spend of £4,775k for the same period. The October year-to-date NHSI agency ceiling target is £4,737k. This Trust is exceeding this limit by £1,271k.

5 Finance and Performance Committee (FPC)

NHS Improvement (NHSI) use of resources indicators

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

5.2 As at 2019/20 month 07, the year to date financial assessment is scored at two (2). The 2019/20 forecast outturn score is also two (2).

NHS Improvement (NHSI) operational performance indicators

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

5.4 The Trust continues to meet its national access targets for six week diagnostic services and two week early intervention in psychosis services. The Trust failed to meet its target for 18 week referral to treatment (RTT) services with performance at 86.2% against a lower limit threshold of 92% for incomplete waits. Breaches occurred due to demand outstripping capacity. The Trust has no patients waiting more than 52 weeks for treatment on RTT pathways (see Annex A – detailed exception report – national access standards).

5.5 Inappropriate adult mental health out of area (OOA) bed days have shown an overall reduction since April 2018 as the Trust works to reduce mental health OOA bed days to zero by 2020/21. Over the last 12 months, the Trust has seen a sustained decline in OOA bed days from 1673 in 2018/19 quarter one to 1364 in 2019/20 quarter one. Quarter two bed days are showing as 2711. October 2019 OOA Bed days are showing as 663.

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

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

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

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

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

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

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

5.12 The July 2019 DQMI MHSDS compliance rate has decreased to 88.0% from 90.6% the previous month. Targeted actions are in place to identify the cause of the decline with a view to see improvements during 2019/20 quarter two (See Annex A – detailed exception report – data quality maturity index (DQMI)).

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

5.14 2019/20 quarter two gate keeping performance is achieved 99.1% against a lower limit threshold of 95%. It should be noted; the monthly performance breakdown for this quarter to date is 98.8% in October 2019, which suggests the improvements made over the period following the implementation and embedding of the new gatekeeping protocol from April 2019 had the desired impact. This indicator will continue to be closely monitored in the directorate to maintain the level of improvements.

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

Trust operational performance indicators

5.16 The management of patients experiencing a delayed transfer of care (DToC) remains high on the Trust agenda. As at October 2019, the Trust is above the 3.5% upper limit threshold at 4.4%. It should be noted the Leicester, Leicestershire and Rutland (LLR) DToC rate, which incorporates delays in the acute trust and LLR patients delayed in non-LLR hospitals is within the target threshold.

6 Conclusion

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

7 Recommendations

1 The Trust Board is recommended to:

i. Receive assurance with regard to areas of quality and performance where performance improvement action is being undertaken;
ii. Receive the NHSI compliance segment rating of three.

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

8 Appendices

Appendix one – description of NHSI segmentation

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

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

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

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

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

Leicestershire Partnership NHS Trust

Integrated Quality and Performance Report

Advancing health and well-being

End of October 2019 Position

Data to 31 October 2019 unless otherwise stated

Previous month's data refreshed where available

Leicestershire Partnership NHS Trust

Contents

NHS Improvement Themes of the Single Oversight Framework

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

Segment Rating: 3

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

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

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

Leicestershire Partnership NHS Trust

NHS Improvement Quality of Care Metrics

	NHSI Sector	Indicator	NHSI Monitoring Frequency	Monthly Performance: Reporting Period (rolling three months) Aug-19	Sep-19	Oct-19	Sparkline YTD	Quarterly Performance: 2018/19 Q4	2019/20 Q1	Q2	Q3	Q4	Annual Performance: 2018/19 Year End Total	2019/20 Year to Date Total	Trigger (two consecutive monthly breaches)	Current month directorate performance: Adult Mental Health/ Learning Disabilities	Community Health	Families, Young People & Children	Enabling Services	Comments
SAFE	All	**Occurrence of any Never Event**	Monthly *(six month rolling)*	**0**	**0**	**0**		**0**	**0**	**0**			**1**	**0**	0	**0**	**0**	**0**	**0**	Methodology: count of 'never events' in rolling six- month period
	All	**NHS England/NHS Improvement Patient Safety Alerts not completed by deadline**	Monthly	**0**	**0**	**0**		**0**	**0**	**0**			**0**	**0**	0	**0**	**0**	**0**	**0**	Methodology: number of NHS England or NHS Improvement patient safety alerts outstanding in most recent monthly snapshot
	Acute	**VTE Risk Assessment**	Monthly	**238**	**261**	**260**		**793**	**737**	**745**			**3249**	**1742**	0		**260**			
	Acute	**Clostridium Difficile Occurrence (against contractual year to date target of 12)**	Monthly	**1**	**1**	**1**		**2**	**1**	**2**			**5**	**4**	1	**0**	**1**	**0**		
	Acute	**Clostridium Difficile - infection rate (per 100,000 bed days)**	Monthly	**39.93**	**38.2**	**37.09**		**26.74**	**13.06**	**26.32**			**13.06**	**22.28**	0	**0**	**36.47**	**0**		Source of methodology is DoH website Cdiff annual data report
	Mental Health	**Admissions to adult facilities of patients who are under 16 years**	Monthly	**0**	**0**	**0**		**0**	**0**	**0**			**1**	**0**	0	**0**	**0**	**0**		Methodology: number of children and young persons under 16 who are admitted to adult wards
EFFECTIVE	Mental Health	**Care Programme Approach (CPA) follow up - proportion of discharges from hospital followed up within 7 days**	Monthly	**92.6%**	**89.2%**			**94.6%**	**93.1%**	**90.8%**					1					Methodology: proportion of discharges from general psych wards followed up within 7 days (including MHSOP)
	Mental Health	**% clients in employment (two months in arrears)**	Monthly	*Not due*	*Not due*	*Not due*		**0.0%**	**2.0%**	*Not due*					0	**2.0%**				Methodology: percentage of people aged 18 to 69 period in contact with mental health services in employment Latest data is for July 2019 Low performance is linked to a technical submission issue and is not reflective of practice. Work continues with NHS Digital to resolve the reported performance
	Mental Health	**% clients in settled accommodation (two months in arrears)**	Monthly	*Not due*	*Not due*	*Not due*		**37.0%**	**36.0%**	*Not due*					0	**36.0%**				Methodology: percentage of people aged 18 to 69 in contact with mental health services in settled accommodation Latest data is for July 2019
CARING	All	**Written complaints - rate**	Quarterly	**56.0%**	**72.2%**	**62.5%**		**68.2%**	**70.2%**	**67.2%**			**70.2%**	**68.3%**	0	**28.6%**	**87.5%**	**100.0%**		Methodology: count of written complaints/ count of total complaints
	Acute	**Mixed sex accommodation breaches (sleep breaches only)** *National methodology aligned to NHS England guidance*	Monthly	**0**	**0**	**0**		**0**	**0**	**0**			**0**	**0**	0	**0**	**0**	**0**		Methodology: The number of breaches of mixed-sex accommodation (MSA) sleeping accommodation
	All	**Staff Friends and Family Test % recommended - care**	Quarterly			**69.0%**									0					
	Acute	**Inpatient scores from Friends & Family Test - % positive**	Monthly	**95.9%**	**94.2%**	**95.0%**									0	**82.5%**	**96.4%**	**0.0%**		Methodology: count of those categorised as extremely likely or likely to recommend/ count of all responders
	Community	**Community scores from Friends & Family Test - % positive**	Monthly	**96.5%**	**96.2%**	**96.9%**									0	-	**96.6%**	**98.1%**		Methodology: count of those categorised as extremely likely or likely to recommend/ count of all responders
	Mental Health	**Mental Health scores from Friends & Family Test - % positive**	Monthly	**94.0%**	**91.2%**	**95.9%**									0	**91.7%**	**100.0%**	**100.0%**		Methodology: count of those categorised as extremely likely or likely to recommend/ count of all responders

Identified Triggers	2

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

NHS Improvement Financial and Use of Resources Metrics (2019/20 M7)

Area	Weighting	Metric	Definition	Scoring				YTD Score/ weighted score		F/OT Score/ weighted score	
				1	2	3	4				
				Year to Date (YTD)		Forecast/ Outturn (F/OT)					
Financial sustainability	0.2	Capital servicing capacity	Degree to which provider's generated income covers its financial obligations	>=2.5x	1.75 - 2.5x	1.25 - 1.75x	<1.25x	2	0.4	2	0.4
				2.2		2.3					
	0.2	Liquidity (days)	Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown	>=0	(7) - 0	(14) - (7)	<(14)	1	0.2	1	0.2
				11.3		4.8					
Financial efficiency	0.2	Income and expenditure (I&E) margin	I&E surplus or deficit / total revenue	>=1%	0-1%	(1) - 0%	<=(1%)	2	0.4	2	0.4
				0.59%		0.77%					
Financial controls	0.2	Distance from financial plan	Year-to-date actual I&E margin (surplus/deficit) in comparison to year-to-date plan I&E margin (surplus/deficit) on a control basis	>=0%	(1)-0%	(2) - (1%)	<=(2)%	1	0.2	2	0.4
				0.00%		-0.20%					
	0.2	Agency spend	Distance from provider's cap	<=0%	0% - 25%	25 - 50%	>50%	3	0.6	2	0.4
				26.8%		16.8%					

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

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

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

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

NHS Improvement Operational Performance

	NHSI Sector	Indicator	Target	NHSI Monitoring Frequency	Monthly Performance: Reporting Period (rolling three months) Aug-19	Sep-19	Oct-19	Sparkline YTD	Quarterly Performance: 2018/19 Q4	2019/20 Q1	Q2	Q3	Q4	Annual Performance: 2018/19 Year End Total	2019/20 Year to Date Total	Trigger (two consecutive monthly breaches)	Current month directorate performance: Adult Mental Health/ Learning Disabilities	Community Health	Families, Young People & Children	Comments
OPERATIONAL PERFORMANCE METRICS	Acute & Specialist	**Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway**	>=92%	Monthly	**92.4%**	**92.6%**	**86.2%**		**96.5%**	**96.8%**	**93.1%**			**96.8%**	**93.6%**	0	**86.2%**			Methodology: count of the number of patients whose clock period is less than 18 weeks during the calendar months of the return/ count of number of patients whose clock has not stopped during the calendar months of the return
	Acute & Specialist	**Maximum 6-week wait for diagnostic procedures - patients on an incomplete pathway**	>=99%	Monthly	**100.0%**	**100.0%**	**100.0%**		**100.0%**	**100.0%**	**100.0%**			**100.0%**	**100.0%**	0			**100.0%**	Methodology: proportion of patients referred for diagnostic tests who have been waiting for less than six weeks
	Mental Health	**People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral (SDCS and MHSDS) - patients on a completed pathway**	>=53%	Quarterly *(three month rolling)*	**81.3%**	**65.2%**	**66.7%**		**76.5%**	**83.3%**	**75.4%**			**83.3%**	**76.5%**	0			**66.7%**	Methodology: percentage of people with a first episode of psychosis beginning treatment with a NICE-recommended care package within two weeks of referral
		Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas:																		
	Mental Health	**a) Inpatient Wards**	>=90%	Annually												0				Methodology: the number of patients in the defined audit sample who have both: - a completed assessment for each of the cardio-metabolic parameters with results documented in the patient's electronic care record held by the secondary care provider. - a record of interventions offered where indicated, for patients who are identified as at risk as per the red zone of the Lester Tool. a) Internal mental health provider sample submitted to national audit provider for the CQUIN b) Early intervention: Internal mental health provider sample submitted to the Royal College of Psychiatrists CCQI EIP Network c) Mental health: Internal mental health provider sample submitted to national audit provider for the CQUIN
		b) Early Intervention in Psychosis Services	>=90%	Annually												0				
		c) Community Mental Health Services (people on CPA)	>=65%	Annually												0				
	Mental Health	**Inappropriate adult mental health out of area placements (OAPs)**	0 by March 2020	Monthly	**1248**	**736**	**663**		**538**	**1364**	**2711**			**3462**	**4738**	0				Methodology: Total number of bed days patients have spent out of area in period This measure should show a demonstrable reduction in total number of bed days patients have spent inappropriately out of area against rolling annual baseline, working towards elimination of inappropriate out of area placements by 2020/21
	Mental Health	**Data quality maturity index (DQMI) score (mental Health services only)**	>=95%	Quarterly	See DQMI exception report for details				*not yet available*							0				Methodology: MHSDS quarterly score in DQMI (ethnic category, general medical practice code (patient registration), NHS number, organisation code (code of commissioner), person stated gender code, postcode of usual address)

Identified Triggers	0

NHS Improvement Organisational Health

	NHSI Sector	Indicator	NHSI Monitoring Frequency	Monthly Performance: Reporting Period (rolling three months) Aug-19	Sep-19	Oct-19	Current Year to Date Total	Quarterly Performance: 2018/19 Q4	2019/20 Q1	Q2	Q3	Q4	Annual Performance: 2018/19 Year End Total	2019/20 Year to Date Total	Trigger (two consecutive monthly breaches)	Current month directorate performance: Adult Mental Health/ Learning Disabilities	Community Health	Families, Young People & Children	Enabling Services	Comments
ORGANISATIONAL HEALTH	All	**Staff Sickness (month in arrears)**	Monthly	**4.8%**	**4.9%**			**4.3%**	**4.5%**	**4.8%**			**4.9%**	**not due**	0	**5.5%**	**5.1%**	**5.1%**	**2.9%**	Methodology: number of days sickness reporting within the month/ number of days available within the month
	All	**Staff Turnover**	Monthly	**8.5%**	**8.7%**	**8.8%**			*not applicable to quarterly reporting*				**9.6%**		0	**9.6%**	**9.1%**	**8.8%**	**6.4%**	Methodology: number of leavers reported within the period / average of number of total employees at end of the month and total employees at end of the month for previous 12 month period
	All	**NHS Staff Survey** Key Finding 2. Staff satisfaction with the quality of work and care they are able to deliver	Annual	**3.69**					*not applicable to quarterly reporting*						0					2018 staff survey results Methodology: staff recommendation of the organisation as a place to work or receive treatment
	All	**Proportion of Temporary Staff**	Monthly	**12.2%**	**13.3%**	**12.1%**		**12.2%**	**12.7%**	**13.3%**					0					Methodology: agency staff costs (as defined in measuring performance against the provider's cap) as a proportion of total staff costs. Calculated by dividing total agency spend over total pay bill.
	Acute	**CQC Inpatient/MH and Community Survey: Community**	Annual	**6.1**					*not applicable to quarterly reporting*						0					Survey results for 2018. Rating of Overall Experience out of 10.0, where 10.0 is the highest rating.
	Mental Health	**CQC Inpatient/MH and Community Survey: Mental Health**	Annual	**6.6**					*not applicable to quarterly reporting*						0					Survey results for 2018. Rating of Overall views of care and services out of 10.0, where 10.0 is the highest rating.

Identified Triggers	0

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

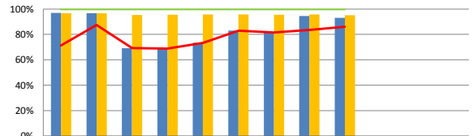
Nationally Comparable Performance

This section of the report aims to collate nationally published performance data and show both local Trust and wider LLR STP performance. This information is generally used to support performance conversations with Trust regulators and is available for the public to view.
- www.england.nhs.uk/statistics/statistical-work-areas
- www.england.nhs.uk/publication/mental-health-five-year-forward-view-dashboard

LPT Nationally comparable Performance

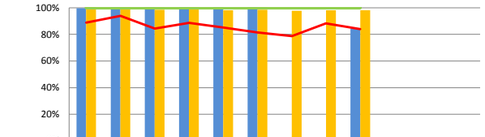
LPT Level Information	Benchmarking comparisons are taken from NHS England's official statistics publications. Each graph show the Leicestershire Partnership NHS Trust performance against the highest and lowest performing trusts in that period **IMPORTANT**: National data conforms to strict data quality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

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



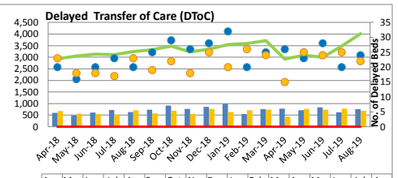
	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20
LPT	96.9%	96.7%	69.2%	68.8%	73.4%	83.0%	81.6%	94.6%	93.1%			
England	96.7%	96.7%	95.4%	95.5%	95.8%	95.7%	95.5%	95.8%	95.1%			
Highest	100.0%	100.0%	100.0%	100.0%	100.0%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

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



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

Delayed Transfer of Care (DToC)

