The theme Community Health Services Being Observed by NHS I

Leicestershire Partnership NHS Trust

Public Meeting of the Trust Board
9.30 am Tuesday 14th January 2020
Venue: Sparkenhoe Committee Room, County Hall

Public meeting					
Item No.	**Timings**	**Item**	**Purpose**	**Paper Ref**	**Discussion to be led by**
1	**09.30**	Apologies for absence: Anne Scott and welcome: Cathy Geddes and NHSI observers Mark Farmer – Healthwatch Millie Weston – LPT Graduate Scheme Emma Wallis (deputising for Anne Scott) Ashiedu Joel, NHSI Next Director NED development scheme MHSOP Team: Simon Guild, MHSOP service manager Stuart Kennedy, clinical lead Rob Snow, team administrator			Cathy Ellis
2	09.35 10 mins	Patient voice film CHS MHSOP memory service	Quality Improvement		Rachel Bilsborough
3	09.45 30 mins	Staff voice CHS MHSOP memory service Attendees: Simon Guild, MHSOP service manager Stuart Kennedy, clinical lead Rob Snow, team administrator	Quality Improvement		Rachel Bilsborough
4	10.15 25 mins	Declarations of interest in respect of items on the agenda			

5		Minutes of the previous public meeting: 3 December 2019	Assurance	A	Cathy Ellis
6		Matters arising actions	Assurance	B	Cathy Ellis
7		Chairman's Report	Information	C	Cathy Ellis
8		Chief Executive's Report Plastic Waste Reduction Pledge	Information Approval	D	Angela Hillery
		Governance and Risk			
9	10.40 10 mins	Organisational Risk Register	Assurance	E	Chris Oakes
Total for section = 75 minutes					
		Strategy and System Working			
10	10.50 20 mins	Community Health Services: • Community Service Redesign go-live update 10mins (oral) • Ageing Well strategic update 10 mins (oral)	Assurance	Oral	Rachel Bilsborough
11	11.10 10 mins	System Flow - Winter Plan and Current Pressures	Assurance	Oral	Rachel Bilsborough Gordon King Helen Thompson
12	11.20 10 mins	Break			
Total for section = 30 minutes (excluding the break)					
		Quality Improvement and Compliance			
13	11.30 5 mins	Quality Assurance Committee Highlight report 10 December 2019	Assurance	F	Liz Rowbotham
14	11.35 5 mins	Director of Nursing, AHPs and Quality Report	Assurance	G	Emma Wallis

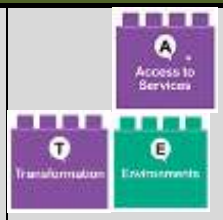
15	11.40 10 mins	Care Quality Commission (CQC) progress Report	Assurance	H	Emma Wallis
16	11.50 10 mins	Safer Staffing - Monthly Report	Assurance	I	Emma Wallis
17	12.00 10 mins	Freedom to Speak Up Guardian 6 monthly Report	Approval	J	Angela Hillery
18	12.10 10 mins	Patient Safety Quarterly Report Q2	Assurance	K	Emma Wallis
Total for section = 50 minutes					
		Performance and Assurance			
19	12.20 5 mins	Finance and Performance Committee highlight report 10 December 2019 Joint Meeting of Finance and Performance Committee and Quality Assurance Committee Highlight Report 10.12.19	Assurance	Li Lii	Geoff Rowbotham
20	12.25 10 mins	Finance Monthly Report – month 8	Assurance and Information	M	Dani Cecchini
21	12.35 10 mins	Performance Report	Assurance and Performance	N	Dani Cecchini
22	12.45 10 mins	Performance Management and Accountability Framework	Approval	O	Dani Cecchini
23	12.55 5 mins	Charitable Funds Committee Highlight Report 17 December 2019	Assurance	P	Cathy Ellis
24	1.00 5 mins	Audit and Assurance Committee Highlight Report 6 December 2019	Assurance	Q	Darren Hickman
25	1.05 5 mins	Review of risk – any further risks as a result of board discussion?	Assurance	Oral	Cathy Ellis
Total for section = 50 minutes					

26	1.10 10 mins	Information Pack (circulated to Board members only) containing: • Documents Signed Under Seal (Quarter 3) • Integrated Quality Performance Report • Organisational Risk Register slides	Information		Cathy Ellis
27		Any other urgent business			Cathy Ellis
28		Public questions on agenda items			Cathy Ellis
29	1.20	**Date of next meeting:** The next public Trust Board meeting will be held on Tuesday 3rd March 2020, venue to be confirmed.			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
2.00 pm on Tuesday 14th January 2020
Venue: Sparkenhoe Committee Room, County Hall

AGENDA

Item No.	Timings	Item	Purpose	Paper Ref	Discussion to be led by
1	2.00	Apologies for absence: Anne Scott And welcome: Emma Wallis Cathy Geddes and NHSI observers			Cathy Ellis
2	2.00	Declarations of interest in respect of items on the agenda			Cathy Ellis
3	2.00 5 mins	Minutes of the previous Confidential Meeting, 3rd December 2019 Minutes of the Board Development Meeting 20th December 2019	Assurance	AAi AAii	Cathy Ellis
4		Matters arising	Assurance	BB	Cathy Ellis
5	2.05 10 mins	Chief Executive's report	Assurance	Oral	Angela Hillery
Total for section = 15 minutes					
		Governance and Risk			
6	2.15 10 mins	System Governance	Assurance	Oral	Angela Hillery
7	2.25 5 mins	Highlight Report from Remuneration Committee 1st November 2019	Assurance	CC	Ruth Marchington
Total for section = 15 minutes					
		Strategy and System Working			
8	2.30 15 mins	Better Care Together Planning and Contract Approach 2020/21	Assurance	Oral	Dani Cecchini

9	2.45 10 mins	Single Strategic Commissioner Developments	Information	DD	Angela Hillery
10	2.55 10 mins	Break			
Total for section = 25 minutes (excluding the break)					
		Quality Improvement and Compliance  			
11	3.05 15 mins	Safeguarding Overview and Capacity Report	Assurance	EE	Emma Wallis
12	3.20 15 mins	Elimination of Dormitory Accommodation	Approval	FF	Dani Cecchini
Total for section = 30 minutes					
		Performance and Assurance 			
13	3.35 15 mins	Financial Turnaround	Assurance	Oral	Dani Cecchini
14	3.50 5 mins	Review of risk – any further risks as a result of board discussion?	Assurance	Oral	Cathy Ellis
Total for section = 20 minutes					
15	3.55	Confidential Board information pack: • System Governance – new arrangements • Single Strategic Commissioner Report			
16	3.55	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
17	3.55 5 mins	Any Other Business	Assurance	Oral	Cathy Ellis
Total for section = 5 minutes					
18	4.00	Close			

UNCONFIRMED

Leicestershire Partnership NHS Trust

Trust Board

Minutes of the Meeting held in public on Tuesday 3rd December 2019, 9.30 am

A

Leicester Racecourse

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
Mrs 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, AHPs and Quality
Dr Sue Elcock, Medical Director

In Attendance:

Ms Rachel Bilsborough, Director of Community Health Services
Mr Gordon King, Director of Adult Mental Health Services
Ms Helen Thompson, Director, Families, Young People & Children Services & Learning Disabilities
Mrs Sarah Willis, Director of Human Resources & Organisational Development
Mr Frank Lusk, Trust Secretary
Ms Kay Rippin, Corporate Affairs Manager
Ms Anna Pridmore, Interim Associate Director of Corporate Governance
Mrs Michele Morton (minutes)
Mr Brendan Daley (item TB/19/208)
Mr Paul Melling (item TB/19/208)
Gemma Clarke, LD Outreach Manager (item TB/19/210)
Mo Henton, LD Outreach Support Worker (item TB/19/210)
Jane Reynolds, LD Outreach Nurse (item TB/19/210)
Sarah Warmington, Associate Director of Commissioning ELRCCG (Item TB/18/218)
Dr Rohit Gumbar, Lead Consultant, Learning Disabilities (Item TB/19/219)
Ms Clare Hazeldine, Clinical Lead Childrens Speech & Language Therapy (observing for development)

		ACTION
TB/19/207	**Apologies and welcome** No apologies for absence had been received. The Chair welcomed Mrs Michele Morton, Mr Brendan Daley, Mr Paul Melling and Mrs Clare Hazeldine. There were no members of the public. The theme for today was Learning Disability Services	
TB/19/208	Veterans' Gold Award	
	Mr Brendan Daley and Mr Rob Melling were introduced and they talked about the employers gold award presented to them by the Ministry of Defence for the excellent work with veterans. The award ceremony in London was part of an Employer Recognition Scheme and LPT was one out of 12 NHS trusts to receive the award nationally and the 5th within Leicestershire since its inception 10 years previously. Considerable hard work had been put into achievement of the prestigious award. Brendan explained that he had been a homeless veteran three years previously and was prevented from committing suicide by the Transition Intervention Service. He added he now acted as the point of contact for veterans whom he visited and tried to change their lives. A local Civil and Materiality Partnership Board had been established that included over 40 external agencies in order to support veterans and work was currently ongoing planning a Regional Civil and Materiality Partnership Boards where hopefully funding would be received by the year end. As an example of the work carried out Brendan explained he had recently had a new volunteer suffering from severe PTSD and when the volunteer had been inducted and issued with a name badge with lanyard he said he felt like he finally had an identity. LPT was one of 35 NHS trusts whose aim was to welcome any veterans, and staff had been trained to signpost them to appropriate services. UHL currently had a NED supporting the work and Brendan asked for a nomination amongst Board members for an LPT NED representative to support and promote the work. In future the team was planning to work with Northamptonshire Health Foundation Trust to support them to reach the gold standard and LPT was also now automatically part of a gold Alumni Association. The Chair thanked Brendan and Paul for their informative presentation	**CE**

	and she wished them well with their future work.	
TB/19/209	Patient Voice Film – Learning Disability services	
	David had been invited to tell his story at a recent learning disabilities symposium. He said he felt that he was listened to and that the service always made him feel safe. One day David said he was feeling very low, almost suicidal and so he told the staff and they went to see him. David also saw one of the doctors in the crisis team and told him things were not working properly and were breaking down. A meeting was held with the community nurses, doctors and crisis team and they were asking him a lot of questions. As a result David went to stay at the Grange for two weeks and he said the staff there talked to him and listened to him. David said he did not feel alone and did not feel closed in and he did not realise there was so much help for people with a learning disability.	
	David explained an incident when he was in the Bradgate Unit and his medication was not right. The nurse had not been very nice and it was an unpleasant experience for David. When asked David said he thought it was because the nurse did not understand his learning disability and therefore he was not receiving the appropriate care and treatment.	
	The Chair thanked David for his story when she had met him at the Learning Disability symposium event. She felt his feedback was balanced and had some positives, for example he was happy where he was currently living, his positive stay at the Grange and that he had a meaningful role as a volunteer, coupled with concerns over some staff at the Bradgate Unit which was a learning point for the Trust.	
	Ms Marchington asked how feedback was routed into the appropriate channels and Ms Thompson replied work continued on the Bradgate Unit to improve understanding of people with a learning disability and autism. The Speech and Language Therapy service was also working across the Bradgate Unit and being effective in the development of passports for people. A learning disability matron had been working on improvements over the last six months and band 7 nurses were undergoing training in transforming care. A core Outreach Team existed and staff were being upskilled and efforts made to ensure improvements remained up to date. Ms Thompson explained some issues had been experienced with the crisis team who had not always responded well to people with autism and some focused training and development had taken place.	
	Ms Hillery said she had been struck by the power of the story which she felt was meaningful.	
	Mr Rowbotham said the story was important to help to recognise David's needs, both positive and his experience at the Bradgate Unit	

	and he queried whether any other sites should be looked at to ensure they were developing a blended approach for certain patients. Ms Hillery replied successful care was based on care planning and the importance of being confident that person-centered care was being delivered. She added it was important to have a holistic approach and everybody with a learning disability should have an 'all about me' booklet to help with communication, for example ensuring the correct levels of medication. The booklet underpinned how people with a learning disability were able to access all the services.	
	The Chair said she had met David previously and thanked him for making the film.	
TB/19/210	Staff Voice – Learning Disability (LD) Services	
	The Chair welcomed Gemma Clarke, LD Outreach Manager, Mo Henton, LD Outreach Support Worker, Jane Reynolds, LD Outreach Nurse and Laura Tubb, Psychologist who had attended the meeting to talk about the LD Outreach Service as follows.	
	Gemma informed Board members the service was open seven days a week, with a purpose of the prevention of inappropriate admissions to the Agnes Unit. People with a learning disability were often admitted inappropriately, which was usually due to the breakdown of placements. The Agnes Unit was also sometimes used inappropriately for respite care. The role of the team was to provide assessments, looking at the person's behaviours and identifying the associated risks. Intensive support was provided to patients that included emotional support and helping them cope in difficult times. The team worked on the provision and development of care packages, interim care arrangements and problem solving that included close working with adult social care.	
	Gemma Clarke said it was important to recognise that challenging behavior was not always due to health issues but was mainly down to the quality of care provided to people with learning disabilities living in the community. Training had been undertaken with social services teams with an aim of providing a better quality and more consistent care. She made the following further points:	
	• The appointment of Amanda, the Discharge Co-ordinator working at the Agnes Unit had made a significant difference to inappropriate admissions and discharges and she also worked closely with the 'at risk' register. Amanda worked closely with staff and she helped to build good relationships.	
	• Shared protocols had been produced that were followed prior to admission. If placements broke down (often due to CHC funding) in the community then data from multiple sources would be collated to determine what needed to be addressed.	

- There had been ten admissions to the Agnes Unit in the current year which had more than halved since 2017/18.

- A dual diagnosis link nurse worked in learning disability services, working with people with drug and alcohol dependency and working with turning point staff to help raise awareness and understanding of people with a learning disability.

- A multi-disciplinary workshop had recently been held that looked at accessible information and some case studies. Feedback from the session generated areas for future working. Mo Henton said several untrained staff had attended the workshop which had empowered her and gave her confidence to speak amongst her peers.

Jane Reynolds informed the Board she had attended the House of Lords for an all-party parliamentary group through Turning Point and had been subsequently quoted in a published report. She reiterated Gemma's comments above and said ultimately success was about the quality of basic social care.

Laura Tubb explained she had a new psychology role within the team that focused on consultation, supervision, de-briefing and staff reflection that helped to upskill the team. She carried out a few individual sessions in order to understand individual stories. Board members noted there were huge levels of distress in Learning Disability services for a variety of reasons that included trauma and emotional abuse and people often felt dis-empowered. When the levels were unable to be contained situations became unmanageable and care teams suffered from burnout. Situations often called for more and more injections of resources, but that was not always the solution. One of Laura's roles was to keep the team grounded and to remind them why people sometimes behaved the way they did. Often encouraging people to be honest about their feelings allowed them to stay emotionally healthy.

Mr Hickman said it was encouraging to see staff supported by psychology. He felt that they were focused on their objectives and the work around the prevention of admissions came across clearly. He pointed out the responsibilities social care services now had to find alternative placements for people and he sought reassurance that was working well. The team acknowledged there had been some significant changes and every effort was being made to develop positive relationships with social services and to foster joint working.

Ms Hillery said the multi-disciplinary team working came across in a positive manner and she asked how the team worked with families. Gemma replied that not many referrals existed where people were still at home. However all staff were experienced in working with families and support was offered. As an example there was often a tension when children became bigger and as parents aged they had less emotional and physical resilience. It was also important to talk to

	families at an earlier stage to discuss the future of their children.	
	The Chair thanked the team for attending and said it was good to hear about the work being carried out by such an effective team.	
TB/19/211	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/19/212	Minutes of the previous public meeting, 1st November 2019 The minutes of the meeting held on Tuesday 1st November 2019 were approved and accepted as a correct record. **Resolved: The minutes of the meeting held on Tuesday 1st November 2019 were confirmed.**	
TB/19/213	Matters arising actions	
	Trust Board members reviewed the list of matters arising actions at Paper B and noted the following: Green rated items were confirmed as closed, Amber rated items were discussed:	
	899 – Joint CEO highlighted as a risk – discussions had taken place – to be completed by January 2020.	
	903 – Assurance that a solution had been found on appropriate recording and monitoring of data for out of area beds – the number of errors in the data had reduced but some still remained. A correct position was anticipated once SystmOne was up and running. Mr King said further clarification of the situation was expected shortly. Some clarity on progress had shown patients being progressed through beds and discharged which was a combination of data quality improvements and a clearer understanding around assurance.	
	Resolved: The Matters Arising had been reviewed by the Board and status of actions agreed and minuted.	
TB/19/214	Chair's Report	
	The Chair presented paper C and reported on key highlights, that she had:	
	• Given an opening speech at the Therapeutics in Learning Disability conference for approximately 100 specialists from across the country. The annual conference had been founded several years	

	ago by Professor Sab Bhaumik who had sadly recently passed away. Professor Bhaumik had been a wonderful leader within LPT and extremely active in research.	
	• Attended a learning forum 'CQC progress meeting' for LPT staff that focused on collaborative care planning, research and mixed sex accommodation.	
	• Given an opening speech at LPT's health and wellbeing conference for staff to highlight work taking place across the trust.	
	• Had a fourth session with her mentor as part of the BAME reverse mentoring programme. The ambition had been to consider equality and diversity in a more robust way throughout the work of the Trust.	
	• Observed the Quality Assurance Committee and Finance and Performance Committee, both of which were making progress on transition to the new governance structure.	
	Resolved: The Trust Board received the Chair's report.	
TB/19/215	Chief Executive's Report	
	Ms Hillery presented paper D and highlighted the following:	
	• The development of the Better Care Together workforce plan continued. The plan was aligned to the NHS Long Term Plan and the Interim NHS People Plan. A local plan had been developed that detailed the strategic approach for LLR, and currently RAG rated as Amber with a need to develop more focus on how the changes would be delivered and the gaps addressed.	
	• A system bid had been submitted to NHS England/Improvement for the Ageing Well programme, a national framework for delivering NHS Long Term Plan commitments in relation to all community services	
	• Part of the Community Services Redesign, the 'home first' service had commenced on 1st December 2019. Ms Bilsborough was thanked for her contribution to such a significant step. Ms Bilsborough added that consultation had taken place with over 600 people and some concerns had been expressed due to the scale of change.	
	• LPT health and safety officers had visited the health and safety team at NHFT to look at their model of care around integrated health.	
	• £146,000 Winter pressure monies had recently been received for the CAMHS service, which was a welcome addition to the Winter pressures.	

	Ms Marchington referred to the health and wellbeing workshop and asked whether psychological therapies would be offered in the future to all staff as discussed previously – the staff voice presentation earlier had highlighted the advantages of doing so. Mrs Willis confirmed that she had submitted a case to the Executive Team.	
	Ms Marchington referred to the workforce section in BCT and the lack of information on equality and diversity. She added that great work was being carried out locally but it should also be taking place on a regional scale. Mrs Willis replied that she sat on a regional group that had a sub-group with a focus on equality and diversity and she acknowledged that key messages did need to be published. Ms Hillery added that quality improvement work was taking place across the system and that included equality and diversity.	
	Professor Harris asked if the trust had considered strategic links with DNRS, the national facility being proposed for rehabilitation purposes and Ms Hillery agreed to follow that up.	**AH**
	Resolved: The Trust Board received the Chief Executive's Report	
	Governance and Risk	
TB/19/216	Organisational Risk Register (ORR)	
	Ms Newham presented paper E that provided a summary of the organisation risk register that included current and residual risk scores. She explained that arrangements for the implementation of the revised risk management policy and the ORR continued to develop and be embedded. Further development work was planned that would provide clarity over the risk review cycle at the different levels. The risk review cycle was presented in appendix D. Ms Newham reported that the risk assurance and escalation process from level 3 to the level 1 and 2 committees and groups would start to embed during quarters 1 and 2 in 2020/21. During the intervening period an interim measure was being introduced to prioritise the top three risks:	
	• Top three risks with the highest residual score where they were red.	
	• Where closure or re-scoring for risk was proposed.	
	• Where current or residual scores had increased in the last month.	
	• Where risk review should be rotated to ensure coverage.	

	All the changes would be submitted to the Strategic Executive Group on the 6th December and presented for approval at the January Trust Board. Key points of note included:	
	• A potential lack of flu vaccine and a risk at directorate level linked to non-achievement of the flu target (risk 3958). That was being monitored by NHS England on a weekly basis. Additional stock of the flu vaccine had been received and there the risk was not currently recommended for escalation.	
	• Failure to deliver timely access to assessment and treatment which could impact on patient safety and outcomes – revised scoring from 12 to 16.	
	• Unmitigated demand might result in patients being unable to access services in clinically appropriate timescales – revised scoring from 12 to 16.	
	• IQPR – revised scoring at 12 – 20 (from 12 – 16).	
	The Chair said she could see that the risk register was being actively used and under regular review and this would flow into the Finance and Performance and Quality Assurance Committees on 10th December. Ms Marchington added that risks would be reviewed in relation to the changes in the executive team and that would form part of the CEO capacity risk.	
	Resolved: The Trust Board: • **Noted the organisational risk profile that included the changes since the last risk report** • **Approved the risk appetite statement in appendix C**	
TB/19/217	Standing Orders, Standing Financial Instructions and Scheme of Delegation	
	Ms Cecchini presented paper F that provided assurance that the Trust reviewed its governance requirements regularly and incorporated any necessary changes, at least annually, to support achievement of statutory financial requirements. They were last updated and approved in April 2019. Board members noted the changes had previously been reviewed by the Strategic Executive Board and due to the timing of the Board meeting the report would be presented to the Audit and Assurance Committee on 6th December as an adequacy check post Trust Board approval. A summary of the changes were shown in appendix 1 and copies of the full documents were available on request.	

	Mr Rowbotham pointed out (ref 9, align capital authorisation limits with new capital investment process) the increase to £1 million was quite significant and he asked what the reasoning was behind that. Ms Cecchini agreed that further clarification was required and the issue would be submitted back to the Audit and Assurance Committee for testing out. It was also noted that the Director of Nursing title should be correctly stated as 'Director of Nursing AHPs and Quality'	**DC**
	Resolved: The Trust Board approved the changes made to the trust's SFIs SORD and SOs subject to clarification of the above discussion.	
	Strategy and System Working	
TB/19/218	STP Workstream - LLR Learning Disability and Autism Transforming Care Programme Update	
	The Chair welcomed Sarah Warmington, Associate Director of Commissioning ELRCCG who gave a presentation with Ms Thompson that included the following headlines:	
	• Background to transforming care.	
	• Transforming care in perspective o Building the right support publication in October 2015. o National Plan outlined three key expectations: ▪ Implementation of enhanced community provision. ▪ Reduction of in-patient capacity. ▪ Rolling out care and treatment reviews in line with published policy.	
	• Establishment of the LLR Transforming Care Partnership in December 2015 – with a multi-agency approach.	
	• The total LLR cohort was made up of individuals with a learning disability and/or autism in an inpatient setting across a number of services. The programme considered: o Admission avoidance and the use of a dynamic risk register. o Reducing the length of stay and the use of the least restrictive environment possible. o Learning Disabilities Mortality Review (LeDeR) Programme. o Promoting people remaining in their community and living as independent a life as they could.	
	Board members noted the following:	
	• Admissions were avoided wherever possible and a dynamic risk of admission register was used and reviewed every two weeks and	

	was also used for discharge purposes.	
	• The plan was to reduce the length of stay for patients and that inpatient environments were less restrictive.	
	• LPT had participated in a learning disability mortality review that determined the extent that people were leading individual lives, that people were living in the appropriate environment and where packages of care could be reduced to a minimal level.	
	• One of the biggest challenges was to find appropriate accommodation for people to move into. It also took 12-16 weeks to employ the staff to support individuals.	
	The Chair asked how the Board was able to be assured of the progress being made. Ms Warmington replied a supportive action plan was in existence across the system that executive directors had access to.	
	Mrs Rowbotham said that the QAC had considered holding a deep dive on transforming care in February 2020, the results of which would be fed back to the Trust Board.	**HT**
	Board members noted that Ms Trevithick, the Chief Nurse and Quality Lead at the CCG would take the lead for Learning Disabilities across the system and would be working with Ms Hillery as Senior Responsible Officer. The Trust continued to work towards continuity within the system by making appropriate changes and keeping pace with progress.	
	Mr Rowbotham said he was attempting to understand the scale and size of the service provision within the community and also the number of people being cared for out of area. Ms Warmington replied there was an approximate 50/50 split between the Agnes Unit and alternative hospital placements. She added a whole range of Learning Disability services were currently under review, with an aim of clarifying what currently existed, where the gaps were and co-ordinating services with social care and the three different councils whose working methods were slightly different. The main aim was to ensure equitable access to services.	
	Mr Hussain emphasised the importance of good multi-disciplinary partnerships when providing services for such a vulnerable cohort of patients; especially voluntary organisations and housing associations when there was a need to be as creative as possible.	
	Ms Hillery said the above was a very clear example of where LPT could not work in isolation. Learning disabilities was an area of transformation in respect of 'Step up to Great' and it was therefore important not to lose sight of what was required as part of the overall system. Some diagnostic work had taken place as a system to understand how service	

	provision could be strengthened and more learning needed to be built in going forward.	
	Mr Rowbotham asked to what extent hard to reach groups were a challenge. Ms Warmington said some cohorts existed, particularly in the City where patients did not come forward until a crisis point was reached and people appeared when families were no longer able to manage.	
	Ms Warmington was thanked for her presentation and attendance and she was wished well in her new forthcoming role.	
	Resolved: The Trust Board received a presentation on the STP Workstream - LLR LD and Autism Transforming Care Programme Update	
	Quality Improvement and Compliance	
TB/19/220	Service Presentation: Learning Disability Service Update – Supporting the system delivery plan	
	The Chair welcomed Dr Rohit Gumbar, Lead Consultant, Learning Disabilities, who presented the following slides with Ms Thompson:	
	• Staff (238 WTE): City, County East and County West teams	
	• Short break locations, inpatient beds, LLR Outreach and Autism Team.	
	• Budget (£9.95 million).	
	• Regulators feedback: o Inpatient and short breaks. o Community learning disability services.	
	• Transforming care in learning disabilities: o How LPT's learning disability improvement programme supported the delivery of the system. o BCT transforming care plan.	
	• Agnes Unit Admissions.	
	• Length of stay and delayed transfers of care.	
	• Admission source / admission and discharge review.	
	• Learning from reviews.	
	• Learning Disability Forensic Network.	

• Local Rehabilitation Provision.	
• Health Short Breaks Review.	
• Looking forward.	
The Chairman acknowledged the learning cycle around improvements in Learning Disabilities, specifically related to the changes being introduced and tested out and she felt the compassion came through in the presentation and that everything was centered around improving the experience for patient care.	
Mrs Rowbotham referred to the workforce challenges and made reference to the mature age profile in nursing staff. Ms Thompson replied that work was ongoing with Demontfort University and the development of the new nursing degree at Leicester University. Good quality placements for students was a high priority and a good national profile existed that was helping with recruitment to vacant posts. Mrs Willis added a retire and return scheme had recently been launched where staff had been written to with various options for future flexible working. Some support was being received on wider workforce planning and an update would be presented at the next Transforming Care Partnership Board.	
Ms Marchington said she liked the person centered approach and she asked what action was being taken with regard to violence and aggression towards staff from service users. Dr Gumbar acknowledged a higher level of violence and aggression existed within learning disability services and he said staff wellbeing was a priority. A focus was on wellbeing champions and also psychology led reflection sessions occurred within each community team that allowed staff to voice their concerns and express their feelings. Staff valued those sessions and feedback was channeled back into the Trust. Ms Scott said dynamic team working helped each team member and multi-disciplinary de-briefs helped to gauge how night shifts had been.	
Ms Marchington sought assurance that the risk assessments were working with regard to assurance and safety of staff. Dr Gumbar replied risk assessments were regularly audited and were generally robust and of a good quality. Risk assessments in the community required extra focus and how risks were being managed was also considered important.	
Mr Hussain said it was encouraging to hear that physical health was considered as important as mental health. He also referred to the 7 day service of the crisis team and asked if there was any merit in extending those hours. Dr Gumbar replied that the same level of input was not required at night; the level of support was much lower and would require a different model of care.	

	Ms Pridmore asked how learning had been disseminated across the whole Trust and Dr Gumbar explained that the quality and safety team had embedded an 'up and down' process that considered issues from professional meetings and anything the team was involved in was disseminated via other teams within the Trust. Learning was also fed into the learning forums.	
	The Chair congratulated Dr Gumbar for his achievements within the team and thanked him for his informative presentation.	
	Resolved: The Trust Board received a Service Presentation: Learning Disability Service Update – Supporting the system delivery plan	
TB/19/221	Quality Assurance Committee (QAC) Highlight Report November 2019	
	Mrs Rowbotham presented paper G, a highlight report from the meeting held on the 19th November. She reported that the new governance report was received and she made the following points with regard to the red areas:	
	• There was lack of assurance on compliance with fire regulations and health and safety regulations with respect to contractors. The issues had been raised directly with the responsible director.	
	• There was a lack of assurance on the accuracy of the quality of the data in respect to the two Quality Account Indicators. Significant concerns were expressed regarding the outcome of the external auditors review and further discussions would be held at the joint QAC and FPC meeting in December 2019.	
	• An additional risk was identified around the flu vaccination rates, CPA 7 day performance and quality account indicators. A request was made for a review or that the risks be included in the ORR.	
	Ms Cecchini said the fire risk related to the seals around the fire doors. It had been reported to NHS Property Services and a flash report had been circulated to the Board. The seals did require urgent attention but did not render the property unsafe for occupation. She added the potential did exist for escalation to the Fire service who might issue a differential notice which would be an ultimate lever for resolution.	
	Ms Cecchini explained that the sub-contractors situation related to multi-layers of sub-contracting in IT services. Work referred to in the report had been completed; however an issue remained on how future contracts should be handled so that they were in line with health and safety requirements. The issue would subsequently be followed up.	

	Mrs Rowbotham said an update on the health and safety action plan was expected at the December QAC.	
	Mrs Rowbotham said she had chaired a meeting in relation to the CPA 7 day target and some improvements had been made that would be reported back on. Board members acknowledged the Quality Account Indicators would be clearer following the joint QAC and FPC meeting in December.	
	In respect of the CPA Mr Rowbotham commented that the FPC was receiving Statistical Process Control (SPC) data that indicated a more robust process was taking place on outcomes. The Committee was informed that a theme existed around better information and quality via SPC but the actions were not delivering. Mr Rowbotham said he would welcome suggestions on how to make the decisions more robust.	
	With regard to the waiting lists Ms Hillery said more clarity was required around the data which was causing some concern. A performance management challenge was required to determine whether improvements could be made with the resources available, for example, within the CAMHS services. It should be very clear who would be taking the necessary action and all the elements of information were required in order to make the correct assumptions and decisions on where trajectories needed improvement.	
	Resolved: The Trust Board received the Quality Assurance Committee Highlight Report November 2019	
TB/19/222	Director of Nursing's Report including AHP Report	
	Mrs Newham presented paper H that provided an update in respect of quality and safety. Board members noted the following key points:	
	• **Flu vaccination** – the Trust had been identified as being in the lowest quartile for 2018/19. Conversations had been held with neighbouring organisations on how to increase uptake. Considerable incentives had been introduced; however staff were still choosing not to have the vaccination.	
	• **Privacy and dignity** – that related to dormitory accommodation. MHSOP had developed a shared room risk assessment that was going to be adopted by adult mental health.	
	• **Sexual Safety National Collaborative** – LPT had been accepted into a national collaborative to improve understanding and implementation of sexual safety on all wards. Thanks were extended to Michelle Churchyard-Smith for her work on that initiative.	