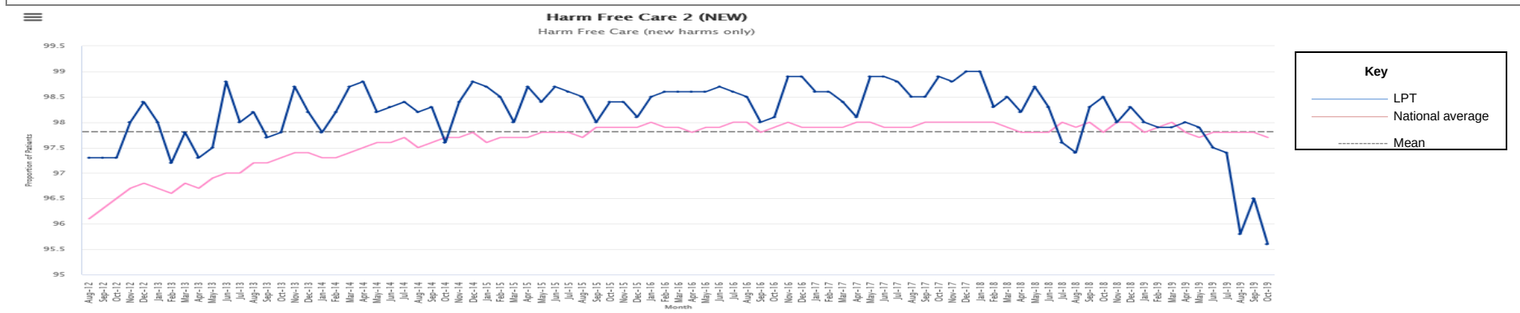


	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
LPT Days Delayed	600	490	613	719	631	737	912	767	862	994	548	762	775	709	840	618	759
UHL Days Delayed	682	563	544	527	711	574	689	554	768	632	717	739	435	768	730	784	688
Highest Days Delayed	2927	3059	3130	3106	3244	3326	3480	3231	3345	3542	3588	3718	2915	3087	2996	3480	4023
Lowest Days Delayed	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
LPT Ave. people delayed per day	20	16	20	23	20	25	29	26	28	32	20	25	26	23	28	20	24
UHL Ave. people delayed per day	23	18	18	17	23	19	22	18	25	20	26	24	15	25	24	25	22

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

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

Harm Free Care 2 (NEW)
Harm Free Care (new harms only)

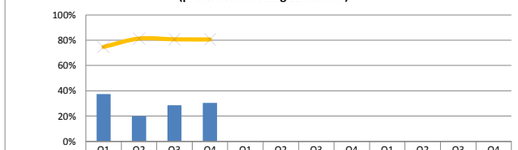


Comments:
Patient Safety Thermometer: The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing 'harm free' care. The data shown relates to prevalence of harm (VTEs, falls, pressure ulcers, UTIs), collected on a specific day; and is not directly comparable to the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

LLR STP Nationally Comparable Data

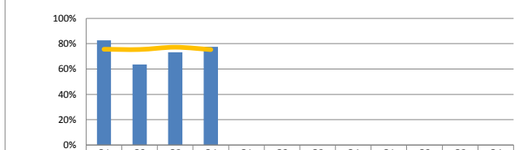
LLR STP Level Information	Benchmarking comparisons are taken from NHS England's 'Mental Health Five Year Forward View' dashboard Each graph shows the Leicester, Leicestershire and Rutland performance at an STP level

CAMHS Eating Disorder - Urgent Complete Waits (1 week) (presented as rolling 12 months)



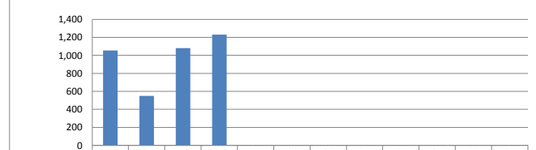
	Q1 2018-19	Q2 2018-19	Q3 2018-19	Q4 2018-19	Q1 2019-20	Q2 2019-20	Q3 2019-20	Q4 2019-20	Q1 2020-21	Q2 2020-21	Q3 2020-21	Q4 2020-21
LLR STP	37.5%	20.0%	28.6%	30.4%								
England	74.7%	81.3%	80.7%	80.6%								

Early Intervention in Psychosis - 2 Week Complete Waits



	Q1 2018-19	Q2 2018-19	Q3 2018-19	Q4 2018-19	Q1 2019-20	Q2 2019-20	Q3 2019-20	Q4 2019-20	Q1 2020-21	Q2 2020-21	Q3 2020-21	Q4 2020-21
LLR STP	82.7%	63.6%	73.3%	77.6%								
England	75.6%	75.4%	77.2%	75.3%								

No. of Inappropriate MH Bed Days (Out of Area)



	Q1 2018-19	Q2 2018-19	Q3 2018-19	Q4 2018-19	Q1 2019-20	Q2 2019-20	Q3 2019-20	Q4 2019-20	Q1 2020-21	Q2 2020-21	Q3 2020-21	Q4 2020-21
LLR STP	1055	550	1080	1230								

Comments:

Leicestershire Partnership NHS Trust

Trust Quality of Care

		Trust Performance													Current month directorate performance					
		Source	Reporting Frequency	Quality Indicator	Reporting Period (rolling three months) Aug-19	Sep-19	Oct-19	Sparkline YTD	2018/19 Q4	2019/20 Q1	Q2	Q3	Q4	Year to Date Position	Year End Target	Adult Mental Health/ Learning Disabilities	Community Health	Families, Young People & Children	Enabling Services	3rd party/ External	Comments
SAFE	Total incidents reported (including near misses) taken from Safeguard	TRUST	Monthly		1578	1498	1586		4316	4579	4908			11001		636	679	148	13	110	
	- of which Total Serious Incidents (SIs)	COM	Monthly		2	26	1		14	30	42			74		0	0	1	0	0	
	STEIS - SI action plans implemented within timescales	COM	Monthly	=100%	90.9%	100.0%	-		96.3%	100.0%	93.7%			94.8%	=100%	-	-	-			
	Total patient safety incidents reported (including near misses) (NRLS)	TRUST	Monthly		938	917	996		2753	2728	3008			6705		460	419	107	10		
	MRSA Bacteraemia cases - Community	COM	Monthly		0	0	0		0	0	0			0	0	0	0	0			
	Clostridium Difficile (C Diff) Occurrence	COM	Monthly	<=12 (per annum)	1	1	1		2	1	2			4	12	0	1	0			
	NHSE/ NHSI Patient Safety Alerts Outstanding	NHSI	Monthly	=0	0	0	0		0	0	0			0	0	0	0	0			
CARING	Total compliments received	TRUST	Monthly		99	50	108		243	298	272			678		33	61	14	0		
	Total complaints received	TRUST	Monthly		25	18	16		107	84	64			164		7	8	1	0		
	Complaints acknowledged within 3 working days	TRUST	Monthly	=100%	100.0%	100.0%	100.0%		100.0%	98.8%	100.0%			99.3%	=100%	100.0%	100.0%	100.0%			
EFFECTIVE	Meeting commitment to serve new psychosis cases by early intervention teams: % newly diagnosed cases against commissioner contract	COM	Monthly	>=95%	136.4%	181.8%	209.1%		145.5%	136.4%	169.7%			161.0%	>=95%			209.1%			
	Care Programme Approach (CPA) patients: % receiving follow-up contact within seven days of discharge (in arrears)																				
	- Only patients identified as being discharged on CPA	TRUST	Monthly	>=95%	94.1%	91.2%			96.8%	95.6%	94.0%			94.7%	>=95%	88.0%	100.0%	100.0%			
	- All patients discharged from a psychiatric inpatient unit *(national methodology aligned to Quality Account)*	TRUST	Monthly	>=95%	92.6%	89.2%			94.6%	93.1%	90.8%			91.9%	>=95%	86.6%	97.2%	100.0%			
	Care programme approach (CPA) patients: % having formal review within 12 months	TRUST	Monthly	>=95%	90.8%	89.0%	92.4%							92.4%	>=95%	92.8%	99.0%	79.2%			
	Access to Healthcare for All		Monthly	=4	4	4	4		4	4	4			4	4						

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

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

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

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

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

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

Clostridium Difficile (C Diff) Occurrence: The trajectory for 2019-20 for Clostridium difficile is twelve (12). There has been 1 reported case for Clostridium difficile during the month of October 2019 at East Ward, Hinckley and Bosworth Hospital.

Compliments: All figures received are subject to continual validation and any changes will be reported in the next IQPR.

Complaints: All figures received are subject to continual validation and any changes following data validation will be reported in the next IQPR.

Complaints Acknowledged within 3 working days: 1 acknowledgement letter did not meet the 3 working day target for April 2019. The complaint was for Community Services and was very complex with issues from 2013. Due to this the acknowledgement was also used to advise some of the issues were out of time to be investigated and the letter therefore took longer to compose due to needing to tailor the information.

Meeting commitment to serve new psychosis cases by early intervention teams - % newly diagnosed cases against commissioner contract: The small numbers involved in the denominator for the calculation of this indicator can equate to significant swings in performance month on month. The figures are refreshed each month to ensure an accurate position is monitored and accounts for data entry after IQPR production cut off. The service enters data by the 15th of the month therefore performance maybe underinflated due to the early deadline set for the IQPR. 209.1% for the month of October 2019 is the result of 23 newly diagnosed cases against the provisional monthly commissioner target of 11. The service is dependent on the number of referrals received and the appropriateness of the referral.

Care Programme Approach (CPA) patients: % receiving follow-up contact within seven days of discharge (All patients discharged from a psychiatric inpatient unit): The Trust has undertaken a deep dive data quality review on CPA 7 day data. The outcome is an improvement in 2018/19 Q1 performance in line with the Q2 performance of approximately 80%. We are awaiting confirmation from NHS Digital to resubmit this information nationally. The reported position for August 2019 contains three data quality errors.

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

National CCG CQUINS 2019-20

CQUIN No	Description	Min Threshold	Max Threshold		Q1	Q2	Q3	Q4	Commentary
CCG 2	Staff Flu Vaccinations	60%	80%				**50.0%**	**80.0%**	Currently meeting all objectives outlined in the Trust Flu strategy plan.
CCG 3a	Alcohol & Tobacco- Screening	40%	80%			**50.0%**	**80.0%**	**80.0%**	2019/20 Q1 requirements are to provide a position statement. New systems are in place to capture data and training is being provided.
CCG 3b	Tobacco Brief Advice	50%	90%			**50.0%**	**75.0%**	**90.0%**	
CCG 3c	Alcohol Brief Advice	50%	90%			**50.0%**	**65.0%**	**90.0%**	
CCG 4	72 Hour follow up post discharge	50%	80%				**75.0%**	**80.0%**	Not due to report until 2019/20 Q3. Early indications show LPT are meeting the minimum threshold.
CCG 7	Three high impact actions to prevent hospital falls	25%	80%			**30.0%**	**50.0%**	**80.0%**	2019/20 Q1 position statement required. Only applicable to community hospitals. Templates are being introduced to enable data capture.
CCG 9	Stroke 6 Months reviews	35%	55%		**55.0%**	**55.0%**	**45.0%**	**45.0%**	SSNAP is a new way of reporting in LPT. Service is embracing the new system however waiting times have increased. Therefore following PDSA cycle new process is being implemented using a partial booking letter.

NHSE CQUINS 2019-20

CQUIN No	Description	Min Threshold	Max Threshold		Q1	Q2	Q3	Q4	Commentary
PSS4	Health weight in adult secure MH services	N/A	N/A		**100.0%**	**100.0%**	**100.0%**	**100.0%**	Full payment is expected for Q2. The Phoenix Ward staff are establishing new programmes including physical activity and healthy eating to help inpatients to maintain a healthy weight. The level of staff involvement and engagement with the Clinical Reference Groups work streams support the likelihood of achieving the milestones for this NHSE CQUIN.
PSS5	Addressing CAMHS T4 staff training Needs	N/A	N/A		**100.0%**	**100.0%**	**100.0%**	**100.0%**	100% achieved for Q1 Lead is aiming to achieve all elements of the CQUIN

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

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

Leicestershire Partnership NHS Trust

Trust Operational Performance

	Trust Performance														Current month directorate performance		
	Source	Reporting Frequency	Monthly target	Reporting Period (rolling three months) Aug-19	Sep-19	Oct-19	Sparkline YTD	2018/19 Q4	2019/20 Q1	Q2	Q3	Q4	Year to Date Position	Year End Target	Adult Mental Health/ Learning Disabilities	Community Health	Families, Young People & Children
Occupancy Rate - Mental Health Beds	TRUST	Monthly	<=85%	90.4%	86.9%	86.2%		83.4%	87.7%	88.9%			88.2%	<=85%	89.7%	79.4%	72.5%
Occupancy Rate - Community	TRUST	Monthly	>=93%	84.7%	88.3%	89.7%		89.4%	87.8%	85.8%			87.0%	>=93%		89.7%	
% Delayed Transfer of Care (DTOC)	DOH	Monthly	<=3.5%	4.6%	4.1%	4.4%		4.7%	4.8%	4.1%			4.5%	<=3.5%	4.7%	4.4%	Reported only by exception
Patients admitted to inpatient services who are given access to Crisis Resolution/ Home Treatment teams in line with best practice standards - % patients gatekept *(national methodology aligned to Quality Account)*	TRUST	Monthly	>=95%	100.0%	97.5%	98.8%		*not available*	84.5%	99.1%			93.6%	>=95%	98.8%		
Total number of Home Treatment episodes carried out by Crisis Resolution team year to date	COM	Monthly	>=145	246	249	287		743	740	780			1810	1740	287		

Comments and Actions:

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

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

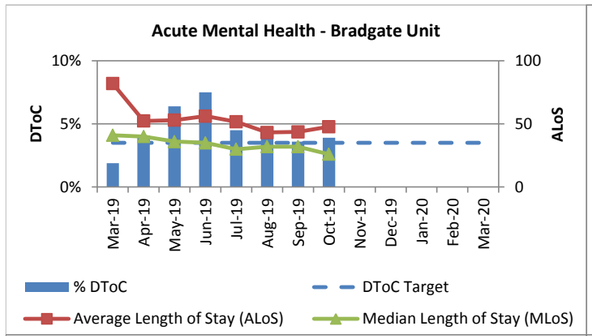
Patients admitted to inpatient services who are given access to Crisis Resolution/ Home Treatment teams in line with best practice standards: This item is no longer subject to significant data quality concerns and national report has recommenced from 1st April 2019. The reported position for September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

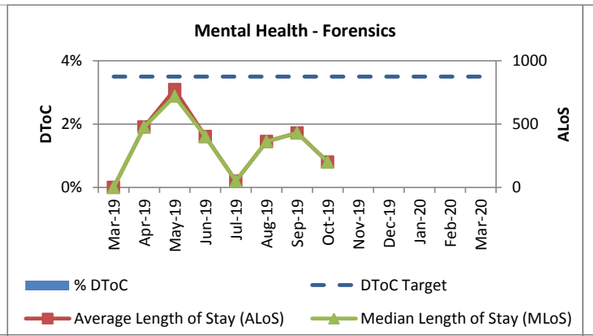
Total number of Home Treatment episodes carried out by Crisis Resolution team year to date: Year to date performance is currently 178.3% which equates to 1810 episodes against a pro-rata target of 1015.

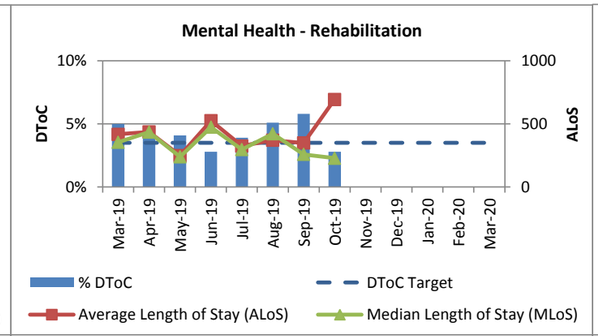
Leicestershire Partnership NHS
NHS Trust

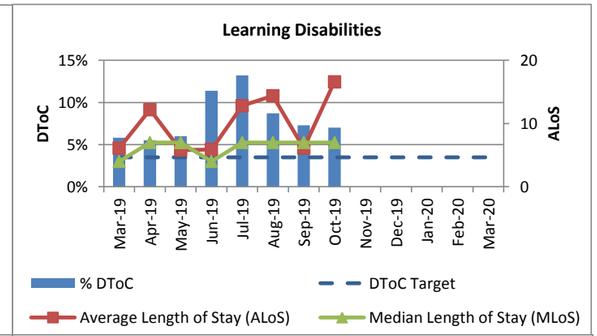
Trust Inpatient Performance

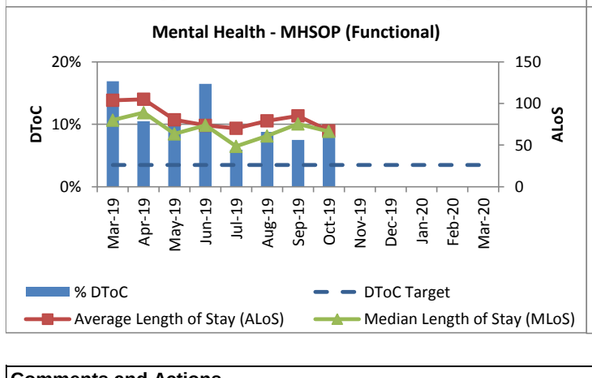
The Better Care Fund (BCF) planning guidance requires cross system organisations to work together to achieve the local, agreed ambition for delayed transfer of care (DTOC) to not equate to more than 3.5% of hospital beds. DToC rates are aligned to national Unify submissions.