	• **Buddy Forum** – Mrs Basra had taken a lead on the promotion of the buddy relationships with NHFT and information was regularly tweeted.	
	Mrs Rowbotham referred to the new way of reporting serious incidents which was set out in the report and would help to improve the flow of information. Mr Rowbotham sought clarification on the timeliness of reporting and expressed concern that once reporting was bi-monthly Board members might wait a considerable time to be informed of incidents. Mrs Rowbotham explained the two stage approach being adopted and the information in the report related to the second stage; the outcome of investigations, lessons to be learnt and how they were being embedded throughout the organisation. Discussions had been held previously about having a similar approach to the front-end of incidents when they had recently occurred.	
	Ms Newham added she was no longer producing a reportable incidents log but that Board members would receive a flash report if they needed to be informed of an incident immediately.	
	Resolved: The Trust Board noted the contents of the report.	
TB/19/223	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. She added there was a risk that the Trust might not routinely achieve regulator standards which impacted on the achievement of the 'step up to great' objective set by the Trust.	
	Mrs Rowbotham emphasised the importance of encouraging staff to update the actions in the plan so that evidence on improvements was available.	
	Ms Newham reported the plan was working very well, particularly in the area of the spot checks illustrated in the table on page 3 of the report.	
	Mr Hussain said it was good to see progress with the actions but he did not have a sense of a timescale for completion. Ms Newham said some actions had been translated into deep dives but all of the actions would be completed within the next three months.	
	Mrs Rowbotham sought assurance over the issues that were considered problematic and Ms Newham replied significant issues in all of the areas were discussed in depth at SIAM, CQRG and theQuality Assurance Committee	
	Ms Hillery said it was encouraging that evidence was being collected and Board members must be reminded that achievements documented	

	in all of the areas would be a feature of the 'Well Led' domain in relation to the CQC. People should also be clear about what was required for standards of care in services generally and not just what was contained in the action plan.	
	Ms Hillery reminded Board members about being aware of the complete picture. Mr Hussain agreed and said in the past when the Trust had been exposed to a weakness in one area and work was focused on improvements, and then other areas had slipped. Ms Hillery said staff were being encouraged to show their abilities which was helped by the workshops around outstanding practice. Conversations were also being held with staff when they were encouraged to speak out on what was stopping them from making improvements.	
	Mr Rowbotham referred to a receive service visit and felt the Trust should be ambitious enough to ask staff how they intended to reach outstanding which he felt should be an aspiration. Ms Hillery replied the Trust was planning to move in that direction and aim towards outstanding practice.	
	Mr Hussain said the CQC quality improvement toolkit might help to illustrate outstanding work. The Chair agreed and said it was important to ensure improvements were occurring across the whole of the Trust.	
	Resolved: The Trust Board received assurance over CQC related activity, including delivery against the actions identified following the 2019/19 inspection findings and proactive work in readiness for the 2019/20 inspection regime.	
TB/19/224	Patient and Carer Experience and Involvement (including Complaints)	
	Ms Newham presented paper J that aimed to present a rounded picture of patient experience and as such, provided information on all aspects of experience, good and less positive. Where poor experience was reported, actions were taken to ensure improvements were made and featured in future reports. Ms Newham highlighted the following:	
	• There was a risk that the Trust did not positively impact on the experiences of service users, carers and families that used the service.	
	• Patients did not always find it easy to share their experiences and the Trust did not as a result receive feedback.	
	• A Patient Experience and Involvement Framework was under development and until that was fully embedded there was a risk of not being able to evidence the delivery of quality patient experience.	
	Ms Newham reported on the following areas:	

	• **Compliments** – a high number of compliments had been received that demonstrated that patients and carers were mainly happy with the attitude of staff towards them.	
	• **Complaints** – there had been a reduction in the number of complaints received. Complaints were being diffused with good conversations held at an early stage.	
	• **Friends and Family Test** – The Trust was currently below the response rate of 3%, with a 1% response rate. A listening into action event had been held in September 2019 and themes had been identified from that. A 20 week improvement programme had been established. However the programme was reliant mainly on paper based information captured and alternative IT systems were being explored that would support the programme.	
	Mr Rowbotham said it was reassuring that material was being triangulated and that the major themes were being identified. He added that regular boardwalks were also bringing out themes and it would be good to add some detail to those rather than just the gathering of general statements.	
	Resolved: The Trust Board received the Patient and Carer Experience and Involvement Report (including Complaints)	
TB/19/225	Safer Staffing Report – October 2019	
	Mrs Newham presented paper K that provided an overview of the nursing safe staffing during the month of October 2019, triangulating workforce metrics, quality and outcomes linked to Nurse Sensitive Indicators 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.	
	Thanks were extended to Ms Bilsborough for leading on a piece of work on agency use which had been beneficial.	
	The Chair noted the reduction in size of the report and greater clarity. Mrs Rowbotham added the safer staffing report would be received at QAC from December onwards, which would provide some sub-committee scrutiny prior to submission to Board.	
	Mr Hickman pointed out the large number of temporary staff (mainly healthcare workers) at the Agnes Unit. Ms Newham replied numbers always increased for one to one observations with patients.	
	Ms Newham reported an issue with achievement of clinical mandatory	

	training and the need to be compliant to be deemed a safe organisation. As part of working towards compliance a piece of work had been completed to determine what was and was not mandatory. Mrs Willis added that issue has been discussed at the strategic workforce committee and the register had been split into statutory and non-essential modules. An additional piece of work would also be looking at bank staff compliance. Ms Hillery emphasised that even with a split register it would be important to be totally compliant and to produce an improved trajectory.	
	The Chair highlighted the red level on MAPPA as concerning and Ms Bilsborough replied a plan was in place for compliance by the end of the year.	
	The Chair asked if any action could be taken to improve the consistent hot spot areas for safer staffing. Mrs Willis replied the areas were always reported through to QAC and the recruitment team was being tasked to review the approach that would include a listening into action session and talking to the nurses about an additional focus around recruitment and retention.	
	The Chair said the main reason areas were highlighted as hot spots was due to the high concentration of agency staff. Mr Rowbotham agreed and said if staff were highly trained and highly effective they were more likely to be low risk and that could be looked at as another level of analysis. Dr Scott replied that nurse assessments provided that level of detail. When discussions took place as part of risk assessments nurses would highlight the significant risks and would identify peer staff skills with high levels of acuity.	
	Mr Hickman said he took comfort from point 22 of the report that provided assurance that there was sufficient resilience across the Trust not withstanding some hot spot areas, to ensure that every ward and community team was safety staffed. Ms Newham said conversations had commenced about triangulating information and what it meant and results fed back into reports. Dr Elcock added that it was important to include medical staffing figures as part of that and this would feature in future reports.	
	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/19/226	Guardian of Safer Working Hours (Junior Doctors contract) – Annual Report	
	Dr Elcock presented paper L that provided assurance that doctors in training in LPT were safely rostered and had safe working hours that complied with the terms and conditions of their service. The report also:	

	• Showed that seven exception reports had been raised.	
	• Gave information on work schedule reviews and rota gaps.	
	• Provided information on the implementation of changes to the 2016 terms and conditions of service as implemented in August 2019.	
	With regard to exception reporting Dr Elcock said the junior doctors were completing their monitoring reports and the senior staff needed to be encouraged to complete their exception reporting. If they were non-compliant then the rotas would have to be changed.	
	The Chair noted that seven exception reports was the highest received since this report was introduced. Dr Elcock advised that they were all satisfactorily resolved. Mrs Rowbotham remarked that if a rota gap was showing it would be important to know if that gap had been identified the previous quarter. Dr Elcock explained that vacancies would always exist by the very nature of the way the system worked and rota gaps were not filled year on year.	
	Resolved: The Trust Board received the Annual Report of the Guardian of Safer Working Hours (Junior Doctors contract)	
	Performance and Assurance	
TB/19/227	Finance and Performance Committee highlight report November 2019	
	Mr Rowbotham presented paper M, a FPC highlight report, November 2019. He said from a governance point of view FPC was implementing the new governance structure. The report would adopt the same style as the QAC report for the January 2020 Board meeting.	
	With regard to the 2020/21 contracting discussion the FPC noted progress was being made with system partners towards the creation of a position across LLR, supported by a memorandum of understanding for an integrated services contract. The Board would need a better understanding of the arrangement in due course as questions would be raised from a strategic perspective. Ms Hillery said that would be a good topic for a future Board Development Session. The issue would also be flagged to the Audit and Assurance Committee due to the fundamental changes that would occur.	**FL**
	There were five key areas the FPC were not assured on, and one new areas; waiting times, where more narrative had been requested:	
	• **Waiting times** – progress was confirmed in relation to the eight targets over seven priority services and work to address over 52 week waiters as at 30th September 2019.	

	• **Data Quality Improvement Plan** – One change had been made to the plan as a result of joint working between the QAC and PFC. There would also be further in depth discussion at the next joint QAC/FPC meeting in December.	
	• **IQPR and Performance Management** – the committee noted the CPA seven day target was not being met and the CDiff position had deteriorated but was still within target range. Good progress was being made on out of area placements and a significant improvement in gatekeeping was noted.	
	• **Organisational Risk Register** – the committee maintained a level of not assured due to the gap in review by tier 2 committees and tier 3 engagement.	
	• **Financial Position** – an update on progress was received with delivery of the financial turnaround plan. Considerable work had also been carried out by the finance team to complete a detailed run rate that gave an indication of stronger grip.	
	• **Estates and Facilities Management** – an update on progress with the key issues was presented. The committee was not assured due to the substantial gaps around maintenance and a plan was requested for management of the interim maintenance position.	
	Ms Marchington said there were significantly more Red areas reported for December and Mr Rowbotham replied that was due to the level 2 committee work which had only just commenced. Once work had been embedded consideration would be given to moving some areas to Amber next month.	
	Mr Rowbotham clarified to Ms Marchington that some risks were approaching fruition and that assurance was difficult to achieve during the transition period. Ms Cecchini referred to the organisational risk register and the suggested list of the top three risks that would mitigate against the temporary lack of crossover to level 2 and 3 committees. Ms Pridmore replied the issue would fall into the remit of the Audit and Assurance Committee for assurance that a system of control existed within the organisation that was effectively managed.	
	Ms Bilsborough referred to the LLR integrated therapy services and a current set of proposals around new arrangements. She added it was important for the Board to recognise that a musculo-skeletal and home first flow formed part of those improvements. The home first flow was already a part of the community service redesign work that illustrated that it was possible to work in new and different ways without impacting on contractual forms.	

	Resolved: The Trust Board: • **Received the FPC highlight report from 19th November 2019 meeting.** • **Approved the FPC Terms of Reference.**	
TB/19/228	Finance monthly report – month 7	
	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 report showed a £983,000 surplus which was in line with plan.	
	• The Trust was achieving its NHS Trust statutory duties with the exception of the Better Payment Practice Code and the Cost Improvement Targets	
	• Operational budgets were currently overspending by £2,850,000. The run-rate overspend for month 7 was £278,000, a reduction from £495,000 in month 6. 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 if the current rate of overspend was maintained.	
	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/19/229	Integrated Quality and Performance monthly report Waiting Times Compliance AMH & LD	
	M Cecchini presented paper O that provided the Trust Board with an integrated quality and performance report that showed levels of compliance with the NHS Improvements Single Oversight Framework and Care Quality Commission registration, together with detailed analysis for those areas that required additional action to ensure achievement of targets.	
	Ms Bilsborough reminded Board members in respect of delayed transfers of care, that the target system wide was being managed very well, even though LPT was challenged with the placement of patients with a high number of bed days.	
	Mrs Rowbotham requested that the figures surrounding the serious incidents be adjusted and corrected for the next report.	
	Ms Marchington acknowledged that the report was under review and	

	details would be updated to reflect new information, but added it was still important to ensure the actions were kept updated whilst the report was still being used.	
	The Chair said whilst the report remained in use it would be important to record the actions on the 52 week waiters and the harm process.	
	Resolved: The Trust Board: • **Received assurance with regard to areas of quality and performance where performance improvement action was being undertaken.** • **Received the NHS Improvement compliance segment rating of three.**	
TB/19/230	Review of risk – any further risks as a result of board discussion • Care Programme Approach 7 day target. • CQC consistency, improvement and planning for next time. • Safer Staffing – medical staffing and possible combination with nursing. Plus a request for a report from the QAC. • Financial position. • Data quality.	
	Resolved: The Trust Board agreed the above risk areas.	
TB/19/231	Receipt of Documents for Information	
	Resolved: The Trust Board confirmed receipt of: • LPT Annual Safeguarding Report 2018-2019 • Organisational Risk Register	
TB/19/232	Any Other Urgent Business No other urgent business.	
TB/19/233	Public Questions on agenda items There were no public questions.	
TB/19/234	Date of Next Meeting	
	The next public meeting would be held at 9.30 am on Tuesday 14 January 2020, Sparkenhoe Committee Room, County Hall.	

B

Leicestershire Partnership NHS Trust

TRUST BOARD 14 January 2020

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 Corporate Affairs Manager. 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)
899	October TB/19/158	The joint Chief Executive Officer role had been highlighted as a risk at NHFT so Chair suggested that the same risk be added to the LPT risk register.	Frank Lusk	3 December 2019	Email from CEO to Executive team on 13 December 2019 providing the full details of Risk "Insufficient executive capacity (including Joint Chief Executive role) to cover demand and impacts on LPT ability to achieve its strategic aims". The Risk owners are CEO and Director of HR/OD and the risk has been scored at 16 with Residual risk score of 12. Action CLOSED.
903	November TB/19/200	Assurance sought that a solution had been found on the appropriate recording and monitoring	Dani Cecchini	14 January 2020	The number of errors in the data had reduced but some still remained. A correct position was anticipated once SystmOne was up and running. Mr. King said further

Action No	Meeting month and minute ref	Action/issue	Lead	Due date	Outcome/evidence (actions are not considered complete without evidence)
		of data for out of area beds.			clarification of the situation was expected shortly.
904	December TB/19/208	Explore the possibility of an NED supporting and promoting the work around Veterans.	Cathy Ellis	14th January 2020	Ruth Marchington will be the NED Champion for our work with veterans. CLOSED
905	December TB/19/215	Explore the possibility of strategic links with DNRS (the national facility being proposed for rehabilitation)	Angela Hillery	3rd March 2020	Not yet due
906	December TB/19/217	Seek further clarification around ref. 9 – align capital authorization limits with new capital investment process – as the increase to £1 million was quite significant.	Dani Cecchini	14th January 2020	
907	December TB/19/218	QAC to feed back to the Board once the Deep Dive into Transforming Care which is due to be done in February 2020, is completed.	Helen Thompson	3rd March 2020	Not yet due
908	December TB/19/227	The issue of 2020/21 Contracting discussion/MOU for Integrated Services Contract needs to be flagged with the Audit and Assurance Committee as changes are fundamental.	Frank Lusk	3rd March 2020	Not yet due

C

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

Trust Board 14th January 2020

The period covered by this report is from 3rd December 2019 to 14th January 2020

Hearing the patient and staff voice	• Chair boardwalk to the Evington Centre visiting both Beechwood and Clarendon Community Health Service Wards. Saw evidence of higher patient acuity, higher occupancy levels and staff pressures all being managed with strong leadership. • Non-Executive Directors 5 boardwalks to: o FYPC – Health Visiting Market Harborough o CHS- Mental Health Services for Older People Psychology team; o AMH/LD – Criminal Justice and Liaison Service: Street Triage; Community Mental Health Team Charnwood; Recovery College
Connecting for Quality improvement	• Gave opening speech at Medical Trainees Awards. Great to celebrate the excellent achievements of our trainees in patient care and research. Thank you to Professor Wendy Burn the President of the Royal College of Psychiatrists for her presentation. • CQC engagement meeting – specific focus on pharmacy improvements, Quality Improvement launch, Mental Health improved patient flow with reduction in out of area placements
Promoting Equality Leadership & Culture	• Attended café conversation at Coalville Hospital with change champions and staff to discuss Leadership Behaviours. The input from several sessions across the Trust is being used to shape the behaviours that will reflect our values • BAME Reverse Mentoring programme – personal research and reading as directed by my mentor. • Meeting with Freedom to Speak up Guardian to review our self-assessment
Building strong Stakeholder relationships	• NHSI System Improvement & Assurance Meeting to review LPT performance • NHSI Midlands Chairs meeting which focused on national and regional update, the leadership compact, public health working with communities. • National Chairs and CEO briefing from NHSI/E leadership team on plans and priorities for 2020
Good Governance	• Board development session on 20th December with focus on: Well-Led, Freedom to Speak Up, Assurance, Infection Prevention & Control • Observed Quality Assurance Committee and Finance & Performance Committee - both committees making progress on transition to the new governance structure. Committees observed by NHSI and feedback received for action in January 2020 meetings. • Chaired the Charitable Funds Committee – refer to Highlight report on agenda

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	14th January 2020
Paper number	D

Name of Report Chief Executive's Report

For approval		For assurance		For information	x

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

Alignment to CQC domains:		Alignment to LPT priorities for 2019/20 (STEP up to GREAT):	
Safe		S – High Standards	
Effective		T - Transformation	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. The Board is asked to support the national pledge to reduce plastic waste within the NHS.

1. Introduction/Background

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

2. Aim

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

3. Recommendations

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

The Board is asked to support the national pledge to reduce plastic waste within the NHS.

4. Discussion

National Developments

NHS taskforce

NHS chief Simon Stevens has announced that a new taskforce will be set up to improve current specialist children and young people's inpatient mental health, autism and learning disability services in England. The NHS Long Term Plan sets out an ambitious programme to transform mental health services, autism and learning disability; with a particular focus on boosting community services and reducing the over reliance on inpatient care, with these more intensive services significantly improved and more effectively joined up with schools and councils.

The NHS chief also announced that Anne Longfield OBE, Children's Commissioner for England, will chair an independent oversight board to scrutinise and support the work of the taskforce. The Children's Commissioner and her board will be given wide-ranging scope to track progress and propose rapid improvements in existing services, examine the best approach to complex issues such as inappropriate care, out of area placements, length of stays and oversee the development of genuine alternatives to care, closer to home.

Pensions tax impacts on the NHS – a solution for 2019/20

We have received communication from NHS Chief Executive Simon Stevens and Amanda Pritchard informing us of a temporary scheme for frontline clinicians in England who face a tax charge in respect of work undertaken this year (2019/20) as a result of breaching their annual pension allowance.

Personal health budget update

From 2 December, people who require aftercare services under section 117 of the Mental Health Act will have access to a personal health budget. Personal health budgets give people greater choice, flexibility and control over their health and care support. Further information can be found here

NHS Midlands Pledge to Reducing Plastic Waste

As set out in the Long-Term Plan (LTP) the NHS has committed to significantly reducing waste and making hospitals healthier for patients and staff. As part of this there is a drive to reduce the single-use of plastics in hospitals with retailers operating hospitals committing to cut the use of avoidable plastics starting with straws and stirrers from April 2020, and cutlery, plates and cups phased out over the coming 12 months.

NHSE have urged hospitals with in-house catering services to sign a pledge to support the reduction of the amount of plastic waste in the NHS. Through the scheme, signatories commit to:

- By April 2020, no longer purchase single-use plastic stirrers and straws, except where a person has a specific need, in line with the government consultation

- By April 2021, no longer purchase single-use plastic cutlery, plates or single-use cups made of expanded polystyrene or oxo-degradable plastics

- By April 2021, go beyond these commitments in reducing single-use plastic food containers and other plastic cups for beverages – including covers and lids

Going forward, where clinically appropriate, further work will be undertaken to reduce plastics waste from common clinical products and the NHS will work to reduce plastic packaging within the supply chain.

The Trust has been asked to sign up to the pledge and as part of this submit data-submissions to NHSE/I on the volumes of single-use plastic catering items purchased to help monitor progress against the above targets. I ask that as a Board we support this scheme and sign up to the pledge. This piece of work will be monitored through the Sustainability Champions Group that reports into the Estates Group.

Further information can be found here

Recent publications:

NHS Standard Contract: NHS England and NHS Improvement has published the draft 2020/21 NHS Standard Contract for consultation. Comments from Stakeholders are requested by 31st January 2020.

Recent appointments:

Health Education England (HEE) Chief Executive Ian Cumming has announced that he is to leave the Arms-Length Body (ALB) after eight years of leading the NHS's education and training organisation. He will leave HEE at the end of March 2020**.**

NHS Confederation: Lord Victor Adebowale CBE has been appointed as the NHS Confederation's new chair and will take up post in April 2020. He has been chief executive of social enterprise Turning Point since 2001 and a non-executive on the Board of NHS England from 2012 to 2018.

Local Developments

Out of Area Placements

We recently received positive correspondence from Leicester City CCG and this was reinforced at the regional LLR meeting with Dale Bywater acknowledging the impact of the work that LPT has undertaken, in conjunction with system partners, to reduce the number of out of areas placements for the county. I would like to thank all staff involved in this outcome and acknowledge their hard work which has a positive impact on our patients as the majority of them can receive treatment at their local inpatient mental health facility.

Buddy work with Northamptonshire Healthcare Foundation NHS Trust

I wanted to update you on our buddy work with NHFT. As I have previously discussed NHFT were asked by NHSI to buddy with LPT due to their outstanding rating and this is a role other good and outstanding trusts do too. This relationship involves some targeted support in specific areas of governance, risk, strategy, communications and some clinical reviews identified between both Trusts and NHSE/I. Part of the Buddy Work is also about sharing best practice as we would with other trusts. I am encouraged to read, hear and see from staff the growing opportunities for us both to learn from each other.

To further strengthen our existing capacity, particularly in relation to system working and developing regional new care models, I have discussed the extension of our NHFT buddy trust relationship to introduce two shared executive director roles with NHFT that do not currently exist within LPT. This is to cover the portfolios of corporate governance/risk and strategy and business development, both areas which are fundamental in strengthening our leadership in these areas to Step up to Great. These shared roles reflect the approach that many NHS trusts now adopt to strengthen, build capacity and resilience, whilst ensuring value for money too.

I welcome Chris Oakes as shared Director of Corporate Governance and Risk and David Williams as shared Director of Strategy and Business Development.

Executive Team Update

I am pleased to confirm Dani Cecchini was successful in her application for the position of Deputy Chief Executive; this position is in addition to her current portfolio as Director of Finance, Performance and Estates.

Leicestershire Academic Health Science Centre (LeAHSC) application

In July 2019 University of Leicester (UoL), Leicester Partnership Trust (LPT) and University Hospital Leicester (UHL) signed a Memorandum of Understanding establishing the Leicestershire Academic Health Partners (LAHP).

LeAHSC unites four partners (UoL/LPT/UHL and the East Midlands Academic Health Science Network) to address strategic healthcare challenges faced locally and globally. LeAHSC's mission is to improve quality and sustainability of health and care for the population of LLR through an exciting strategic partnership linking NHS organisations to world-class academia, with shared sector-leading industry partners and regional innovators. LeASHC will work closely with regional stakeholders, driving innovation, promoting economic growth and reducing healthcare inequalities.

The LeAHCS has submitted its Academic Health Science Centre application and expect to hear if it's been short listed in February 2020.

Flu Vaccination

At the time of preparing this report the Trust's flu vaccination uptake for front line staff is 55.7%. Extensive work has taken place to promote our flu vaccination clinics and the alternative opportunities that are available for staff to be vaccinated, however compliance is not sufficient and we are connecting with other trusts to share best practice and learning. Compliance updates continue to be circulated to Senior Leaders on a regular basis for targeted work to take place to increase compliance.

Leicester, Leicestershire and Rutland (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 here and includes updates on the arrival of Andy Williams, Joint Chief Executive of Leicester, West Leicestershire and East Leicestershire CCGs and our new vision.

Recent events

Infection Prevention and Control visit

At the time of writing this report we are expecting an Infection Prevention and Control visit by NHS England/Improvement (NHSE/I) on 7th January 2020. NHSE/I conducted infection prevention and control inspection in September 2019 and they will be revisiting on 7 January to inspect our Coalville Hospital Wards 2 and 3. A third inpatient area will be chosen by their team. Feedback from the visit in September was shared and the teams have been reviewing this feedback and taking actions to address issues raised

Single EPR: Clinical Overview

A team of medics and nurses from Adult Mental Health/Learning Disability and Mental Health SOP services are helping shape LPT's new single electronic patient record (EPR). To date, four medics from adult mental health services, a nurse and an allied health professional representative have been recruited as our Trust's Single EPR 'clinical champions'. Their mission is to provide a clinical voice through the on-going development and implementation, by June 2020, of SystmOne as our new Single EPR.

Changes to Nursing & Therapy Teams

On December 1st there was a significant change in the way our nursing and therapy services are organised and delivered across LLR. A number of integrated community hubs arranged in eight geographical locations aligned to Primary Care Networks have replaced the separate services delivering planned nursing, planned therapy and Intensive Community Support (ICS). Each hub offers integrated community nursing and therapy services that will deliver core services and adopt 'Home First' principles.

Home First is an offer which aims prevent patients from being admitted to hospital via an urgent community response, and supports timely discharge by offering rehabilitation and re-ablement for up to six weeks, delivered in partnership with social service departments from Leicester City, Leicestershire County and Rutland County Councils. Staff from LPT and social services will work alongside each other to triage and deliver care as an integrated response.

One of the most significant changes is the delivery of physiotherapy and occupational therapy to patients at weekends and on bank holidays. The changes we are making are part of a more extensive Community Service Redesign (CSR) which sees changes in how primary and social care is delivered. The CSR is also aligned to the national 'Ageing Well' Programme.

LLR announced as an accelerator site for Ageing Well.

Ageing Well is the national programme for delivering the NHS Long Term plan priorities for community services. There are three elements of the national planning guidance which local services need to deliver. They are:

- Urgent Crisis Response
- Anticipatory Care
- Enhanced Care in Care Homes

LLR has been selected as the Midlands accelerator site for the Ageing Well programme. This means that we will join 6 other regional sites who will lead the approach to implementing urgent crisis response services in the community, delivering the national expectation that people receive an at home crisis response within 2 hours, and commencing re-ablement within 2 days. This is good news for LLR, and is recognition that we are well advanced in the work we have been doing to develop integrated community services.

As part of the national programme, we will receive support from the national team to develop an approach to delivering the national standards that can be rolled out and adopted across the country. We will participate in a community of practice exploring some of the challenges in delivering prompt and high quality care for people in their own homes or living in care homes. There is non-recurrent funding available to support the accelerators and CCG leads are in discussions with the national team about our funding requirements to consistently deliver the national standards by April 2021.

- As well as rapidly working to achieve the national standards, the accelerators will be supported to:
- Develop single points of access for community crisis response services
- Develop solutions to plan capacity and respond to demand based on e-rostering/e-scheduling software
- Fully utilise the updated community health data set to capture standardised information to evidence meeting the national standards
- Create a live capacity tracker of the community urgent care services, that will be
- available to all relevant local health and social care providers
- Develop a sustainable workforce to deliver the new care model
- Work with Local Authority and partner health organisations to co-produce a solution for all intermediate care/rehabilitation (bed based and home packages of support) to deliver the 2-day standard.

The Integrated Community programme will oversee the LLR approach to Ageing Well, connecting the accelerator work with existing prices of work such as the Community Services Redesign project. We are looking forward to a visit from the national team in February 2020.

Change Champions:
I'm always proud to hear about the hard work that our Change Champions are up to across the Trust, most recently focusing on leadership behaviours for all staff, which we know is key to making a culture change. A series of well attended café conversations took place around Trust sites during December which gave the opportunity for staff to have their say on the types of behaviour they expect and want to see from their colleagues. Feedback from these events will be fed into the next Senior Leadership Team meetings. There were 338 positive responses posted informing us what good looks and feels like and 32 suggested behaviour titles across the following 5 themes; inclusion, results, valuing one another, teamwork and change

Leicester Partnership Trust/Age UK Leicestershire and Rutland – Christmas gifts
The Trust joined up with Age UK Leicestershire and Rutland to provide more than 300 presents for older patients who were in our wards on Christmas Day. The presents were donated by members of the public at charity's shops, sorted centrally and then distributed to each of our MHSOP and community hospital wards.

Mark Randell, UK-Med team
I was proud to read of the emergency relief work that Mark Randell, an Advanced Nurse Practitioner in our community paediatrics team, has been undertaking in Samoa. Mark has recently returned from spending two weeks providing emergency relief as part of a 13-strong UK-Med team responding to the measles epidemic there. Mark was also deployed to Bangladesh in January 2018 to provide support for a diptheria outbreak.

Awards news
Medical Trainees Awards Ceremony
I was honored to attend the recent Medical Trainees Awards Ceremony at which we came together to celebrate the achievements of our trainee medical staff. We were joined by Professor Wendy Burn, president of the Royal College of Psychiatry, who presented the awards alongside myself and the Chair.

Well done to all the winners who received trophies and certificate, and were filmed at the end of the event to help create a video to recruit future medical trainees.

Cavell Award
Congratulations to Traci Jarvis, Public Health Nurse (Health Visitor) who received a Cavell Star nursing award recently for her work in some of Leicester city's most deprived areas.

Operational Services Support Worker of the Year 2019
Congratulations to Claire Hands, senior clinical secretary for children's therapies and specialist nursing on being named Operational Services Support Worker of the Year 2019 for the East Midlands region at the national Our Health Heroes awards ceremony on Wednesday 20 November. She was nominated in recognition of the incredible support she offers families as their first point of contact with the Trust.

Apprentices in children's speech and language therapy
It was fantastic to hear that LPT's first ever apprentices in children's speech and language therapy achieved distinctions in their level 3 allied health professions support qualification and meeting their apprenticeship standards this summer. Congratulations to Gurpreet Panacer, Carys Plant and Holly Meredith.

Relevant External Meetings attended since last Trust Board meeting

Service visits by Executive Directors since last Trust Board

Dec 2019/Jan 2020
Stewart House/Mill Lodge
Evington Centre – Wards 1, 2 & 3
St Lukes, Market Harborough
Speech and Language Therapy Team Day
Coalville Hospital
Langley Ward and Crisis Team
Dalgleish Ward
OT services at Neville Centre
Bradgate (All Units)
* DIANA service

Executive Directors: external meetings since last Trust Board

Dec 2019/Jan 2020	
Healthwatch (Rutland)	Health Watch
Leicester City Health & Wellbeing Scrutiny Commission	A & E Delivery Board
Leicestershire County Council - Health and Well-Being Board	UCR Accelerator Site meetings
COO meeting at UHL	Met with Director of Operations/ Director of HR and OD – NHFT
County Hall members	CSR Modelling meeting
Leicestershire Police	Tamsin Hooton – West Leicestershire CCG
CQC Engagement Meeting	Operational Flow meeting – UHL/LPT
Understanding 2020-2021 Efficiencies (meeting between LPT, UHL and CCGs)	Operational Flow meeting – UHL/LPT
System Sustainability Group	Winter Escalation Capacity meetings
LLR System Leadership Team Meeting	Director of Health and Integration – Leicestershire County Council
Chief Officers	HWB Board planning
Mental Health Programme Delivery Board Pre-Meet	Transforming Care Programme Escalation Call with regulators
Senior Leadership NHS Event	
* Meeting with Director of Public Health and Lead Councillor for Health	
*LPT/CCG approach to contracting/service developments – 2019/20	

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

5. Conclusions

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

As part of this report the Board is asked to support the Trust in signing the national pledge to reduce plastic waste.