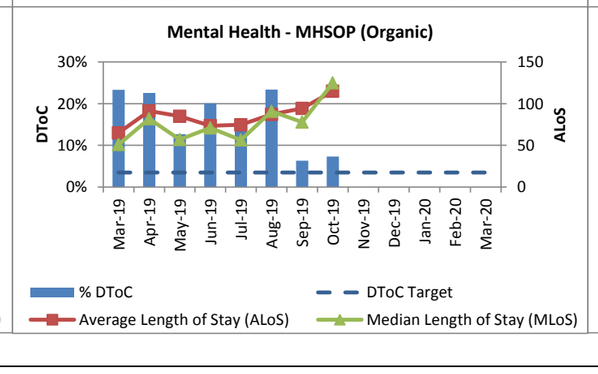


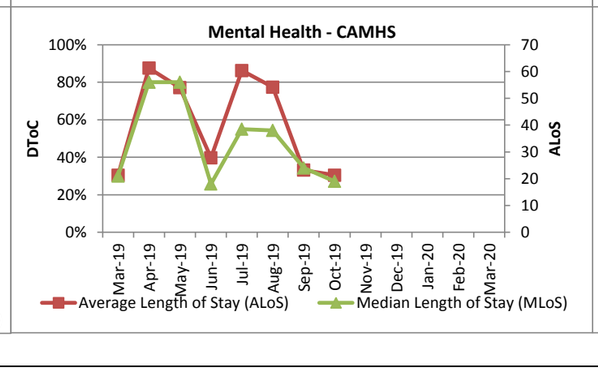


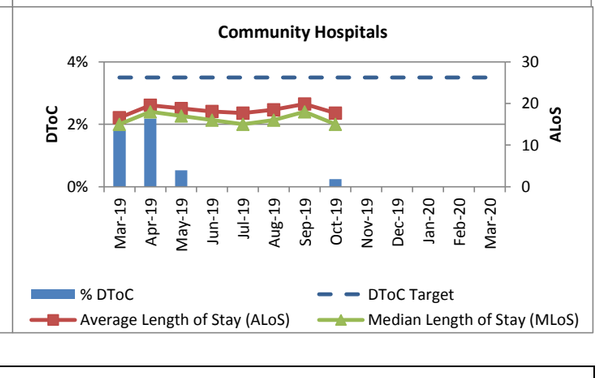












Comments and Actions

Delayed Transfer of Care (DToC)

The calculation methodology for DToC is*:

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

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

Delayed transfers of care attributable to social are included.

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

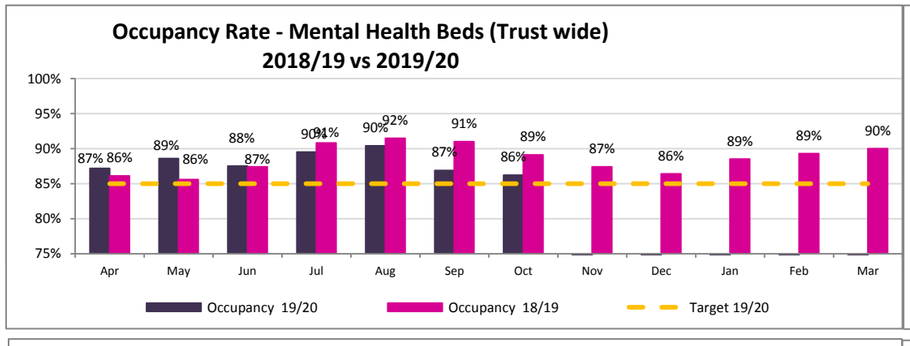
- implementing an integrated discharge team and trusted assessor model which will be extended to community hospitals and mental health wards during 2017/18 following a pilot at the acute trust;
- improvements in pathways into community hospitals - for which an audit of step down beds will be used for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

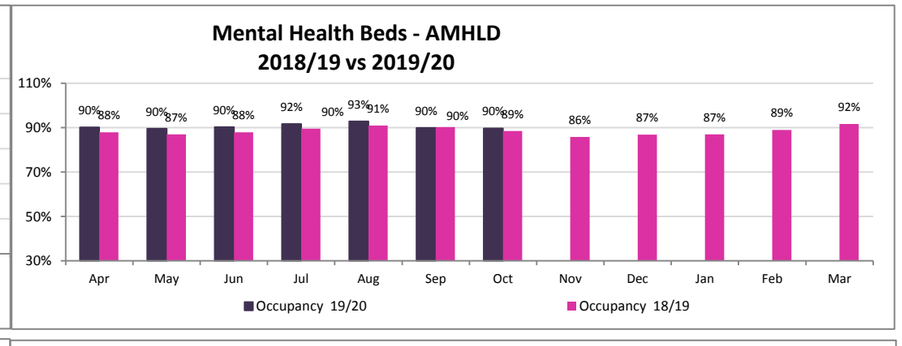
Length of Stay (LoS)

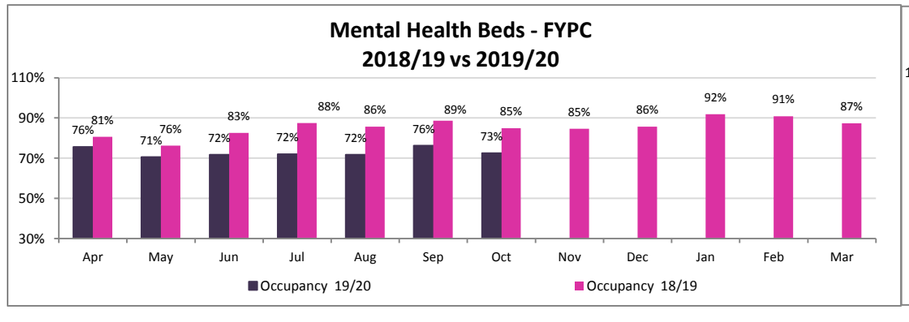
The length of stay displayed is the national operating framework definition, which takes data from Hospital Episode Statistics (HES) and includes ALL services and lengths. LoS is measured from admission to discharge, therefore a ward with no discharges in the period will not have a LoS calculated. All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

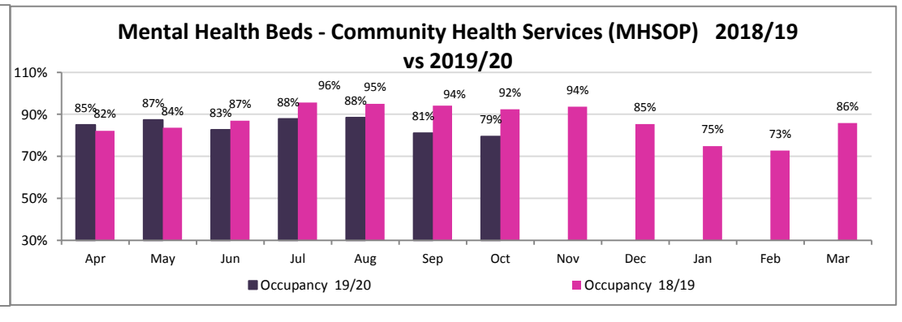
IMPORTANT: There are no patients excluded from this calculation and this KPI is not comparable with the LoS CQUIN or national benchmarking which is calculated using different exclusion parameters.

Mental Health Bed Occupancy Rate (%)









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

Comments and Actions:

CAMHS (FYPC) - On leave beds counted as admitted

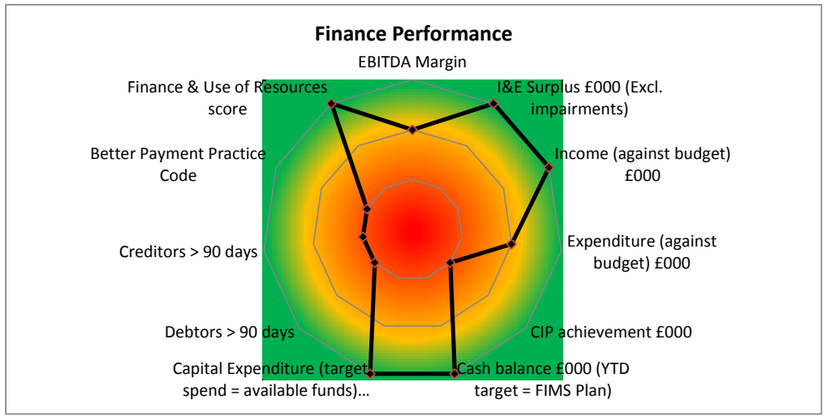
LD - On leave beds counted as admitted
This may result in occupancy rates above 100%

Leicestershire Partnership NHS Trust

Performance - Finance October 2019 (Month 7)

Comments and Actions:

- **Position:** As at 2019/20 month 7, the Trust is achieving the planned year to date surplus of £983k. A year end surplus of £2.6m is forecast based on the receipt of Sustainability and Transformation funding of £2.1m.
- **EBITDA:** The EBITDA margin as at 2019/20 month 7 is 5.8%. 76.4% of the 2019/20 year to date CIP target was achieved this month.
- **Cash Balance:** The cash balance at the end of 2019/20 month 7 is £10.8m. Planned cash for the month end was £7m. Debtors over 90 days are 22%. Creditors over 90 days are 12.6%.



FINANCE KPIs	TOTAL TRUST				Services											
					AMHLD		COMM SERVICES		FYPC		ENABLING		RESERVES		HOSTED	
	YTD Target (Budget)	YTD Actual	Year end target	Year end forecast	YTD Target	YTD Actual	YTD Target	YTD Actual	YTD Target	YTD Actual	YTD Target	YTD Actual	YTD Target	YTD Actual	YTD Target	YTD Actual
EBITDA Margin	5.9%	5.8%	6.0%	6.2%												
I&E Surplus £000 (Excl. impairments)	983	983	2,648	2,648												
Income (against budget) £000	164,479	166,004	278,567	278,567												
Expenditure (against budget) £000	163,495	165,021	275,919	275,919												
CIP achievement £000	2,061	1,575	4,047	2,758	353	188	508	508	342	342	324	297	175	175	359	65
Cash balance £000 (YTD target = FIMS Plan)	7,014	10,758	8,000	8,000												
Capital Expenditure (target spend = available funds) £000	4,279	4,279	13,957	13,957												
Debtors > 90 days	5.0%	22.0%	5.0%	5.0%												
Creditors > 90 days	5.0%	12.6%	5.0%	5.0%												
Better Payment Practice Code	95.0%	89.8%	95.0%	95.0%	95.0%	97.2%	95.0%	99.4%	95.0%	99.0%	95.0%	81.0%	100.0%	100.0%	95.0%	99.0%

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

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

Leicestershire Partnership NHS Trust

Trust Human Resources - Workforce Performance

		Trust Performance													Current month directorate performance				
					Reporting Period (rolling three months)				2019/20										
		Source	Reporting Frequency	Monthly target	Aug-19	Sep-19	Oct-19	Sparkline YTD	Q1	Q2	Q3	Q4	Year to Date Position	Year End Target	Adult Mental Health/ Learning Disabilities	Community Health	Enabling Services	Families, Young People & Children	Hosted Services
Workforce Profile	Number of WTE Employed	TRUST	Monthly		4642.35	4601.26	4658.77		4638.03	4601.26					1184.9	1719.6	471.2	1056.2	226.9
	Substantive Staff Headcount	TRUST	Monthly		5338	5291	5349		5331	5291					1317	1997	521	1276	238
	Bank Only Headcount	TRUST	Monthly		1009	1016	1015		1047	1016									
	% Vacancy Rate	TRUST	Monthly	G: <=7% R: >10%	8.9%	9.6%	8.8%		8.1%	9.6%				G: <=7% R: >10%	11.8%	9.6%	6.9%	5.8%	0%
	% Staff From a BME Background	TRUST	Quarterly	>=20%	22.3%	22.6%	22.5%		22.1%	22.6%				>=20%					
	% of Males Employed	TRUST	Quarterly		17.1%	17.3%	17.3%		17.0%	17.3%									
	% Staff Aged 16-29 Years	TRUST	Quarterly	>=12%	12.5%	12.3%	13.0%		12.5%	12.3%				>=12%					
Sickness Absence (one month in arrears)	% of Sickness Absence (1 month in arrears)	TRUST	Monthly	G: <=4.5% R: >=4.75%	4.8%	4.9%			4.5%	4.8%				G: <=4.5% R: >=4.75%	5.5%	5.1%	2.9%	5.1%	2.5%
	WTE Days Lost to Sickness (1 month in arrears)	TRUST	Monthly		6830	6680			18248	18567			38269		1908	2618	406	1578	171
	% Short Term Sickness (1 month in arrears)	TRUST	Monthly		2.0%	2.0%			1.9%	2.0%					2.4%	2.0%	1.0%	2.0%	0.9%
	% Long Term Sickness (1 month in arrears)	TRUST	Monthly		4.9%	2.9%			2.8%	2.8%					3.1%	3.1%	1.9%	3.1%	1.6%
	Cost of Sickness (£) (1 month in arrears)	TRUST	Monthly		£ 622,953	£ 618,974			£ 1,606,632	£ 1,807,302			£ 3,413,934		£166,660	£231,405	£50,553	£147,063	£23,294
Turnover	% Normalised Workforce Turnover (Rolling previous 12 months)	TRUST	Monthly	G: <=10% R: >12%	8.5%	8.7%	8.8%		9.0%	8.7%				G: <=10% R: >12%	9.6%	9.1%	6.4%	8.8%	6.0%
	% Total Workforce Turnover (Rolling previous 12 months)	TRUST	Monthly	G: <=10% R: >12%	9.0%	9.3%	9.4%		9.3%	9.3%				G: <=10% R: >12%	9.6%	10.2%	6.6%	9.2%	7.3%
	Executive Team Turnover	TRUST	Monthly		26.4%	26.4%	26.4%		13.2%	26.4%									
	Starters minus Leavers (headcount)	TRUST	Monthly		20	4	30		14	17			123		24	-4	0	8	2
	Stability Index No. of employees with one or more years' service now/ No. of employees employed one year ago x 100	TRUST	Monthly	G: >90% R: <85%	91.3%	90.6%	90.3%		90.7%	90.9%				G: >90% R: <85%	88.4%	91.5%	89.9%	91.5%	90.0%
Temporary Staffing	Bank Costs	TRUST	Monthly		£ 1,322,613	£ 1,401,294	£ 1,311,604		£ 3,813,641	£ 4,043,866			£ 9,169,111						
	Agency Costs (NHSI National 2017/18 Target)	TRUST	Monthly	<=£7.7m (p/a)	£ 813,941	£ 926,375	£ 867,920		£ 2,523,307	£ 2,617,282			£ 6,008,509	<=£7.7m					
	Agency Costs (LPT Internal Target)	TRUST	Monthly	<=£9.5m	£ 813,941	£ 926,375	£ 867,920		£ 2,523,307	£ 2,617,282			£ 6,008,509	<=£9m					
	Temporary Staffing Spend as a % of Total Paybill (Inc. bank, agency and additional hours worked)	TRUST	Monthly		12.2%	13.3%	12.1%		12.7%	13.3%									
	No of Off Framework Agency Usages	TRUST	Monthly		305	191	83		414	732			1229						
	No of Breaches to Agency Price Cap	TRUST	Monthly		683	629	527		1531	1865			3923						
	Agency volume (number of shifts filled by agency)	TRUST	Monthly		2963	2621	2488		7707	8345			18540						
	Roster approval period (weeks)	TRUST	Monthly	G: >6	5.50	5.66	5.34		5.20	5.65									
	% Split of Substantive to Bank to Agency Staff (Nurses band 2-6, inpatient areas only, taken from Safer Staffing portal)	TRUST	Monthly		65.9%, 29.4%, 4.8%	68.1%, 27.7%, 4.2%	70.4%, 25.7%, 3.9%												
	% Split of Qualified to Unqualified Staff (Nurses band 2-6, inpatient areas only, taken from Safer Staffing portal)	TRUST	Monthly		36.4%, 63.6%	36.4%, 63.6%	36.3%, 63.7%												
Organisational Change	Number of Staff Made Redundant	TRUST	Monthly		0	2	0		0	3			0		0	0	0	0	0
	Number of Staff on Pay Protection	TRUST	Monthly		29	25	16		28	27			16		4	6	4	2	0
Employee Relations	Number of open formal grievances	TRUST	Monthly		1	2	2		1	2					1	0	0	1	0
	Number of open bullying and harassment cases	TRUST	Monthly		3	6	6		1	4					1	5	0	0	0
	Number of open formal disciplinary cases	TRUST	Monthly		8	8	10		7	8					3	5	0	2	0
	Number of open employment tribunals	TRUST	Monthly		2	2	1		1	2					0	1	0	0	0
	Concerns raised to an external organisation	TRUST	Monthly		0	0	0		2	0			2		0	0	0	0	0
	Concerns raised in house	TRUST	Monthly		5	13	10		16	31			57		4	4	0	2	0
Employee Engagement	% Staff recommend LPT as a place to work	TRUST	Quarterly	G: >=57%	N/A	N/A	61%		N/A	N/A				G: >=57%					
	% Staff happy with standard of care provided	TRUST	Quarterly	G: >=67%	N/A	N/A	69%		N/A	N/A				G: >=67%					
	Pulse and Staff Survey Response Rate	TRUST	Quarterly	G: >=50%	N/A	N/A	15%		N/A	N/A				G: >=50%					
Learning and Development Overview	% of Consultants with a completed annual appraisal	TRUST	Monthly	G: >=90% R: <75%	96.0%	93.0%	96.0%		96.3%	95.3%				G: >=90% R: <75%	95%	100%		96%	
	% of Staff with a Completed Annual Appraisal	TRUST	Monthly	>=80% R: <75%	93.4%	93.1%	93.5%		92.0%	93.1%				>=80% R: <75%	91.9%	94.9%	90.3%	93.8%	94.5%
	% All Mandatory Training Compliance for substantive staff	TRUST	Monthly	G: >=85% R: <75%	92.1%	92.2%	92.1%		92.8%	92.4%				G: >=85% R: <75%	90.0%	92.9%	88.6%	94.1%	92.4%
	% All Mandatory Training Compliance for bank-only nursing staff	TRUST	Monthly	G: >=75% R: <65%	86.6%	82.2%	81.4%		81.0%	83.9%				G: >=75% R: <65%					
	% of new starters who attended Trust Induction on their first day (excluding bank staff)	TRUST	Monthly	G: >=85% R: <75%	100.0%	100.0%	100.0%		100.0%	100.0%				G: >=85% R: <75%					
	% of staff who have undertaken clinical supervision within the last 3 months	TRUST	Monthly		80.0%	84.5%	86.0%		80.7%	84.5%					79.5%	92.2%	62.5%	82.9%	100.0%
Learning and Development (Detail for Substantive Staff)	% Core Mandatory Training Compliance	TRUST	Monthly	G: >=85% R: <75%	95.1%	95.2%	95.4%		95.4%	95.1%				G: >=85% R: <75%	94.1%	97.1%	91.5%	96.3%	92.4%
	% Fire Safety training compliance	TRUST	Monthly	G: >=85% R: <75%	88.8%	89.0%	90.0%		88.9%	88.9%				G: >=85% R: <75%	87.1%	92.0%	87.6%	91.3%	86.6%
	% of Information Governance training compliance	TRUST	Monthly	G: >=95% R: <75%	91.2%	91.5%	92.6%		90.9%	91.2%				G: >=95% R: <75%	89.2%	95.7%	85.8%	93.1%	95.0%
	% Clinical Mandatory training compliance	TRUST	Monthly	G: >=85% R: <75%	92.1%	91.9%	92.1%		92.8%	92.2%				G: >=85% R: <75%	89.6%	94.7%	64.7%	92.3%	100.0%
	% Mental Health Act training compliance	TRUST	Monthly	G: >=85% R: <75%	82.3%	82.0%	83.4%		80.9%	82.1%				G: >=85% R: <75%	82.6%	93.2%	23.1%	81.6%	-
Declaration of Protected Characteristics	Declared Disability	TRUST	Monthly	G: >=85% R: <75%	76.9%	76.1%	79.3%		78.4%	77.1%				G: >=85% R: <75%					
	Declared Sexual Orientation	TRUST	Monthly	G: >=85% R: <75%	80.8%	81.0%	81.0%		80.4%	80.8%				G: >=85% R: <75%					
	Declared Religious Belief	TRUST	Monthly	G: >=85% R: <75%	79.4%	79.6%	79.6%		79.2%	79.5%				G: >=85% R: <75%					

Comments and Actions:

% Sickness Absence - see exception report

Agency Usage - see exception report

Leicestershire Partnership NHS Trust

DETAILED EXCEPTION REPORT - Clostridium Difficile (C Diff) Cases

Responsible Director	Anne Scott
Responsible Committee	QAC

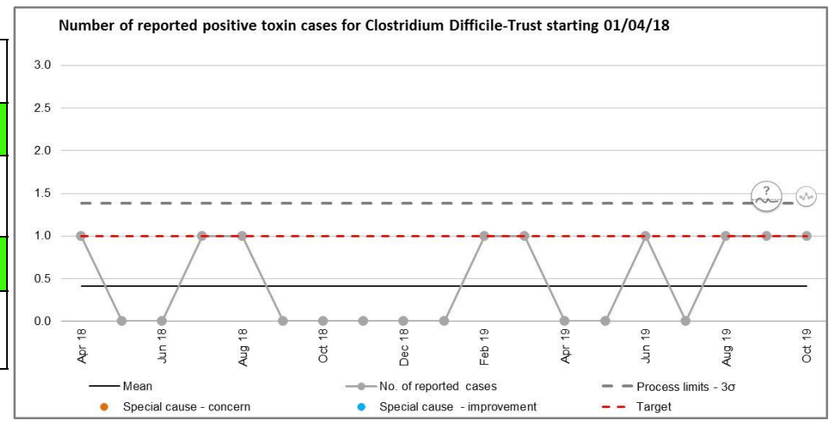
Responsible Services	All
KPI Reference ID	MSP.02

Risk Reference	
Risk Owner	

Risk Description:

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

Clostridium Difficile (C Diff) Cases	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
2018/19	1	0	0	1	1	0	0	0	0	0	1	1	**5**
Wards	EC - Beechwood Ward	-	-	EC - Clarendon Ward	CV - Snibston Ward	-	-	-	-	-	BC - Langley Ward	H&B - North Ward	
2019/20	0	0	1	0	1	1	1						**4**
Wards	-	-	EC - Beechwood Ward	-	SL - Ward 3	FP - General Ward	H&B - East Ward						



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

Comments and Actions:

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

There has been 1 reported case for Clostridium difficile during the month of October 2019 at East Ward, Hinckley and Bosworth Hospital.

The total Clostridium Difficile cases for this year is four (4).

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

Leicestershire Partnership NHS Trust

DETAILED EXCEPTION REPORT - CPA 7 Day Follow-up

Responsible Director	Gordon King, Rachel Bilsborough
Responsible Committee	QAC

Responsible Services	AMH, CHS
KPI Reference ID	

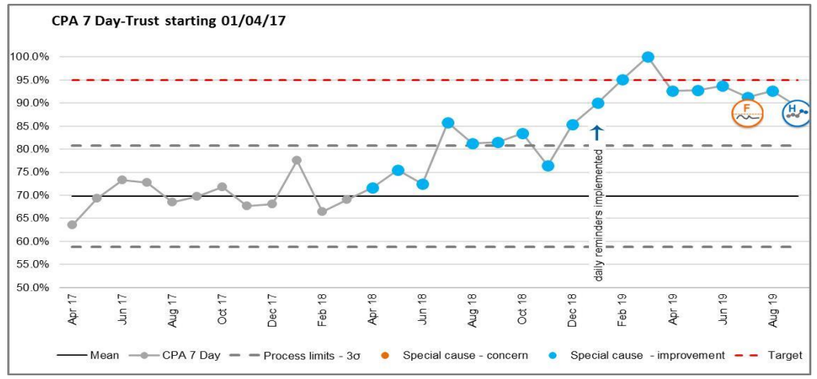
Risk Reference	
Risk Owner	

Risk Description:

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

Performance (%)	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20
Adult Mental Health Services	100.0%	91.0%	91.8%	91.5%	89.3%	91.4%	86.6%					
Community Health Services	100.0%	100.0%	100.0%	100.0%	100.0%	96.0%	97.2%					
Trust Total	100.0%	92.7%	92.8%	93.7%	91.3%	92.6%	89.2%					

CPA 7 Day is reported one month in arrears



Comments and Actions:

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

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

Leicestershire Partnership NHS Trust

DETAILED EXCEPTION REPORT - CPA 12 Month Review

Responsible Director	Gordon King, Rachel Bilsborough
Responsible Committee	QAC

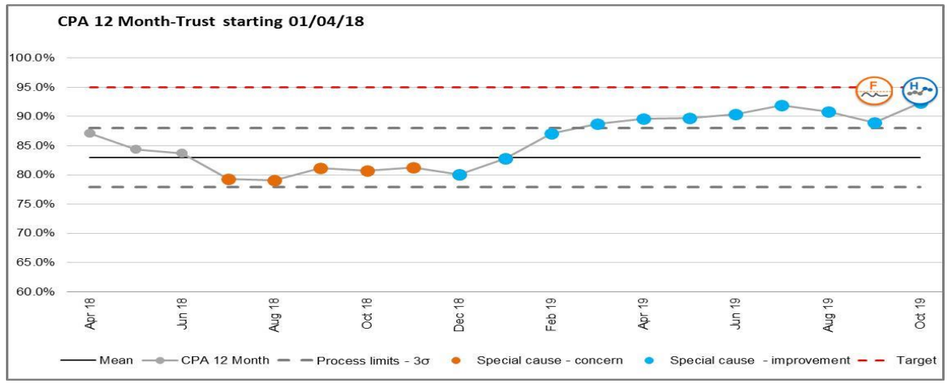
Responsible Services	AMH, CHS
KPI Reference ID	

Risk Reference	
Risk Owner	

Risk Description:

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

Performance (%)	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Adult Mental Health Services	88.1%	89.5%	89.6%	90.8%	91.9%	91.7%	89.9%	92.8%					
Community Health Services	96.4%	93.7%	96.3%	95.2%	100.0%	98.0%	95.1%	99.0%					
Trust Total	88.7%	89.6%	89.7%	90.4%	91.9%	90.8%	89.0%	92.4%					



Comments and Actions:

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

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

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

Leicestershire Partnership NHS Trust

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

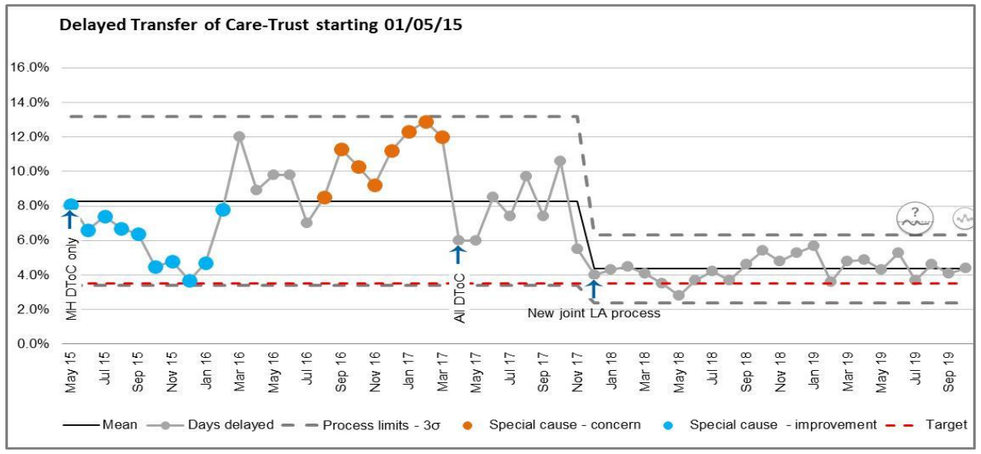
Responsible Director	Rachel Bilsborough, Gordon King
Responsible Committee	FPC

Responsible Services	AMH
KPI Reference ID	QEFS.06

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

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

DTOC (%)	Target	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Acute Mental Health - Bradgate Unit	<=3.5%	1.9%	4.1%	6.4%	7.5%	4.5%	4.5%	3.6%	3.9%					
Mental Health - Forensics	<=3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%					
Mental Health - Rehabilitation	<=3.5%	5.0%	4.1%	4.1%	2.8%	3.9%	5.1%	5.8%	2.8%					
Learning Disabilities	<=3.5%	5.8%	5.5%	6.0%	11.4%	13.2%	8.7%	7.3%	7.0%					
Mental Health - MHSOP (Functional)	<=3.5%	16.9%	10.5%	10.3%	16.5%	5.9%	8.8%	7.5%	8.2%					
Mental Health - MHSOP (Organic)	<=3.5%	23.3%	22.6%	12.7%	20.1%	16.0%	23.4%	6.3%	7.3%					
Community Hospitals	<=3.5%	1.8%	2.2%	0.5%	0.0%	0.0%	0.0%	0.0%	0.2%					
TRUST TOTAL	<=3.5%	4.8%	4.9%	4.3%	5.3%	3.7%	4.6%	4.1%	4.4%					



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

Comments and Actions:

% DToC - Mental Health: Patients delayed during discharge for the month of October 2019 are the result of the following top three categories: Other (24.0%), Joint (12.9%), Social Services (12.9%) and all other reasons (50.0%).

% DToC - Community: Delays for community hospital patients during the month of October 2019 are the result of the following delay: LA Funded Care Package (100%).

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

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

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

Risk Associated Actions:

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

Leicestershire Partnership NHS Trust

DETAILED EXCEPTION REPORT - National Access Standards

Responsible Director	Gordon King
Responsible Committee	FPC

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

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

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

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

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
STF RTT Trajectory - max no. of referrals breaching in month	6	6	6	9	9	6	6	6	9	9	6	6	6	6	6	9	9	6	6	6	9	9	6	6
Referrals waiting over 18 weeks	0	11	8	9	1	2	1	7	30	31	16	8	0	11	26	0	36	34	70	0	0	0	0	0
- of which patient choice	*4*	*11*	*8*	*9*	*1*	*2*	*1*	*7*	*30*	*31*	*16*	*8*	*11*	*11*	*26*	*0*	*14*	*14*	*15*	*0*	*0*	*0*	*0*	*0*
- of which Trust delays	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*22*	*20*	*55*	*0*	*0*	*0*	*0*	*0*
Incomplete waiting time compliance (%)	98.3%	96.7%	97.6%	97.4%	99.7%	99.4%	99.7%	98.5%	94.1%	94.0%	97.0%	98.5%	98.0%	97.7%	94.9%	94.3%	92.4%	92.6%	86.2%					

Key: Forecast figures (may change)

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

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

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

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
No. of RTT referrals over 52 weeks	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0					

Comments and Actions:
The RTT services participate in regular patient tracking list (PTL) meetings to manage patient access. This process allows the service to predict potential and known breaches as shown in the pink trajectory section of the table. Patient choice allows patients the right to defer their treatment to a date to suit them, which may breach the 18/ 6 week target and these instances are recorded in the trajectory table.

In some cases, a patient who has requested an appointment 18/ 6+ weeks in the future may show as a breach in the trajectory table; however if they do not attend (DNA) or cancel multiple appointments, the clinician may use professional clinical judgement to cancel the referral and refer the patient back to their GP. In this case, the patient will be removed from the waiting list and will not be identified as an 18/ 6 week breach in line with national guidelines. However, if the decision to remove the referral from the waiting list is after the breach date, the referral breach may still be reported nationally. These scenarios are managed by the service PTL on a case by case basis.

Leicestershire Partnership NHS Trust

DETAILED EXCEPTION REPORT - Mental Health Inappropriate Out of Area (OOA) Bed Days

Responsible Director	Gordon King
Responsible Committee	QAC

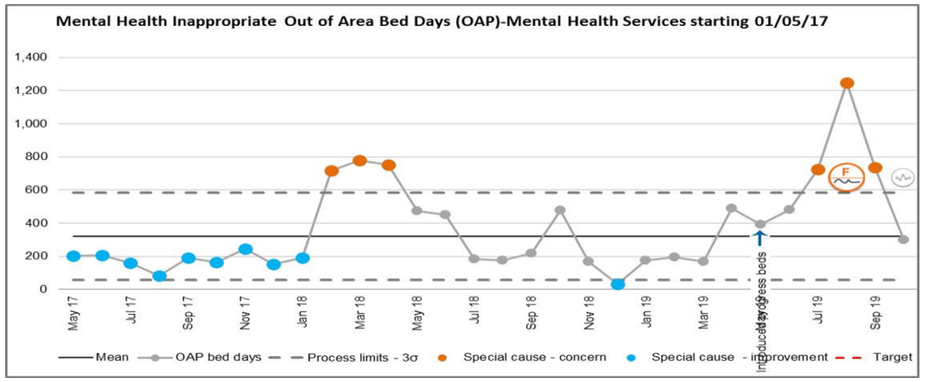
Responsible Services	AMH, CHS
KPI Reference ID	

Risk Reference	
Risk Owner	

Risk Description:

Calculation Method	Total number of Mental Health Inappropriate Out of Area (OOA) Bed Days in period

Performance	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Adult Mental Health Services	166	491	391	482	727	1248	736	663					



Comments and Actions:

Leicestershire Partnership NHS Trust

DETAILED EXCEPTION REPORT - Data Quality Maturity Index (DQMI)

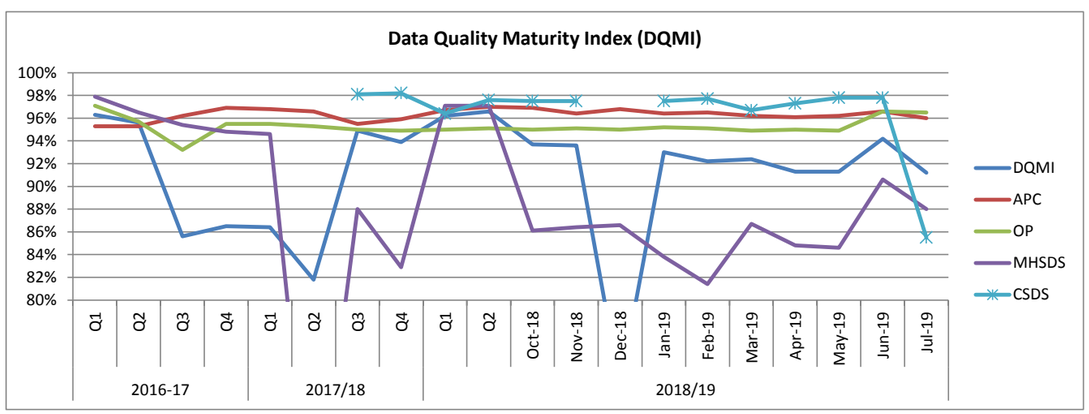
Responsible Director	Dani Cecchini
Responsible Committee	FPC