Cardinal Square – 4th Floor
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Derby
DE1 3QT

E: jeff.worrall@nhs.net
W: www.england.nhs.uk and
www.improvement.nhs.uk

30th December 2019

To: Midlands NHS Trusts Chairs & Chief Executives

Sent via E-Mail

Dear Colleagues

Re: Sustainability - NHSE/I Pledge to reduce Plastic Waste

You will be aware from the Long-Term Plan (LTP) that the NHS has committed to significantly reducing waste and making hospitals healthier for patients and staff.

Between 2013 and 2018, NHS services across England used more than 600 million disposable cups and millions of other disposable cutlery pieces, as well as many other avoidable single-use items. While much NHS plastic waste is already recovered for recycling or energy from general waste, we are still a significant contributor to the 34 billion tonnes of plastic that will pollute our natural environment by 2050.

One part of the LTP is to reduce the single-use of plastics in hospitals (acute/ MH and Community) with retailers operating hospitals committing to cut the use of avoidable plastics starting with straws and stirrers from April 2020, and cutlery, plates and cups phased out over the coming 12 months.

In October, Simon Stevens urged hospitals who have in-house catering services to 'step up and match our suppliers' commitment by signing a pledge to support the reduction of the amount of plastic waste in the NHS. Through the scheme, signatories commit to:

- **By April 2020, no longer purchase single-use plastic stirrers and straws, except where a person has a specific need, in line with the government consultation**

- **By April 2021, no longer purchase single-use plastic cutlery, plates or single-use cups made of expanded polystyrene or oxo-degradable plastics**

- **By April 2021, go beyond these commitments in reducing single-use plastic food containers and other plastic cups for beverages – including covers and lids**

By signing upto the pledge, we also ask trusts, CCGs, retailers and suppliers to provide NHS England and NHS Improvement with four data-submissions on the volumes of single-use plastic catering items purchased. This will give an indication on the progress being made.

Submission date	Time period for data to cover (financial year)
January 2020	**Q1 to Q4 2018/19**
April 2020	**Q1 to Q4 2019/20**
October 2020	**Q1 and Q2 2020/21**
April 2021	**Q3 and Q4 2020/21**

Over time, where clinically appropriate, we will look further at reducing plastics waste from our most common clinical products such as gloves, gowns and hygiene products. We will also work with our supply chain on plastic packaging.

Making this pledge and providing the evidence requested will help demonstrate how organisations have made progress in minimising the use of plastics, as required by the 2019/20 NHS Standard Contract.

As you can see from **Table 1**, 10 Midlands organisations have already made the pledge and we thank those organisations for doing so. However, we would like to urge all the remaining Midlands Trust Boards to consider the commitment and look to signing the pledge before the **deadline of 31st January 2020** please.

In addition we would also urge Midlands Commissioning (CCGs) organisations copied into this letter to sign up to the pledge. NHSE/I will also participate in the delivery of this commitment.

I am sure you will all agree that the NHS Midlands is well placed to lead by example in supporting this commitment to eliminate avoidable plastic waste. We therefore ask if the Boards would work with their operational teams, stakeholders, and suppliers during 2019/20, and confirm the commitment by signing the pledge using the following link please:

https://www.engage.england.nhs.uk/survey/dee161d9/consultation/subpage.2019-08-19.1656315056/

Within the above link, it will ask each organisation to confirm two points of contact for sustainable development within their organization:

1. A senior responsible officer (Director-level)
2. A sustainable development lead for your organisation

NHS Midlands will use these links to provide further information about the pledge and to communicate with you regarding the wider sustainability programme.

In addition, within the NHS Midlands we are already looking to join up the sustainability work which key stakeholders such as NHS Sustainable Development Unit and Public Health England. And to build upon the existing East & West Midlands Sustainability Networks.

Equally NHSE/I is also looking for a NHS Chair or Chief Executive sponsor to assist NHS Midlands on championing the Sustainability agenda to help deliver the NHS LTP ambitions which are outlined on page 6.

If anyone is interested in becoming the Midlands Chair/ Chief Executive NHS sponsor please could you let Nick Hardwick, Director of Performance (nick.hardwick@nhs.net) know.

By delivering the LTP Sustainability ambitions they will help enhance our role and responsibility in mitigating the negative impacts on climate change.The achievement of these ambitions are only possible if the whole NHS Midlands, and all those who work within it, play our part. Your leadership and contribution could therefore not be more urgently required at this time.

Yours sincerely

Jeff Worrall
Director of Performance and Improvement - Midlands
NHS England and NHS Improvement

cc.
CCG AOs

Dale Bywater, NHSE/I Regional Director

Dr Rashmi Shukla, Director Public Health England

STP Leads

NHSE/I S&T Directors colleagues

Table 1: Current status on Midlands Trusts signed upto the Plastics Pledge

Trust Code	Trust Name	Commissioning Region	Trust Type	Plastics Pledge
RXT	BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	No
RYW	BIRMINGHAM COMMUNITY HEALTHCARE NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	COMMUNITY	Yes
RQ3	BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - SPECIALIST	No
TAJ	BLACK COUNTRY PARTNERSHIP NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	CARE TRUST	Yes
RFS	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - SMALL	No
RYG	COVENTRY AND WARWICKSHIRE PARTNERSHIP NHS TRUST	MIDLANDS COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	No
RY8	DERBYSHIRE COMMUNITY HEALTH SERVICES NHS TRUST	MIDLANDS COMMISSIONING REGION	COMMUNITY	No
RXM	DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	No
RYK	DUDLEY AND WALSALL MENTAL HEALTH PARTNERSHIP NHS TRUST	MIDLANDS COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	No
RX9	EAST MIDLANDS AMBULANCE SERVICE NHS TRUST	MIDLANDS COMMISSIONING REGION	AMBULANCE	No
RLT	GEORGE ELIOT HOSPITAL NHS TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - SMALL	No
RNQ	KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - SMALL	No
RT5	LEICESTERSHIRE PARTNERSHIP NHS TRUST	MIDLANDS COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	No
RY5	LINCOLNSHIRE COMMUNITY HEALTH SERVICES NHS TRUST	MIDLANDS COMMISSIONING REGION	COMMUNITY	Yes
RP7	LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	Yes
RRE	MIDLANDS PARTNERSHIP NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	No
RLY	NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST	MIDLANDS COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	No
RNS	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - MEDIUM	No
RP1	NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	No
RX1	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - TEACHING	No

RHA	NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	MENTAL HEALTH AND LEARNING DISABILITY	Yes
RL1	ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - SPECIALIST	Yes
RRJ	ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - SPECIALIST	No
RXK	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - LARGE	Yes
RK5	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - MEDIUM	Yes
RXW	SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - LARGE	Yes
R1D	SHROPSHIRE COMMUNITY HEALTH NHS TRUST	MIDLANDS COMMISSIONING REGION	COMMUNITY	No
RJC	SOUTH WARWICKSHIRE NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - SMALL	No
RNA	THE DUDLEY GROUP NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - MEDIUM	Yes
RL4	THE ROYAL WOLVERHAMPTON NHS TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - LARGE	No
RWD	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - LARGE	No
RJE	UNIVERSITY HOSPITAL OF NORTH MIDLANDS NHS TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - TEACHING	No
RRK	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - TEACHING	No
RKB	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - TEACHING	No
RTG	UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - TEACHING	No
RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - TEACHING	No
RBK	WALSALL HEALTHCARE NHS TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - MEDIUM	No
RYA	WEST MIDLANDS AMBULANCE SERVICE NHS FOUNDATION TRUST	MIDLANDS COMMISSIONING REGION	AMBULANCE	No
RWP	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - LARGE	No
R1A	WORCESTERSHIRE HEALTH AND CARE NHS TRUST	MIDLANDS COMMISSIONING REGION	COMMUNITY	No
RLQ	WYE VALLEY NHS TRUST	MIDLANDS COMMISSIONING REGION	ACUTE - SMALL	No

Sustainable Development Unit

NHS

Towards a Greener NHS: LTP Priority Areas for the Midlands

Improving Air Quality

Reducing carbon, waste and water

Reducing single use plastics

Targets	By 2023/24, we will cut business mileages and fleet air pollutant emissions by 20%	By 2025, we will reduce our carbon footprint by 51% against 2007 levels	We will deliver reductions in single use plastics throughout the NHS supply chain
Key initiatives	• Reducing NHS fleet emissions (including ambulances) and other specialist vehicles • Reducing outpatient appointments by a third • Working with local government to reduce emissions	• Greening our estates and facilities, including phasing out coal and oil fuel as primary heating • Switching to greener asthma inhalers • Reducing the carbon footprint from anaesthetic gases	• Reducing single use plastics across NHS catering as well as clinical and supply chain domains • Working to improve the disposal and recycling processes for plastics • Developing innovation in plastics
Enablers	• Strong and robust regional leadership commitment • Well functioning and committed Regional Sustainability Network with expertise and passion • Supporting data and analytics • National procurement and supply chain • Innovation & Technology • Communications & Engagement		

Meeting Name and date	Trust Board 14 January 2020
Paper number	E

Name of Report: Organisational Risk Register

For approval		For assurance	**x**	For information	

Presented by	Chris Oakes, Head of Corporate Governance and Risk	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
Strategic Executive Team	6 December 2019
Quality Assurance Committee	10 December 2019
Finance and Performance Committee	10 December 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 and action being undertaken to support maturity of the risk system.

Leicestershire Partnership NHS Trust

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 Key changes following risk review in December 2019 are outlined below:

- Risks 6, 7 and 8: Committee oversight for the three transformation risks has moved from QAC to FPC.
- Risk 21 Payroll has been closed. 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.
- Risk 32 PMO has been closed. A Head of PMO is in post temporarily to support and introduce the mechanism to manage the quality improvement plan.
- Risk 33: A new risk reflecting the shared Chief Executive has been drafted for inclusion.
- Risk 34: Directorate risk 3958 re the non-achievement of the flu target has been escalated to the ORR.

2.2 Proposed changes for January 2020

- Risk 7 Failure to implement the community service re-design may result in loss of business opportunities. To be de-escalated to the Directorate risk register once approved by the CSR Programme Board in January 2020.
- A new risk to address phase 2 of the community service re-design will be drafted and shared in February 2020. This will highlight the risk to our reputation and the potential impact on the recruitment and retention of staff.
- Risk 11 regarding the estate configuration to be updated with dates for short, medium and long term work programmes.
- There are six risks with the same current and residual scores. These continue to 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.
- A new risk will be proposed on the ORR to reflect data quality concerns.

2.3 ORR maturity

- Arrangements for implementing the revised risk management policy and the organisational risk register continue to develop and embed.
- The ORR has been identified as one of the drivers for determining quality improvement projects monitored by the Quality Improvement Board going forward. This will be facilitated by the PMO.
- The QAC now meets bi-monthly. The governance processes for review of quality risks for those months where the QAC does not meet will be via the Operational Executive Team.
- A follow-up review has recently been completed by internal auditors '360 Assurance' which confirmed that all actions agreed as a result of the 'arrangements for the management of risk' audit (report reference 1819/LPT/35, issued during June 2019) have been satisfactorily implemented or superseded and the review is therefore concluded.
- A 2019/20 internal audit of 'governance and risk management' is due to start in January 2020; this will inform the Head of Internal Audit Opinion at year end. The strategic risk management arrangements section will focus on the adequacy of the Trust's strategy, accountability and reporting structure. Any recommendations made during this review will be reported to QAC, FPC and the Board.

3. Organisational risk register summary: December 2019

Due to on-going maturity of the ORR, the column showing the risk level at October 2019 has been removed. A new column has been included to show how many months the risk has been on the ORR. A further column has been included to indicate which 'Step Up to Great' objective the risk is associated with.

New additions are indicated in red text, deletions indicated with strikethrough text.

Risk ID	Risk Title	Risk Owner	Responsible Committee	SUTG	Months on ORR	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	High Standards	3	16	12
2	The Trust's safeguarding systems do not fully safeguard patients	DoN	QAC	High Standards	3	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	High Standards	3	15	10
4	Services do not have the right number of staff with the right skills at the right time	DoN	QAC	High Standards	3	12	8
5	Capacity and capability to deliver KLOEs	DoN	QAC	High Standards	3	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	FPC	Transformation	3	16	12
7	Failure to implement the Community Service Redesign may result in loss of business opportunities	DoCHS	FPC	Transformation	3	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	FPC	Transformation	3	16	12
9	Failure to maintain the level of cleanliness required within the Hygiene Standards	DoF	QAC	Environment	3	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	Environment	3	16	12
11	The current estate configuration is not fit for the delivery of modern mental health, community and LD services	DoF	FPC	Environment	3	20	20
12	The Trust does not positively impact on the experience of service users, carers and families that use our services	DoN	QAC	Patient Experience	3	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	Patient Experience	3	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	Patient Experience	3	12	9
15	Risk of disruption to service and detrimental impact on patient safety as a result of EU exit	DoN	FPC	Well Governed	3	15	12
16	The Leicester/Leicestershire/Rutland system is unable to work together to deliver an ICS by April 2020	CEO	FPC	Well Governed	3	16	12
17	Failure to meet financial plan and statutory breakeven duty	DoF	FPC	Well Governed	3	16	12
18	The Trust does not routinely achieve regulator standards which impacts on the achievement of the step up to great framework set by the Trust	CEO	QAC	Well Governed	3	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	Well Governed	3	12	12
20	Performance management framework is not fit for purpose	DoF	FPC	Well Governed	3	20	16
~~**21**~~	~~Operations are disrupted due to supplier failing to deliver their payroll contract~~	~~DoHR~~	~~FPC~~	~~Well Governed~~	~~3~~	~~15~~	~~10~~
22	Financial, reputational or service delivery harm or loss resulting from information breaches and attacks on information systems	DoF	FPC	Well Governed	3	16	12

23	Failure to deliver the EPR system and realise the benefits of the system	MD	FPC	Single Patient Record	3	16	8
24	Failure to deliver workforce equality, diversity and inclusion	DoHR	QAC	Equality, Leadership and Culture	3	12	9
25	Failure to create a culture of collective leadership that empowers staff to improve the services we provide	DoHR	QAC	Equality, Leadership and Culture	3	16	12
26	Insufficient staffing levels to meet capacity and demand, and provide quality services	DoHR	QAC	Equality, Leadership and Culture	3	16	12
27	Failure to improve the health and well-being of our staff	DoHR	QAC	Equality, Leadership and Culture	3	9	6
28	Failure to deliver timely access to assessment and treatment which could impact on patient safety and outcomes	Divisional Directors	QAC/FPC	Access to Services	3	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	Access to Services	3	20	15
30	Unmitigated demand may result in patients being unable to access services in clinically appropriate timescales	DoF / DDs	QAC/FPC	Access to Services	3	16	16
31	Projects will not deliver sufficiently to embed a consistent QI framework	MD	QAC	Trust-wide Quality Improvement	3	9	9

~~32~~	~~Failure to secure the resources and develop a PMO to support the delivery of the Trust QI plan~~	~~DoN~~	~~QAC~~	~~Trust-wide Quality Improvement~~	~~3~~	~~12~~	~~8~~
33	Insufficient executive capacity (including Joint Chief Executive role) to cover demand and impacts on LPT ability to achieve it's strategic aims	DoHR/OD and CEO	FPC	Well Governed	1	16	12
34	The Trust will not meet the 19/20 flu vaccination target (80% end of February 2020) of front line health care workers. Non-achievement has a risk to Trust reputation and is a staff and patient safety risk.	DoN	QAC	High Standards	1	16	12

4. 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	29	
	4			4, 9, 18, 19	1, 6, 8, 10, 16, 17, 22, 23, 25, 26, 28, 30, 33,34	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	29		
	4		4, 9, 18, 23	1, 6, 8, 10, 16, 17, 19, 22, 25, 26, 33, 34	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)

F

Leicestershire Partnership NHS Trust

QUALITY ASSURANCE COMMITTEE – DATE 10 December 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
Update of New Governance Structure: TORS & work plans	High	QAC approved the Quality Forum and Quality Improvement Board Terms of Reference. QAC work plan is 90% complete and on track, further work required on flow of papers from and to committees. Work plan to be reviewed again, once the level 3 committees are in place.	20
Organisational Risk Register	Medium	Discussion held with regard to moving responsibility for risks 6, 7and 8 related to transformation to FPC. Risk 6 all age mental health and risk 8 LLR transforming of care need to be updated. Risk 7 Community service redesign (CSR) to be reviewed at the1 December CSR programme board to review if the risk can be deescalated off the ORR. QAC felt assured that quality elements of the risks would be addressed by QIB, who feed into FPC and QAC. QAC suggested the responsibility of Risks 6, 7 and 8 moves to FPC and asked this was discussed by the executive team. A deep dive on Risks 12, 13 14for Patient involvement was presented to Strategic Executive Board in the November 2019. QAC requested an updated to be provided and assurances progress is being made.	All

Report	Assurance level*	Committee escalation	ORR Risk Reference
Director of Nursing, AHPs and Quality Update.	High	Flu vaccinations uptake is lower in comparison to other trusts. Buddy arrangements with Northampton Healthcare FT and Nottinghamshire Healthcare FT in place and this has provided assurance that LPT are doing everything possible to increase the update, including a dedicated peer vaccinator. Privacy and dignity relating to dormitories has number of actions in place, including risk assessments and ensuring that they are patient appropriate. A paper on dormitories to be presented to the January Trust Board meeting. LPT have been accepted into the national collaborative to improve understanding and implementation of sexual safety on all wards. QAC will receive all Serious Incidents executive summaries from February 2020 and will decide which are required to be escalated to Trust Board.	18
CQC report	Medium	97% for warning notice and must do actions are complete with two actions outstanding and these are linked to pieces of work scheduled in phase 2. Six should do actions are ongoing with five on track and the training package developed by the Assertive Outreach team requires a better understanding of the training requirements and further capacity, which will be known shortly. QAC has requested the Quality Forum provide assurances regarding the Medicines management spot checks results and to update QAC via the highlight report.	18
Patient Safety Quarterly report	Medium	A learning event was held in Q2 following an external review of a Serious incident. A number of actions were identified and further work to review the pathways will be carried out. Serious Incident report highlighted concerns of the number of late reports, due to capacity issues. National patient safety strategy launched in July 2019 is currently being reviewed and actions are being identified. Assurance provided that since July 2019 all SI's are signed off by the Medical Director, Director of Nursing or the Director for AMH. QAC recommended that the Patient Safety report for Quarter 2 is to be included within the Trust	1 3 18

Report	Assurance level*	Committee escalation	ORR Risk Reference
		Board pack in full for January 2020 to provide assurance on the progress being made.	
Learning from Deaths Quarterly report	Medium	Report to be presented at the Quality Forum which will oversee the operational level of details for discussion and escalation; the quarterly reports presented to Trust Board will include figures and thematic analysis of what the learning has been. Clinical lead for learning for deaths has been appointed.	18
Safer staffing report	No rating as presented to December 2019 Trust Board	It has been agreed the safer staffing report will be presented to QAC before going to Trust Board going forward. This report has already been presented to Trust Board. A big piece of work is underway to reduce agency spend, which decreased in October 2019. Clinical supervision rates now green rated. However a number of mandatory training levels are red rated. HR is carrying out a piece of work to clarify what is role essential and mandatory for staff across the Trust. An update on progress to be provided via the Strategic Workforce Committee Highlight Report. Six areas across the Trust are continually showing as staffing hotspots. A triangulation piece of work is underway to get an understanding of why these are hotspots. An update to be provided in the next report.	
Draft Integrated Quality Performance Report (IQPR)	Medium	There were zero identified NHSI triggers for November 2019 Performance for patients discharged on CPA was 99% against a target of 95% and performance for all patients discharge on CPA and on no CPA was 97.8% against a target of 95% during October 2019. Due to the daily follow ups and support from the business team. The Director of Nursing, AHP's and Quality thanked the teams for all of their hard work. Staff sickness rates remains above target at 5.2% during October 2019, ongoing support offered to managers by HR. A piece of triangulation work is being carried out and further information will be provided following the February Strategic Workforce Committee meeting.	20

Report	Assurance level*	Committee escalation	ORR Risk Reference
		Staff turnover was at 8.8% for November 2019	
Health & Safety assurance related to HSE Inspection	Medium	Meetings take place on a bi weekly basis. To allow actions to be progressed. A number of the actions are complete and with the remaining actions on track. It was noted that the action plan is reflective of what needs to be done this includes actions that not related to the Notification of contraventions.	18
Quality Forum	Medium	Patient Carer and Experience Group (PCEG) highlighted the lack of a strategic lead for Carers within the Trust. The forum asked PCEG to undertake a piece of work around 'what good looks like' for a Carers strategy, bench marking against other Trusts and present the report to the Forum in February 2020. FFT response rate for 2019 is significantly below the national average. This is a risk for the Trust as this is below the quality schedule target. The Forum was not assured. To return for discussion at the next Forum. To help mitigate the risk for 2020 a capital bid for HIS support is to be submitted. Serious Incident report highlighted concerns of the number of late reports, due to capacity within the team and quality issues. Head of patient safety to have an open invitation to attend the Directorate's governance meetings to offer support	12 13 14 12 14 3
QIB	Medium	Concern noted regarding the Transformation-transforming brick. A programme structure is in place for the Transforming Care recovery plan; however various risks have been identified, regarding project management capacity and development of a business model for rehabilitation beds in the Agnes unit. Assurance provided QIB were on track with progress of each bricks.	8
Seclusion actions including 360 internal audit report	Low	Overview of the Positive and Safe – Seclusion update presentation highlighted that further work is required to improve seclusion, The part time Positive and Safe Lead, will move to a full time post in December 2019 until July 2020 The Positive and Safe Group continues to review	1

Report	Assurance level*	Committee escalation	ORR Risk Reference
		the 4 focus areas for 2019/20 Following the 360 assurance audit seclusions findings – limited assurance. An action plan has been developed, with a number of actions put in place, with a timescale for completion expected between December 2019 and the end of January 2020. Further update on progress to be provided via the highlight report	
Clarification of earlier papers and any further risks	Low	Risks identified as Capacity issues to of sign off Serious incident reports within the timescales and Seclusion compliance.	1 18

Chair	Liz Rowbotham

Meeting Name and date	Trust Board – 14th January 2020
Paper number	G

Name of Report Director of Nursing AHPs and Quality Update Report

For approval		For assurance	x	For information	

Presented by	Emma Wallis Associate Director of Nursing	Author (s)	Anne-Maria Newham Director of Nursing AHPs and Quality & Anne Scott Acting 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 December/January 2020 to Trust Board presented on 14th January 2020

Welcome

Welcome to a transition update report that closed Anne-Maria Newham's tenure and introduces Anne Scott into the role of Acting Director of Nursing AHPs and Quality.

The purpose of this paper is to give a brief summary of events and horizon scanning that is pertinent to the Quality agenda.

In order to ensure all Board members receive timely notifications of issues, concerns and highlights a method of flash reporting is in place which is distributed by the Trust secretary and in the absence of the Trust secretary this will be led by the lead director for the report.

18th November 2019 – Mapping Level 3 Governance structures

As a Trust we have now completed the work around Quality Governance structures Level 1 and 2, which have been agreed and approved at the Oct 2019 Trust Board. We have now also started the next stage to look at frameworks, accountabilities, controls and roles at level 3 within the directorates. This is a wide piece of work and will be developed over Jan /Feb 2020.

21st November 2019 – Concerns from FYPC staff re toy cleaning

Several staff have approached the CEO and also directors on Board walks about toy cleaning impacting on capacity. Anne-Maria and Amanda Hemsley (IPC lead) met with several staff to discuss. Staff were asking if we could renegotiate our cleaning contract with UHL to accommodate cleaning toys. On the whole we have resolved all of the issues, there remains some concerns which we continue to resolve. Clarity given that toys are classed as therapeutic equipment and as such the clinician is responsible for their equipment.

Seclusion

QAC receives a quarterly report which details the Trust's progress on implementing the recommendations in 'Positive and Proactive Care – Reducing the need for restrictive interventions'. Following issues highlighted in the Trust Seclusion Audit in 2018 and CQC inspection visit in Autumn 2018 the Seclusion Policy has been reviewed and the recording forms have been through a small improvement cycle. The part time Positive and Safe Lead post was converted into a full time post in December 2019 until July 2020.

In quarter 2 the Positive and Safe Group considered the CQC report 'Segregation in MH wards for Children and young people with LD / Autism' 2019. The Positive and Safe Group continues to look at the agreed 4 focus areas for 2019/20 which are:

Full implementation of less restrictive practice models - Safewards
Move from two types of training (MAPA and SCIP) to a programme that meets multiple service and patient needs.
Improving seclusion and segregation and recording in line with the MHA Code of Practice.
Developing use of Positive Behaviour Support Care Plans for patients and enhanced patient and carer involvement.

26th November 2019 - SIAM Meeting

Alison Kirk, Head of Patient Involvement and Experience lead the deep dive on Patient involvement. Attendees were very positive about the progress made in the Trust around this important agenda. Of particular note was the huge reduction in out of area patients for mental health.

December 2019 – support for UHL

Anne Maria Newham and Rachel Bilsborough have had several calls with the Chief Nurse and Director of Operations from UHL in relation to support in this unprecedented time of demand. There was a particular plea around children's staff as they had had more children's admissions than normal. They have made a difficult decision to re-purpose a team of staff to support in-reach to UHL and identify patients who can be discharged to our community beds.

11th December 2019 – Inaugural Legislative Committee

Anne-Maria chaired the first legislative committee which combines Safeguarding, MHA, MCA and positive and safe. The TOR were approved and will go to the Quality Forum in January 2020.

17th December 2019 - CQC relationship meeting

There was a deep dive on medicines management which was delivered by Anthony Oxley, Lead Pharmacist. The attendees were really impressed with the progress made to date. The meeting took place at the Agnes Unit and the CQC did a tour after the meeting which was well received.

27th December - Anne-Maria Newham's last working day within the Trust

Thank you Anne-Maria

27th December – Successful Health Education England (HEE) Allied Health Professional (AHP) Faculty Test Bed Project Bid

Over the past 18 months we have successfully implemented apprenticeship opportunities for unregistered AHP staff to become qualified OTs and Physios. Eight LPT AHP staff started studying Occupational Therapy and Physiotherapy as part of the first cohorts at Coventry University in September 2019. Across LLR system, Leicester City Council have supported 2 OT staff to start training and other AHP groups and organisations are interested in developing apprenticeships. Success in this bid means that we have 3 months support from HEE and 3 months funding to develop and deliver an AHP faculty project plan. The expectation is that we will be expected to share our work regionally and nationally.

31st December – NHSI contact/introduction meeting

NHSI /NHSE are in the process of transition which means there are some changes within the Central locality Nursing and Quality team. The 2 clinical posts that have been appointed to in the new locality for Nursing and Quality structures are Vanessa Wort, Deputy Director of Nursing and Quality and Kimberly Kingsley, Assistant Director of Nursing and Quality.

Vanessa, who was our NHSI lead for Quality, is moving geographical areas to another county and Kimberley was introduced as the new lead contact for LPT's Quality Surveillance within NHSI.

Flu Vaccination

The Trust's flu vaccination uptake for front line staff is 56% and we recognise that this is one of the lowest rates of uptake for NHS Trusts in the country. To date we have offered 115 clinics at 60 locations and one of the key challenges seems to be staff uptake and attitude.

Planned actions:-

- Dedicated Peer Vaccinator to complete in-patient 'floor walks' in early January 2020 – Bradgate, Loughborough, Mill Lodge & Stewart House, HP to try to capture staff on shift
- Dedicated peer vaccinator to run and offer twilight and weekend clinics –aimed at bank staff following review of temporary worker utilisation and deployment
- Further Comms story about Feilding Palmer staff who last year had patients admitted with the flu and this year the increased staff uptake
- Directorate action plans
- Focussed work on Bank Staff uptake.

7th January 2020 – NHSI Infection Prevention & Control (IPC) re-visit – follow up from August 2019 visit.

Dr. Debra Adams, Lead IPC Nurse NHSI and Kimberly Kingsley, Assistant Director of Nursing NHSI, visited Ward 2 (CHS) and Ward 3 (CAMHS) in Coalville as planned visits and the Agnes Unit as an unannounced visit.

Overall they have suggested that we remain within the Amber rating as determined at the last visit and will plan to revisit in May to see further developments. However this is now a strong Amber moving towards the Green as opposed to an Amber nearly Red following the last visit last year.

They were pleased with the improvements and were very complimentary about the engagement and the enthusiasm of our staff and the sense of disappointment that was felt when an area was found to be sub-standard, which indicated a sense of pride. They found areas of good practice and noted improvements in standards and practices across the board; however areas noted for improvement and/or immediate action are:-

- High dusting in 1 area clinic room
- 1 Resus trolley dust
- 1 Mattress ingress – actioned at the time.
- 3 soiled Duvets in cupboards – noted not in circulation for use – actioned at the time
- Green 'Im Clean' stickers out of date in 1 area
- Maintenance programme for Washing Machines not noted in 1 area
- Freezer temperatures not current so cold food chain undetermined in 1 area
- 1 witnessed interaction with a patient where PPE was not being used appropriately – actioned at the time.

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board 14 January 2020
Paper number	**H**

Name of Report: Care Quality Commission Report

For approval		For assurance	**x**	For information	

Presented by	Emma Wallis Associate Director of Nursing	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
Quality Assurance Committee	10 December 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 ORR 18 Well Led

Recommendations of the report
To receive assurance over CQC related activity, including delivery against the actions identified following the 2018/19 inspection.

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

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.

3. Discussion

Overall the Trust has completed 91% of the actions; the 'warning notice and must do' actions remain 97% complete; 'should do' actions are 77% complete (last month 62%).

3.1 Actions

3.1.1 Two 'warning notice / must do' actions are continuing.

- Ensure patient waiting times for assessment and treatment meet commissioned targets and the NHS constitution for children and young people (W1).

  The neurodevelopmental waiting list is off-trajectory due to there being a higher proportion of neurodevelopmental (ND) cases in the access backlog than anticipated. The service is continuing to fund the over recruitment of ND specialist staff to undertake assessment, and expand use of the online provider Healios. The service is submitting a business case to access investment money for next year to continue to reduce the waiting list and bring this in line with trajectory. The waiting list continues to be monitored; this is currently at 490 against a target of 345 (as at 02/12/19).

- The Trust must ensure it reviews arrangements of dormitory accommodation with a view to eliminating this in line with national guidance (M3).