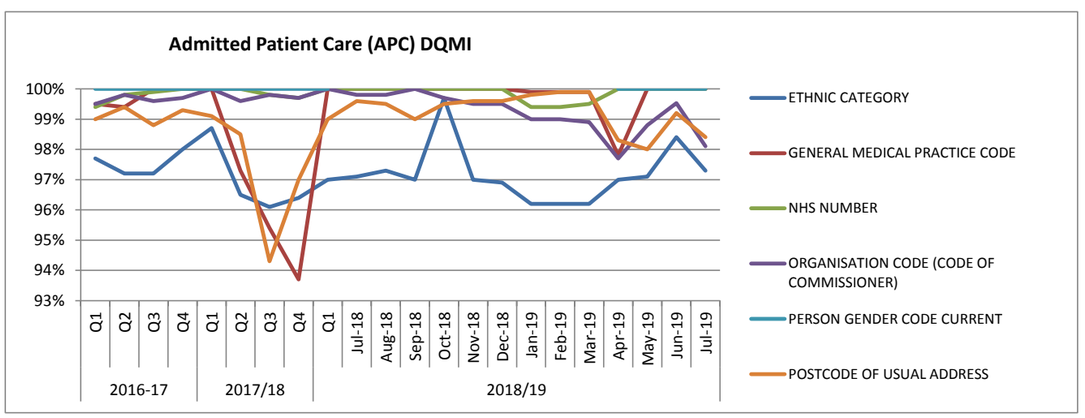
Responsible Services	AMH, CHS, FYPC
KPI Reference ID	

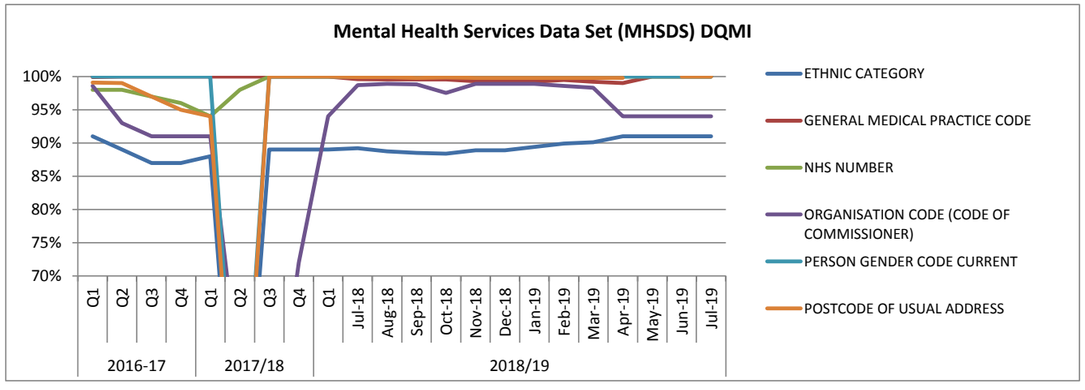
Risk Reference	1119
Risk Owner	Dani Cecchini

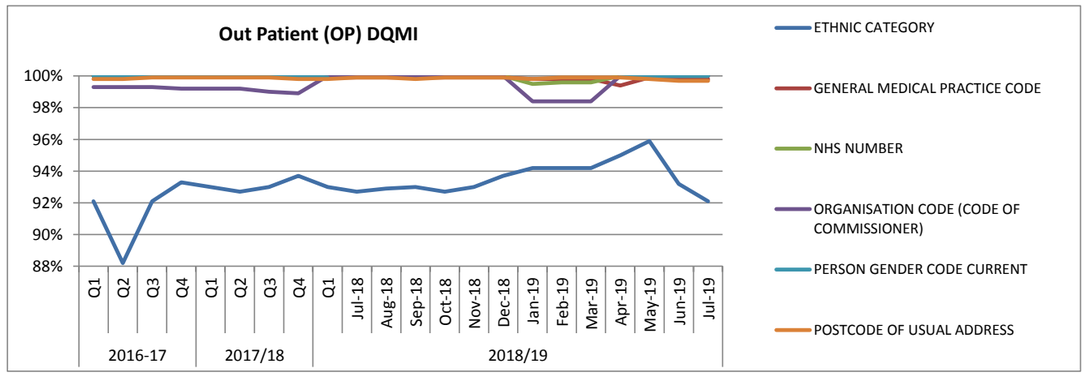
Risk Description: There is a risk we cannot assure ourselves of the accuracy and validity of all information we provide from our patient information systems; which could adversely affect patient outcomes where information is required to make decisions.

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









Comments and Actions:

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

Data Quality Maturity Index (DQMI)

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

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

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

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

Leicestershire Partnership NHS
NHS Trust

DETAILED EXCEPTION REPORT - % Staff Sickness

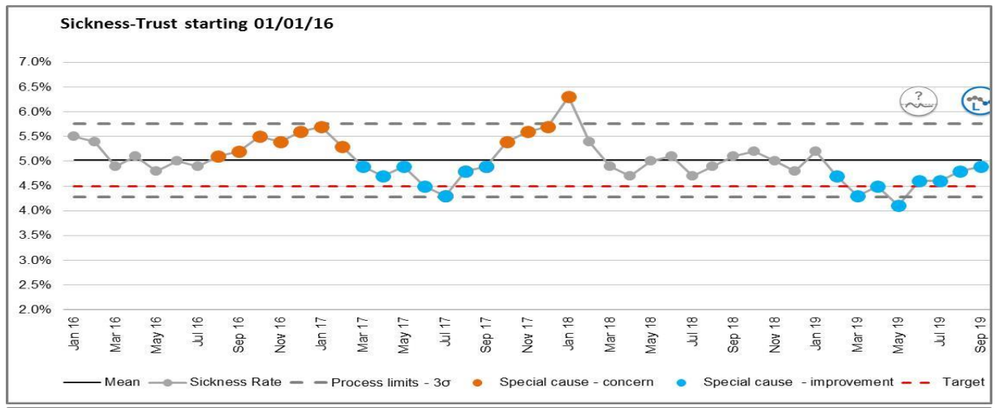
Responsible Director	Sarah Willis
Responsible Committee	SWG

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

Risk Reference	1833	**Risk Description:** Quality of service provided to our patients and service users will be affected by the high level of sickness absence within the Trust. There will also be an impact on the health and wellbeing linked to the increased reliance on use of temporary staffing.
Risk Owner	Kathryn Burt	

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

Performance (%)	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Adult Mental Health Services	<=5.6%	5.3%	4.9%	5.8%	5.3%	6.2%	5.5%						
Community Health Services	<=4.8%	4.9%	4.4%	4.9%	5.2%	5.2%	5.1%						
Families, Children and Young People's Services	<=4.3%	4.6%	4.1%	4.4%	4.4%	4.4%	5.1%						
Enabling Services	<=2.3%	2.5%	2.0%	2.4%	2.8%	2.4%	2.9%						
Hosted Services	<=2.3%	2.1%	1.5%	1.9%	1.2%	2.0%	2.5%						



Comments and Actions:

% Sickness Absence:

AMH.LD sickness is showing significant improvement from last year however has recently taken an upturn. The cumulative rate for 201 8/19 was 5.4 % (below target of 5.6%). This is a 0.8% reduction from 2017/18 and builds on improvements made in 2016/17. Advice from Amica and Occupational Health is that the complexity of the client group supported in AMH.LD means that higher levels of sickness absence should be anticipate d.

Actions in place:
HR support to focus on supporting, training and coaching Managers.
Target setting for staff who reach the Trust triggers and if breached formal action taken.
Monthly teleconference for managers, HR and the Director to discuss actions being taken to tackle sickness absence.
HR Team focusing on supporting staff with underlying health conditions using guidance from the Reasonable Adjustment Policy a nd Tailored Adjustment Agreements.

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

FYPC Sickness increased in September as the previous month and is now showing as Red, and is a slight improvement on same time las t year.. This is discussed in length at Workforce Meetings, FYPC SMT have also agreed to discuss this in more detail in the FYPC Operational Meetings on a monthly basis and are now considering a monthly telephone conference call to deal specifically with sickness. Work will continue with Team s and Managers, including training, advice on target setting and continued monthly monitoring of staff sickness within teams. Information has been prov ided to SMT on staff who are line managers and have not attended Management of Ill Health Training and also to encourage Managers to attend half day refre sher training. Stress Tools are discussed at Workforce Group and communicated to Managers through Comms and individual Team Meetings. The HR team will undertake further 1 x 1 work with Managers who have a 6% and over the target rate. Hot spots will be identified and fed back to SMT for discussion. HR have devised a one page guide to supporting staff on long term absence and a tracker form which managers can use to record important information rela ting to LTS as a reminder and to enable the manager to evidence action.

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

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

Risk Associated Actions:

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

Leicestershire Partnership NHS Trust

DETAILED EXCEPTION REPORT - Agency Costs

Responsible Director	Anne Scott
Responsible Committee	FPC/ SWG

Responsible Services	All
KPI Reference ID	PW.35

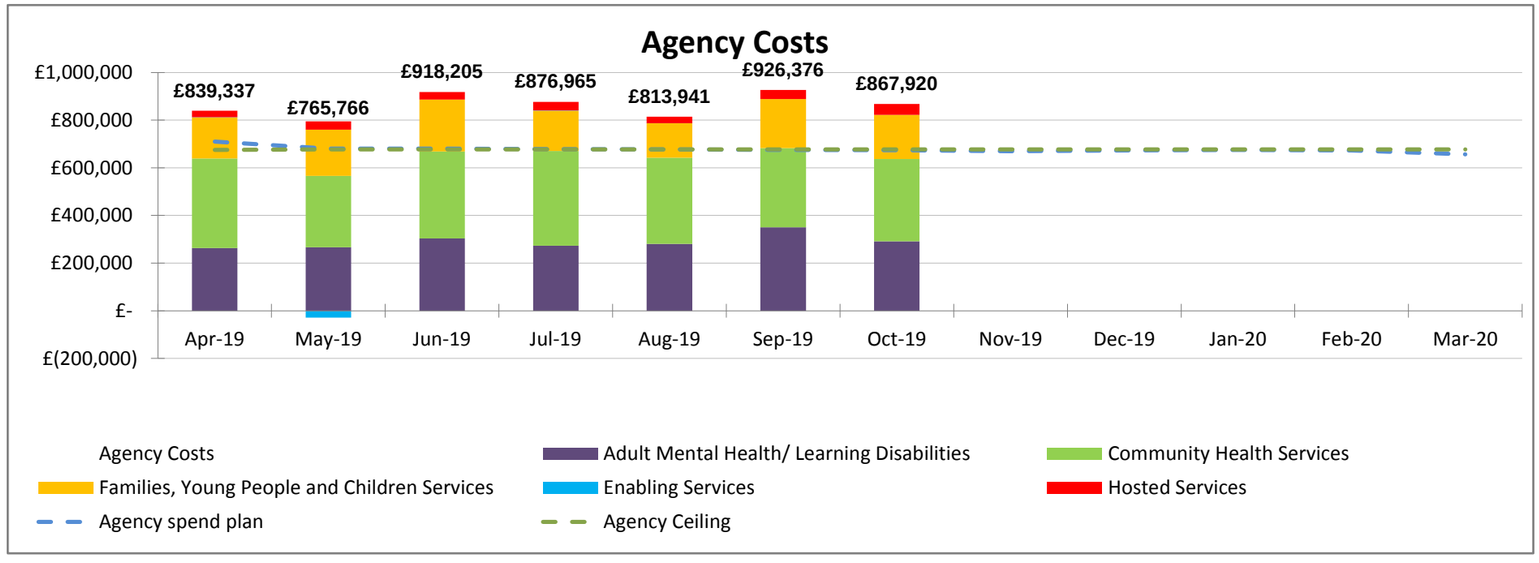
Risk Reference	4271	**Risk Description:** Insufficient staffing levels to meet capacity and demand and provide quality service. Links to risks 1037, 1038, 2515 and the safer staffing risk.
Risk Owner	Sarah Willis	

Risk Reference	4277	**Risk Description:** There is a risk that services do not have the right number of staff with the right skills at the right time. Links to risk 1932.
Risk Owner	Anne Scott	

Calculation Method	Total cost of Trust agency pay bill

Split by Services

	Current Month	Previous Month
Adult Mental Health/ Learning Disabilities	£ 291,561	£ 350,199
Community Health Services	£ 344,783	£ 332,942
Families, Young People and Children Services	£ 185,460	£ 205,424
Enabling Services	£ -	£ -
Hosted Services	£ 46,116	£ 37,811



Comments and Actions:

Cumulative year-to-date Trust agency costs were £6,008K as at 31 October 2019 (month 7). This is above the planned spend of £4,775k for the same period.

The October year-to-date NHSI agency ceiling target is £4,737k. This Trust is exceeding this limit by £1,271k.

Risk Associated Actions:

Appendix 1: IQPR Change Log

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

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Corporate Business Information Team

Waiting Times Compliance - Adult Mental Health Services and Learning Disabilities
Leicestershire Partnership Trust Total

Leicestershire Partnership NHS
NHS Trust

Service Details				Patient Flow (referrals and discharges in month)								Incomplete Pathways (at end of month)									Complete Pathways (in month)									Information Assurance Framework				
				No. of New Referrals Received				No. of Discharges				No. of Referrals Waiting			Length of Wait		Waiting Time Compliance					No. of Referrals Seen			Length of wait		Waiting Time Compliance												
Service Spec	Service Name	Target Waiting Time (days unless stated otherwise)	Wait Time Measure	Aug-19	Sep-19	Oct-19	Referrals Trendline (Rolling 12 Months)	Aug-19	Sep-19	Oct-19	Discharge Trendline (Rolling 12 Months)	No of Patients Within Target	Patients > target < 52 weeks	Patients > target >= 52 weeks	Longest Waiter Over target <52 Weeks	Longest Waiter >= 52 Weeks	Target	Aug-19	Sep-19	Oct-19	Incomplete Compliance Trendline	No of Patients Within Target	Patients > target < 52 weeks	Patients > target >= 52 weeks	Longest Waiter Over target <52 Weeks	Longest Waiter >= 52 Weeks	Target	Aug-19	Sep-19	Oct-19	Complete Compliance Trendline	Service Line Mapping Agreed	Targets Agreed	SOP in place	PTL in place	KPI authorised as correct by executive
LD02	LD - Community Teams	8 Weeks	Referral to Assessment	94	97	124		86	101	116		110	6	0	11	0	95%	69.0%	71.6%	94.8%		117	9	0	19	0	95%	92.0%	92.7%	92.9%						
MH02	Assertive Outreach	6 Weeks	Referral to Assessment	2	9	6		2	2	3		6	1	0	6	0	95%	100.0%	85.7%	85.7%		3	1	0	7	0	95%	N/A	100.0%	75.0%						
MH06	Personality Disorders	13 Weeks	Referral to Assessment	73	84	85		57	40	50		278	423	1	41	62	95%	43.3%	54.4%	39.6%		11	39	0	45	0	95%	62.5%	29.7%	22.0%						
MH07	Dynamic Psychotherapy	13 Weeks	Referral to Assessment	23	29	22		8	4	18		39	0	0	0	0	95%	100.0%	100.0%	100.0%		28	0	0	0	0	95%	100.0%	100.0%	100.0%						
MH08	Perinatal Mental Health Service	4 Weeks	Referral to Assessment	106	85	113		84	95	85		28	10	0	17	0	95%	84.3%	65.0%	73.7%		96	7	0	11	0	95%	72.8%	92.9%	93.2%						
		2 Working Days		12	12	26		11	12	24		21	4	0	11	0	95%	N/A	N/A	84.0%		25	0	0	0	0	95%	100.0%	91.7%	100.0%						
		4 Hours		0	0	1		0	0	0		1	0	0	0	0	95%	N/A	N/A	100.0%		0	0	0	0	0	95%	N/A	N/A	N/A						
MH09	Psycho-oncology (Routine and Urgent)	4 Weeks	Referral to Assessment	17	26	27		24	16	6		32	59	0	31	0	95%	58.8%	43.6%	35.2%		2	10	0	25	0	95%	23.5%	20.0%	16.7%						
		48 Hours		14	4	9		6	4	2		5	9	0	16	0	95%	90.9%	69.2%	35.7%		4	1	0	1	0	95%	0.0%	0.0%	80.0%						
MH10	Liaison - Psychiatry	1 Working Day	Referral to Assessment	40	41	44		34	40	41		3	3	0	2	0	95%	53.8%	90.0%	50.0%		25	18	0	2	0	95%	93.3%	85.3%	58.1%						
		13 Weeks		8	9	14		58	26	29		18	1	0	41	0	95%	87.5%	86.7%	94.7%		12	1	0	15	0	95%	94.7%	89.5%	92.3%						
MH11	Cognitive Behavioural Therapy	13 Weeks	Referral to Assessment	54	51	36		28	27	30		95	3	0	16	0	95%	97.5%	99.0%	96.9%		30	1	0	14	0	95%	100.0%	94.7%	96.8%						
MH13	Forensic - Community and Out Patients	8 Weeks	Referral to Assessment	18	39	19		14	12	33		51	11	0	22	0	95%	51.5%	89.9%	82.3%		12	8	0	34	0	95%	66.7%	52.2%	60.0%						
MH18	Adult General Psychiatry - Community Mental Health Teams and Outpatients - Treatment	6 Weeks	Referral to Assessment	381	426	486		442	442	474		624	633	10	47	100	95%	60.5%	59.6%	49.3%		209	199	2	45	74	95%	51.8%	71.0%	51.0%						
		5 Days		14	12	10		12	10	9		4	6	0	8	0	95%	18.2%	50.0%	40.0%		5	1	0	1	0	95%	72.7%	70.0%	83.3%						
MH20	Mett Day Centre and Linnaeus Nursery	4 Weeks	Referral to Assessment	1	12	11		7	4	2		4	0	0	0	0	95%	100.0%	100.0%	100.0%		10	0	0	0	0	95%	N/A	100.0%	100.0%						
MH21	Huntington's Disease	4 Weeks	Referral to Assessment	2	2	0		0	2	1		0	1	0	8	0	95%	83.3%	100.0%	0.0%		0	0	0	0	0	95%	100.0%	100.0%	N/A						
MH23	Adult ADHD Service Consultant-Led Service	National incomplete target 92%: 18 Weeks	Referral to Treatment	84	86	114		30	61	43		358	68	0	38	0	92%	83.0%	96.2%	84.0%		6	45	0	29	0	95%	74.3%	14.9%	11.8%						
MH24	Homeless Service	1 Week	Referral to Assessment	42	35	43		42	37	42		9	16	0	11	0	95%	4.0%	40.0%	36.0%		24	12	0	6	0	95%	71.4%	75.0%	66.7%						
MH25	Aspergers Assessment Consultant-Led Service	National incomplete target 92%: 18 Weeks	Referral to Treatment	35	43	55		40	32	32		80	2	0	22	0	92%	91.3%	96.6%	97.6%		44	10	0	32	0	95%	46.8%	85.7%	81.5%						
MH48	Crisis Intervention (Crisis Level 1 and 2)	4 Hours	Referral to Assessment	7	4	5		7	3	6		0	0	0	0	0	95%	N/A	N/A	N/A		2	3	0	0	0	95%	50.0%	75.0%	40.0%						
		24 Hours		297	291	331		357	277	322		10	0	0	0	0	95%	100.0%	100.0%	100.0%		282	45	0	6	0	95%	78.6%	86.4%	86.2%						
MH49	Mental Health Triage Team	1 Hour	Referral to Assessment	400	411	468		356	389	436		0	0	0	0	0	95%	N/A	N/A	N/A		195	233	0	1	0	95%	73%	55%	46%						
		Emergency 2 Hours	Referral to Assessment	400	411	468		356	389	436		16	14	0	15	0	95%	32.1%	60.0%	53.3%		317	137	0	1	0	95%	85%	70%	70%						
		Crisis 4 Hours	Referral to Assessment	47	32	31		40	31	24		4	4	0	4	0	95%	25.0%	N/A	50.0%		21	5	0	0	0	95%	97.6%	93.2%	80.8%						
MH16	Adult General Psychiatry-Acute Recovery Team	3 Working Days																																		
		48 hours																																		
		7 days																																		

Comments and Actions:

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

Methodologies

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

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

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

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Corporate Business Information Team

Waiting Times Compliance - Adult Mental Health Services and Learning Disabilities LLR Total

Leicestershire Partnership NHS
NHS Trust

Service Details				Patient Flow (referrals and discharges in month)								Incomplete Pathways (at end of month)									Complete Pathways (in month)									Information Assurance Framework				
				No. of New Referrals Received				No. of Discharges				No. of Referrals Waiting			Length of Wait		Waiting Time Compliance					No. of Referrals Seen			Length of wait		Waiting Time Compliance									
Service Spec	Service Name	Target Waiting Time (all targets are locally agreed unless otherwise stated)	Wait Time Measure	Aug-19	Sep-19	Oct-19	Referrals Trendline (Rolling 12 Months)	Aug-19	Sep-19	Oct-19	Discharge Trendline (Rolling 12 Months)	No of Patients Within Target	Patients > target < 52 weeks	Patients > target >= 52 weeks	Longest Waiter Over target < 52 Weeks	Longest Waiter >= 52 Weeks	Target	Aug-19	Sep-19	Oct-19	Incomplete Compliance Trendline	No of Patients Within Target	Patients > target < 52 weeks	Patients > target >= 52 weeks	Longest Waiter Over target < 52 Weeks	Longest Waiter >= 52 Weeks	Target	Aug-19	Sep-19	Oct-19	Complete Compliance Trendline	Service Line Mapping Agreed	Targets Agreed	SOP in place	PTL in place	KPI authorised as correct by executive
LD02	LD - Community Teams	8 Weeks	Referral to Assessment	92	96	123		86	100	113		110	6	0	11	0	95%	88.1%	93.2%	94.8%		114	8	0	13	0	95%	92.0%	85.4%	93.4%						
MH02	Assertive Outreach	6 Weeks	Referral to Assessment	2	9	6		2	2	3		6	1	0	6	0	95%	100.0%	85.7%	85.7%		3	1	0	7	0	95%	N/A	100.0%	75.0%						
MH06	Personality Disorders	13 Weeks	Referral to Assessment	73	82	83		56	40	50		274	422	1	41	62	95%	43.3%	42.0%	39.3%		11	39	0	45	0	95%	25.0%	29.7%	22.0%						
MH07	Dynamic Psychotherapy	13 Weeks	Referral to Assessment	23	29	22		8	4	18		39	0	0	0	0	95%	100.0%	100.0%	100.0%		28	0	0	0	0	95%	100.0%	100.0%	100.0%						
MH08	Perinatal Mental Health Service	4 Weeks	Referral to Assessment	100	83	110		79	91	83		27	10	0	17	0	95%	68.6%	80.0%	73.0%		93	6	0	8	0	95%	85.6%	85.7%	93.9%						
		2 Working Days		12	12	24		11	12	22		21	4	0	11	0	95%	N/A	N/A	84.0%		23	0	0	0	0	95%	100.0%	91.7%	100.0%						
		4 Hours		0	0	1		0	0	0		1	0	0	0	0	95%	N/A	N/A	100.0%		0	0	0	0	0	95%	N/A	N/A	N/A						
MH09	Psycho-oncology (Routine and Urgent)	4 Weeks	Referral to Assessment	16	26	27		24	16	6		32	57	0	31	0	95%	17.5%	37.2%	36.0%		2	10	0	25	0	95%	23.5%	20.0%	16.7%						
		48 Hours		10	4	7		5	3	2		5	5	0	16	0	95%	81.8%	69.2%	50.0%		2	1	0	1	0	95%	0.0%	0.0%	66.7%						
MH10	Liaison - Psychiatry	1 Working Day	Referral to Assessment	34	37	40		26	36	38		3	3	0	2	0	95%	53.8%	80.0%	50.0%		21	17	0	2	0	95%	86.7%	70.6%	55.3%						
		13 Weeks		8	9	14		56	26	29		18	1	0	41	0	95%	87.5%	86.7%	94.7%		12	1	0	15	0	95%	94.7%	89.5%	92.3%						
MH11	Cognitive Behavioural Therapy	13 Weeks	Referral to Assessment	53	51	36		26	27	30		95	3	0	16	0	95%	97.5%	99.0%	96.9%		30	1	0	14	0	95%	100.0%	94.7%	96.8%						
MH13	Forensic - Community and Out Patients	8 Weeks	Referral to Assessment	18	39	19		14	12	28		51	11	0	22	0	95%	52.9%	79.7%	82.3%		10	8	0	34	0	95%	66.7%	52.2%	55.6%						
MH18	Adult General Psychiatry - Community Mental Health Teams and Outpatients - Treatment	6 Weeks	Referral to Assessment	378	421	479		413	409	451		617	629	10	47	100	95%	41.1%	47.8%	49.1%		206	199	2	45	74	95%	53.5%	41.9%	50.6%						
		5 Days		14	12	9		12	10	9		3	6	0	8	0	95%	18.2%	50.0%	33.3%		5	1	0	1	0	95%	72.7%	70.0%	83.3%						
MH20	Mett Day Centre and Linnaeus Nursery	4 Weeks	Referral to Assessment	1	11	11		7	4	2		4	0	0	0	0	95%	100.0%	100.0%	100.0%		10	0	0	0	0	95%	N/A	100.0%	100.0%						
MH21	Huntington's Disease	4 Weeks	Referral to Assessment	2	2	0		0	2	0		0	1	0	8	0	95%	66.7%	100.0%	0.0%		0	0	0	0	0	95%	N/A	100.0%	N/A						
MH23	Adult ADHD Service Consultant-Led Service	National incomplete target 92%: 18 Weeks	Referral to Treatment	82	83	110		27	58	41		347	68	0	38	0	92%	94.7%	92.3%	83.6%		6	44	0	29	0	95%	48.5%	29.9%	12.0%						
MH24	Homeless Service	1 Week	Referral to Assessment	42	33	39		40	37	38		9	15	0	7	0	95%	4.0%	40.0%	37.5%		21	10	0	6	0	95%	71.4%	50.0%	67.7%						
MH25	Aspergers Assessment Consultant-Led Service	National incomplete target 92%: 18 Weeks	Referral to Treatment	35	43	55		40	31	32		80	2	0	22	0	92%	82.6%	93.1%	97.6%		44	10	0	32	0	95%	93.7%	71.4%	81.5%						
MH48	Crisis Intervention (Crisis Level 1 and 2)	4 Hours	Referral to Assessment	7	4	5		7	3	6		0	0	0	0	0	95%	N/A	N/A	N/A		2	3	0	0	0	95%	50.0%	75.0%	40.0%						
		24 Hours		290	278	322		346	266	312		9	0	0	0	0	95%	100.0%	100.0%	100.0%		275	44	0	2	0	95%	85.7%	88.3%	86.2%						
MH49	Mental Health Triage Team	1 Hour	Referral to Assessment	368	369	441		324	349	410		0	0	0	0	0	95%	N/A	N/A	N/A		195	233	0	1	0	95%	51.8%	46.5%	45.6%						
		Emergency 2 Hours	Referral to Assessment	368	369	441		324	349	410		15	13	0	15	0	95%	32.1%	60.0%	53.6%		300	128	0	1	0	95%	76.3%	76.1%	70.1%						
		Crisis 4 Hours	Referral to Assessment	43	22	30		38	21	23		4	4	0	4	0	95%	25.0%	N/A	50.0%		21	5	0	0	0	95%	95.2%	86.4%	80.8%						
MH16	Adult General Psychiatry-Acute Recovery Team	3 Working Days																																	
		48 hours																																	
		7 days																																	

Comments and Actions:

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

Methodologies

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

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

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

WeAreC.B.I.T
Corporate Business Information Team

Waiting Times Compliance - Community Health Services
Leicestershire Partnership Trust Total

Leicestershire Partnership NHS
NHS Trust

Service Details				Patient Flow (referrals and discharges in month)							
				No. of New Referrals Received				No. of Discharges			
Service Spec	Service Name	Target Waiting Time (all targets are locally agreed unless otherwise stated)	Wait Time Measure	Aug-19	Sep-19	Oct-19	Referrals Trendline (Rolling 12 Months)	Aug-19	Sep-19	Oct-19	Discharge Trendline (Rolling 12 Months)
CHS03	Continence Nursing Service	20 Working Days	Referral to first clinically relevant contact	662	720	607		897	806	922	
		Level 1 Assessment									
CHS04	Respiratory Specialist Service	Urgent	Referral to first clinically relevant face to face contact	6	5	8		7	6	4	
		Routine		150	164	205		136	141	141	
		Rapid Response									
CHS07	Heart Failure Service	Urgent	Referral to first clinically relevant face to face contact	10	8	9		6	15	14	
		Routine		173	175	195		122	113	171	
CHS10	Physiotherapy	Routine 4 Weeks	Referral to first clinically relevant contact	0	0	0		411	276	31	
		Urgent 5 Working Days		0	0	0		74	62	1	
		Non self Urgent RTT 5 Working Days	Referral to Treatment	22	19	19		28	23	29	
		Non self Routine RTT 30 Working Days		334	223	239		349	379	436	
		Self Referrals Urgent RTT 5 Working Days		430	323	139		297	276	343	
		Self Referrals Routine RTT 30 Working Days		1776	1986	2480		1197	1226	1570	
CHS19	Podiatry	Routine 20 Working Days	Referral to first clinically relevant face to face contact	1366	1282	1355		1271	1485	1309	
		Urgent 5 Working Days		34	22	28		14	11	14	
CHS22	Speech Therapy	Routine 4 Weeks	Referral to first clinically relevant face to face contact	341	316	348		293	257	314	
		Urgent 10 Working Days		40	47	43		36	51	31	
CHS69/70/80	Community Therapy	3 Working Days (P1)*	Referral to first clinically relevant contact	119	141	153		127	125	139	
		20 Working Days (P2)*		578	580	649		585	490	723	
		60 Working Days (P3)*		99	78	85		104	83	114	
CHS87	Stroke & Neuro	3 Working Days	Referral to first clinically relevant contact	5	8	9		6	12	8	
		20 Working Days		216	203	243		183	235	219	
MH37	MHSOP Community Teams	High Priority 4 Weeks	Referral to first clinically relevant face to face contact	26	21	34		19	9	23	
		Routine 6 Weeks		93	119	157		81	85	101	
MH40	MHSOP - Memory Clinics	RTT 18 Weeks	Referral to Treatment	225	216	235		140	132	199	
		High Priority 4 Weeks	Referral to first clinically relevant face to face contact	0	0	0		0	0	0	
		Routine 6 Weeks		0	0	0		13	6	10	
MH45	MHSOP Outpatient Service	High Priority 4 Weeks	Referral to first clinically relevant face to face contact	2	1	4		3	4	5	
		Routine 6 Weeks		130	132	145		109	113	95	
CHS05a	Planned End of Life Care Service (Hospice at Home)	2 Weeks	Referral to first clinically relevant face to face contact	1	0	2		1	0	2	
		24 Hours		62	61	227		61	63	221	
		2 Hours		62	56	611		62	55	609	
MH55	Integrated Care – Mental Health	15 Working Days	Referral to first clinically relevant face to face contact	26	33	23		24	26	30	
CHS17	City Reablement Service	5 Working Days	Referral to first clinically relevant face to face contact	46	52	77		62	52	63	
CHS05b	Specialist Palliative Care Nursing Service (Macmillan)	2 Working Days									
		5 Working Days									
MH38	Care Homes In Reach Team	72 Hours									

		Incomplete Pathways (at end of month)									
		No. of Referrals Waiting			Length of Wait		Waiting Time Compliance				
Service Spec	Target Waiting Time	No of Patients Within Target	Patients > target < 52 weeks	Patients > target >= 52 weeks	Longest Waiter Over target < 52 Weeks	Longest Waiter >= 52 Weeks	Target	Aug-19	Sep-19	Oct-19	Incomplete Compliance Trendline
CHS03	20 Working Days	447	1069	0	49	0	95%	32.1%	47.7%	29.5%	
CHS03	Level 1 Assessment										
CHS04	Urgent	1	0	0	0	0	90%	100.0%	100.0%	100.0%	
CHS04	Routine	158	19	0	10	0	90%	91.5%	88.3%	89.3%	
CHS04	Rapid Response										
CHS07	Urgent	3	0	0	0	0	90%	N/A	N/A	100.0%	
CHS07	Routine	134	3	0	10	0	90%	91.7%	93.0%	97.8%	
CHS10	Routine 4 Weeks	0	0	0	0	0	95%	6.3%	25.0%	N/A	
CHS10	Urgent 5 Working Days	0	0	0	0	0	95%	N/A	N/A	N/A	
CHS10	Non self Urgent RTT 5 Working Days	5	2	0	8	0	92%	63.6%	88.9%	71.4%	
CHS10	Non self Routine RTT 30 Working Days	133	208	0	26	0	92%	70.7%	69.9%	39.0%	
CHS10	Self Referrals Urgent RTT 5 Working Days	7	25	0	10	0	92%	72.4%	53.1%	21.9%	
CHS10	Self Referrals Routine RTT 30 Working Days	1298	43	0	22	0	92%	72.4%	72.2%	96.8%	
CHS19	Routine 20 Working Days	855	11	2	22	77	95%	98.3%	98.4%	98.5%	
CHS19	Urgent 5 Working Days	2	0	0	0	0	95%	75.0%	80.0%	100.0%	
CHS22	Routine 4 Weeks	240	34	0	48	0	95%	81.6%	63.8%	87.6%	
CHS22	Urgent 10 Working Days	11	0	0	0	0	95%	94.1%	100.0%	100.0%	
CHS69/70/80	3 Working Days (P1)*	19	1	0	1	0	95%	93.8%	72.4%	95.0%	
CHS69/70/80	20 Working Days (P2)*	450	391	0	19	0	95%	47.3%	74.2%	53.5%	
CHS69/70/80	60 Working Days (P3)*	182	33	0	25	0	95%	76.7%	76.5%	84.7%	
CHS87	3 Working Days	2	0	0	0	0	95%	N/A	N/A	100.0%	
CHS87	20 Working Days	172	59	0	16	0	95%	81.9%	57.5%	74.5%	
MH37	High Priority 4 Weeks	21	4	0	8	0	95%	64.0%	66.7%	84.0%	
MH37	Routine 6 Weeks	152	27	0	16	0	95%	80.9%	80.7%	84.9%	
MH40	RTT 18 Weeks	729	50	0	51	0	92%	91.7%	92.4%	93.6%	
MH40	High Priority 4 Weeks	0	0	0	0	0	95%	N/A	N/A	N/A	
MH40	Routine 6 Weeks	0	0	0	0	0	95%	N/A	N/A	N/A	
MH45	High Priority 4 Weeks	1	1	0	12	0	95%	50.0%	0.0%	50.0%	
MH45	Routine 6 Weeks	158	16	0	15	0	95%	78.3%	89.3%	90.8%	
CHS05a	2 Weeks	0	0	0	0	0	95%	N/A	N/A	N/A	
CHS05a	24 Hours	5	0	0	0	0	95%	N/A	N/A	100.0%	
CHS05a	2 Hours	2	0	0	0	0	95%	N/A	0.0%	100.0%	
MH55	15 Working Days	14	18	0	6	0	95%	63.0%	75.0%	43.8%	
CHS17	5 Working Days	13	1	0	1	0	95%	100.0%	100.0%	92.9%	
CHS05b	2 Working Days										
CHS05b	5 Working Days										
MH38	72 Hours										