  Options to eliminate existing dormitory accommodation at in-patient wards across acute mental health services and mental health services for older people have been assessed; a detailed paper will be presented to the Strategic Executive Board on the 6 December 2019. Following this, the CQC action plan and the organisational risk register will be updated with any short, medium and long term actions and timescales.

3.1.2 Six 'should do' actions are on-going.

The following (action S11) is escalated due to issues potentially impacting on timely completion:

- 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 bitesize training package has been developed by the Assertive Outreach (AO) service. Training has been delivered however, a register of training requirements is not yet complete and therefore the full training requirement is not understood. The AO service no longer has capacity to deliver training to the CMHT's.

  This has been flagged internally and a solution is currently being determined.

3.2 Spot checks

Phase 3 of the methodology for responding to CQC findings is the spot check programme to ensure that action taken has been embedded and sustained. These are business as usual, monitored via the Trust's internal governance system.

There are two areas where spot check activity is highlighting that action taken is not yet fully embedded;

3.2.1 Seclusion

- Matrons to complete a review of all seclusions and documentation one month after the implementation of the new policy and documentation (W38)

  The Trust's internal auditors (360 Assurance) confirmed that significant improvements had been made to the seclusion paperwork, however, they found that there is currently poor compliance with completion of the paperwork, with standard documents missing or specific questions not answered. This aligns with feedback from the matron's spot check programme, and a recent external peer review.

  The QAC will receive a presentation in December 2019. On-going action will be detailed for review at the Quality Forum in January 2020, with escalation of any concerns to the QAC in February 2020.

- Seclusion room checks will be completed after patient seclusion is terminated (M7).

The seclusion room checklist is in place and checks are happening routinely as part of the process when seclusion is terminated; these checks are identifying an occasional inconsistency. This continues to be monitored and will be signed off as complete when full compliance is achieved.

3.2.2 Medicines management (W33)

Monthly clinic room spot checks are carried out by an audit nurse within Adult Mental Health and there has been consistent improvement over a three month period; despite this there are pockets of non compliance on some of the inpatient wards. Each member of the pharmacy management team has been allocated a ward at the Bradgate Unit to provide support with operational aspects for medicines management. Monthly feedback and spot check results are provided to the wider management team for oversight and scrutiny.

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

The latest poster continues to contain an inaccuracy. The rating for wards for people with a learning disability or autism has a 'not rated' section on the poster for the Well Led component of the inspection. In the report this had been rated as 'requires improvement'. The latest poster is displayed at each premises where a regulated activity is being delivered (including main place of business and our website).

5. Conclusion

The Trust continues to make progress against the CQC inspection action plan and spot check programme. The CQC progress meetings continue with preparedness for the forthcoming inspection.

Meeting Name and date	Trust Board – 14 January 2020
Paper number	I

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

For approval		For assurance	x	For information	

Presented by	Emma Wallis	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		

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 – 14 JANUARY 2020

SAFE STAFFING – NOVEMBER 2019 REVIEW

Introduction/Background

1 This report provides an overview of nursing safe staffing during the month of November 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 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 November 2019

Right Staff

- Overall the planned staffing levels were achieved across the Trust.
- Temporary worker utilisation rate increased overall this month 0.9%; reported at 30.5% and Trust wide agency usage increased this month by 0.1% to 4.0% overall.
- Six month establishment reviews; acuity and dependency data collection using the Mental Health Optimal Staffing Tool (MHOST) commenced on 18 November 2019 for 20 days over 4 weeks for all AMH, MHSOP & FYPC in-patient wards. Permission granted to pilot the Learning Disability Optimal Staffing Tool (LDOST) on the Agnes Unit and Short Breaks and Keith Hurst ADL assessment tool in community hospitals (data collection commences on 30 December 2019 and 6 January 2020 respectively). Data will be

triangulated with patient outcomes and professional judgement as recommended in NHSi Developing Workforce Safeguards, to be reported in February 2020.

- There are fifteen 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. To note nine of the fifteen are due to agency utilisation above 6%.
- 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 to maintain patient safety.
- 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 December 2019 Trust wide;
    - Appraisal sustained GREEN at 93.5%
    - Clinical supervision sustained GREEN increased 0.2% to 86.2%
    - Mandatory training; following Trust wide review the following subjects have been removed from the mandatory training register and moved to the role essential training register; Display Screen Equipment, Mental Health Act, Record Keeping and Care Planning, Induction, Mental Capacity Act, Suicide Awareness and Supportive Observations and Engagement. Compliance will continue to be reported and monitored for mandatory and role essential.
    - Substantive staff; of the 23 core and clinical mandatory subjects; most are GREEN with the exception of five topics that are AMBER with improvements.
    - Bank staff; there is continued improvement in bank staff compliance most are GREEN with the exception of eight topics; two at RED and six 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. High utilisation will be considered in the establishment reviews.
- The total Trust CHPPD average (including ward based AHPs) is reported at 11.50 CHPPD in November 2019, with a range between 4.7 (Skye Wing) and 35.9 (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 November 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%
Sept 19	100.2%	201.9%	107.0%	179.6%	31.9%
Oct 19	102.1%	199.4%	108.7%	186.4%	29.6%
Nov 19	**104.2%**	**201.7%**	**108.7%**	**187.9%**	**30.5%**

Table 1 - Trust level safer staffing

7 Temporary worker utilisation rate increased overall this month 0.9%; reported at 30.5% and Trust wide agency usage increased this month by 0.1% to 4.0% overall. The following wards utilised above 6% agency staff; Belvoir, Heather, Griffin, Beechwood, Feilding Palmer, St Lukes Ward 3, Coalville Ward 2, Coalville Ward 3 (CAMHS) East and North Ward.

8 The Trust Agency Spend task and finish group continues to implement actions to reduce agency and off-framework agency utilisation including;

- To ensure rotas are signed off 6 weeks ahead of shifts as per policy
- Review of off framework registered nurse usage, including a deep dive of Beechwood Ward spend
- Non-registered off framework usage in CHS – New process communicated to ward teams and on-call managers aimed to reduce usage
- Bank staff working over 200 hrs per month for last 6 months – Matrons to have conversations with individual bank staff to see if interested in converting to substantive employment.
- To develop a crib sheet of why becoming a substantive member of staff is beneficial
- DRA process to be reviewed with lead nurses
- Bank staff rota fill – Community Hospitals will test out offering proactive bank worker shift fill to top 4 hospital wards using agency to see if there is a reduction in agency/off framework spend
- A review of medical agency spend in FYPC and AMH
- A review of AMH administration agency spend
- A review of CHS AHP agency spend

Summary of staffing hotspots – Inpatients

Hot spot wards	Sept 2019	Oct 2019	Nov 2019
Hinckley and Bosworth - East Ward	X		X
Hinckley and Bosworth – North Ward			X
Beechwood	X	X	X
Clarendon		X	X
Feilding Palmer	X	X	X
St Lukes Ward 3	X	X	X
Coalville Ward 1			X
Short Breaks - The Gillivers	X	X	X

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

Table 2 – In-patient staffing hotspots

9 Nine wards; Belvoir, Heather, Griffin, Beechwood, Feilding Palmer, St Lukes Ward 3, Coalville Ward 2, Coalville Ward 3 (CAMHS) East and North Ward are hot spots due to utilising over 6% agency staff. These are the wards with high vacancy factor, increased acuity and dependency and or hard to fill bank areas.

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

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	Sept 2019	Oct 2019	Nov 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			
CAMHS County - FYPC	X	X	X
CAMHS Crisis - FYPC	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. The service has requested enhanced bank and agency rates to support fill rates for these teams.

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 remains a hot spot due to sickness; one staff member is on phased return. The band 7 leader is now fully inducted and in the numbers, in conjunction with internal moves clinical risk and activity are supported and managed.

17 There are no community hot spots in November 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 in December 2019.

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 Acting 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:	Emma Wallis- Associate Director of Nursing and Professional Practice on behalf of Anne Scott – Acting Director of Nursing, AHPs and Quality
Author:	Emma Wallis – Associate Director of Nursing and Professional Practice

Annexe 1 - November 2019

Ward Group	Ward name	Average no. of Beds on Ward	Average no. of Occupied Beds	Fill Rate Analysis (National Return) – Actual Hours Worked divided by Planned Hours: Nurse Day (Early & Late Shift) – Average % fill rate registered nurses	Nurse Day – Average % fill rate care staff	Nurse Night – Average % fill rate registered nurses	Nurse Night – Average % fill rate care staff	AHP Day – Average % fill rate registered AHP	AHP Day – Average % fill rate non-registered AHP	Skill Mix Met (NURSING ONLY)	% Temporary Workers (NURSING ONLY) – Total	Bank	Agency	Overall CHPPD (Nursing and AHP)
				>= 80%	>= 80%	>= 80%	>= 80%	-	-	(based on 1:8 plus 60:40 split) >= 80%	<20%	-	-	
AMH Bradgate	Ashby	21	20	93.9%	135.0%	100.0%	206.7%			86.7%	26.5%	24.7%	1.8%	5.6
	Aston	19	18	88.5%	191.7%	101.7%	210.0%			68.9%	34.6%	33.3%	1.4%	6.9
	Beaumont	22	21	111.8%	179.2%	96.7%	460.0%			86.7%	37.0%	36.7%	0.3%	7.3
	Belvoir Unit	8	8	117.5%	299.3%	166.7%	371.7%			93.3%	51.6%	44.2%	7.4%	20.9
	Bosworth	20	19	85.0%	171.7%	101.7%	186.7%			63.3%	30.9%	30.0%	0.8%	6.3
	Heather	18	18	95.5%	136.7%	90.0%	180.0%			81.1%	42.0%	31.2%	10.8%	6.2
	Thornton	20	19	90.6%	155.8%	98.3%	111.9%			77.8%	36.1%	36.1%	0.0%	6.2
	Watermead	20	19	90.6%	296.7%	98.3%	510.0%			78.9%	53.5%	51.3%	2.2%	9.5
	Griffin Female PICU	5	5	198.6%	239.0%	200.0%	203.3%			93.3%	40.4%	26.4%	14.0%	20.9
AMH Other	HP Phoenix	12	12	105.0%	155.8%	110.0%	148.3%			100.0%	15.2%	12.0%	3.2%	9.2
	SH Skye Wing	30	27	107.5%	150.3%	193.3%	111.7%			96.7%	34.6%	34.4%	0.2%	4.7
	Willows Unit	28	27	147.5%	162.1%	121.7%	244.9%			95.6%	15.2%	14.5%	0.7%	9.2
	ML Mill Lodge (New Site)	13	10	101.7%	217.2%	95.0%	151.7%			90.0%	46.0%	43.7%	2.3%	13.1
CHS City	BC Kirby	24	19	85.7%	235.8%	98.3%	141.7%			65.6%	29.7%	28.4%	1.3%	7.0
	BC Welford	24	15	99.2%	177.5%	91.7%	111.7%			80.0%	15.1%	13.4%	1.8%	7.7
	CB Beechwood	22	20	80.0%	229.2%	96.7%	130.0%	101.8%	97.5%	63.3%	30.0%	19.5%	10.5%	7.8
	CB Clarendon	23	20	76.7%	240.5%	100.0%	116.7%			64.4%	14.9%	10.4%	4.5%	6.5
	EC Coleman	20	18	67.1%	306.7%	93.3%	165.0%			48.9%	24.7%	23.9%	0.8%	9.0
	EC Gwendolen	20	15	85.4%	311.7%	98.3%	206.7%			77.8%	28.3%	23.8%	4.5%	10.8
CHS East	FP General	9	9	134.9%	76.8%	98.2%	-	100.9%	100%	66.7%	34.2%	19.6%	14.6%	7.9
	MM Dalgleish	16	14	100.0%	128.0%	103.4%	163.3%	100%	100%	96.7%	11.6%	9.0%	2.6%	9.4
	Rutland	16	13	98.3%	119.2%	96.7%	113.3%			94.4%	10.5%	7.9%	2.5%	6.7
	SL Ward 1 Stroke	16	11	104.9%	184.4%	96.7%	96.7%	100.6%	99.8%	96.7%	19.4%	17.9%	1.5%	13.7
	SL Ward 3	12	11	104.2%	111.7%	196.7%	143.3%	97.6%	106%	86.7%	41.0%	28.3%	12.7%	9.6
CHS West	CV Ellistown 2	18	15	100.0%	192.5%	200.0%	101.7%	102.7%	100%	98.9%	11.2%	5.1%	6.1%	9.4
	CV Snibston 1	14	13	100.7%	151.0%	98.3%	101.7%	96.7%	97.2%	86.7%	8.1%	5.4%	2.7%	11.4
	HB East Ward	20	18	86.5%	213.3%	100.0%	130.0%	101.3%	99.8%	68.9%	19.6%	11.6%	7.9%	8.5
	HB North Ward	19	18	121.7%	174.2%	95.0%	98.3%			97.8%	26.8%	16.6%	10.2%	6.6
	Lough Swithland	24	21	100.0%	238.3%	100.0%	200.0%	99.2%	99.8%	100.0%	12.4%	9.1%	3.2%	8.3
FYPC	Langley	15	14	106.6%	201.7%	100.0%	113.3%	100%	95.0%	97.8%	38.4%	38.4%	0.0%	8.9
	CV Ward 3	10	8	168.4%	353.1%	146.3%	351.2%			95.6%	49.3%	38.4%	10.9%	18.5
LD	3 Rubicon Close	4	3	120.0%	138.3%	90.0%	116.7%			88.9%	24.9%	24.9%	0.0%	20.6
	Agnes Unit	11	8	145.3%	509.2%	129.8%	629.8%			96.7%	53.9%	50.7%	3.3%	35.9
	The Gillivers	5	2	91.7%	161.3%	56.7%	163.3%			72.2%	18.1%	18.1%	0.0%	25.5
	The Grange	4	2	-	110.0%	-	190.0%			82.2%	18.2%	18.2%	0.0%	27.0
Trust Total				**104.2%**	**201.7%**	**108.7%**	**187.9%**			**81.3%**	**30.5%**	**26.4%**	**4.0%**	

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	93.9%	135.0%	100.0%	206.7%	26.5%	5.6	20.3%↑	0	4↑	0	100%
Aston	18	88.5%	191.7%	101.7%	210.0%	34.6%	6.9	6.4%↓	0	1	0	100%
Beaumont	21	111.8%	179.2%	96.7%	460.0%	37.0%	7.3	12.1%↓	0↓	2↓	0↓	nil
Belvoir Unit	8	117.5%	299.3%	166.7%	371.7%	51.6%	20.9	36.8%↓	2↑	0	0	nil
Bosworth	19	85.0%	171.7%	101.7%	186.7%	30.9%	6.3	16.3%↑	0	4↑	3↑	100%
Heather	18	95.5%	136.7%	90.0%	180.0%	42.0%	6.2	17.7%	4↑	1↑	0	nil
Thornton	19	90.6%	155.8%	98.3%	111.9%	36.1%	6.2	8.9%↓	0↓	1↓	0	nil
Watermead	19	90.6%	296.7%	98.3%	510.0%	53.5%	9.5	13.8%↑	2↓	4↑	2↑	nil
Griffin F PICU	5	198.6%	239.0%	200.0%	203.3%	40.4%	20.9	18.6%	0↓	0	2↑	nil
TOTALS									**8↑**	**17↑**	**7↑**	

Table 3 - Acute inpatient ward safe staffing

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

Temporary worker utilisation is Red for Belvoir and Watermead Wards at 51.6% and 53.5% respectively. The high utilisation is associated with both vacancies and increased patient acuity related to risk and higher levels of staffing required to meet enhanced levels of observation.

Belvoir Unit has reduced bank and agency utilisation due to increased patient acuity; however utilisation remains high due to the high number vacancies; including one band 6 and two band 5 RN vacancies and fourteen band 2 vacancies, over half the band 2 HCSW establishment. There is ten HCSW staff in the recruitment process.

Watermead Ward has had a higher level of patient acuity requiring additional staff for safe therapeutic observation and support for patients accessing ECT. The ward also has an increase in RN and HCSW sickness and two staff on maternity leave requiring cover.

A review of the NSIs and patient feedback has not identified any staffing impact on the quality and safety of patient care/outcomes. The increased falls on Bosworth and Watermead Wards are related to patients who are not using their mobility support consistently due to their mental health presentation. On Bosworth the increased falls are related to medication changes and ongoing mobility issues for patients.

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	120.0%	138.3%	90.0%	116.7%	24.9%	20.6	22.2%↑	0	1↑	1↑	100%
Agnes Unit	8	145.3%	509.2%	129.8%	629.8%	53.9%	35.9	10.7%↓	0	4↑	0	100%
The Gillivers	2	91.7%	161.3%	56.7%	163.3%	18.1%	25.5	15.0%↑	0	0	0	100%
The Grange	2	-	110.0%	-	190.0%	18.2%	27.0	28.6%↑	0	1↑	0	nil
TOTALS									**0**	**6↑**	**1↑**	

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 this reduces the RN fill rate on nights as the skill mix is adjusted according to patient needs, utilising HCSWs who are trained to administer medication and carry out delegated health care tasks. Where RN night cover is required it can also 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.

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	12	105.0%	155.8%	110.0%	148.3%	15.2%	9.2	8.3%↑	0	0	0↓	25%

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	27	107.5%	150.3%	193.3%	111.7%	34.6%	4.7	1.6%	2↑	1↑	0	66.7%
Willows Unit	27	147.5%	162.1%	121.7%	244.9%	15.2%	9.2	1.6%	0	0	0↓	77.8%
Mill Lodge	10	101.7%	217.2%	95.0%	151.7%	46.0%	13.1	16.1%↑	0	3↑	0	nil
TOTALS									**2↑**	**4**	**0↓**	

Table 6 - Rehabilitation service safe staffing

All ward/units met the planned staffing thresholds for all shifts the higher utilisation of temporary workers was related to vacancy cover or patient acuity.

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	9	134.9%	76.8%	98.2%	-	34.2%	7.9	44.5%	1↑	4↑	0	100%
MM Dalgliesh	14	100.0%	128.0%	103.4%	163.3%	11.6%	9.4	-9.9%	0	4	0↓	nil
Rutland	13	98.3%	119.2%	96.7%	113.3%	10.5%	6.7	16.5%	0	5↑	0	100%
SL Ward 1	11	104.9%	184.4%	96.7%	96.7%	19.4%	13.7	15.2%↓	1↓	2	0	100%
SL Ward 3	11	104.2%	111.7%	196.7%	143.3%	41.0%	9.6	31.3%↓	1↓	3↑	1↑	89.5%
CV Ellistown 2	15	100.0%	192.5%	200.0%	101.7%	11.2%	9.4	6.6%↑	0	1↓	0	100%
CV Snibston 1	13	100.7%	151.0%	98.3%	101.7%	8.1%	11.4	16.3%↑	0	2↓	0	100%
HB East Ward	18	86.5%	213.3%	100.0%	130.0%	19.6%	8.5	5.9%↑	2	3↑	0	100%
HB North Ward	18	121.7%	174.2%	95.0%	98.3%	26.8%	6.6	19.4%↑	0	3	0	100%
Swithland	21	100.0%	238.3%	100.0%	200.0%	12.4%	8.3	22.6%	0	5↑	0↓	94.9%
CB Beechwood	20	80.0%	229.2%	96.7%	130.0%	30.0%	7.8	14.6%↑	2↑	4↓	1	83.3%
CB Clarendon	20	76.7%	240.5%	100.0%	116.7%	14.9%	6.5	13.6%↑	1↑	5	0	87.5%
TOTALS									**8↑**	**41↑**	**2↓**	

Table 7 - Community hospital safe staffing

All wards met the thresholds for RN and HCSW planned staffing in November 2019 with the exception of Feilding Palmer on days for HCSW and Clarendon Ward on days for Registered Nurses. Feilding Palmer HCSW staffing was adjusted in line with bed occupancy and patient need, Clarendon Ward at times did not have a third RN on duty, this was still within safe parameters.

Feilding Palmer, St Lukes Ward 3, North Ward and Beechwood are hot spots associated with increased temporary workforce usage due to vacancies, maternity leave and sickness.

A review of the NSIs for the community hospital wards has identified that there was an increase in falls incidents on Swithland, East, St Lukes Ward 3, Feilding Palmer and Rutland Ward. There has been an increase in medication errors on Clarendon and Beechwood Wards which were prescribing and procedural related errors. Review of the increased incidences 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	85.7%	235.8%	98.3%	141.7%	29.7%	7.0	25.7%↓	0	10↑	0	50%
BC Welford	15	99.2%	177.5%	91.7%	111.7%	15.1%	7.7	19.2%	3↑	0↓	0	nil
Coleman	18	67.1%	306.7%	93.3%	165.0%	24.7%	9.0	16.2%↑	0	3↓	1↑	nil
Gwendolen	15	85.4%	311.7%	98.3%	206.7%	28.3%	10.8	14.3%	1↑	6↓	0	100%
TOTALS									**4↑**	**19↓**	**1↑**	

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 67.1% of the time. Analysis has shown there were 11 shifts with one registered nurse. Safe staffing was maintained with support from the Charge Nurse, Medicines Administration Technician (MAT) and registered staff from Gwendolen ward.

Both Gwendolen and Welford Wards had 10 shifts where there was one registered nurse, due to reduced occupancy rates on those wards they didn't trigger as hot spots. The wards were supported by the Charge Nurse, MAT and registered staff from 'sister' wards.

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	14	106.6%	201.7%	100.0%	113.3%	38.4%	8.9	-8.1%	0	0↓	0	100%
CV Ward 3 - CAMHS	8	168.4%	353.1%	146.3%	351.2%	49.3%	18.5	13.6%	2↑	0	0	nil
TOTALS									**2↑**	**0↓**	**0**	

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

Both wards met the thresholds for RN and HCSW planned staffing in November 2019, the wards continue to utilise an increased number of temporary workers to manage increased patient acuity and maintain patient safety. A review of the medication errors on Ward 3 CAMHS has not identified any staffing impact on the quality and safety of patient care/outcomes. There was no harm as an outcome of the errors

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board – 14th January 2020
Paper number	J

Name of Report Freedom to Speak Up Report

For approval	X	For assurance		For information	

Presented by	Angela Hillery - CEO	Author (s)	Pauline Lewitt – Freedom to Speak Up Guardian

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

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

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

Recommendations of the report
The Trust Board is recommended to: • Approve the completed NHS England and NHS Improvement self-review tool including actions and review dates (Attachment 1) • Support the current mechanisms and activities in place for raising awareness of the FTSU agenda. • To approve the proposed actions thereby supporting the significant impact speaking can have in supporting our Trust vision “Creating high quality, compassionate care and wellbeing for all”.

Leicestershire Partnership NHS Trust

Trust Board – January 2020

Freedom to Speak Up Report (6 monthly)

Introduction/Background

1. The Freedom to Speak Up (FTSU) review led by Sir Robert Francis into speaking up in the NHS provided independent advice and recommendations on creating a more open and transparent culture in the NHS.

2. The role of the FTSU Guardian incorporates being an additional route for speaking up but extends well beyond, aiming to develop cultures where safety concerns are identified and addressed at an early stage. FTSU has three components: improving and protecting patient safety, improving and supporting staff experience and visibly promoting learning cultures that embrace continual development.

Aim

3. This report provides an update from the Trust's FTSU Guardian on activities that strengthen the arrangements for staff to speak up, thereby creating a more open and transparent culture, and supporting improvements in patient care and the work experience for staff.

4. The report will also highlight updates from the National Guardian's Office.

5. In addition the report contains details of the concerns raised with the FTSU Guardian during the period July 2019 to December 2019.

Recommendations

The Trust Board is recommended to:

- Approve the completed NHS England and NHS Improvement self-review tool including actions and review dates (Attachment 1)
- Support the current mechanisms and activities in place for raising awareness of the FTSU agenda.
- To approve the proposed actions thereby supporting the significant impact speaking can have in supporting our Trust vision "Creating high quality, compassionate care and wellbeing for all".

Discussion

7. The FTSU Guardian has received support from Angela Hillery - Chief Executive and Sarah Willis - Director of HR & OD, with scheduled monthly meetings, Darren Hickman - Non-Executive Director to the Trust Board through quarterly meetings and Cathy Ellis - Chair at six monthly meetings.

Activity

8. *Freedom to Speak Up Partners* – Training for the second cohort of Freedom to speak up partners took place on Wednesday 31 July, with a further 7 partners volunteering (22 in total). This training session was supported by Northamptonshire Healthcare NHS Foundation Trust (NHFT) with their

guardian co-delivering and external delegates from Kettering General Hospital and Nottingham Citycare Partnership, in attendance. The Guardian and Executive leads for FTSU will meet quarterly with the partners to discuss and shape the work the Trust is doing to make 'speaking up business as usual'.

9. *Senior Leadership Forum* - The FTSU Guardian presented an update of the role and ongoing work at the Senior Leadership Forum, highlighting information in relation to the CQC well-led evidence from FTSU, National FTSU Index report including benchmarking data and local FTSU staff survey results. This session included an activity to facilitate discussion to identify the barriers to speaking up at all levels and in various circumstances. Further engagement sessions are planned for 2020.

10. *NHS Improvement FTSU self-review* – The first self-review was completed in September 2018. In July 2019, NHS England and NHS Improvement issued an updated version of the self-review tool which requires the Trust Board approval. This has been completed by the Executive Lead for speaking up, Non-executive lead for speaking up, The Trust Chair, the Director of Organisational Development and Human Resources and the FTSU Guardian. In December 2019, the review evidence and rating for each section was considered by the Board and the final document is to be submitted for approval in January 2020. (Attachment 1)

11. #*SpeakUptoMe* – October is National Speak Up month and throughout October 2019 the FTSU Guardian held a series of advertised drop-ins and engagement activities across Leicester, Leicestershire and Rutland raising awareness to the role and thereby encouraging and welcoming staff to speak up.

11. **NGO updates**

Regional Liaison Leads - The Trust guardian attended an engagement event on Friday 19 July, with 17 other colleagues from across the country to support and co-produce the NGO strategy for the future. This included working with the new Regional Liaison Leads (RLL) now employed by the NGO to support the delivery of Freedom to speak up into Primary Care and the third sector. The Midlands RLL has recently become vacant and the region is temporarily covered by existing RLL from 2 surrounding areas.

12. *NGO case review: Brighton and Sussex University Hospitals NHS Trust (BSUHT)* – This review took place in response to information received from current and former workers that suggested there was not a positive speaking up culture in the trust, particularly in relation to issues raised by black, Asian and minority ethnic (BAME) members of staff. This report was presented at the Equality, Diversity and Inclusion (EDI) focus group for discussion and highlighted to staffside lead for information.

The review underlines the importance of supporting minority groups across the trust. LPT have FTSU partners from all of the staff networks and strong links with all of the Lead Advocates. The FTSU Guardian is a core member of the Equality, Diversity and Inclusion(EDI) workforce group and meets regularly with the EDI lead, OD Lead and senior HR representative.

13. *Regional Integration Development Event (RIDE)* – This planned for 24 March 2020. It is an invitation for all guardians across the Midlands and will include representatives from both secondary and primary care and Arm's Length Bodies (ALBs). The agenda includes presentations from Henrietta Hughes – National FTSU Guardian, a key note speaker and development workshops to share best practice and continued development of the role.

14. In October 2019 the first FTSU Index benchmarking report was published by the NGO. The index was calculated as the mean average of responses to the following four questions from the NHS annual staff survey:

Q 17a - % of staff responded "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss or incident fairly
Q 17b - % of staff responded "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents
Q 18a - % of staff responded "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice, they would know how to report it
Q 18b - % of staff responded "agreeing" or "strongly agreeing" that they would feel secure raising concerns about unsafe clinical practice (question 18b)

F2SU index highlights LPT at 80% which is the average for trusts of our type - the highest was Solent NHS Trust at 86%

Freedom to Speak Up activities in the Trust

Raising Concerns

15. In the last 6 months (July 2019 – December 2019 inclusive), 63 members of staff have raised concerns either individually or as a group. There is a wide cross-section of the Trust workforce that have contacted the Guardian and these have included, clinical development leads, junior doctor, practice development team, matrons, nurses, administrators, health care support workers, student nurses, practitioners and other Allied Health Professionals

16. The majority request that their issue be dealt with confidentially however with support and reassurance many have felt confident to be identified and further-more discuss issues openly with their senior managers and Human Resource business partners as part of a 'listening meeting'.

Summary of speaking up cases in detail below: previous data provided for comparison

Month	No. of Contacts	Internal	FTSU	External	Anonymous
July	13	13	10	0	3
August	5	5	2	0	0
September	13	13	13	0	0
October	11	11	10	0	1
November	16	16	16	0	0
December	5	4	4	1	1
TOTAL	**63**	**49**	**55**	**1**	**5**

Service Area	Jan 19 – June 19	Jul 2019 – Dec 2019
AMH/LD	17	22
CHS	11	22
Enabling	6	3
FYPC	10	16
Hosted	0	0
TOTAL	**44**	**63**

Themes *	Jan 19 – June 19	Jul 2019 – Dec 2019
Patient Safety	13	35
Staff Safety	9	19
Attitudes & Behaviours	20	44
Bullying/Harassment	2	13
System/Process	21	35
Infrastructure/Environment	1	5
Cultural	10	24
Leadership	1	26
Senior Management Issue	1	6
Middle Management Issue	13	31

Concerns often contain multiple themes

Discussion of Themes

17. The majority of issues raised with the Guardian did not instigate a formal investigation and therefore the categorisation has been based on the account given from the staff member's perspective and as such is not formally substantiated.

18. The nature of the role of the FTSU Guardian tends to lead to individual members of staff speaking up in relation to specific individual cases and therefore it is difficult to see generalised themes within specific teams, departments, directorates or indeed across the Trust.

19. *Culture* - During the period July 2019 – December 2019 there has been wide reaching staff engagement as part of the 'Our Future, Our Way' (OFOW) culture and leadership project. There appears to be a significant increase in the number of staff speaking up about issues in relation to culture including negative attitudes, behaviours and perceived bullying or harassment. Certainly, as part of the initial discussions with staff that want to speak up mention has often been made to the OFOW focus groups, Change Champions and the encouraging Trust wide communications for speaking up. In many of these cases, staff have felt empowered to have open conversations with their managers or senior managers individually and have requested no further action from the FTSU Guardian. Others have been resolved through supported 'listening meetings' which ensures that staff have the opportunity to speak up are subsequently made aware of actions that will be taken as a result of their speaking up.

20. It is anticipated that as speaking up is an intrinsic part of the (OFOW) programme and is referenced in the design phase - future actions will promote a positive culture in line with our Trust values and vision. The FTSU Guardian has been an active voice in the discussions relating to leadership behaviours guidance.

21. *Process and Procedures* - A number of issues have also been raised in relation to processes and procedures. These have included:

- HR policy and processes around dealing with grievances and the associated affect investigations have on individual staff and team members that may or may not be directly involved but who are working with and thereby supporting their colleagues.
- Issues in relation to individual 'reasonable adjustments' or 'flexible working' arrangements.
- Response to action plans and revision of processes and how these are integrated into existing work plans and models e.g. Infection control, CQC or Health and Safety.
- Overpayment and the administrative process to reclaiming overpayments.
- Repayment of course fees in specific circumstances.