		Complete Pathways (in month)										Information Assurance Framework				
		No. of Referrals Seen			Length of wait		Waiting Time Compliance									
Service Spec	Target Waiting Time	No of Patients Within Target	Patients > target < 52 weeks	Patients > target >= 52 weeks	Longest Waiter Over target < 52 Weeks	Longest Waiter >= 52 Weeks	Target	Aug-19	Sep-19	Oct-19	Complete Compliance Trendline	Service Line Mapping Agreed	Targets Agreed	SOP in place	PTL in place	KPI authorised as correct by executive
CHS03	20 Working Days															
CHS03	Level 1 Assessment	69	168	0	50	0	95%	13.1%	25.6%	29.1%						
CHS04	Urgent	7	0	0	0	0	90%	83.3%	100.0%	100.0%						
CHS04	Routine	141	26	0	8	0	90%	91.7%	85.9%	84.4%						
CHS04	Rapid Response															
CHS07	Urgent	6	0	0	0	0	90%	91.7%	100.0%	100.0%						
CHS07	Routine	159	22	0	19	0	90%	92.3%	88.8%	87.8%						
CHS10	Routine 4 Weeks	0	2	0	44	0	95%	0.0%	20.0%	0.0%						
CHS10	Urgent 5 Working Days	0	0	0	0	0	95%	N/A	N/A	N/A						
CHS10	Non self Urgent RTT 5 Working Days	15	6	0	2	0	95%	61.1%	66.7%	71.4%						
CHS10	Non self Routine RTT 30 Working Days	165	88	0	31	0	95%	79.2%	87.1%	65.2%						
CHS10	Self Referrals Urgent RTT 5 Working Days	84	241	0	6	0	95%	45.2%	74.0%	25.8%						
CHS10	Self Referrals Routine RTT 30 Working Days	2189	62	0	26	0	95%	96.8%	98.0%	97.2%						
CHS19	Routine 20 Working Days	1428	85	0	14	0	95%	92.0%	96.1%	94.4%						
CHS19	Urgent 5 Working Days	20	0	0	0	0	95%	100.0%	93.3%	100.0%						
CHS22	Routine 4 Weeks	262	82	0	13	0	95%	72.1%	63.7%	76.2%						
CHS22	Urgent 10 Working Days	41	3	0	2	0	95%	96.9%	97.8%	93.2%						
CHS69/70/80	3 Working Days (P1)*	120	39	0	5	0	95%	95.1%	95.6%	75.5%						
CHS69/70/80	20 Working Days (P2)*	303	442	0	19	0	95%	71.7%	38.9%	40.7%						
CHS69/70/80	60 Working Days (P3)*	48	59	0	23	0	95%	74.6%	41.6%	44.9%						
CHS87	3 Working Days	6	1	0	1	0	95%	100.0%	100.0%	85.7%						
CHS87	20 Working Days	150	94	0	16	0	95%	76.0%	53.4%	61.5%						
MH37	High Priority 4 Weeks	21	5	0	10	0	95%	76.2%	75.0%	80.8%						
MH37	Routine 6 Weeks	82	16	0	13	0	95%	83.3%	81.4%	83.7%						
MH40	RTT 18 Weeks	194	46	1	39	56	95%	86.2%	82.2%	80.5%						
MH40	High Priority 4 Weeks	0	0	0	0	0	95%	N/A	N/A	N/A						
MH40	Routine 6 Weeks	0	0	0	0	0	95%	N/A	N/A	N/A						
MH45	High Priority 4 Weeks	3	0	0	0	0	95%	100.0%	100.0%	100.0%						
MH45	Routine 6 Weeks	118	20	0	16	0	95%	88.2%	77.7%	85.5%						
CHS05a	2 Weeks	2	0	0	0	0	95%	100.0%	N/A	100.0%						
CHS05a	24 Hours	200	19	0	1	0	95%	91.8%	93.1%	91.3%						
CHS05a	2 Hours	517	87	0	0	0	95%	75.0%	94.3%	85.6%						
MH55	15 Working Days	5	18	0	8	0	95%	24.1%	16.0%	21.7%						
CHS17	5 Working Days	57	10	0	3	0	95%	87.2%	89.8%	85.1%						
CHS05b	2 Working Days															
CHS05b	5 Working Days															
MH38	72 Hours															

Comments and Actions:

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

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

CHS10 - Physiotherapy
Provided New MSK Physiotherapy RTT data. Still awaiting final sign off by commissioners.

The service started to accept referrals from 1st February 2019 on the referral to treatment (RTT) pathway.
The different 'Target Waiting Time' are:
• Urgent RTT 5 working days (Non-self Referrals) – these referrals exclude referrals sources: 'Self Referral' and 'Self-Referral: GP Suggested'
• Routine RTT 30 working days (Non-self Referrals) – these referrals exclude referrals sources: 'Self Referral' and 'Self-Referral: GP Suggested'
• Urgent RTT 5 working days (Self Referrals) – these referrals only include referrals sources: 'Self Referral' and 'Self-Referral: GP Suggested'
• Routine RTT 30 working days (Self Referrals) – these referrals only include referrals sources: 'Self Referral' and 'Self-Referral: GP Suggested'

CHS05a - Hospice at Home
The significantly increase in the number of referrals into the service and the number of patients on the complete pathway was due to the implementation of the first phase of the new model (Integrated Community Specialist Palliative Care) with the introduction of a new EOL & Palliative Care Co-ordination Centre. The aim of the Co-ordination Centre is to improve end of life and palliative care for all patients. Therefore, all referrals and tasks for EOL & Palliative care patients were triaged directly through the Co-ordination Centre. Now, a robust operational process and referral criteria has been developed to reduce the number of inappropriate referrals directed to the Co-ordination Centre.

CHS19 - Podiatry 52 Week Breach
Both breaches were due to the service accidentally discharging patients already under the care of the service. The service then created a new referral and backdated the referral date causing the long waiting time. The service have been informed that they can re-open the discharged referral and have agreed to fix this and end the newly created referral as a duplicate. These breaches are non-genuine.

MHSOP Memory clinics (complete pathway):
This was a YODAS patient who was referred on 21/9/18 and assessed on 26/11/19 (9 weeks). MRI scan requested on 28/11/18 and results received on 20/1/19 (7 weeks). Patient had their follow up appointment on 8/3/19 (this is usually when a patient receives a diagnosis) however the service were unable to diagnose therefore an internal referral was made to the Psychology service for further investigation.

Methodologies

RTT Methodology:
The RTT methodology is correct as per the way that RiO electronic patient record functions. There are system level action dates that are needed to sequence the information for the calculation. This means that the front end processing of RTT needs to happen as it occurs and entered in to RiO. Therefore, any information entered into RiO that is back dated will take the action date as the RTT status/outcome. We are educating staff to outcome appointments within a timely manner as defined by Trust policy for record keeping.

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

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

WeAreC.B.I.T
Corporate Business Information Team

Waiting Times Compliance - Community Health Services
LLR Total

Leicestershire Partnership NHS
NHS Trust

Service Details				Patient Flow (referrals and discharges in month)								Incomplete Pathways (at end of month)										Complete Pathways (in month)										Information Assurance Framework				
				No. of New Referrals Received				No. of Discharges				No. of Referrals Waiting			Length of Wait		Waiting Time Compliance					No. of Referrals Seen			Length of wait		Waiting Time Compliance									
Service Spec	Service Name	Target Waiting Time (all targets are locally agreed unless otherwise stated)	Wait Time Measure	Aug-19	Sep-19	Oct-19	Referrals Trendline (Rolling 12 Months)	Aug-19	Sep-19	Oct-19	Discharge Trendline (Rolling 12 Months)	No of Patients Within Target	Patients > target < 52 weeks	Patients > target >= 52 weeks	Longest Waiter Over target < 52 Weeks	Longest Waiter >= 52 Weeks	Target	Aug-19	Sep-19	Oct-19	Incomplete Compliance Trendline	No of Patients Within Target	Patients > target < 52 weeks	Patients > target >= 52 weeks	Longest Waiter Over target < 52 Weeks	Longest Waiter >= 52 Weeks	Target	Aug-19	Sep-19	Oct-19	Complete Compliance Trendline	Service Line Mapping Agreed	Targets Agreed	SOP in place	PTL in place	KPI authorised as correct by executive
CHS03	Continence Nursing Service	20 Working Days	Referral to first clinically relevant contact	661	717	606		893	805	919		447	1069	0	49	0	95%	30.9%	35.5%	29.5%																
		Level 1 Assessment																				69	168	0	50	0	95%	13.1%	25.6%	29.1%						
CHS04	Respiratory Specialist Service	Urgent	Referral to first clinically relevant face to face contact	6	5	8		7	6	4		1	0	0	0	0	90%	100.0%	100.0%	100.0%		7	0	0	0	0	90%	83.3%	100.0%	100.0%						
		Routine		149	164	205		135	140	141		158	19	0	10	0	90%	91.5%	88.3%	89.3%		141	26	0	8	0	90%	83.3%	85.9%	84.4%						
		Rapid Response																																		
CHS07	Heart Failure Service	Urgent	Referral to first clinically relevant face to face contact	10	8	9		6	15	14		3	0	0	0	0	90%	N/A	N/A	100.0%		6	0	0	0	0	90%	91.7%	100.0%	100.0%						
		Routine		173	175	195		122	113	171		134	3	0	10	0	90%	91.7%	93.0%	97.8%		159	22	0	19	0	90%	92.3%	88.8%	87.8%						
CHS10	Physiotherapy	Routine 4 Weeks	Referral to first clinically relevant contact	0	0	0		411	276	31		0	0	0	0	0	95%	12.5%	50.0%	N/A		0	2	0	44	0	95%	0.0%	20.0%	0.0%						
		Urgent 5 Working Days		0	0	0		74	62	1		0	0	0	0	0	95%	N/A	N/A	N/A		0	0	0	0	0	95%	N/A	N/A	N/A						
		Non self Urgent RTT 5 Working Days	Referral to Treatment	22	19	19		28	23	29		5	2	0	8	0	92%	63.6%	88.9%	71.4%		15	6	0	2	0	95%	61.1%	66.7%	71.4%						
		Non self Routine RTT 30 Working Days		333	219	239		346	377	433		133	208	0	26	0	92%	41.4%	39.7%	39.0%		163	88	0	31	0	95%	58.5%	74.3%	64.9%						
		Self Referrals Urgent RTT 5 Working Days		427	320	139		297	276	342		7	25	0	10	0	92%	44.8%	56.1%	21.9%		84	239	0	6	0	95%	40.4%	48.0%	26.0%						
		Self Referrals Routine RTT 30 Working Days		1770	1982	2472		1196	1220	1567		1295	42	0	22	0	92%	78.0%	94.4%	96.9%		2183	62	0	26	0	95%	93.7%	96.0%	97.2%						
CHS19	Podiatry	Routine 20 Working Days	Referral to first clinically relevant face to face contact	1356	1277	1349		1246	1425	1286		854	11	2	22	77	95%	96.5%	96.9%	98.5%		1422	85	0	14	0	95%	93.1%	92.1%	94.4%						
		Urgent 5 Working Days		34	22	27		14	11	14		2	0	0	0	0	95%	75.0%	80.0%	100.0%		20	0	0	0	0	95%	100.0%	93.3%	100.0%						
CHS22	Speech Therapy	Routine 4 Weeks	Referral to first clinically relevant face to face contact	326	309	344		283	252	310		236	29	0	17	0	95%	88.2%	87.5%	89.1%		260	76	0	13	0	95%	77.4%	77.3%	77.4%						
		Urgent 10 Working Days		40	47	43		36	51	31		11	0	0	0	0	95%	94.1%	100.0%	100.0%		41	3	0	2	0	95%	96.9%	97.8%	93.2%						
CHS69/70/80	Community Therapy	3 Working Days (P1)*	Referral to first clinically relevant contact	118	140	153		125	122	139		19	1	0	1	0	95%	93.8%	72.4%	95.0%		120	39	0	5	0	95%	90.3%	91.1%	75.5%						
		20 Working Days (P2)*		576	579	648		583	489	722		449	391	0	19	0	95%	44.7%	48.5%	53.5%		302	442	0	19	0	95%	43.4%	38.9%	40.6%						
		60 Working Days (P3)*		99	78	85		103	83	114		182	33	0	25	0	95%	76.7%	76.5%	84.7%		48	59	0	23	0	95%	49.3%	41.6%	44.9%						
CHS87	Stroke & Neuro	3 Working Days	Referral to first clinically relevant contact	5	8	9		6	12	8		2	0	0	0	0	95%	N/A	N/A	100.0%		6	1	0	1	0	95%	100.0%	100.0%	85.7%						
		20 Working Days		214	202	243		183	234	216		172	59	0	16	0	95%	63.9%	65.1%	74.5%		150	94	0	16	0	95%	52.0%	53.4%	61.5%						
MH37	MHSOP Community Teams	High Priority 4 Weeks	Referral to first clinically relevant face to face contact	26	21	34		18	9	23		21	4	0	8	0	95%	64.0%	66.7%	84.0%		21	5	0	10	0	95%	76.2%	75.0%	80.8%						
		Routine 6 Weeks		93	119	157		80	82	101		152	27	0	16	0	95%	80.9%	80.7%	84.9%		82	16	0	13	0	95%	83.3%	81.4%	83.7%						
MH40	MHSOP - Memory Clinics	RTT 18 Weeks	Referral to Treatment	225	216	235		140	132	198		729	50	0	51	0	92%	91.7%	92.4%	93.6%		194	46	1	39	56	95%	86.2%	82.2%	80.5%						
		High Priority 4 Weeks	Referral to first clinically relevant face to face contact	0	0	0		0	0	0		0	0	0	0	0	95%	N/A	N/A	N/A		0	0	0	0	0	95%	N/A	N/A	N/A						
		Routine 6 Weeks		0	0	0		7	4	7		0	0	0	0	0	95%	N/A	N/A	N/A		0	0	0	0	0	95%	N/A	N/A	N/A						
MH45	MHSOP Outpatient Service	High Priority 4 Weeks	Referral to first clinically relevant face to face contact	2	1	4		3	4	5		1	1	0	12	0	95%	50.0%	0.0%	50.0%		3	0	0	0	0	95%	100.0%	100.0%	100.0%						
		Routine 6 Weeks		128	132	145		106	109	92		158	16	0	15	0	95%	81.7%	89.3%	90.8%		118	20	0	16	0	95%	76.4%	80.5%	85.5%						
CHS05a	Planned End of Life Care Service (Hospice at Home)	2 Weeks	Referral to first clinically relevant face to face contact	1	0	2		1	0	2		0	0	0	0	0	95%	N/A	N/A	N/A		2	0	0	0	0	95%	100.0%	N/A	100.0%						
		24 Hours		62	61	227		61	63	221		5	0	0	0	0	95%	N/A	N/A	100.0%		200	19	0	1	0	95%	91.8%	93.1%	91.3%						
		2 Hours		62	56	610		62	55	608		2	0	0	0	0	95%	N/A	0.0%	100.0%		516	87	0	0	0	95%	75.0%	94.3%	85.6%						
MH55	Integrated Care – Mental Health	15 Working Days	Referral to first clinically relevant face to face contact	26	33	23		24	26	30		14	18	0	6	0	95%	63.0%	75.0%	43.8%		5	18	0	8	0	95%	24.1%	16.0%	21.7%						
CHS17	City Reablement Service	5 Working Days	Referral to first clinically relevant face to face contact	46	52	77		62	52	63		13	1	0	1	0	95%	100.0%	100.0%	92.9%		57	10	0	3	0	95%	87.2%	89.8%	85.1%						
CHS05b	Specialist Palliative Care Nursing Service (Macmillan)	2 Working Days																																		
		5 Working Days																																		
MH38	Care Homes In Reach Team	72 Hours																																		

Comments and Actions:

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

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

CHS10 - Physiotherapy
Provided New MSK Physiotherapy RTT data. Still awaiting final sign off by commissioners.

The service started to accept referrals from 1st February 2019 on the referral to treatment (RTT) pathway.
The different 'Target Waiting Time' are:
• Urgent RTT 5 working days (Non-self Referrals) – these referrals exclude referrals sources: 'Self Referral' and 'Self-Referral: GP Suggested'
• Routine RTT 30 working days (Non-self Referrals) – these referrals exclude referrals sources: 'Self Referral' and 'Self-Referral: GP Suggested'
• Urgent RTT 5 working days (Self Referrals) – these referrals only include referrals sources: 'Self Referral' and 'Self-Referral: GP Suggested'
• Routine RTT 30 working days (Self Referrals) – these referrals only include referrals sources: 'Self Referral' and 'Self-Referral: GP Suggested'

CHS05a - Hospice at Home
The significantly increase in the number of referrals into the service and the number of patients on the complete pathway was due to the implementation of the first phase of the new model (Integrated Community Specialist Palliative Care) with the introduction of a new EOL & Palliative Care Co-ordination Centre. The aim of the Co-ordination Centre is to improve end of life and palliative care for all patients. Therefore, all referrals and tasks for EOL & Palliative care patients were triaged directly through the Co-ordination Centre. Now, a robust operational process and referral criteria has been developed to reduce the number of inappropriate referrals directed to the Co-ordination Centre.