22. The FTSU guardian continues to work closely with HR colleagues, Health and Safety Team and Infection Control team and Learning and Development team to ensure staff are actively engaged through effective local and trust wide communication and therefore providing consistency in responding to speaking up matters.

23. *Patient Safety* – This remains the highest category of concern; in line with the principles of Freedom to Speak Up. Issues however have tended to be isolated situations and have been suggested by the reporter often as an effect of:

- Team interaction and working relationships
- Updated procedures and effective communication to support this
- Potential effect of decommissioning of specialist services
- Potential effect of transformation to provide effective care
- Mandatory training – Basic life support.
- Effective communication within a wider multi-disciplinary team across service provision

24. All incidents and potential themes have been reported to the appropriate Directorate Management Teams or delegated representatives and managed at a local level. In all cases the staff that have spoken up have received feedback on the progress made to resolve issues or the final outcome where appropriate observing confidentiality.

Actions

- Continue working with Organisational Development to ensure that 'Speaking Up' is encapsulated in the outcomes of the Our Future, Our Way project and implicit within the 'leadership behaviours for all' publication.
- Review of the role of FTSU partners planned for April 2020 to include quarterly meetings 2020-2021
- Review of existing triangulation methods and strengthen within the current Quality and Governance structure in relation to Speaking Up – planned for March 2020
- Report to Strategic Executive Board quarterly.
- Ensure there are available opportunities to speak up explicit to all exit surveys and personal exit interviews.
- FTSU Guardian to liaise with regional colleagues to gain clarity and consensus on current interpretation of guidance and case review gap analysis to inform best practice.
- Include consistent and clear information on LPT external website to embed key message that 'speaking up is business as usual' in this organisation.
- Maintain and increase visibility across the wider trust to raise awareness of speaking up role and embedding FTSU message.
- Continue to engage in regional and national FTSU meetings and conferences thereby using updates, information and recommendations to inform best practice.

Conclusion

25. The Freedom to Speak Up agenda is building an environment where staff know their concerns, feedback and commentary are taken seriously and welcomed as an opportunity to guide service improvement and transformation.

26. Feeling free to speak up is a significant culture change across the NHS. Success is not only the responsibility of those in the guardian role. It is vital the Trust learn from concerns that staff raise and ensure changes or actions are implemented, otherwise there will be no value in the process and we would be missing out on some of the most valuable information that comes from these reports.

Presenting Director: Angela Hillery
Author(s): Pauline Lewitt

Freedom to Speak Up review tool for NHS trusts and foundation trusts

July 2019

NHS England and NHS Improvement

How to use this tool

This is a tool for the boards of NHS trusts and foundation trusts to accompany the *Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts* (cross referred with page numbers in the tool) *and the* *Supplementary information on Freedom to Speak Up in NHS trusts and NHS foundation trusts* (cross referred with section numbers).

We expect the executive lead for Freedom to Speak Up (FTSU) to use the guidance and this tool to help the board reflect on its current position and the improvement needed to meet the expectations of NHS England and NHS Improvement and the National Guardian's Office.

We hope boards will use this tool thoughtfully and not just as a tick box exercise. We also hope that it is done collaboratively among the board and also with key staff groups – why not ask people you know have spoken up in your organisation to share their thoughts on your assessment? Or your support staff who move around the trust most but can often be overlooked?

Ideally, the board should repeat this self-reflection exercise at regular intervals and in the spirit of transparency the review and any accompanying action plan should be discussed in the public part of the board meeting. The executive lead should take updates to the board at least every six months.

It is not appropriate for the FTSU Guardian to lead this work as the focus is on the behaviour of executives and the board as a whole. But getting the FTSU Guardian's views would be a useful way of testing the board's perception of itself. The board may also want to share the review and its accompanying action plan with wider interested stakeholders like its FTSU focus group (if it has one) or its various staff network groups.

We would love to see examples of FTSU strategies, communication plans, executive engagement plans, leadership programme content, innovative publicity ideas, board papers to add them to our Improvement Hub so that others can learn from them. Please send anything you would specifically like to flag to nhsi.ftsulearning@nhs.net

NHSI are happy to support trusts on any aspect of the review process or the improvement work it reveals. Please get in touch with NHSI's Whistleblowing support team via rachel.clarke31@nhs.net

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Review date		
Behave in a way that encourages workers to speak up					
Individual executive and non-executive directors can evidence that they behave in a way that encourages workers to speak up. Evidence should demonstrate that they: • understand the impact their behaviour can have on a trust's culture • know what behaviours encourage and inhibit workers from speaking up • test their beliefs about their behaviours using a wide range of feedback • reflect on the feedback and make changes as necessary • constructively and compassionately challenge each other when appropriate behaviour is not displayed	Section 1 p5	**Fully (Dec 2019)**	Dec 2020	National Staff Survey (NSS) results show an increased positive safety culture (2017-2018) Open culture of feedback reflected through complaints/compliments and Friends and Family programme Executive and Non-Executive Directors are visible to frontline staff via Boardwalks and drop-ins. Staff are encouraged to speak openly and feedback is brought into Board and Committee meetings and escalated to the Directorate as required. Evidenced via Boardwalk feedback forms and Board/Committee minutes. Staff voice at Board meetings encourages staff to tell the Board what it is like to work in LPT. Evidenced in Board minutes. 'Our Future, Our Way' – Board involvement at all stages of the culture project including co-production of the leadership behaviours.	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Review date		
Demonstrate commitment to FTSU					
The board can evidence their commitment to creating an open and honest culture by demonstrating: • there are a named executive and non-executive leads responsible for speaking up • speaking up and other cultural issues are included in the board development programme they welcome workers to speak about their experiences in person at board meetings • the trust has a sustained and ongoing focus on the reduction of bullying, harassment and incivility • there is a plan to monitor possible detriment to those who have spoken up and a robust process to review claims of detriment if they are made • the trust continually invests in leadership development • the trust regularly evaluates how effective its FTSU Guardian and champion model is • the trust invests in a sustained, creative and engaging communication strategy to tell positive stories about speaking up.	p6 Section 1 Section 2 Section 3	**Fully (Dec 2019)**	Dec 2020	Executive Lead and Non-executive lead both named in Trust policy including contact details. Freedom to Speak Up review included as a reflection tool and assurance mechanism as part of the Trust board development programme Dec 2019 Executives present at all Corporate Induction sessions supporting a positive and open culture. Staff enabled to present their experiences in person at Trust board to support understanding and learning. Regular meetings between HR and FTSU guardian to ensure detriment is not experienced by staff after speaking up. Board interviews by Change Champions as part of focussed feedback for 'Our Future, Our Way' programme: board engagement in the discovery design phase - working around the 9 identified priorities. The change champions have presented to the board twice and each priority has two Board members supporting it. The change champions have made video blogs about their story and why each priority is important to them. FTSU Guardian is a member of the Anti-Bullying and Harassment Service (ABHS) help-line focus group. ABHS has been identified as a key priority in the 'Our Future, Our Way' programme and will form part of the subsequent action planning. Engagement of staff in 'Step Up to Great' with regular communications about this at staff conferences, video blogs and staff news. Board member - champion for Equality, Diversity and Inclusion (EDI) for staff and patients, his impact has encouraged staff to speak up. We have a leadership and development framework offer available for staff which includes supportive management behaviour training, healthy conversations and responding to concerns. The trust induction programme embeds FTSU. There is a Trust values video.	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Review date		
Have a strategy to improve your FTSU culture					
The board can evidence it has a comprehensive and up-to-date strategy to improve its FTSU culture. Evidence should demonstrate: • as a minimum – the draft strategy was shared with key stakeholders • the strategy has been discussed and agreed by the board • the strategy is linked to or embedded within other relevant strategies • the board is regularly updated by the executive lead on the progress against the strategy as a whole • the executive lead oversees the regular evaluation of what the strategy has achieved using a range of qualitative and quantitative measures.	P7 Section 4	**Fully (Dec 2019)**	Dec 2020	The FTSU strategy was agreed at Trust Board in July 2018. The strategy will be reviewed as part the final outcome 'Our Future, Our Way' and aligned with the Step Up to Great Strategy and Trust vision and presented as part of board paper – Jan 2020. Executive lead/FTSU guardian 1:1 discussions in relation to future plans for embedding and integration of FTSU messages in the organisation as part of Step Up to Great strategy. The Board receives a report from the Executive Lead and FTSUG twice per year. Quarterly reports to the Strategic Executive Board (SEB) commencing Jan 2020 Annual presentation to the Audit Committee to provide assurance in line with current guidelines. Annual review of LPT self-review document which is jointly prepared by the FTSUG and Board members as part of Board Development session. Quarterly data reports to NGO (identifying open and anonymous reporting), NSS, FTSU index, FFT (Friends and Family Test), feedback from uLearn and FTSU guardian survey provide quantitative measures which create opportunities to evaluate achievements against the strategy.	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Review date		
Support your FTSU Guardian					
The executive team can evidence they actively support their FTSU Guardian. Evidence should demonstrate: • they have carefully evaluated whether their Guardian/champions have enough ring fenced time to carry out all aspects of their role effectively • the Guardian has been given time and resource to complete training and development • there is support available to enable the Guardian to reflect on the emotional aspects of their role • there are regular meetings between the Guardian and key executives as well as the non-executive lead. • individual executives have enabled the Guardian to escalate patient safety matters and to ensure that speaking up cases are progressed in a timely manner • they have enabled the Guardian to have access to anonymised patient safety and employee relations data for triangulation purposes • the Guardian is enabled to develop external relationships and attend National Guardian related events	p7 Section 1 Section 2 Section 5	**Fully (Dec 2019)**	Dec 2020	FTSU Guardian works 0.9 WTE in the role 15 FTSU partners - maximum of 10 hours per year + 1 full day initial foundation training (voluntary role by agreement with line-manager) Monthly 1:1 meetings between FTSU guardian and Executive lead Monthly 1:1 between FTSU guardian and Director of OD & HR Regular meeting with Non-executive lead Twice yearly meeting with Chair Various examples where the guardian has engaged with Directors of Nursing, Community Health Services, Families Young People & Children's Services, Adult Mental Health & Learning Disabilities and the Medical Director to escalate patient safety matters ensuring these cases are progressed in a timely manner Access to any data required is provided on request. Additional triangulation meetings are planned between Dep. Director of HR and Patient Experience and Improvement Lead FTSU to attend the Learning Lessons Exchange Group FTSU guardian supported to attend National Guardian Office (NGO) training workshops, development opportunities and conferences FTSU supported to actively participate in Midlands regional network group activity FTSU has direct links with Northamptonshire Healthcare Foundation Trust (NHFT) as 'buddy' organisation.	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Review date		
Be assured your FTSU culture is healthy and effective					
Evidence that you have a speaking up policy that reflects the minimum standards set out by NHS Improvement. Evidence should demonstrate: • that the policy is up to date and has been reviewed at least every two years • reviews have been informed by feedback from workers who have spoken up, audits, quality assurance findings and gap analysis against recommendations from the National Guardian.	P8 Section 8 National policy	**Fully (Dec 2019)**	Dec 2020	Freedom to Speak Up: Raising Concerns (Whistleblowing) policy updated in January 2019. This was circulated to the Senior Management Teams, Staff-side and adopted at the Workforce and Wellbeing Group NHS Improvement is expected to publish an updated policy template (early 2020). Following this publication, and with reference to NGO case reviews, the LPT policy will be reviewed, co-produced and updated based on feedback from :- • FTSU Partners • Staff who have spoken up • Staff-side representatives • HR colleagues	
Evidence that you receive assurance to demonstrate that the speaking up culture is healthy and effective. Evidence should demonstrate: • you receive a variety of assurance • assurance in relation to FTSU is appropriately triangulated with assurance in relation to patient experience/safety and worker experience. • you map and assess your assurance to ensure there are no gaps and you flex the amount of assurance you require to suit your current circumstances • you have gathered further assurance during times of change or when there has been a negative outcome of an investigation or inspection • you evaluate gaps in assurance and manage any risks identified, adding them to the trust's risk register where appropriate.	P15 Section 6 *Think this is an LPT gap – needs strengthening*.	**Partial (Dec 2019)**	July 2020	FTSU Board report - Six-monthly report includes qualitative narrative on themes and trends and numeric data in respect of: • Nat. Staff Survey comparisons (annual) • Case figures reported to NGO(quarterly) • FTSU survey (annual) • FTSU Index • CQC feedback and action plan Report presented at Strategic Workforce Committee. Data is triangulated with other data from Boardwalks, Serious Incidents and Safer Staffing report. Speaking Up is an agenda item on Ops Exec meeting where themes are discussed and triangulated Presentation at the Audit Committee with documentation to support tasks completed both proactively and reactively giving examples of triangulation for example: • Quality summits have taken place in relation to CHS and BMHU, discussions as part Equality, Diversity and Inclusion (WRES action plan) and feedback from Bank Staff survey. There are planned follow-up communications and engagement to support staff as the new models of work is	***Review of existing triangulation methods within the current Quality and Governance structure in relation to Speaking Up – planned for March 2020***

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Review date		
				embedded. • Quality summit with Director of HR, Equality Lead, Head of OD & FTSU Guardian • Regular meetings with Patient Experience Lead, Patient Safety Lead and Workforce and Wellbeing Group creating ongoing dialogue and triangulation. • FTSU to review risk-register as part of triangulation methods • Staff engagement sessions have been held in specific areas that are experiencing change or pressures. Examples are District Nursing staff shortages in the City and ICS teams when service was transferred into core district nursing	
The board can evidence the Guardian attends board meetings, at least every six months, and presents a comprehensive report.	P8 Section 7	**Fully (Dec 2019)**	Dec 2020	FTSU Board report - Six-monthly report includes numeric data: • Nat. Staff Survey comparisons (annual) • Case figures reported to NGO(quarterly) • FTSU survey (annual) • FTSU Index • Qualitative narrative also provided Board paper authored and presented at the public section of Trust Board in person by the FTSU guardian in January and July 2019 as evidenced by Board minutes. FTSUG to attend Board development session in December 2019 to prepare evaluation with Board prior to presenting paper at January 2020 Board meeting	
The board can evidence the FTSU Guardian role has been implemented using a fair recruitment process in accordance with the example job description (JD) and other guidance published by the National Guardian.	Section 1 NGO JD	**Fully (Dec 2019)**	Dec 2020	FTSU guardian recruited through open recruitment process (January 2019) following 2 year secondment to role	
The board can evidence they receive gap analysis in relation to guidance and reports from the National Guardian.	Section 7	**Fully (Dec 2019)**	Dec 2020	Most recent case review reports highlighted and embedded within the FTSU Board report – NGO updates section. Published case review reports discussed with relevant Directors and Senior Managers to share learning and highlight best practice. Further focus identified to appropriate work areas where necessary for example Human Resources (HR), Equality, Inclusion and Diversity (EDI).	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Review date		
				NGO case review discussed at regional HR networks sharing learning Case reviews discussed at FTSU Partners forum to identify how specific learning can be used to support FTSU agenda and embedding consistent messages across LPT	
Be open and transparent					
The trust can evidence how it has been open and transparent in relation to concerns raised by its workers. Evidence should demonstrate: • discussion with relevant oversight organisation • discussion within relevant peer networks • content in the trust's annual report • content on the trust's intranet website • discussion at the public board • welcoming engagement with the National Guardian and her staff	P9	**Fully**	Dec 2020	FTSU Board report presented and discussed openly at the Public board. FTSU meetings with CQC during inspection visit providing supporting evidence as required. Open access to local CQC inspector. Themes shared with staff side colleagues at Joint Staff Consultative and Negotiating Committee (JSCNC). Quarterly Report presented at Strategic Workforce Committee (SWC) FTSU guardian attends all staff support groups liaising regularly with lead advocates. Learning shared through communications series of 'You said – We did' style of responses to NSS comments through Trust intranet. Dedicated page to Freedom to Speak Up on the staff intranet eSource which includes links to stand alone documents including policy, leaflets, flowcharts, and 5 steps approach information when responding to concerns Completion of discovery phase of 'Our Future, Our Way' programme identifying 9 key priorities from cross-section of focus groups supporting feedback from across the workforce, patients/carers and external stakeholders. Midlands Regional Liaison Lead (NGO representative) welcomed to LPT as part of hosted regional network meeting. FTSU Guardian working with as part of core regional network team and NGO to develop and present Regional Integration Development Event (RIDE) to take place February 2020	***Stretch Action -*** ***Include consistent and clear information on LPT external website to embed key message that 'speaking up is business as usual' in this organisation.***

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Review date		
Individual responsibilities					
The chair, chief executive, executive lead for FTSU, Non-executive lead for FTSU, HR/OD director, medical director and director of nursing should evidence that they have considered how they meet the various responsibilities associated with their role as part of their appraisal.	Section 1	**Fully (Dec 2019)**	Dec 2020	Senior Leaders comply with requirements of annual appraisal identifying evidence to meet the various responsibilities associated with their role including culture and leadership, Trust values discussed through 'Our Future, Our Way' programme and 'Step Up to Great' as the Trusts strategic plan. Chair appraisal reflects staff survey and culture feedback. NED lead reflects regular liaison with FTSUG.	

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board January 2020
Paper number	**K**

Name of Report Patient Safety report Q2

For approval		For assurance	x	For information	

Presented by	Emma Wallace Associate Director of Nursing and Professional Practice	Author (s)	Tracy Ward Head of Patient Safety

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

Report previously reviewed by	
Committee / Group	Date
QAC	10/12/19

Assurance: What assurance does this report provide in respect of the Organisational Risk Register?	Links to ORR risk numbers
This report provides the assurance that we are triangulating incidents and other data to identify that we accurately identify where patients have come to harm or may come to harm This report also describes how we learn from both individual incidents and from themes from multiple incidents and use these to develop system learning together with teams	1 3

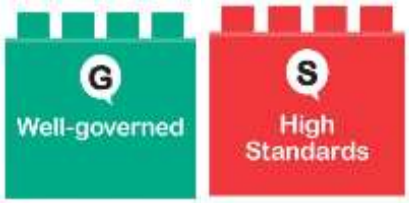
The report also describes compliance with regulatory requirements (i.e. Duty of Candour)	18

Recommendations of the report
This report is provided to assure Trust Board that we are monitoring the available information to; Identify were action is required or action taken is being effective and that this is taking place in a coordinated way across the three directorates. To also note the additional work identified as required that will begin as staff come into post and via the work of the Patient Safety Improvement Group and the incident and serious incident oversight group as they work with the Directorate Governance teams. The report was provided to QAC and then on to Clinical Quality Review Group and some of the included sections are required by the 19/20 Quality Schedule. To note there has been a change in the reporting requirements of Serious incidents and this has resulted in showing out of control. The reason for this is described in section 4. This SPC control limits will be re calculated for Q3 when there will be 6 data points.

Leicestershire Partnership NHS Trust

PATIENT SAFETY REPORT

Quarter 2 2019/20



CONTENTS

1. EXECUTIVE SUMMARY

This report is being shared to provide an overview of incidents across the organisation and key learning identified; this includes serious incidents (SI's). Reports previously have only described serious incidents across the Trust not the themes and trends from incidents, learning and identified areas for quality and safety improvement.

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

This style of report was trialled for Q4 2018/19 and feedback was positive. Staff availability and changes within the Patient Safety Team has challenged further development; however, it is expected that this report will develop over time as the PSIG develop and in response to feedback of its usefulness.

During Q4 2018/19 we shared the increase in deaths under the care of the Acute Mental Health Crisis team. In Q1 we commissioned an external Crisis Consultant to re review initially one SI where a patient took their own life while under the care of this team. The learning from this has been shared and in Q2 a learning event held with the team. A series of key actions have come out of this and include looking at options for auto planning of visits to improve both continuity of carer and efficiency for staff around travel time and reading patient notes. Duplication was also identified as an area to consider in order to unlock staff time. Links have been developed with Coventry and Warwick Crisis team to share learning. During Q2 there was a preventing future deaths report received from HM Coroner in relation to some of the concerns around capacity and continuity (see section 10).

Grade 4 pressure ulcers continue to be investigated as Serious Incidents and there have been some key learning coming through around patient information and how this aids their understanding of how pressure ulcers develop. There was also variable quality in relation to risk assessments and therefore interventions put in place. There is now a single "Your Skin matters" improvement plan. All new grade 4 pressure ulcers are considered and learning cross referenced with the wider improvement plan to ensure it is all captured.

The patient safety team have been challenged with staff sickness and IT issues. Since StEIS's host was transferred to NHSI there have been compatibility issues that we have not been able to immediately identify the cause. Both of these issues have resulted in incidents being sporadically inputted to StEIS. This has resulted in the figures not being a timely reflection.

National Patient Safety Strategy

Q1 report described the new NHS Patient Safety Strategy (NHSE/I) and its launch at the National Patient safety Congress in April 2019 and was welcomed. The formal launch and publication occurred in July 2019; we are currently in the processing of reviewing this and identifying local actions for the Corporate Patient Safety Team based on patient safety culture and systems, gaining insight, involving teams and partners and identifying systems and processes that are effective in supporting sustainable change and improvement through learning.

We are awaiting further guidance around categories for reporting and methodology for investigating SI's which is being tested by some early adopter organisations and early feedback is that there are some large scale changes.

More information can be found in section 16 of this report with a link to the full document. By quarter 1 2020/21 we will be identifying and sharing key organisational changes and plans linked to the key aims of this new strategy.

The Patient Safety team are however clear that the culture change is pivotal to all of the improvements.

World Patient Safety Day 17th September 2019

From Friday 13 September 2019 there was all staff email communication promoting World Patient safety Day. We started on 13 September with the topic of Pressure Ulcers including detail of key principles to good quality care for their prevention and management.

On 16th Monday September 2019 a further all staff email communication was shared for one of our most significant patient safety risks – medication. Although medicines improve the lives of millions of people, they can also be harmful in certain cases if we miss small things i.e. not rechecking what we have prescribed or read to administer, not varying form safe systems of work and also remembering that there are others with expertise to assist if unsure as a prescriber or administrator.

All staff email communication World Patient Safety Day delivered a message about positive safety culture, speaking up and positive and blame free communication as teams, reporting concerns and incidents and taking ownership for keeping our patients and clients safe.

Community Health Service's (CHS) community hospitals marked World Patient Safety Day by launching a new drive to hold safety hubs to review patient falls, with the aim of making reducing repeat incidents. We shall be reporting on the success and feedback in Q3 & 4.

Next year for Patient Safety day the intention is to hold a Patient Safety and Learning Lessons Conference.

2. TRUST WIDE INCIDENT DATA

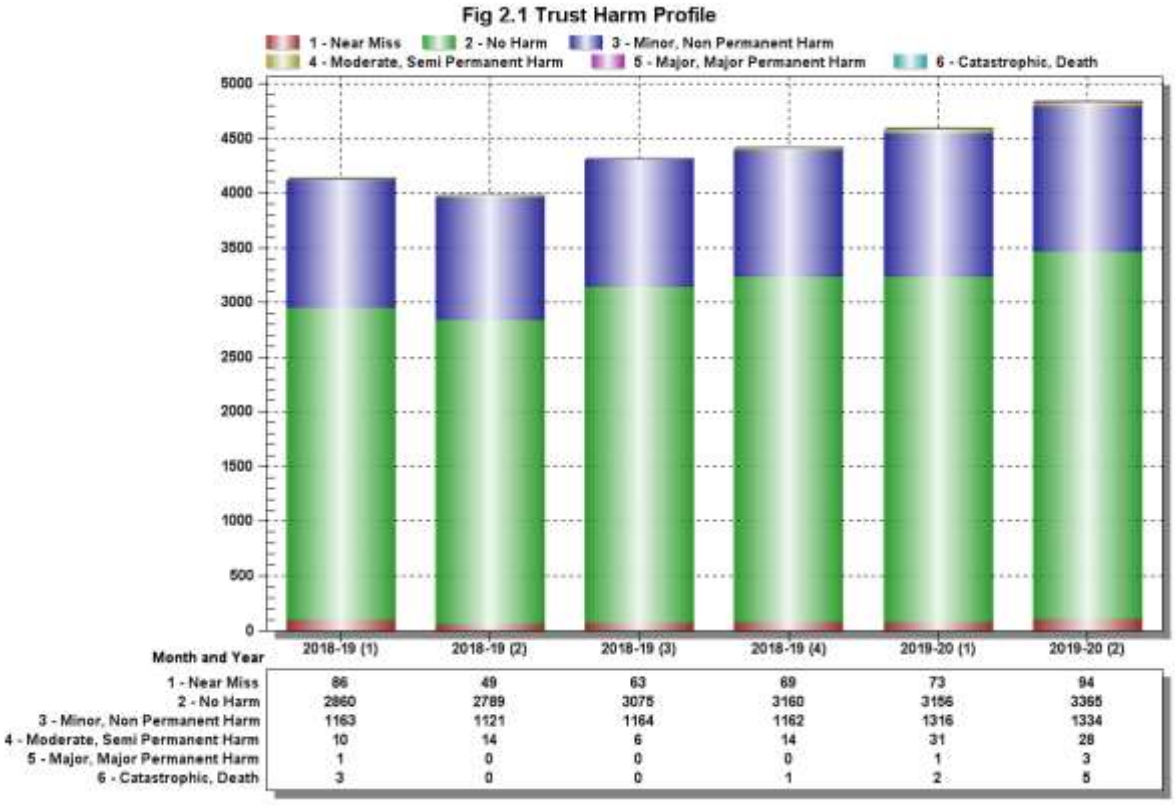


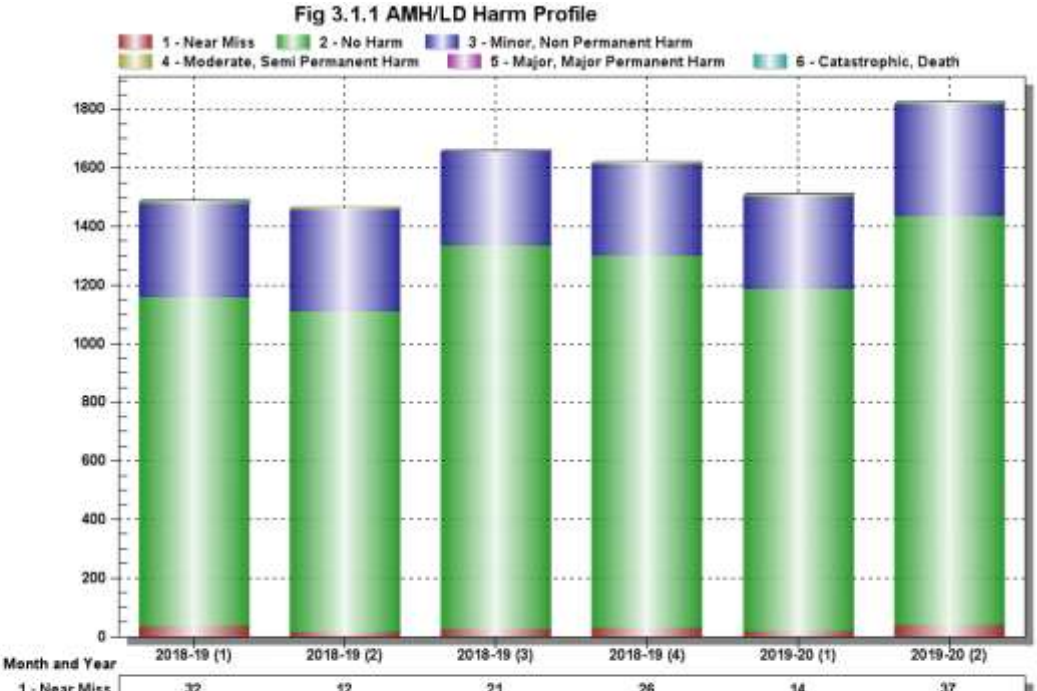
Figure 2.1 above highlights the quarterly data with regarding to numbers of incidents reported by LPT since 1st April 2018. The data shows that there has been an overall increase in reportable incidents from 4,579 in quarter 1 2019/20 to 4,829 in quarter 2 2019/20.

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

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

3. DIRECTORATE INCIDENT DATA AND LEARNING

a. Adult Mental Health and Learning Disabilities



Month and Year	2018-19 (1)	2018-19 (2)	2018-19 (3)	2018-19 (4)	2019-20 (1)	2019-20 (2)
1 - Near Miss	32	12	21	26	14	37
2 - No Harm	1126	1097	1315	1275	1171	1398
3 - Minor, Non Permanent Harm	320	348	319	312	317	381
4 - Moderate, Semi Permanent Harm	5	6	3	5	4	3
5 - Major, Major Permanent Harm	1	0	0	0	1	1
6 - Catastrophic, Death	2	0	0	0	1	3

Figure 3.1.1 above highlights the quarterly data with regarding to numbers of incidents reported by AMH&LD since 1st April 2018. The data shows that there has been an overall increase in reportable incidents from 1,508 in quarter 1 2019/20 to 1,823 in quarter 2 2019/20.

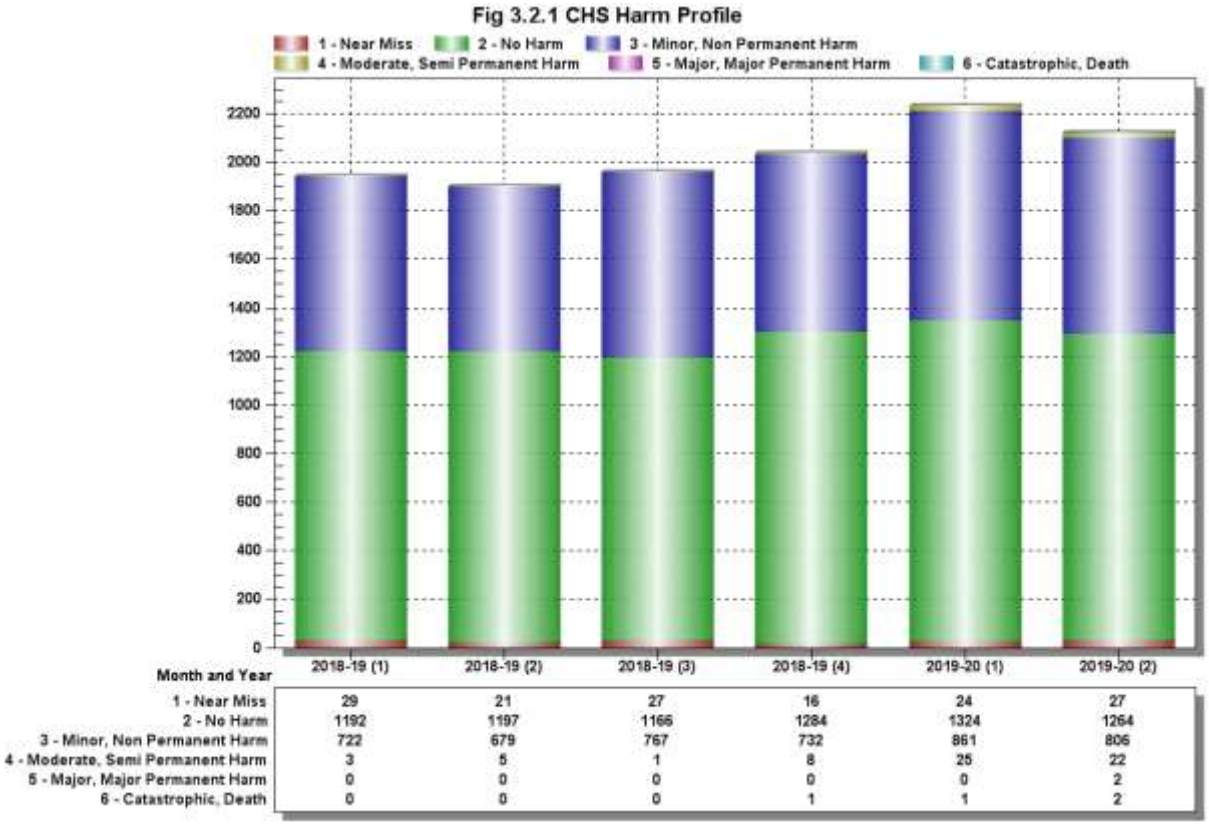
3.1.2 Learning

In Q4 2018/19 AMH/LD describe the two highest reported incidents as violence and aggression and self-harm. In Q1 we undertook two reflective learning events to explore with staff the areas they feel we need to support. One key area that came out of this was around developing a trust wide approach to caring for patients with a diagnosis of personality disorder. This will require a multi professional approach that is consistently applied.

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

early in the implementation process to expect discernible results and is disappointing that we continue to see high reporting of incidents related to this.

b. Community Health Services



Month and Year	2018-19 (1)	2018-19 (2)	2018-19 (3)	2018-19 (4)	2019-20 (1)	2019-20 (2)
1 - Near Miss	29	21	27	16	24	27
2 - No Harm	1192	1197	1166	1284	1324	1264
3 - Minor, Non Permanent Harm	722	679	767	732	861	806
4 - Moderate, Semi Permanent Harm	3	5	1	8	25	22
5 - Major, Major Permanent Harm	0	0	0	0	0	2
6 - Catastrophic, Death	0	0	0	1	1	2

Figure 3.2.1 above highlights the quarterly data with regard to numbers of incidents reported by CHS since 1st April 2018. The data shows that there has been an overall decrease in reportable incidents from 2,235 in quarter 1 2019/20 to 2,123 in quarter 2 2019/20. There continues to be an increase in 'moderate harm' incidents from 8 in quarter 4 2018/19 to 25 in quarter 1 2019/20; we have seen a small decline in quarter 2 to 22. These changes in moderate incidents are monitored by the Corporate Patient Safety Team; they remain related to the change in reporting of pressure ulcers relating to their harm.

3.2.2 Learning

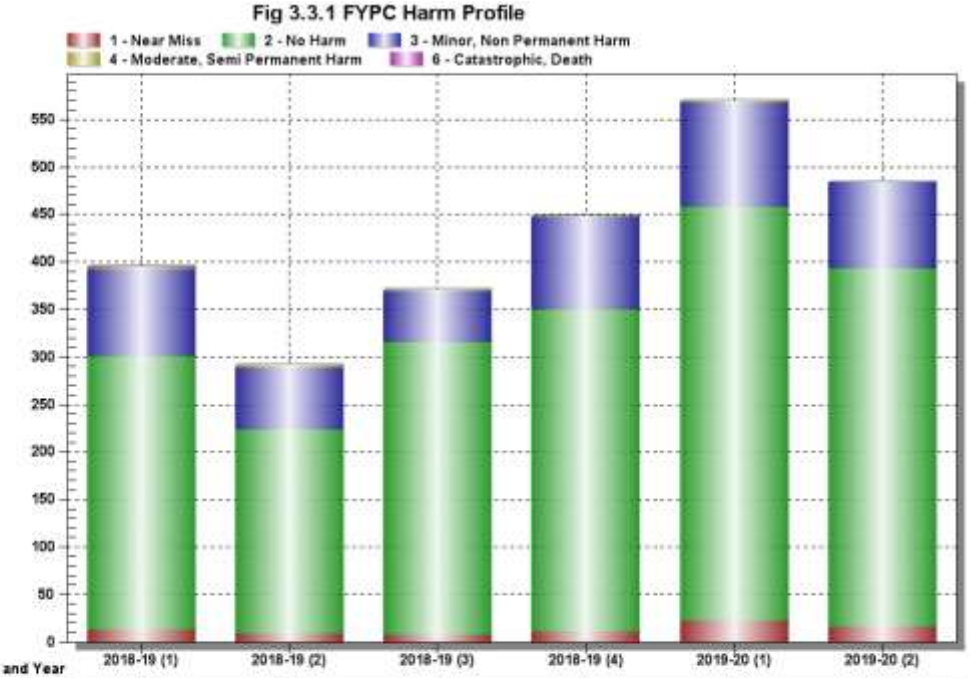
From the learning shared in quarter 1 report related to staff knowledge re referral for advice and guidance for lower limb concerns and equipment compliance this remains a focus in exploring ways forward to facilitate training for carers who support our patients but whom are employed from outside organisations. This is a much bigger piece of work across the health economy that needs to be pulled together to reduce the distress to patients, carers time and financial cost to the NHS.

In relation to falls prevention the use of post fall huddles was trialled in quarter 1 and formally launched on World patient Safety day 17 September 2019.

The work being undertaken in relation to falls and pressure ulcers is detailed in sections 12 and 13

c. Families, Young People and Children Services

Fig 3.3.1 FYPC Harm Profile



Month and Year	2018-19 (1)	2018-19 (2)	2018-19 (3)	2018-19 (4)	2019-20 (1)	2019-20 (2)
1 - Near Miss	12	8	7	10	21	15
2 - No Harm	289	215	308	340	437	378
3 - Minor, Non Permanent Harm	91	65	54	97	110	91
4 - Moderate, Semi Permanent Harm	2	3	2	1	2	0
6 - Catastrophic, Death	1	0	0	0	0	0

Figure 3.3.1 above highlights the quarterly data with regard to numbers of incidents reported by FYPC since 1st January 2018. The data shows that there has been an overall decrease in reportable incidents from 570 in quarter 1 2019/20 to 484 in quarter 2 2019/20. We have identified that the reduction is accounted for a change in reporting in relation to the making of safeguarding referrals

3.3.2 Learning

Learning from incidents continues to highlight MDT working and the difficulty for practitioners holding a case on their own. There has been a change in the methodology used for supervision to support staff to discuss these more complex cases and receive objective views and support. The maintaining of confidentiality with patients as well as sharing concerns around risk will be considered as this is a wider challenge. Our buddy trust NHFT is already considering this so there is potential for some joint learning.

4. SERIOUS INCIDENT DATA TRUST WIDE (NB Data Updated following feedback from QAC)

In quarter 2 2019/20 there were 30 SIs that met the reporting criteria for reporting on StEIS

Chart 1

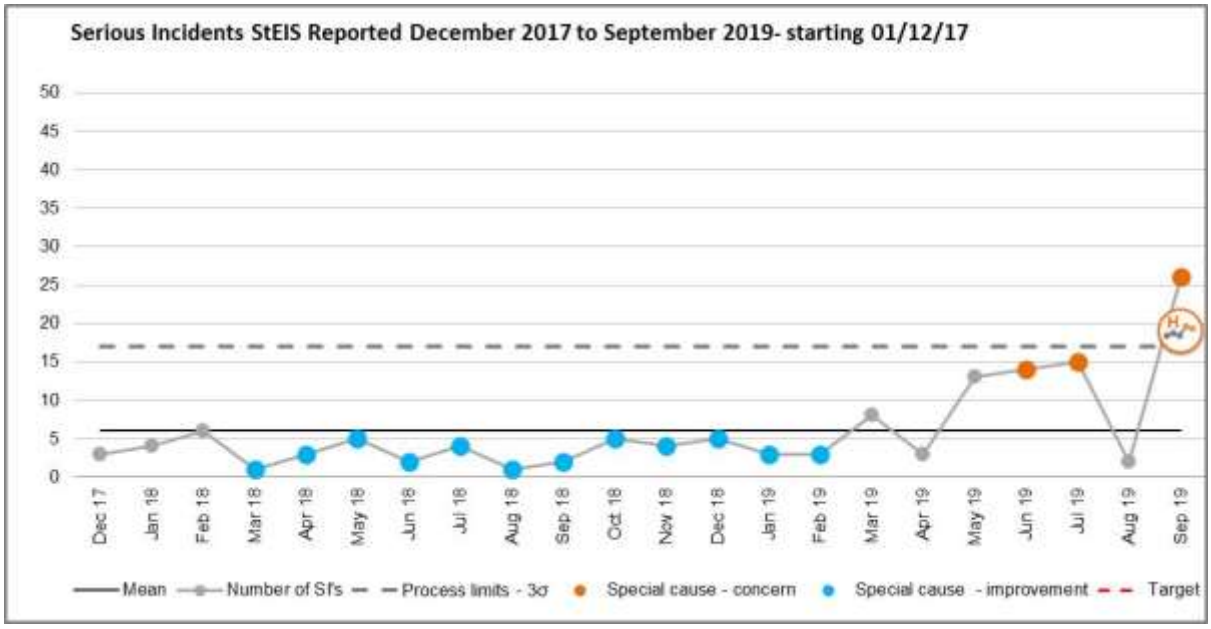
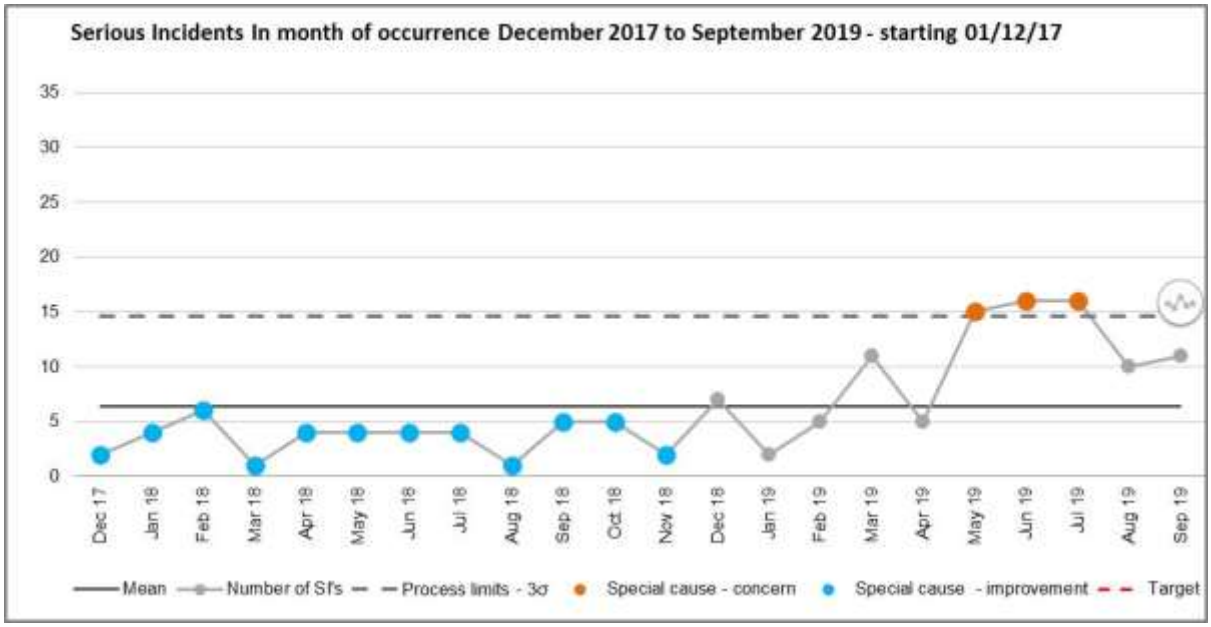


Chart 2



Statistical Process Control Chart (SPC Chart)

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

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

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

Interpretation

Chart 1. Shows out of control limits for reporting these delay's in entering on StEIS were caused by IT difficulties, Team absence and delayed identification.

Chart 2. Demonstrates that whilst there are three points outside of control limits for the numbers of SI's occurring this is as a result of changes in the classification of Grade 4 pressure ulcers (15 in total for Q2)

Counting numbers of incidents alone is not a good indicator and further analysis of themes and learning is supplied (Shorrock 2019, Dekker 2014 – references available)

The above SPC charts highlight the monthly data with regard to numbers of serious incidents reported by LPT since 1 December 2017.

- Chart 1 details the month reported onto StEIS
- Chart 2 details the month of occurrence of the Serious Incident

There was an increase in SIs reported starting May 2019; this was due to the additional reporting requirements of pressure ulcer Grade 4 onto StEIS which were previously reported on using different criteria. The largest number and criteria of SIs reported during quarter 2 2019/20 is Pressure Ulcer Grade 4 (36%).

New SIs logged onto StEIS in Q2 2019/20

30 SI's in total:

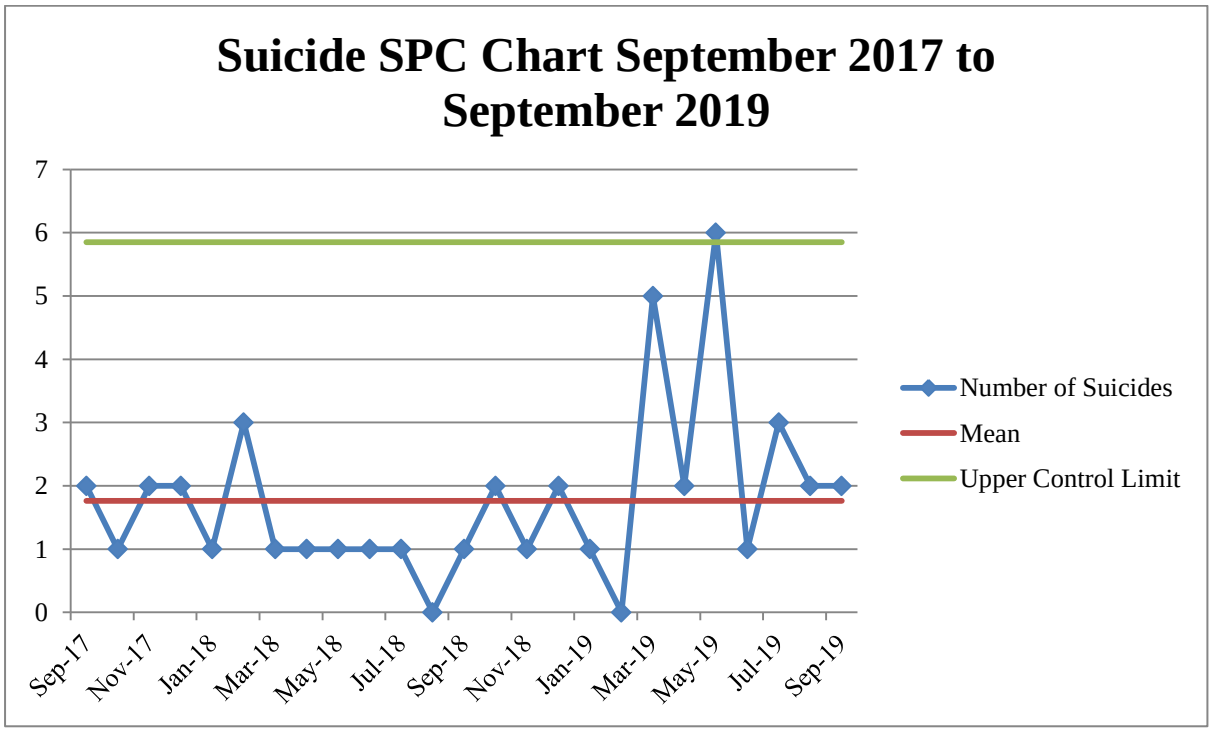
- 15 related to Tissue viability reporting grade 3 and 4 pressure ulcers. None developed in the hospital setting all identified in the community. (Those at Grade 3 had caused severe harm.)
- 9 suicides were reported in Q2 and these are detailed in the table in section 4
- 6 other SI's were reported and the details of these are in the table below.

- There was 1 Homicide during Q2 in which a patient open to an AMH CMHT allegedly murdered his father who was being treated by the ICS service in CHS. This investigation is being completed by an independent investigator who is leading the panel.

Due to communication delay of the tissue viability incident review process there was an increase in those pressure ulcers reported in September 2019 as the Patient Safety Team and CHS Governance Team reviewed all pressure ulcer grade 4s to establish those that had developed or deteriorated in LPT care. This process is now consistently robust and the Patient Safety Team and CHS Governance Team are regularly meeting to review all grade 4 pressure ulcers.

Incident number	Incident Type	Service
242726	Acute deterioration in Patient's condition	Agnes Unit
237865	VTE	Welford Ward
242711	Self-Harm	MHSOP West Leics CMHT
222187	Allegation against Healthcare Professional	Beechwood Ward
242019	Sub Optimal Care	NW Leics hub DNT
242716	Inappropriate admission of an 11 year old	Ward 3 CAMHS

5. SUICIDE DATA TRUST-WIDE



SPC Chart

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

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

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

Interpretation

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

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

Future reports will also describe this data as month of death to provide a clearer picture

5.1 Suspected Suicide SIs reported in Q2 19/20

The patient safety team are beginning to provide more analysis around the patient under our care who take their own lives so that this information builds and we have opportunities to respond to any emerging themes

Incident and StEIS number	Incident date	Gender	Age	Method death	Diagnosis	Ethnic origin	Service
239415 2019/15103	7th July 2019	M	48	Hanging	Bi Polar	White British	AMH City West CMHT
239478 2019/15072	8th July 2019	M	73	Self-poisoning	Depression	White British	Welford Ward (on leave)
239930 2019/16308	15th July 2019	M	31	Hanging	Depression	White British	Crisis Team

240766 2019/18827	30th July 2019	M	32	Fall from Height	Schizo Affective Disorder	White British	Charnwood CMHT AMH
241096 2019/17327	4th August 2019	M	26	Hanging	ADHD	Not Stated	ADHD Out Patients
242408 2019/20519	19th August 2019	F	36	Overdose	EUPD and Anxiety disorder	White British	Francis Dixon Lodge
243059 2019/20314	9th September 2019	M	65	Hit by Train	Bi Polar	White British	AMH Crisis and City West CMHT
242836 2019/20514	5th September 2019	F	72	Hanging	Depressive episode secondary to physical health	Asian Indian	FOPALS
243042 2019/20098	9th September 2019	F	69	Suspected over dose	Depressive episode	White British	FOPALS

The two deaths of patients under the care of the FOPAL teams will be carefully considered for themes on completion of the individual investigations.

The care of the patient, who took his own life, while on leave from Welford ward has had a thorough and compassionate investigation in which his wife was completely involved. This did not identify any learning that could have affected this outcome.

There has been an increase noted in deaths of patients under the care of the Crisis Team with six having been reported in the six months of 2019 compared to a total of three for the whole of 2018. Looking at the National Confidential Inquiry data there has also been a national increase noted. This increase will be reviewed for themes/trends and findings shared. There is a National increase in Suicide particularly in young males. The Community team have also noted an increase and methodology for a thematic review is being discussed.

Calendar year	On the ward	Off ward on planned leave	Off ward unplanned leave (AWOL)	Community Treatment Order	Within 10 days of discharge	Under the care of crisis team	Within 5 days of discharge from Crisis	Community suicides
2015	0	1	0	0	0	3	0	21
2016	1	1	0	0	2	2	0	12
2017	0	3	0	0	0	2	0	13
2018	0	0	1	1	2	3	0	10
2019	0	2	0	1	0	6	1	18

Suicide Reduction

LPT are part of the LLR multi agency approach to suicide prevention which focusses on patients in the wider community as well as being under the care of LPT

Zero Suicide for In-Patient Ambition Plan 2019

NHSE have worked with trusts to support them to develop a zero approach to in-patient suicide plan. This includes patients on authorised and unauthorised leave. Whilst developing this and on review of our local data we are extending the focus of this work to include patient's within 10 days of discharge and patients under the care of the Crisis team. As this plan develops and learning is identified this approach will be widened.

The plan will be held by the Suicide Prevention Group and monitored against progress by the Learning from deaths group.

The self-harm policy has also recently been reviewed and a lack of Clinical leadership and a trust wide approach for this agenda has been identified. This will be considered by the suicide prevention group chaired by the Associate Medical Director for Quality and recommendations made to approach this.

A positive example of how we are driving forward our commitment to the learning from deaths and suicide's is the success of the business case for a new learning from deaths and Suicide Prevention Lead practitioner. This post has been advertised late quarter 2 with expectation to interview early November 2019.

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

An 11yr old was admitted to the CAMHS Inpatient unit, This is a breach of the service spec as the ward is only commissioned for 13-18yr olds. This was after spending 35 hours in the emergency department and was detained on a section 2 without a bed being identified.

7. PERFORMANCE

7.1 Quality of Investigation Reports

	No. CCG feedback received	No. SIs closed	No. SI action plans requiring amendment as a result of CCG feedback
Q 2 – 19/20	14	11(80%)	0(0%)
Q 1 – 19/20	18	9 (50%)	0 (0%)

Q 4 – 18/19	15	8 (53%)	2 (13%)
Q 3 – 18/19	15	9 (60%)	0 (0%)

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

Submission	Total No. of SIs reported	Q2-19/20	Q1 – 19/20	Q4 – 18/19	Q3– 18/19
Green (within timeline)	9	30%	93%	100 %	93%
Amber (breached ≤ 7 days)	*3	10%	1	0	0
Red (breached ≥ 8 days)	*18	60%	1	0	1

* The 3 that were reported after 7 days were because these were all reported by the service. The 18 that were reported after more than 8 days was due to technical issues with STESI that were escalated to NHSI and the CCG

7.3 Final report submission (≤ 60 working days)

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

Submission	Q2 19/20	Number	Q1 19/20	Number	Q4 18/19	Number	Q3 18/19	Number
Green (within timeline)	50%	17	31%	5	57%	4	100%	8
Amber (breached ≤ 7 days)	20%	7	38%	*6	29%	*2		-
Red (breached ≤ 8 days)	30%	11	31%	*5	14%	*1		-

*The reasons for late submissions was due to the capacity of senior staff to write up reports, or having been reviewed by the Head of Patient Safety some were not considered to a standard to appropriately identify the learning in some more complex investigations in order to be assured of appropriate scrutiny.

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

8. DUTY OF CANDOUR

There was zero duty of candour breaches in quarter 2 2019/20 in relation to those SIs that were logged onto StEIS or where an Internal Root Cause Analysis, Falls

Template or Pressure Ulcer Template was completed. The Patient Safety team have also been monitoring the quality of the Duty of Candour response and making suggestions for improvement where required.

The Governance Teams within the Directorates are now monitoring those incidents which have been categorised as moderate but have not been the subject of an investigation to ensure that the level of harm has been categorised correctly as moderate and if not then they will update the Ulysses system. The Patient Safety Team are also monitoring the daily report of Moderate incidents to ensure that all those that are appropriately identified as resulting in moderate harm generate an appropriate investigation and that the Directorate are clear with the requirements of the Duty of Candour.

9. SI ACTION PLAN TRACKER – Q2 19/20

AMH/LD

There were 36 action plans due for completion in quarter 2 2019/2020 for AMH/LD. 33 met timescales and the other 3 were closed the following month but still within the quarter. The reason for the late closure of 3 was the delay in supplying evidence from the service not that the action was not complete.

FYPC

There were 3 action plans due for completion in Q2 2019/2020 and all 3 met timescale.

CHS

There were 10 action plans due for completion in Q2 2019/2020 8 met timescale and 2 were closed the following month still within the quarter the reason for the late closure was the delay in supplying evidence from the service not that the action was not complete.

10. PREVENTING FUTURE DEATHS (Regulation28) AND RESPONSES

During Q2 we received a preventing future deaths report from HM Coroner in relation to a patient under the care of the Crisis team.

The areas that we were required to consider and respond to related to;

The level of service delivered in relation to such high risk individuals particularly around the number of different staff that the patient came into contact with, this resulted in significant distress when having to repeat their story. The patients

discharge from the team before formal transfer to the community service had been implemented.

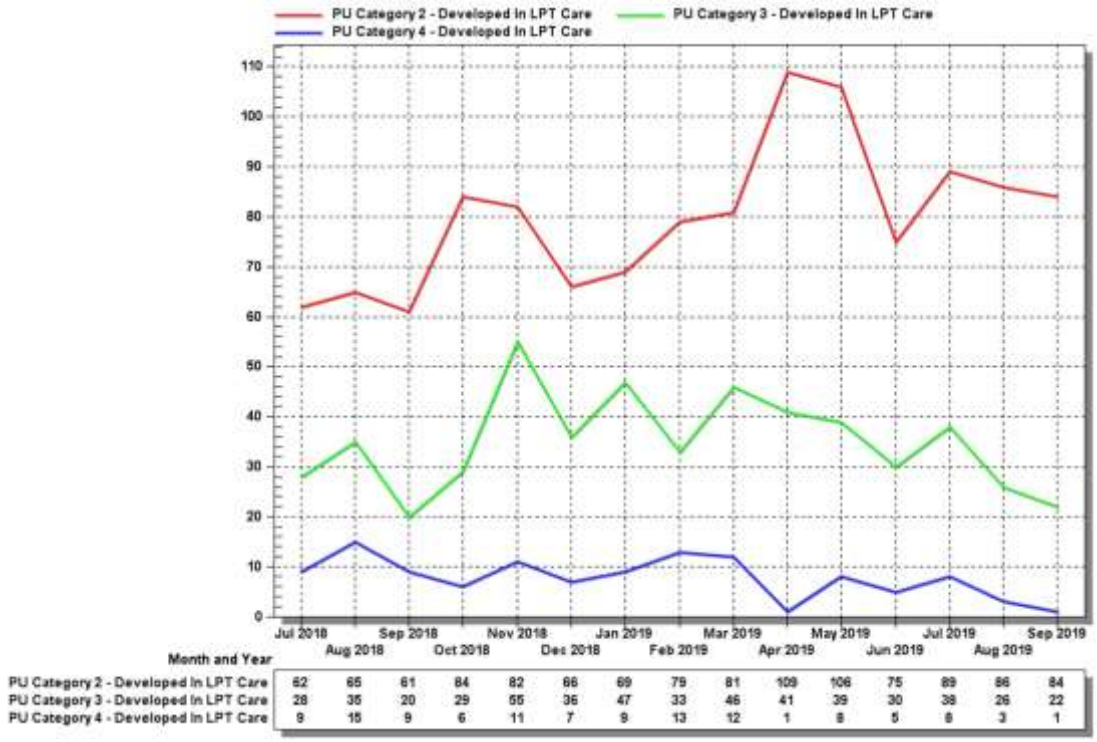
The actions relating to this will be monitored via Patient Safety Improvement Group (PSIG)

11. NEVER EVENTS

No Never Events were reported for Q1 or Q2.

12. PRESSURE ULCERS

The pressure ulcer incidents graph overleaf shows that category 2 pressure ulcers developed in LPT care are the highest category of pressure ulcers but overall there has been a reduction in numbers of all categories reported during quarter 2. A drill down shows that the majority of pressure ulcers are reported by community nursing services.



NB. Some of these reports will be the same pressure ulcer that has deteriorated. Consideration is being given to how to identify the data by number of patients as well as number of pressure ulcers.

Grade 4 Pressure Ulcers Q2

Month developed Grade 4	Number on StEIS Community	Number on StEIS In patient
July	9	0
August	4	0
September	3	0

NB When there are enough data points this data will be converted into an SPC chart in order to monitor the trajectory to ensure there is a sustained downward trend. The total for the previous quarter was 18

Analysis of Pressure ulcer themes and trends identified during quarter 2 and lessons learned

A review of 20 pressure ulcer serious incident investigation reports has been undertaken by the Lead Nurse for Community Services. This review has identified the following issues:

- Staff task focused and not always thinking about the whole patient and their family dynamics
- Poor initial and on-going patient assessments
- Timely, robust continence management for patients a risk of or have moisture lesions
- Inappropriate delegation of care to non-registered and agency staff
- Patients and carers not being enabled to be fully engaged with their care needs, while being helped to understand the risks and issues associated.
- Patients and carers not being taught the broad range of causal factors and /or then associated risk of pressure damage and ulceration.
- Staff not working in partnership with care agencies and care homes to ensure a robust plan of care and clear escalation of concerns or gaps in care is in place
- Equipment ordered without careful consideration for its installation and how the patient may be able to access and use it

The pressure ulcer group have discussed these issues and identified actions that could be taken to address these, which will be included in the “Your Skin matters” improvement plan

13. FALLS

The learning from falls incidents investigated have identified some themes around staff knowledge of undertaking a top to toe assessment prior to lifting patients from the floor. There is no guidance currently in the policy on how to undertake this. This is being explored. There is also no facility to flat lift patients from the floor if they have a suspected fracture. The current option is to call an emergency ambulance. However, in periods of high demand these ambulances can be quite delayed. Options are to be explored as there is equipment available on the market.

There have also been some fractures sustained by patients rolling out of low low beds. The current falls pathway does not contain a risk assessment for the use of low low beds as these are not suitable for all patients and can actually increase risk. This risk assessment and guidance for staff is also being developed.

We have been informed that there has been a regional decision made that all falls that result in fracture are to be reported on StEIS as a serious incident. This will result in a small increase in the number of SI reportable incidents but will not alter the scrutiny and learning as this was already in place.

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

LPT have low levels of concerns raised through this process and these do not fall in to firm categories. The patient experience team are the conduit for these coming in.

In Quarter 4 19/20 the patient safety team will have available resource to fully engage with this agenda. There is also a need to extend the process as there are an increasing number of incidents reported around missing information for patients transferring from UHL into community hospitals.

Two themes are being addressed in relation to incoming concerns are the use of fax to communicate and errors in labelling blood samples by staff taking blood in the community.

Faxes

A full audit is being undertaken suggesting initially that around 400 faxes are being sent a day. This audit will be completed to fully understand the reason for use of fax

communication. This will then inform a solutions workshop to work up our approach to ceasing to use faxes as per the Government directive by 31st March 2020.

Labelling of blood samples

The Healthcare Safety Investigation Branch (HSIB) undertook an investigation into the mislabelling of blood samples. These have a patient safety risk as at worst patients will be treated on a different patients results or can have their own results delayed as a result of the need to repeat the test when samples are rejected. This is a particular difficulty in the community as the patients do not wear identity bands.

In relation to the findings an observational audit will be undertaken to understand 'work as done' what information staff have to label samples from so that the National learning can be applied.

15. INFORMATION SHARING (T3)

This is a new indicator on the 2019/20 Leicestershire Partnership Trust (LPT) Quality Schedule (QS) and LPT's second collation of information relating to information sharing,

Methodology

Transferring care safely concerns for Q2 have been analysed for numbers and any themes and actions. TCS concerns are an LLR wide project.

There were 20 TCS concerns identified relating to this indicator in Q2.