CHS19 - Podiatry 52 Week Breach
Both breaches were due to the service accidentally discharging patients already under the care of the service. The service then created a new referral and backdated the referral date causing the long waiting time. The service have been informed that they can re-open the discharged referral and have agreed to fix this and end the newly created referral as a duplicate. These breaches are non-genuine.

MHSOP Memory clinics (complete pathway):
This was a YODAS patient who was referred on 21/9/18 and assessed on 26/11/19 (9 weeks). MRI scan requested on 28/11/18 and results received on 20/1/19 (7 weeks). Patient had their follow up appointment on 8/3/19 (this is usually when a patient receives a diagnosis) however the service were unable to diagnose therefore an internal referral was made to the Psychology service for further investigation.

Methodologies

RTT Methodology:
The RTT methodology is correct as per the way that RiO electronic patient record functions. There are system level action dates that are needed to sequence the information for the calculation. This means that the front end processing of RTT needs to happen as it occurs and entered in to RiO. Therefore, any information entered into RiO that is back dated will take the action date as the RTT status/outcome. We are educating staff to outcome appointments within a timely manner as defined by Trust policy for record keeping.

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

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

WeAreC.B.I.T Corporate Business Information Team

Waiting Times Compliance - Families, Young People and Children's Services
Leicestershire Partnership Trust Total

Leicestershire Partnership NHS Trust

Service Details				Patient Flow (referrals and discharges in month)								Incomplete Pathways (at end of month)										Complete Pathways (in month)										Information Assurance Framework				
				No. of New Referrals Received				No. of Discharges				No. of Referrals Waiting			Length of Wait		Waiting Time Compliance					No. of Referrals Seen			Length of wait		Waiting Time Compliance									
Service Spec	Service Name	Target Waiting Time (all targets are locally agreed unless otherwise stated)	Wait Time Measure	Aug-19	Sep-19	Oct-19	Referrals Trendline (Rolling 12 Months)	Aug-19	Sep-19	Oct-19	Discharge Trendline (Rolling 12 Months)	No of Patients Within Target	Patients > target < 52 weeks	Patients > target > = 52 weeks	Longest Waiter Over target < 52 Weeks	Longest Waiter >= 52 Weeks	Target	Aug-19	Sep-19	Oct-19	Incomplete Compliance Trendline	No of Patients Within Target	Patients > target < 52 weeks	Patients > target > = 52 weeks	Longest Waiter Over target < 52 Weeks	Longest Waiter >= 52 Weeks	Target	Aug-19	Sep-19	Oct-19	Complete Compliance Trendline	Service Line Mapping Agreed	Targets Agreed	SOP in place	PTL in place	KPI authorised as correct by executive
CHS23	Childrens Audiology	National incomplete target 99%: 6 Weeks	Referral to clinically relevant contact	340	482	531		471	445	403		351	0	0	0	0	99%	100.0%	100.0%	100.0%		430	1	0	6	0	92%	100.0%	99.9%	99.8%						
CHS24	Childrens Occupational Therapy	18 Weeks	Referral to Treatment	27	36	30		34	26	37		85	1	0	28	0	92%	97.5%	97.9%	98.8%		43	2	0	19	0	92%	98.4%	100.0%	95.6%						
CHS25	Childrens Physiotherapy	18 Weeks	Referral to Treatment	10	11	15		12	15	19		51	3	0	24	0	92%	98.4%	96.7%	94.4%		13	1	0	19	0	92%	83.3%	88.2%	92.9%						
CHS27	Childrens Speech & Language Therapy	18 Weeks	Referral to Treatment	122	156	175		360	372	400		452	1	0	18	0	92%	98.6%	99.8%	99.8%		232	4	0	19	0	92%	98.3%	97.1%	98.3%						
CHS29	LNDS & HENS Domiciliary	4 Weeks	Referral to Assessment	116	122	143		119	133	114		110	39	0	23	0	95%	65.0%	79.8%	73.8%		43	72	0	23	0	92%	76.8%	71.8%	37.4%						
	LNDS & HENS Outpatients	18 Weeks	Referral to Assessment	423	467	456		277	344	325		1110	57	0	37	0	95%	95.1%	94.6%	95.1%		368	35	0	36	0	92%	95.7%	94.7%	91.3%						
CHS34	Community Paediatrics	18 Weeks	Referral to Treatment	67	77	106		59	58	89		245	9	0	29	0	92%	97.5%	97.5%	96.5%		85	9	0	35	0	92%	96.1%	87.3%	90.4%						
MH19	PIER - First Episode in Psychosis Service	National complete target 53%: 2 Weeks	Referral to Treatment	56	61	61		48	36	52		16	7	0	4	0	53%	68.2%	85.7%	69.6%		18	9	0	6	0	56%	90.0%	65.9%	66.7%						
MH30	CAMHS Young People's Team	13 weeks	Referral to Treatment	25	34	38		41	31	24		45	0	0	0	0	92%	100.0%	100.0%	100.0%		33	1	0	13	0	92%	100.0%	100.0%	97.1%						
MH31	CAMHS Learning Disabilities	18 weeks	Referral to Treatment	12	14	20		9	12	12		24	0	0	0	0	92%	100.0%	100.0%	100.0%		15	1	0	19	0	92%	100.0%	100.0%	93.8%						
MH33	CAMHS Paediatric Psychology	18 weeks	Referral to Treatment	27	41	33		53	38	32		84	5	0	23	0	60%	98.1%	95.3%	94.4%		23	13	0	23	0	60%	74.4%	73.4%	63.9%						
MH47	CAMHS - Eating Disorders	Routine 4 Weeks	Referral to face to face assessment	7	12	11		11	20	21		4	1	0	12	0	60%	33.3%	55.6%	80.0%		18	2	0	15	0	60%	66.7%	62.5%	90.0%						
		Urgent 1 Week	Referral to face to face assessment	1	3	3		1	2	4		1	0	0	0	0	60%	N/A	N/A	100.0%		2	0	0	0	0	60%	0.0%	100.0%	100.0%						
MH47	CAMHS - Eating Disorders	Commissioner: Routine 6 Weeks	Referral to NICE Concordant Treatment	7	12	11		11	20	21		3	2	0	12	0	95%	55.6%	83.3%	60.0%		5	3	0	15	0	95%	40.0%	60.0%	62.5%						
		Commissioner: Urgent 4 Weeks		1	3	3		1	2	4		1	0	0	0	0	95%	N/A	100.0%	100.0%		3	0	0	0	0	95%	100.0%	100.0%	100.0%						
MH47	CAMHS - Eating Disorders	National monitoring: no target Routine 4 Weeks	Referral to NICE Concordant Treatment	7	12	11		11	20	21		3	2	0	12	0	95%	33.3%	66.7%	60.0%		5	3	0	15	0	95%	40.0%	60.0%	62.5%						
		National monitoring: no target Urgent 1 Week		1	3	3		1	2	4		1	0	0	0	0	95%	N/A	100.0%	100.0%		2	1	0	1	0	95%	0.0%	100.0%	66.7%						
MH50	CAMHS Access and Outpatients	4 weeks	Referral to first clinically relevant contact	26	52	52		19	33	51		35	2	0	5	0	92%	94.7%	100.0%	94.6%		46	5	0	6	0	92%	81.3%	100.0%	90.2%						
		13 weeks		136	152	246		81	136	190		156	0	0	0	0	95%	99.1%	100.0%	100.0%		189	1	0	14	0	92%	98.6%	98.1%	99.5%						
MH51	CAMHS Crisis and Home Treatment	24 Hours	Referral to first clinically relevant contact	43	94	94		27	68	50		0	3	0	0	0	92%	N/A	50.0%	0.0%		67	15	0	4	0	95%	90.7%	70.8%	81.7%						
CHS28a	CAfSS ;- Diana Community & Family Service	28 calender days	Referral to Assessment																																	
CHS28b	DIANA CHILDRENS COMMUNITY NURSING	2 Working Days	% of acute referrals actioned within 2 working days																																	
CHS29	LNDS & HENS Community Hospital Inpatients	Urgent 48 Hours																																		
		Routine 5 days																																		
CHS67	Childrens Respiratory Physiotherapy	Urgent 48 Hours																																		
		Routine 4 Weeks																																		
MH04	Eating Disorders Outpatients and Day Care	Urgent 10 Days																																		
		Routine 13 Weeks																																		

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

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

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

Methodologies:

RTT Methodology
The RTT methodology is correct as per the way that RiO electronic patient record functions. There are system level action dates that are needed to sequence the information for the calculation. This means that the front end processing of RTT needs to happen as it occurs and entered in to RiO. Therefore, any information entered into RiO that is back dated will take the action date as the RTT status/outcome. We are educating staff to outcome appointments within a timely manner as defined by Trust policy for record keeping.

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

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

WeAre C.B.I.T
Corporate Business Information Team

Waiting Times Compliance - Families, Young People and Children's Services LLR Total

Leicestershire Partnership NHS
NHS Trust

Service Details				Patient Flow (referrals and discharges in month)								Incomplete Pathways (at end of month)										Complete Pathways (in month)										Information Assurance Framework				
				No. of New Referrals Received				No. of Discharges				No. of Referrals Waiting			Length of Wait		Waiting Time Compliance					No. of Referrals Seen			Length of wait		Waiting Time Compliance									
Service Spec	Service Name	Target Waiting Time *(all targets are locally agreed unless otherwise stated)*	Wait Time Measure	Aug-19	Sep-19	Oct-19	Referrals Trendline (Rolling 12 Months)	Aug-19	Sep-19	Oct-19	Discharge Trendline (Rolling 12 Months)	No of Patients Within Target	Patients > target < 52 weeks	Patients > target >= 52 weeks	Longest Waiter Over target < 52 Weeks	Longest Waiter >= 52 Weeks	Target	Aug-19	Sep-19	Oct-19	Incomplete Compliance Trendline	No of Patients Within Target	Patients > target < 52 weeks	Patients > target >= 52 weeks	Longest Waiter Over target < 52 Weeks	Longest Waiter >= 52 Weeks	Target	Aug-19	Sep-19	Oct-19	Complete Compliance Trendline	Service Line Mapping Agreed	Targets Agreed	SOP in place	PTL in place	KPI authorised as correct by executive
CHS23	Childrens Audiology	National incomplete target 99%: 6 Weeks	Referral to clinically relevant contact	331	475	516		462	434	398		340	0	0	0	0	99%	100.0%	100.0%	100.0%		425	1	0	6	0	92%	100.0%	99.7%	99.8%						
CHS24	Childrens Occupational Therapy	18 Weeks	Referral to Treatment	26	36	30		32	25	34		84	1	0	28	0	92%	99.0%	97.6%	98.8%		43	2	0	19	0	92%	96.9%	100.0%	95.6%						
CHS25	Childrens Physiotherapy	18 Weeks	Referral to Treatment	10	11	15		12	15	18		51	3	0	24	0	92%	96.7%	96.0%	94.4%		13	1	0	19	0	92%	83.3%	88.2%	92.9%						
CHS27	Childrens Speech & Language Therapy	18 Weeks	Referral to Treatment	116	153	172		330	347	385		446	1	0	18	0	92%	97.2%	99.6%	99.8%		227	4	0	19	0	92%	96.7%	94.3%	98.3%						
CHS29	LNDS & HENS Domiciliary	4 Weeks	Referral to Assessment	116	120	143		118	132	113		110	39	0	23	0	95%	55.1%	73.3%	73.8%		43	72	0	23	0	92%	53.5%	43.5%	37.4%						
	LNDS & HENS Outpatients	18 Weeks	Referral to Assessment	422	464	454		275	343	322		1105	57	0	37	0	95%	93.0%	93.1%	95.1%		367	35	0	36	0	92%	91.4%	89.4%	91.3%						
CHS34	Community Paediatrics	18 Weeks	Referral to Treatment	67	77	106		59	57	86		245	9	0	29	0	92%	96.0%	96.0%	96.5%		85	9	0	35	0	92%	92.2%	87.3%	90.4%						
MH19	PIER - First Episode in Psychosis Service	National complete target 53%: 2 Weeks	Referral to Treatment	55	52	57		45	34	47		16	6	0	4	0	53%	68.2%	71.4%	72.7%		16	7	0	6	0	56%	80.0%	65.0%	69.6%						
MH30	CAMHS Young People's Team	13 weeks	Referral to Treatment	24	32	36		41	28	24		42	0	0	0	0	92%	100.0%	100.0%	100.0%		33	1	0	13	0	92%	100.0%	100.0%	97.1%						
MH31	CAMHS Learning Disabilities	18 weeks	Referral to Treatment	12	13	20		9	12	12		23	0	0	0	0	92%	100.0%	100.0%	100.0%		15	1	0	19	0	92%	100.0%	100.0%	93.8%						
MH33	CAMHS Paediatric Psychology	18 weeks	Referral to Treatment	19	30	29		37	30	25		69	5	0	23	0	60%	96.2%	92.1%	93.2%		17	13	0	23	0	60%	71.1%	80.0%	56.7%						
MH47	CAMHS - Eating Disorders	Routine 4 Weeks	Referral to face to face assessment	7	12	11		11	20	21		4	1	0	12	0	60%	33.3%	55.6%	80.0%		18	2	0	15	0	60%	66.7%	62.5%	90.0%						
		Urgent 1 Week	Referral to face to face assessment	1	3	3		1	2	4		1	0	0	0	0	60%	N/A	N/A	100.0%		2	0	0	0	0	60%	0.0%	100.0%	100.0%						
MH47	CAMHS - Eating Disorders	Commissioner: Routine 6 Weeks	Referral to NICE Concordant Treatment	7	12	11		11	20	21		3	2	0	12	0	95%	55.6%	83.3%	60.0%		5	3	0	15	0	95%	40.0%	60.0%	62.5%						
		Commissioner: Urgent 4 Weeks		1	3	3		1	2	4		1	0	0	0	0	95%	N/A	100.0%	100.0%		3	0	0	0	0	95%	100.0%	100.0%	100.0%						
MH47	CAMHS - Eating Disorders	National monitoring: no target Routine 4 Weeks	Referral to NICE Concordant Treatment	7	12	11		11	20	21		3	2	0	12	0	95%	33.3%	66.7%	60.0%		5	3	0	15	0	95%	40.0%	60.0%	62.5%						
		National monitoring: no target Urgent 1 Week		1	3	3		1	2	4		1	0	0	0	0	95%	N/A	100.0%	100.0%		2	1	0	1	0	95%	0.0%	100.0%	66.7%						
MH50	CAMHS Access and Outpatients	4 weeks	Referral to first clinically relevant contact	26	52	51		19	33	51		34	2	0	5	0	92%	94.7%	100.0%	94.4%		46	5	0	6	0	92%	81.3%	100.0%	90.2%						
		13 weeks		134	151	245		79	134	190		155	0	0	0	0	95%	98.1%	100.0%	100.0%		189	1	0	14	0	92%	97.3%	98.1%	99.5%						
MH51	CAMHS Crisis and Home Treatment	24 Hours	Referral to first clinically relevant contact	43	92	93		27	67	49		0	3	0	0	0	92%	N/A	100.0%	0.0%		67	15	0	4	0	95%	90.7%	91.7%	81.7%						
CHS28a	CAfSS ;- Diana Community & Family Service	28 calender days	Referral to Assessment																																
CHS28b	DIANA CHILDRENS COMMUNITY NURSING	2 Working Days	% of acute referrals actioned within 2 working days																																
CHS29	LNDS & HENS Community Hospital Inpatients	Urgent 48 Hours																																	
		Routine 5 days																																	
CHS67	Childrens Respiratory Physiotherapy	Urgent 48 Hours																																	
		Routine 4 Weeks																																	
MH04	Eating Disorders Outpatients and Day Care	Urgent 10 Days																																	
		Routine 13 Weeks																																	

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

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

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

Methodologies:

RTT Methodology
The RTT methodology is correct as per the way that RiO electronic patient record functions. There are system level action dates that are needed to sequence the information for the calculation. This means that the front end processing of RTT needs to happen as it occurs and entered in to RiO. Therefore, any information entered into RiO that is back dated will take the action date as the RTT status/outcome. We are educating staff to outcome appointments within a timely manner as defined by Trust policy for record keeping.

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

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

Information Assurance Framework Definition	
Indicator	**Description**
Targets have been agreed in the service spec and are reflected correctly in the report	o Green – Targets agreed as correct in the report against the service line o Red – Targets not agreed as correct in the report against the service line
SOPs are in place to support the data entry and management of the KPI	o Green – SOPs in place and adhered to o Amber - SOPs in development/ rollout o Red – SOPs not yet available
PTLs are undertaken by the service to validate the waiting list prior to release of this report	o Green – PTL in place and compliance agreed as correct o Amber - PTL in place and cleansing waiting lists o Red – PTL not yet in place – show a date when PTLs will start
The KPI has been authorised for release using the Trust authorisation process	o Green – report signed-off by authorised executive o Red – report not signed-off by authorised executive