Table 1: shows the breakdown by category:

Category	Total
Access To Services	1
Communication Between Medical Teams	1
Communication With GP	2
Delay Or Failure In Acting On Test Results	1
Discharge Arrangements	2
Discharge With Incorrect/incomplete/without TTO's	1
Failure To Follow Procedures	2
Failure To Prescribe	1
Incorrect/no Information Given	1
Prescribing	4
Referral – Failure	1
Referral - Refusal/Non	2
Refusal To Prescribe	1
Grand Total	**20**

Table 2: demonstrates a break down by directorate

Directorate	Total
Adult Mental Health And Learning Disabilities	10
Community Health Services	7
Families Young People And Children	2
Grand Total	**19**

The following actions were taken as a result of the TCS concern raised:

The concerns for AMH were around shared care agreements and the responsibility for the ongoing prescription. This is not a new area and the Transferring Care Safely group do have a work stream to consider this

The Concerns for CHS again did not fall into clear themes. Changes have however been made to process in relation to weekly Insulin review care plans are being implemented across the district nursing teams in City East to ensure electronic records for all Insulin patients are reviewed weekly to capture any regime changes which may not have been communicated to the nurses. Communication from medical professionals will still be required to ensure changes to regimes are actioned in a timely manner.

In addition 3 monthly reviews are to be carried out by the District Nurse to review the Diabetic care received by each patient receiving Insulin on the caseloads.

Senior District Nurse emailed the above to all of the leadership team and administration coordinators so they are aware that all referrals regarding medications are to be discussed with the triage nurse or co-ordinator.

The concerns for FYPC were both closed following communication with the GP there were no themes and no wider actions

Following feedback from the last information sharing report the Trust has reviewed complaints and incident data to establish if there are any themes both on transfer and discharge in and out of Leicestershire Partnership sites.

There were 2 incidents in Q2 that were attributable to transfers within LPTs. One related to a CPN not contacting the ward to confirm admission resulting in the patient arriving and staff not expecting them and the other was around a patient being discharged and their CPA not being re-instated.

In addition, the Trusts own complaints reporting system was searched using the following categories relating to this indicator. The table below highlight the number of cases against each category. In order to consider if they did fall into the theme of this indicator they all needed to be read.

	Count of Case Number
Communication Between Medical Teams	1
Communication Failure Between Departments	1
Communication Failure Within Department	2
Communication With Patient	2
Communication With Relatives/carers	4
Conflicting Information	1
Discharge Arrangements	1
Inadequate Discharge Planning	1
Incorrect Entry On Medical Records	1
Incorrect/no Information Given	5
Transfer Arrangements	1
Transfer Without Documentation Or equipment	1
Grand Total	**21**

Incorrect/no information given (5)

One of these relates to the patient disputing a diagnosis previously documented but only aware as it was in a discharge letter. Another relates to the patient reporting there was a lack of information about the risks with newly commenced lithium. Two others relate to timing of visits by district nurses and one a late appointment

Communication with relatives/carers (4)

One related to advice from an OT for patient to remain in bed at home and there being a delay in District nurses beginning visiting due to the management of the referral on their electronic system which closed the call back inappropriately as the phone call was returned but contact not made. Staff shown how to note the call but not close so that it was clear there needed to be repeated calls
Another related to a Complaint regarding nursing care from residential home, DN, OT, GP, UHL, and social services. Due to the large number of agencies involved communication was difficult a key worker was

All other categories are very low numbers.
Patients daughter had complained that her mum was transferred to UHL without notes/copy of and felt that had the UHL OT had the notes she wouldn't have stood her mum up causing pain. Another related to breakdown of communication between community nursing teams, hospice at home and the patients family. It was identified that a referral from UHL or the patients GP was not received into Specialist Palliative Care on discharge from hospital. Instead a very brief referral was made into Community nurses from UHL stating End of Life support and wound care required. UHL later sent in a referral the Specialist Service explaining the likelihood of a rapid decline.

Conclusion

Due to the nature of this indicator the information is not readily available in one place. The head of patient safety and the quality coordinator have read fully and considered the different sources. The two quarters of data have not identified themes that require system change.

16. NATIONAL DEVELOPMENTS

Patient Safety Strategy

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

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

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Leicestershire Partnership NHS Trust

FINANCE AND PERFORMANCE COMMITTEE – 10 DECEMBER 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**	NHSE/I had evaluated the Trust's compliance level as fully compliant following the submission of the Core Standards self-assessment for EPRR 2019/20 and subsequent confirm and challenge meeting on 8 October. SEB had agreed to establish a central PMO function and recruitment was expected to have taken place by 1 April 2020. Interim resources were now in place. An update on progress would be received in March. Feedback from the System Sustainability Group (SSG) meeting on 9 December was received. With regard to the financial gap between the control total set by NHSE/I and the system financial plan, actions had been agreed that reduced the gap from c£93m to £34.5m. LPT had agreed to increase its CIP target and to aim for zero out of area placements by 2021. FPC was fully assured on the issues highlighted and noted discussions were still taking place with the SSG.	32 17
Organisational Risk Register G Well-governed	**Medium**	To improve triangulation, key risks were reviewed within their respective agenda items covering; 10 and 11 (environment), 17 (finance), 20 (performance), 29 and 30 (access to services). The current risk review process in addition highlighted risk 29 (failure to achieve the out of area trajectory by the end of 2020/21). Although the Trust had embarked on a very rigorous programme with some positive results, FPC noted the issue was sustainability and therefore agreed the risk scores should remain high due to the significant quality and financial risk for the organisation. FPC agreed the transfer of three risks from QAC's risk profile; risk 6 (future model for all age mental health services); risk 7	All

Report	Assurance level*	Committee escalation	ORR/Risk Reference
		(failure to implement community services redesign); and risk 8 (failure to deliver LPT's contribution to the LLR STP). A full review of risk 11 (current estate configuration) FPC's highest risk, would be undertaken at the next meeting to ensure all mitigations to make the estate safe were captured. The Committee had a reasonable level of assurance due to the agreed interim risk review process now in place.	
Committee Governance 	**Medium**	FPC received and approved the governance implementation plan and updated terms of reference for three of the level two sub-committees reporting into FPC under the new governance structure; Waiting times, Capital and Estates Committees. Highlight reports were expected to be received at the meeting in January 2020. Further discussion by executive directors was required on the level of membership for the Transformation Committee, an update would be received at the next FPC meeting. The Committee was reasonably assured based on it having a programme of work but it not yet being fully implemented.	11
Draft Performance Report and Performance Framework 	**Medium**	The draft Performance Report was discussed following Trust Board approval, a first live version would be presented to FPC in January. An update report proposed for 2020/21 based on Trust Board feedback, learnings and discussion with key committees would be provided to FPC March 2020. A draft Performance Framework was also presented and approved following review at SEB on 6 December, performance review meetings were expected to start in January. The Committee received a reasonable level of assurance as good progress was being made on the approach to performance management and the issues highlighted were being addressed.	20
IQPR 	**Medium**	The draft IQPR end of November 2019 position was presented for information. CPA 7 day follow up and 12 months std were both showing an improvement in position. Gatekeeping and CDiff maintained their levels of good performance. Key areas of underperformance discussed and not in the FPC agenda were staff sickness, flu vaccinations and DToC.	
Access and Waiting Times 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 31 October 2019. **Priority Services** • There had been some improvements over the past six months. SPC analysis highlighted that the present approach would not achieve the agreed outcomes. • FPC was informed that priority services would only	28

Report	Assurance level*	Committee escalation	ORR/Risk Reference
	Low	achieve their trajectories if something different was done than presently in place. • FPC asked for an update in January on the proposed approach for each priority service to improve outcomes. **52 week waits** • No patients were waiting more than 52 weeks for first appointment. In non-consultant led services 301 patients were waiting over 52 weeks from referral to second appointment / treatment. Total numbers continued to fall, with a significant and continued reduction in CAMHS. Psychological therapy services were highlighted and discussed due to their continued poor performance. • FPC asked to receive an update on the transformation plans and how the newly configured psychological therapy services would look in March. **National Targets** • The 18 week RTT, consultant-led services target was not met for Adult ADHD for incomplete pathways. A plan was in place to negotiate with NHSE/I and commissioners to remove the service from RTT when the new model was in place. The plan and new staffing model was expected to be in place by April and more in-depth discussion on Adult ADHD would be held at the meeting in March. The Committee was not assured as despite there being improved processes in place, they were not yet delivering the agreed outcomes in a sustainable way.	
Finance Report Month 8 2019/20 	**Low**	An update on the financial position for the period ended 30 November 2019 was received, key points were; • The overspend had increased to £3m. The run-rate overspend for month 8 was £159k which was a reduction from the previous month. • AMH/LD, FYPC and CHS had reported an improved position on their present rate of overspends. • CIP delivery was currently 70%. • Control total discussions were continuing with services, the value of savings identified to date was £1.5m which was still £65k short of the target. • Agency spend in month 8 totaled £865k which was a small reduction on month 7 but the forecast outturn position had increased to £9.7m against a plan of £8.1m. • The BPPC position had started to improve and there was a specific drive to achieve 95% by the end of the year. The Committee was not assured due to the risk to the provider sustainability funding. It did however, acknowledge progress was being made to reduce the financial gap.	17, 22

Report	Assurance level*	Committee escalation	ORR/Risk Reference
Estates and Facilities Management Update 	**Low**	The committee focused on FM performance, key points were; • Internal Audit report, limited assurance opinion received. • Performance dashboard showed no improvement. • Establishment of a FM Oversight and Scrutiny Group to meet weekly to review key actions from Internal Audit and track ongoing performance and areas for escalation. • The Facilities Management Transformation Board had been set up and would meet monthly starting in December. • An update on elimination of dormitory accommodation was received, the final paper was being presented to Trust Board in January. FPC acknowledged a significant amount of work was taking place but was not assured because of the ongoing poor level of maintenance performance.	9, 10, 11
Assurance from Sub-Committee Reports;	**Medium**	A highlight report from the IM&T Committee was received from its meeting on 21 November 2019. FPC requested an update on two specific red areas be provided at the next meeting.	

Chair	**Geoff Rowbotham, Non-Executive Director**

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Leicestershire Partnership NHS Trust

JOINT FINANCE AND PERFORMANCE COMMITTEE / QUALITY ASSURANCE COMMITTEE – 10 DECEMBER 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
Harm Assurance Processes for Patients on Waiting Lists in LPT  	**Medium**	An update on the work being undertaken with regard to high risk and over 52 week waiters was received. Two specific pieces of work were taking place, the first was on safe management of patients being entered onto a waiting list. A set of principles had been agreed and all services were benchmarking themselves against them, most services were stating they were generally compliant. The second part of the work related to identifying learning from harms being caused to patients who were on waiting lists. The aim was to do it in a patient centred way, recognising that patients had different demographics. A pilot involving ten patients was starting this month in two services; CMHTs and psychological therapy services. The Committee acknowledged the importance of ensuring there was no additional trauma to this complex group of patients and endorsed a cautious approach. The Committee was reasonably assured based on the progress being made but there was still some uncertainty around this novel piece of work.	28
Quality Account External Limited Assurance Review	**Low**	Concern had been raised at the last QAC meeting about whether the Trust would achieve the actions from previous external audit reviews and whether there was confidence on the 2019/20 external audit review on the gatekeeping and CPA indicators. The committee was informed about the work undertaken on the implementation of the data quality kite mark used to measure data quality compliance levels against the six data quality domains. The Committee was informed the kite mark should cover the end to end process to some extent however,	18

Report	Assurance level*	Committee escalation	ORR/Risk Reference
		the kite mark was not a perfect assurance model, but it would identify where there were gaps. Concern was raised about the process for staff to retrospectively make changes to the data on the system, confirmation was received that the Information Team was working with clinical directorates to make the process more robust. Discussion took place around effectiveness of the assurance methodology and how much value would be added by carrying out a test on the data extracted. The Committee agreed to ask Laura Hughes to carry out kite mark analysis on the CPA and gatekeeping indicators to test the level of assurance they provided. The Executive Team would review the KPMG action plan at its next meeting to ensure the actions were complete. The Committee agreed an extraction of data would be undertaken in January to test whether the adjustments had been made in readiness for the external review for this year. The Committee was not assured as work continued to address two outstanding actions from the 2017/18 and 2018/19 external assurance reviews that related to the indicators proposed for the 2019/20 external assurance review.	
Quarter 2 CIP Quality Impact Review 	**Medium**	The Committee received an update on the CIP process in place for 2019/20 and 2020/21 following the implementation of the Financial Turnaround Plan. The CIP Outcome Panel had been subsumed into the Financial Turnaround Committee and a separate quarterly review meeting set up to monitor QIA in year. In terms of financial turnaround, many of the wider schemes were now grip and control, and the setting of control totals with directorates was helping to achieve financial balance at year end. However, it was not clear whether there would be an adverse QIA and if so, to what extent. The Committee asked that assurance around the QIA process for financial turnaround was presented to the next FPC meeting in January The Committee received assurance that a plan for 1920/21 was being developed and the proposal was for development of CIPs to run through the Financial Turnaround Committee. Service directors confirmed that CIP schemes were already being identified for next year. The Committee had a reasonable level of assurance based on the CIP process in place for 2019/20 and 2020/21.	17

Chair	Liz Rowbotham, Non-Executive Director

Leicestershire Partnership NHS Trust

Meeting Name and date	**Trust Board meeting 14th January 2020**
Paper Reference	**M**

Name of Report:	**Month 8 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	10 December 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.

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

For presentation at the **TRUST BOARD** **19 December 2019**

Contents

Executive Summary and overall performance against targets

Introduction

1. This report presents the financial position for the period ended 30 November 2019 (month 8). The report shows a £1,281k surplus, which is in line with plan.

2. Operational budgets are currently overspending by £3,009k. The run-rate overspend for month 8 was £159k. Whilst the overspend continues to worsen it is encouraging to see that the in-month overspend rate has reduced again (it was £275k in month M7 and £500k in month 6). Whilst Central reserves are now largely exhausted, a fortuitous reversal of balance sheet provisions during the month ensured that the overall reserves underspend was just sufficient to mitigate the operational overspend. This approach to managing the position is clearly not sustainable, and a move towards a balanced operational position going forwards is critical to the achievement of Trust financial targets.

3. Adult Mental Health & Learning Disabilities budgets show the highest level of overspend (£1,674k) followed by Estates services (£1,057k), FYPC Services (£318k) and Community Health Services (£106k). Enabling is the only directorate which is reporting an underspend (£420k).

4. Closing cash for November stood at £10.2m. This equates to 13.8 days' operating costs, and is above the planned cash level of £6.7m for November.

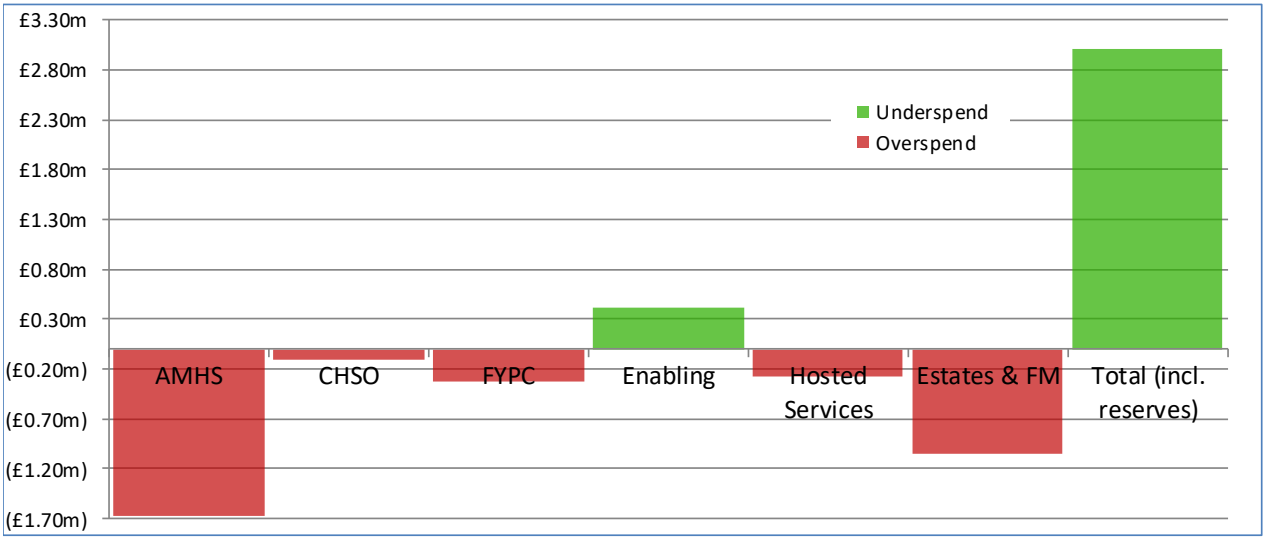
NHS Trust Statutory Duties	Year to date	Year end f'cast	Comments
1. Income and Expenditure break-even.	G	A	The Trust is reporting a surplus of £1,281k at the end of November 2019. This is in line with the Trust plan. The cumulative run-rate increases the risk to delivery of a year end break-even, particularly 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 November is £5.6m, 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 £10.2m 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 November. The achievement of all 4 targets is deemed achievable by the end of the year.
6. Achieve Cost Improvement Programme (CIP) targets.	R	R	CIP schemes are currently under delivering, showing £1,719k achieved compared to a £2,456k year to date target (equating to 70% delivery) at the end of month 8. 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 £1,281k has been reported in month 8, 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 breakeven control total. Delivery of the stretch target surplus by the year end is dependent on delivery of the Financial Turnaround Planand service level control totals.
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 £10.2m was achieved at the end of November 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 £5,635k at the end of month 8; £32k above plan. **[See 'Capital Programme 2019/20']**

Income and Expenditure position

The month 8 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

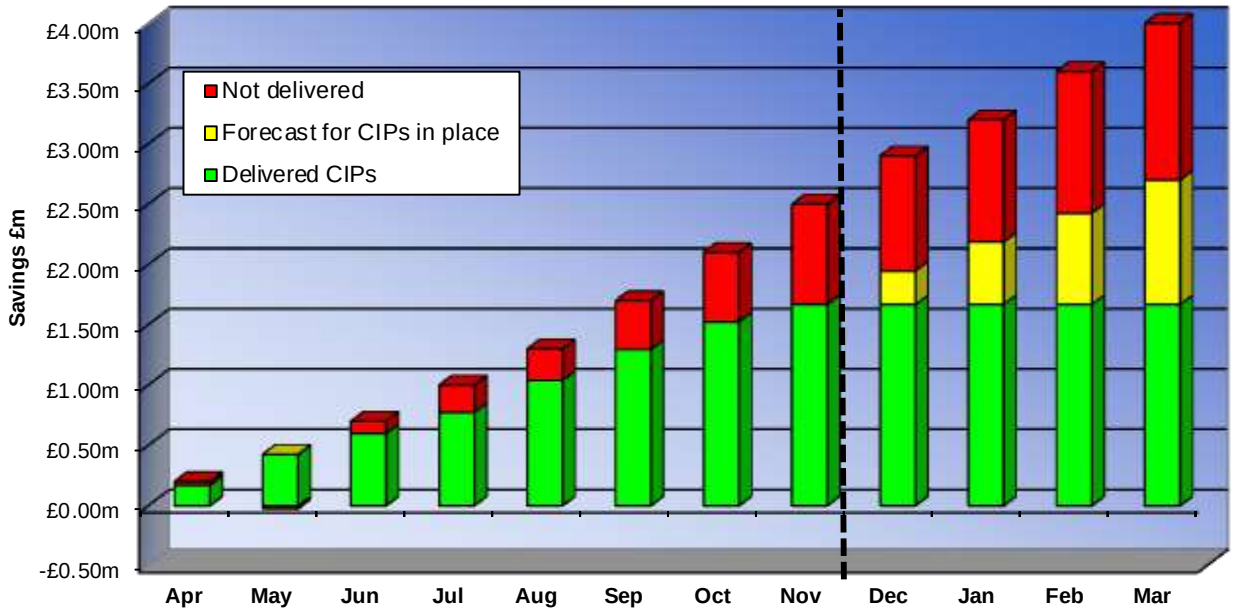
The month 8 operational overspend of £3,009k represents a negative movement of £159k compared to month 7 (£2,850k). Whilst the in-month movement in month 8 improved compared to month 7, the operational overspend needs to be eliminated if the Trust is to achieve its year end financial targets. Central 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. The improvement in the run-rate overspend also translates into an improvement in the year end forecast outturn position. This improved forecast also reflects directorate financial improvement actions, which have been agreed as part of the setting of directorate income and expenditure control total targets to be delivered by 31st March 2020.

In addition to the improved directorate forecasts, the risks and pressures forecast includes further expected benefit attributed to other recovery actions. These are likely to include technical accounting gains, which are still being worked through, and may be subject to agreement with external audit.

Directorate Efficiency Savings Programme

CIP performance (directorate schemes) as at month 8



	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	1,719	1,719	1,719	1,719	1,719
Forecast achieved	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*277*	*518*	*756*	*1,031*
Total savings:	**169**	**474**	**648**	**824**	**1,089**	**1,345**	**1,575**	**1,719**	**1,996**	**2,238**	**2,475**	**2,751**
Variance:	**(43)**	**47**	**(24)**	**(143)**	**(217)**	**(321)**	**(485)**	**(737)**	**(856)**	**(1,011)**	**(1,173)**	**(1,297)**

At the end of November, CIP delivery amounted to £1,719k, against an overall year to date target of £2,456k. This equates to 70% 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: November 2020	2018/19 31/03/19 Audited £'000's	2019/20 30/11/19 November £'000's
NON CURRENT ASSETS		
Property, Plant and Equipment	200,260	200,998
Intangible assets	1,909	1,715
Trade and other receivables	653	653
Total Non Current Assets	**202,822**	**203,366**
CURRENT ASSETS		
Inventories	319	394
Trade and other receivables	13,802	16,480
Cash and Cash Equivalents	8,357	10,189
Total Current Assets	**22,478**	**27,063**
Non current assets held for sale	**0**	**0**
TOTAL ASSETS	**225,300**	**230,429**
CURRENT LIABILITIES		
Trade and other payables	(14,856)	(18,076)
Borrowings	(220)	(220)
Capital Investment Loan - Current	(190)	(190)
Provisions	(1,202)	(405)
Total Current Liabilities	**(16,468)**	**(18,891)**
NET CURRENT ASSETS (LIABILITIES)	**6,010**	**8,172**
NON CURRENT LIABILITIES		
Borrowings	(8,025)	(8,024)
Capital Investment Loan - Non Current	(3,510)	(3,347)
Provisions	(1,129)	(1,129)
Total Non Current Liabilities	**(12,664)**	**(12,500)**
TOTAL ASSETS EMPLOYED	**196,168**	**199,038**
TAXPAYERS' EQUITY		
Public Dividend Capital	83,675	85,263
Retained Earnings	48,288	49,570
Revaluation reserve	64,205	64,205
TOTAL TAXPAYERS EQUITY	**196,168**	**199,038**

Non-current assets

- Property, plant and equipment (PPE) amounts to £201m. This balance will continue to increase as capital spend accelerates in the latter months of the financial year.

Current assets

- Current assets of £27.1m include cash of £10.2m and receivables of £16.5m.

Current Liabilities

- Current liabilities amount to £18.9m and mainly relate to payables of £18m
- Net current assets / (liabilities) show net assets of £8.2m.

Working capital

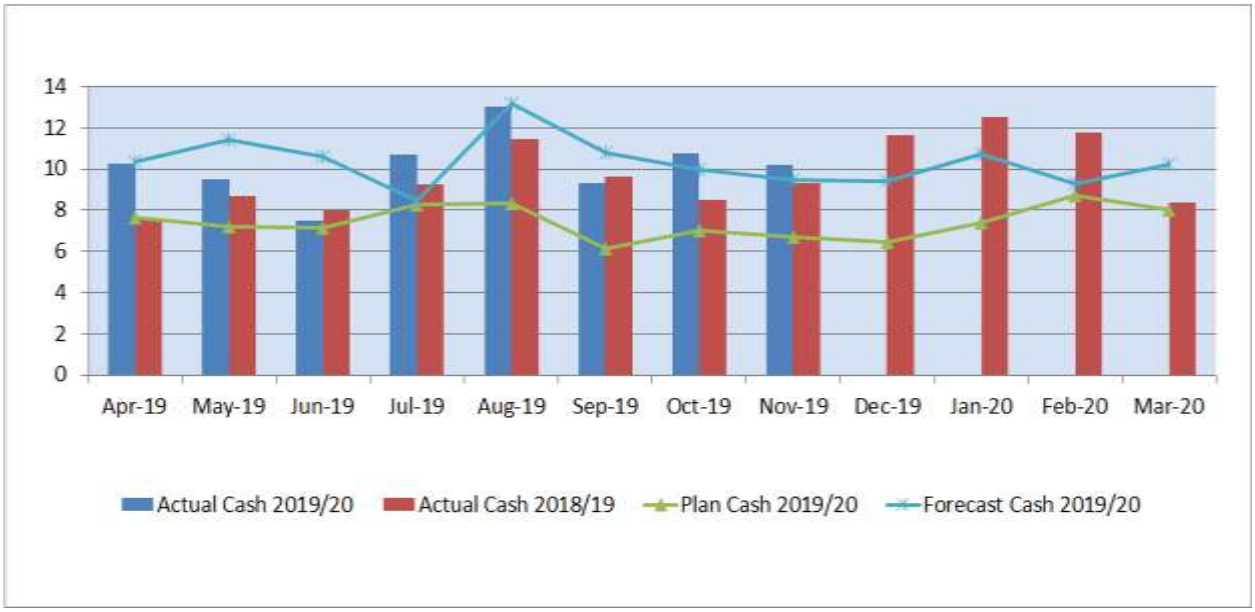
- Cash and changes in working capital are reviewed on the following pages.

Taxpayers' Equity

- November's year to date surplus of £1,281k is reflected within retained earnings.

Cash and Working Capital

12 Months Cash Analysis Apr 18 to Mar 19



Cash – Key Points

November's closing cash balance is £10.2m and equates to 13.8 days' operating expenses - this is £3.5m above the planned cash balance of £6.7m.

The £3.5m cash over-achievement against plan mainly relates to last year's PSF funding being received earlier than expected (planned PSF is phased equally over 12 months) and working capital balances having a favourable impact on cash. As at M8, the debt owed 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 £16.5m.

Receivables	Current Month (November 2019)					
	NHS	Non NHS	Emp's	Total	% Total	% Sales Ledger
	£'000	£'000	£'000	£'000		
Sales Ledger						
30 days or less	2,829	900	52	**3,781**	**22.5%**	**45.0%**
31 - 60 days	532	217	5	**754**	**4.5%**	**9.0%**
61 - 90 days	317	139	6	**462**	**2.7%**	**5.5%**
Over 90 days	2,651	599	162	**3,412**	**20.3%**	**40.6%**
	6,329	1,855	225	**8,409**	**49.9%**	**100.0%**
Non sales ledger	5,594	2,477	0	**8,071**	**47.9%**	
Total receivables current	**11,923**	**4,332**	**225**	**16,480**	**97.9%**	
Total receivables non current		360		360	**2.1%**	
Total	**11,923**	**4,692**	**225**	**16,840**	**100.0%**	**0.0%**

Debt greater than 90 days amounts to £3.4m, a decrease of £462k since last month. Receivables over 90 days should not account for more than 5% of the overall total receivables balance. The proportion at Month 8 is 20.3% (last month: 22%).

Aged debts > 90 days

Based on the RAG ratings below (see key), £3.4m (474 invoices) are greater than 90 days old. It is encouraging to see the reduction of £462k in green and amber debts (12 invoices). Work is continuing with clearing the red rated debts of £564k. 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.

RAG	M6		M7		M8		Diff	
	£000	No	£000	No	£000	No	£000	No
Green	1,733	325	2,039	331	1,979	331	(60)	0
Amber	1,134	105	1,271	112	869	100	(402)	(12)
Red	564	45	564	44	564	43	0	(1)
Total	**3,431**	**475**	**3,874**	**487**	**3,412**	**474**	**(462)**	**(13)**

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 now in the process of write-off and will be included in future months reports.

Payables

The current payables position in Month 8 is £18m, an increase of £88k during the month. £2.26m of the £2.3m 90 days supplier debt relates to two suppliers - UHL (£0.48m) and NHS Property Services disputed invoices (£1.77m). Work is ongoing to resolve specific old year invoice disputes.

Payables	Current Month November 2019				
	NHS £'000	Non NHS £'000	Total £'000	% Total	% Purchase Ledger
Purchase Ledger					
30 days or less	437	1,445	**1,882**	**10.4%**	**36.1%**
31 - 60 days	990	8	**998**	**5.5%**	**19.1%**
61 - 90 days	2	37	**39**	**0.2%**	**0.7%**
Over 90 days	2,259	36	**2,295**	**12.7%**	**44.0%**
	3,688	1,526	**5,214**	**28.8%**	**100.0%**
Non purchase ledger	3,518	9,344	**12,862**	**71.2%**	
Total Payables Current	**7,206**	**10,870**	**18,076**	**100.0%**	
Total Payables Non Current	0	0	**0**		
Total	7,206	10,870	18,076	**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 November. The one cumulative target not met continues to relate to the number of NHS invoices paid within 30 days (94.9%); however this position has improved since the previous month (94.4%).

From November the Finance team introduced 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. Payment processes for utility invoices have recently been refined which has benefited BPPC performance this month.

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 £5.64m at the end of month 8, £32k (or 0.6%) above plan. Month on month spend continues to increase, with November's spend of c£1.4m being the highest so far this year. The monthly spend is forecast 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, Trust-wide backlog maintenance works and IM&T expenditure.

The Capital Management Committee is reviewing progress on all schemes on a monthly basis. New schemes of £1m funded from identified expenditure slippage include additional investment in site maintenance (inc. boilers), agile working, several minor refurbishments and additional EPR support. Final confirmation that our CRL has been approved has not yet been received however informal discussions with NHSI indicate that the CRL uplift has been approved.

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

	Annual Plan	Nov YTD Plan	Nov YTD Actual	Nov YTD Variance	Year End Forecast	Revision to Plan
Sources of Funds	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Depreciation	7,179	3,283	3,315	32	7,179	0
PDC capital for CAMHS	5,102	2,320	2,320	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**	**5,603**	**5,635**	**32**	**13,957**	**0**
Application of Funds	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Estates & Innovation						
Service Improvements	(7,138)	(3,022)	(3,123)	(101)	(7,120)	18
Estates & Equipment	(2,911)	(1,215)	(475)	740	(2,582)	329
Sub-total:	**(10,049)**	**(4,237)**	**(3,598)**	**639**	**(9,702)**	**347**
IT Programme	**(3,908)**	**(1,366)**	**(2,037)**	**(671)**	**(4,255)**	**(347)**
Total Capital Expenditure	**(13,957)**	**(5,603)**	**(5,635)**	**(32)**	**(13,957)**	**0**
(Over)/underspend against resource available	**0**	**0**	**0**	**0**	**0**	**0**

APPENDIX A - Statement of Comprehensive Income (SoCI)

Statement of Comprehensive Income for the period ended 30th November 2019	YTD Actual M8 £000	YTD Plan M8 £000	YTD Var. M8 £000	Year end forecast £000
Revenue				
Total income	189,537	185,730	3,807	278,567
Operating expenses	(183,514)	(179,707)	(3,807)	(268,805)
Operating surplus (deficit)	**6,024**	**6,023**	**1**	**9,762**
Investment revenue	24	24	(0)	36
Other gains and (losses)	0	0	0	0
Finance costs	(664)	(664)	0	(996)
Surplus/(deficit) for the period	**5,383**	**5,383**	**0**	**8,802**
Public dividend capital dividends payable	(4,102)	(4,102)	(0)	(6,154)
I&E surplus/(deficit) for the period (before tech. adjs)	**1,281**	**1,281**	**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	**1,281**	**1,281**	**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:	**1,281**	**1,281**	**0**	**2,648**
Trust EBITDA £000	**11,072**	**11,071**	**1**	**17,336**
Trust EBITDA margin %	**5.8%**	**6.0%**	**-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	416	674
	Actual / Forecast	0	141	10	12	48	18	-40	-125	8	38	34	68	63	211
	Variance	-25	116	-47	-49	-13	-43	-103	-188	-56	-26	-31	3	-353	-463
	Cumulative Variance	-25	91	44	-5	-18	-62	-165	-353	-409	-435	-466	-463		
	Cuml. % delivered	0%	280%	141%	97%	92%	79%	53%	15%	15%	20%	23%	31%	15%	31%
FYPC	Plan	49	49	49	49	49	49	49	49	49	49	49	49	391	586
	Actual / Forecast	49	49	49	49	49	49	49	49	49	49	49	49	391	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	580	870
	Actual / Forecast	73	73	73	73	73	73	73	73	73	73	73	73	580	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	370	555
	Actual / Forecast	45	38	38	38	46	46	46	45	45	44	44	46	342	521
	Variance	-1	-8	-8	-8	0	0	0	-1	-1	-2	-2	0	-28	-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%	93%	94%
Estates Services	Plan	19	22	22	66	66	66	99	100	100	100	101	102	459	862
	Actual / Forecast	2	5	5	5	5	5	38	38	38	38	38	40	103	257
	Variance	-17	-17	-17	-61	-61	-61	-61	-62	-62	-62	-63	-62	-356	-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%	22%	30%
Trust-wide savings	Plan	0	0	0	0	45	65	65	65	65	65	65	65	240	500
	Actual / Forecast	0	0	0	0	45	65	65	65	65	0	0	0	240	305
	Variance	0	0	0	0	0	0	0	0	0	-65	-65	-65	0	-195
	Cumulative Variance	0	0	0	0	0	0	0	0	0	-65	-130	-195		
	Cuml. % delivered	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	100%	61%
Total	**Plan**	**212**	**215**	**246**	**295**	**340**	**360**	**394**	**396**	**396**	**397**	**399**	**400**	2,456	4,047
	Actual / Forecast	**169**	**305**	**174**	**176**	**265**	**255**	**230**	**144**	**277**	**241**	**237**	**276**	1,719	2,751
	Variance	**-43**	**91**	**-72**	**-118**	**-74**	**-104**	**-164**	**-251**	**-119**	**-156**	**-161**	**-124**	-737	-1,297
	Cumulative Variance	-43	47	-24	-143	-217	-321	-485	-737	-856	-1,011	-1,173	-1,297		
														70%	68%
Cumulative Delivered		**80%**	**111%**	**96%**	**85%**	**83%**	**81%**	**76%**	**70%**	**70%**	**69%**	**68%**	**68%**		

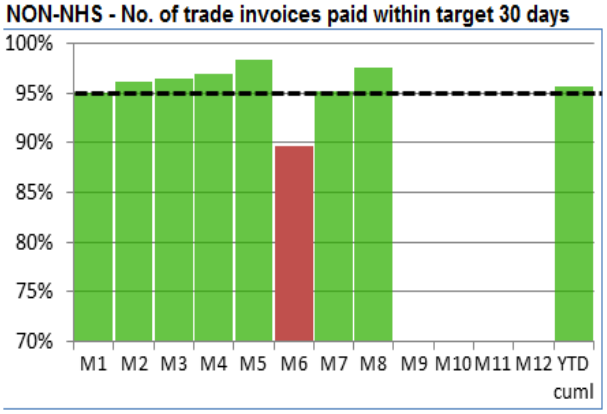
APPENDIX C – BPPC performance

Trust performance – current month (cumulative) v previous

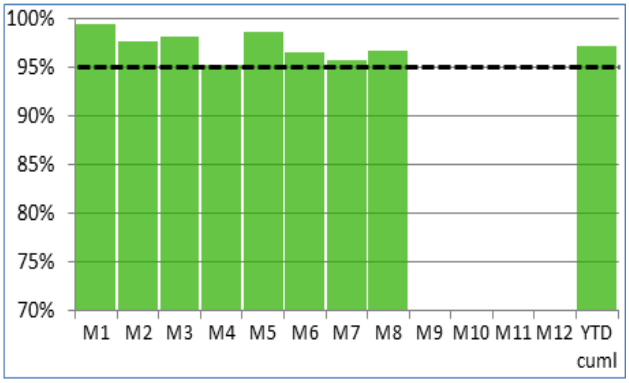
Better Payment Practice Code	November (Cumulative)		October (Cumulative)	
	Number	£000's	Number	£000's
Total Non-NHS trade invoices paid in the year	18,994	68,670	16,290	59,127
Total Non-NHS trade invoices paid within target	18,172	66,735	15,532	57,511
% of Non-NHS trade invoices paid within target	**95.7%**	**97.2%**	**95.3%**	**97.3%**
Total NHS trade invoices paid in the year	584	34,915	486	30,097
Total NHS trade invoices paid within target	554	34,698	459	29,893
% of NHS trade invoices paid within target	**94.9%**	**99.4%**	**94.4%**	**99.3%**
Grand total trade invoices paid in the year	19,578	103,585	16,776	89,224
Grand total trade invoices paid within target	18,726	101,433	15,991	87,404
% of total trade invoices paid within target	**95.6%**	**97.9%**	**95.3%**	**98.0%**

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

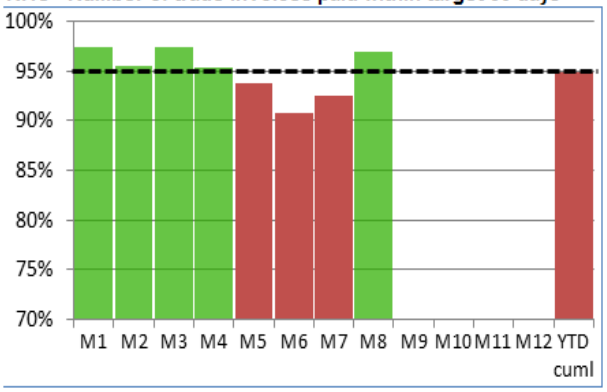
NON-NHS - No. of trade invoices paid within target 30 days



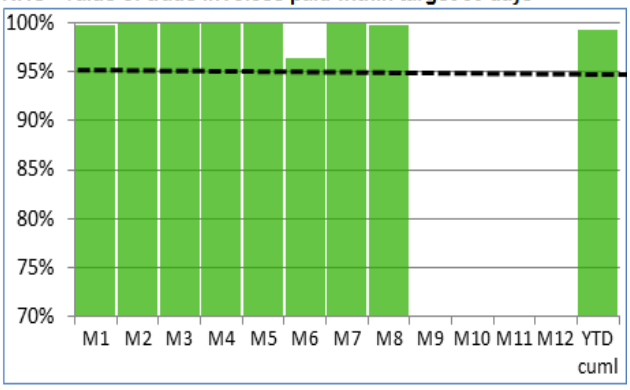
NON-NHS - Value of trade invoices paid within target 30 days



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 Actual	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	-117	-115	-95	-75	-75	-675	-1,035
Agency Nursing	-1,528	-127	-122	-142	-158	-173	-157	-214	-144	-147	-155	-150	-140	-145	-1,256	-1,846
Agency Scient, Therap. & Tech	-232	-19	-33	-18	-21	-26	-23	-12	-22	-15	-18	-18	-18	-18	-170	-242
Agency Non clinical staff costs	-409	-34	-48	-43	-31	-14	-25	-38	-7	-16	-10	-10	-10	-10	-222	-262
Sub-total	**-2,778**	**-231**	**-264**	**-267**	**-303**	**-273**	**-280**	**-350**	**-292**	**-295**	**-298**	**-273**	**-243**	**-248**	-2,324	**-3,386**
CHS																
Agency Consultant Costs	-182	-15	-15	-15	-12	-13	-11	-15	-18	-12	-15	-7	-7	-7	-110	-145
Agency Nursing	-3,579	-298	-306	-243	-305	-332	-302	-279	-298	-252	-290	-290	-250	-240	-2,317	-3,387
Agency Scient, Therap. & Tech	-644	-54	-54	-41	-47	-53	-49	-39	-30	-28	-30	-30	-30	-30	-341	-461
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**	**-291**	**-335**	**-327**	**-287**	**-277**	-2,768	**-3,994**
FYPC																
Agency Consultant Costs	-429	-36	-42	-12	-29	-30	-41	-28	-37	-67	-65	-60	-53	-50	-45	-515
Agency Nursing	-521	-43	-118	-160	-163	-94	-96	-160	-132	-137	-50	-50	-25	-25	-1,060	-1,210
Agency Scient, Therap. & Tech	-26	-2	-4	-7	-11	-16	-5	-9	-10	-4	-5	-4	-3	-3	-67	-82
Agency Non clinical staff costs	-32	-3	-8	-15	-15	-28	-3	-8	-5	-5	-5	-5	-5	-5	-88	-108
Sub-total	**-1,007**	**-84**	**-172**	**-194**	**-218**	**-168**	**-145**	**-205**	**-185**	**-214**	**-125**	**-119**	**-86**	**-83**	-1,502	**-1,915**
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	-23	-9	-9	-9	-9	-75	-111
Agency Non clinical staff costs	-623	-52	-22	-31	-24	-27	-19	-33	-36	-42	-30	-25	-25	-25	-233	-338
Sub-total	**-714**	**-60**	**-28**	**-6**	**-32**	**-38**	**-27**	**-38**	**-46**	**-65**	**-39**	**-34**	**-34**	**-34**	-279	**-420**
TOTAL TRUST															0	
Agency Consultant Costs	-1,220	-102	-117	-90	-136	-103	-126	-130	-174	-196	-195	-162	-135	-132	-1,071	-1,695
Agency Nursing	-5,676	-473	-546	-516	-626	-599	-556	-653	-574	-536	-495	-490	-415	-410	-4,604	-6,414
Agency Scient, Therap. & Tech	-944	-79	-99	-71	-87	-105	-85	-65	-72	-70	-62	-61	-60	-60	-653	-896
Agency Non clinical staff costs	-1,107	-92	-78	-89	-70	-70	-47	-79	-48	-63	-45	-40	-40	-40	-544	-709
Total	**-8,946**	**-746**	**-839**	**-766**	**-918**	**-877**	**-814**	**-926**	**-868**	**-865**	**-797**	**-753**	**-650**	**-642**	-6,873	**-9,715**
Agency ceiling (£8,122k)			-675	-677	-677	-677	-677	-677	-677	-677	-677	-677	-677	-677	-5,414	-8,122
Variance (+better/-worse)			**-164**	**-89**	**-241**	**-200**	**-137**	**-249**	**-191**	**-188**	**-120**	**-76**	**27**	**35**	-1,459	**-1,593**
Trust financial plan			-710	-681	-680	-678	-677	-675	-674	-670	-673	-675	-673	-656	-5,445	-8,122
Variance (+better/-worse)			**-129**	**-85**	**-238**	**-199**	**-137**	**-251**	**-194**	**-195**	**-124**	**-78**	**23**	**14**	-1,428	**-1,593**

At month 8, total Trust agency costs were £6,873k. This is higher than year-to-date planned spend of £5,445k, and also higher than the year-to-date agency spend ceiling of £5,414k 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.

At month 8, the revised forecast for the year is £9.7m 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	NOV FORECAST £'000	NOV ACTUAL £'000	NOV VARIANCE £'000	DEC FORECAST £'000	JAN FORECAST £'000	FEB FORECAST £'000	MAR FORECAST £'000	YTD ACTUAL £'000	19/20 FORECAST £'000
OPENING BALANCE	**10,758**	**10,758**	**0**	**10,189**	**9,445**	**10,744**	**9,295**	**8,356**	**8,356**
INCOME									
CCG Block Contracts	18,078	18,078	**0**	17,995	17,995	17,995	17,995	143,956	215,936
NHS England Specialist Commissioning Contracts	623	623	**0**	623	623	623	623	5,212	7,704
Health Education England Medical Training Contracts	710	710	**0**	716	710	708	715	6,126	8,975
Local Authorities	1,437	1,437	**0**	1,437	1,437	1,437	2,157	10,171	16,639
UHL Contracts	200	200	**0**	200	200	200	400	1,400	2,400
Non Contract Activity (NCA) re service provision for Non- Leicester patients	325	429	**104**	198	325	325	574	1,866	3,288
Health Informatics Service (HIS)	928	287	**(641)**	1,187	940	950	1,236	2,087	6,400
360 Assurance Audit Services	342	231	**(111)**	453	420	242	323	1,231	2,669
Property income for rents and service charges	1,008	0	**(1,008)**	1,134	126	126	126	0	1,512
STP Funding 19/20	322	0	**(322)**	322	465	0	608	322	1,717
STP Funding 18/19 - Q4 plus incentive and bonus allocation	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
HMRC VAT reclaims	323	323	**0**	259	259	259	259	2,277	3,313
Property disposals	0	0	**0**	0	0	0	0	0	0
Capital Loan	0	0	**0**	0	0	0	0	0	0
Other income receipts and recharges (including PDC)	615	1,255	**641**	830	2,397	673	2,092	5,650	11,641
PDC capital funding support	0	0	**0**	1,476	0	0	2,037	1,589	5,102
Income receipts relating to previous year	712	657	**(55)**	98	98	98	98	6,176	6,568
Total Receipts	**25,623**	**24,230**	**(1,393)**	**26,928**	**25,995**	**23,636**	**29,243**	**191,243**	**297,044**
PAYMENTS									
Payroll	16,990	16,970	**(20)**	16,990	16,990	16,990	16,990	136,427	204,387
Capital	1,738	1,231	**(507)**	2,419	1,213	1,263	928	4,634	10,457
Non pay general expenditure	4,875	4,378	**(497)**	5,157	4,460	4,700	5,136	30,905	50,358
UHL - Estates & FM Services	827	827	**0**	827	827	827	827	5,789	9,097
UHL - Other contracts	352	176	**(176)**	352	176	176	176	1,236	2,116
Rents and Service Charges (NHS Properties & Community Health Partnership)	1,297	483	**(814)**	1,143	329	329	330	1,818	3,949
HCL Agency Nursing Costs	400	412	**12**	388	400	500	531	3,135	4,954
Out of Area (OOA) costs for patients placed in private hospitals	300	204	**(96)**	396	300	300	300	2,431	3,727
Public dividend capital payment (PDC)	0	0	**0**	0	0	0	3,077	2,798	5,875
Other finance costs (inc loan interest and principal repayments)	120	118	**(2)**	0	0	0	0	237	237
Total Payments	**26,899**	**24,799**	**(2,100)**	**27,672**	**24,695**	**25,085**	**28,295**	**189,410**	**295,157**
CLOSING CASH BOOK BALANCE	**9,482**	**10,189**	**708**	**9,445**	**10,744**	**9,295**	**10,243**	**10,189**	**10,243**
Plan	**6,681**	**6,681**	**0**	**6,436**	**7,383**	**8,711**	**8,000**	**7,216**	**8,000**
Variance to plan	**2,801**	**3,508**	**708**	**3,009**	**3,361**	**584**	**2,243**	**2,973**	**2,243**

APPENDIX F – Risks, Pressures and Mitigations

Risk adjusted estimated year end position as at month 8

Likely Scenario						Scenario Analysis		
Description	Risk £000	Pressure £000	Mitigation £000	CT adjs £000	Net Total £000	Best £000	Likely £000	Worst £000
Opening 2019/20 budgets - break-even assumption	-	-	-	-	**0**	**0**	**0**	**0**
Operational positions								
Adult Mental Health	(709)	(952)	27	650	**(984)**	(685)	(984)	(1,659)
Learning Disabilities	(72)	(594)	79	0	**(587)**	(551)	(587)	(659)
Community Health Services	(700)	0	349	451	**100**	300	100	(350)
Families, Young People and Childrens Services	0	(1,855)	1,395	335	**(125)**	0	(125)	(46)
Enabling Services	0	(386)	763	100	**477**	550	477	320
Estates - from M8 includes additional risk £400k relating to NHSPS charges	(400)	(2,106)	693	0	**(1,813)**	(1,700)	(1,813)	(2,213)
Hosted Services	0	(1,000)	500	0	**(500)**	(350)	(500)	(600)
Service Delivery - total	**(1,881)**	**(6,893)**	**3,806**	**1,536**	**(3,432)**	**(2,436)**	**(3,432)**	**(5,207)**
Trustwide/Corporate								
Reserves contingency release (includes release of unused 18/19 provisions and further 19/20 VAT reclaims)	**0**	0	2,023	0	**2,023**	2,100	2,023	1,850
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	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	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	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	0	**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	**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 included. Further 50% balance considered in 'additional financial recovery options' below			365	0	**365**	730	365	0
Freeze Invest to Save reserve in 2019/20			550	0	**550**	550	550	550
Cap 2019/20 redundancy costs at £200k			100	0	**100**	100	100	0
Additional financial recovery options, including technical accounting solutions - tbc			664	0	**664**	1,400	664	500
Trustwide/Corporate total:	**(2,490)**	**(770)**	**6,692**	**0**	**3,432**	**5,277**	**3,432**	**873**
Budget variance after net risks, pressures and mitigations	**(4,371)**	**(7,663)**	**10,498**	**1,536**	**0**	**2,841**	**0**	**(4,334)**
Trust plan surplus (includes additional £500k NHSI target)					**2,648**	**2,648**	**2,648**	**2,648**
Net I&E performance					**2,648**	**5,489**	**2,648**	**(1,686)**

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

Leicestershire Partnership NHS Trust

Meeting name and date	Trust Board – 14th January 2020
Paper reference	**N**

Name of Report
Performance Report

For approval		For assurance	X	For information	

Presented by	Dani Cecchini Director of Finance, Business and Estates	Author (s)	Dani Cecchini Director of Finance, Business and Estates

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	
Caring		E – Environments	
Responsive	X	P – Patient Involvement	
Well-Led	X	G – Well-Governed	X
		R – Single Patient Record	
		E – Equality, Leadership, Culture	
		A – Access to Services	X
		T – Trust-wide Quality improvement	X
Equality impact (Y/N)		N	

Report previously reviewed by	
Committee / Group	Date
Finance and Performance Committee	10 December 2019
Strategic Executive Board	10 January 2020

Assurance: What assurance does this report provide in respect of the Organisational Risk Register?	**Links to ORR risk numbers**
Demonstrates delivery against key Trust Performance indicators	20 – Performance Management.

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 Assurance in respect of Harm Review for patients with longer wait times.

Leicestershire Partnership NHS Trust

Trust Board Performance Report

14 January Trust Board meeting

Version 13

Performance headlines – January 2020

Key standards being delivered/improving

- The Trust has continued to make impressive improvements in reducing the number of inappropriate **Out of Areas placements** (from 1,038 bed days in August to 186 in November).

- Further improvements have also been made in improving the **average length of stay.** The length of stay and out of area placement progress is particularly impressive in the context of **increasing demand**.

- The Trust has made further progress in reducing the number of **52 week waits** from 422 in July to 301 in October. Learning Disabilities no longer have any 52 week waits.

- The Trust has delivered the **Care Programme Approach** standard in October and continued to deliver the **Gatekeeping** measure in November.

- The Trust continues to deliver the **EIP, 6-week diagnostic and CYP 13-week standards.**

- The Trust delivered the **CAMHS Eating Disorder one-week standard in November.**

- The Trust continues to deliver the key **equality and diversity**, **turnover**, **mandatory training and annual appraisal** targets.

Performance headlines – January 2020

Key standards not being delivered and/or deteriorating

- The Trust performance against the **Referral to Treatment 18-week incomplete** standard deteriorated again in November. Improvement will be supported by a new Multi-disciplinary team approach to ADHD with recruitment of new staff in early 2020.

- The Trust is consistently failing to deliver the **CMHT access standards.** Improvement plans are being developed.

- The Trust continues to fail to achieve the **CAMHS Eating Disorder four-week standard.** A funded interim improvement plan is in place and on track to deliver the agreed trajectory.

- The Trust is not delivering some of the agreed key **patient flow standards – occupancy and DTOC.** However, the Community Services DTOC rates is well below the agreed ceiling.

- All the key **data quality measures** are being failed. Improvement plans are being developed.

- The Trust is not delivering the targets agreed for **vacancy rates, sickness absence or agency costs**. A vacancy control process and focus on agency spend form part of the financial turnaround processes introduced in the Trust.

- The Trust is well short of the **staff flu vaccination** target of 80% and has been identified as an outlier by NHS Improvement. The Board should receive a verbal update on progress.

Improvement Plans

- Improvement plans are in place for CAMHS Eating Disorders (and on track) and for ADHD RTT (recruiting new staff in January and February).
- Improvement plans for the data standards will be developed by the end of January.
- Improvement plans for CMHT access are being developed. A plan for the urgent five-day standard will be in place by the end of January and a plan to improve the 6-week routine performance by the end of February.
- Vacancy control and agency spend are now subject to escalated processes and review as part of the financial turnaround process.
- The Quality Assurance Committee are undertaking a review of staff sickness rates.

Performance Framework

- The first round of review meetings that form the core of the **new Performance Framework** have been arranged for January 2020.

2020/21 Key Performance Indicators

- A process will be run to take a new set of KPIs to the Board sub committees in February and to the full Board in early April for approval.
- Work is underway to define KPIs, set targets and gather performance information to add performance information on a number of quality measures including repeat falls, restraint, seclusion and pressure ulcers.
- The 2020/21 KPI setting process will include KPIs linked to the Quality Account commitments which will then be reported to the Board through the Performance report.

RAG rating

A simple RAG rating is used:

- Red – a target that is not being delivered
- Amber – a target that is not being delivered but has an approved recovery plan with trajectory that is being met or there is a query about delivery
- Green – a target that is being delivered

1. NHS Oversight

The following targets form part of the new NHS Oversight Framework.

<table>
<tr><th>Target</th><th>Trust performance</th><th>RAG/Comments on recovery plan position</th></tr>
<tr><td>Early Intervention in Psychosis with a Care Co-ordinator within 14 days of referral.

Target is 56%</td><td><table><tr><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td></tr><tr><td>66.7%</td><td>81.8%</td><td>81.3%</td><td>65.2%</td><td>66.7%</td><td>63.6%</td></tr></table></td><td>Target is consistently being delivered</td></tr>
<tr><td>Inappropriate Out of Area bed days for Adult Mental Health services

Target is 0 by end March 2021</td><td><table><tr><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td></tr><tr><td>460</td><td>600</td><td>1038</td><td>515</td><td>328</td><td>186</td></tr><tr><td colspan="6">Trajectory</td></tr><tr><td>460</td><td>600</td><td>1050</td><td>750</td><td>500</td><td>250</td></tr></table></td><td>The Trust has made significant improvements since August in reducing the number of inappropriate Out of Areas placements.</td></tr>
<tr><td>Mental Health data submission to NHS Digital: % clients in employment

Target is 85%</td><td><table><tr><td>2018/19 Q1</td><td>2018/19 Q2</td><td>2018/19 Q3</td><td>2018/19 Q4</td><td>2019/20 Q1</td><td>2019/20 Q2</td></tr><tr><td>0%</td><td>0%</td><td>1%</td><td>0%</td><td>2%</td><td>Not yet published</td></tr></table></td><td>Improvement plan will be in place by end of January to improve issues ahead of System One changes.</td></tr>
<tr><td>Mental Health data submission to NHS Digital: % clients in settled accommodation

Target is 85%</td><td><table><tr><td>2018/19 Q1</td><td>2018/19 Q2</td><td>2018/19 Q3</td><td>2018/19 Q4</td><td>2019/20 Q1</td><td>2019/20 Q2</td></tr><tr><td>13%</td><td>13%</td><td>38%</td><td>37%</td><td>36%</td><td>Not yet published</td></tr></table></td><td>Improvement plan will be in place by end of January to improve issues ahead of System One changes.</td></tr>
<tr><td>18-week Referral to Treatment

Target is 92%</td><td><table><tr><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td></tr><tr><td>94.9%</td><td>94.3%</td><td>92.4%</td><td>92.6%</td><td>86.2%</td><td>78.1%</td></tr></table></td><td>The Trust performance against this standard has deteriorated significantly. ADHD has a new MDT model with appointments being made in January and February.</td></tr>
<tr><td>6-week wait for diagnostic procedures

Target is 99%</td><td><table><tr><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td></tr><tr><td>100.0%</td><td>100.0%</td><td>100.0%</td><td>100.0%</td><td>99.7%</td><td>100.0%</td></tr></table></td><td>The Trust is consistently delivering this standard.</td></tr>
</table>

2. Access – Waiting Time standards

The following performance measures are key waiting time standards for the Trust:

<table>
<tr><th>Target</th><th>Trust performance</th><th>RAG/Comments on recovery plan position</th></tr>
<tr><td>CAMHS Eating Disorder – one week (complete pathway)

Target is 95%</td><td><table><tr><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td></tr><tr><td>100%</td><td>60%</td><td>0%</td><td>100%</td><td>66.7%</td><td>100%</td></tr></table></td><td>The Trust delivered this standard in November.</td></tr>
<tr><td>CAMHS Eating Disorder – four weeks (complete pathway)

Target is 95%</td><td><table><tr><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td></tr><tr><td>0%</td><td>33.3%</td><td>40%</td><td>60%</td><td>62.5%</td><td>62.5%</td></tr></table></td><td>A funded interim improvement plan is in place and on track to deliver the agreed trajectory.</td></tr>
<tr><td>Children and Young People’s Access – four weeks (incomplete pathway)

Target is 92%</td><td><table><tr><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td></tr><tr><td>100%</td><td>62.5%</td><td>94.7%</td><td>100%</td><td>94.4%</td><td>96.7%</td></tr></table></td><td>The Trust is consistently delivering this standard.</td></tr>
<tr><td>Children and Young People’s Access – 13 weeks (incomplete pathway)

Target is 92%</td><td><table><tr><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td></tr><tr><td>98.6%</td><td>98.6%</td><td>99.1%</td><td>100.0%</td><td>100.0%</td><td>99.5%</td></tr></table></td><td>The Trust is consistently delivering this standard.</td></tr>
<tr><td>Adult CMHT Access Five day urgent (incomplete pathway)

Target is 95%</td><td><table><tr><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td></tr><tr><td>25.0%</td><td>18.2%</td><td>50.0%</td><td>66.7%</td><td>66.7%</td><td>66.7%</td></tr></table></td><td>Improvement plan for the five-day urgent standard will be in place by the end of January.</td></tr>
<tr><td>Adult CMHT Access Six weeks routine (incomplete pathway)

Target is 95%</td><td><table><tr><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td></tr><tr><td>48.7%</td><td>60.5%</td><td>59.6%</td><td>56.4%</td><td>50.0%</td><td>50.0%</td></tr></table></td><td>Service redesign is required to consistently deliver this six week standard. Plan in place by the end of February.</td></tr>
</table>

3. 52 week waits

No patient should wait for more than 52 weeks from referral to the start of their treatment. The following services have 52 week waits within their service:

<table>
<tr><th>Service</th><th>Number of 52 week waits</th><th>Longest wait (latest month)</th><th>RAG/Comments on recovery plan position</th></tr>
<tr><td>Adult General Psychiatry - Community Mental Health Teams and Outpatients – Treatment (6 weeks)</td><td><table><tr><td>May-19</td><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td></tr><tr><td>42</td><td>31</td><td>70</td><td>76</td><td>89</td><td>89</td></tr></table></td><td>145 Weeks</td><td>No reduction in the number of 52 week waits. Audit of each patient taking place.</td></tr>
<tr><td>Liaison Psychiatry (13 weeks)</td><td><table><tr><td>May-19</td><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td></tr><tr><td>0</td><td>1</td><td>7</td><td>6</td><td>15</td><td>11</td></tr></table></td><td>60 Weeks</td><td>Service will be subsumed into new Core 24 service. No new referrals from December 2019.</td></tr>
<tr><td>Cognitive Behavioural Therapy (13 weeks)</td><td><table><tr><td>May-19</td><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td></tr><tr><td>39</td><td>48</td><td>42</td><td>31</td><td>30</td><td>28</td></tr></table></td><td>94 Weeks</td><td>Long term plan is a review of Psychological Services. Shorter term plan is a case by case review of each long-wait patient.</td></tr>
<tr><td>Dynamic Psychotherapy (13 weeks)</td><td><table><tr><td>May-19</td><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td></tr><tr><td>58</td><td>62</td><td>62</td><td>56</td><td>51</td><td>47</td></tr></table></td><td>128 weeks</td><td>Long term plan is a review of Psychological Services. Shorter term plan is a case by case review of each long-wait patient.</td></tr>
</table>

<table>
<tr>
<td>Personality Disorder
(13 weeks)</td>
<td>
<table>
<tr><td>May-19</td><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td></tr>
<tr><td>72</td><td>71</td><td>69</td><td>62</td><td>63</td><td>59</td></tr>
</table>
</td>
<td>157
weeks</td>
<td>Long term plan is a review of Psychological Services. Shorter term plan is a case by case review of each long wait patient.</td>
</tr>
<tr>
<td>Medical/Neuropsychology
(18 weeks)</td>
<td>
<table>
<tr><td>May-19</td><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td></tr>
<tr><td>26</td><td>38</td><td>37</td><td>37</td><td>53</td><td>48</td></tr>
</table>
</td>
<td>69
weeks</td>
<td>Recruitment to vacant posts has taken place. Recovery is expected but has yet to be delivered. Small reduction in October. Close performance management with UHL.</td>
</tr>
<tr>
<td>CAMHS
(13 weeks)</td>
<td>
<table>
<tr><td>May-19</td><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td></tr>
<tr><td>144</td><td>138</td><td>131</td><td>115</td><td>51</td><td>19</td></tr>
</table>
</td>
<td>102
weeks</td>
<td>Significant improvement being delivered in line with improvement plan.</td>
</tr>
</table>

4. Patient flow

The following measures are key indicators of patient flow:

<table>
<tr><th>Target</th><th>Trust performance</th><th>RAG/Comments on recovery plan position</th></tr>
<tr><td>Occupancy Rate - Mental Health Beds (excluding leave)

Target is <=85%</td><td><table><tr><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td></tr><tr><td>87.5%</td><td>89.5%</td><td>90.4%</td><td>86.9%</td><td>86.2%</td><td>85.6%</td></tr></table></td><td>The Trust has been successful in reducing occupancy month on month since August despite increased demand.</td></tr>
<tr><td>Occupancy Rate - Community Beds (excluding leave)

Target is >=93%</td><td><table><tr><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td></tr><tr><td>88.0%</td><td>84.9%</td><td>84.7%</td><td>88.3%</td><td>89.7%</td><td>88.5%</td></tr></table></td><td>The Trust is below the target rate of 93%. However, the system has supported this reduction driven by the success in reducing length of stay and DToC.</td></tr>
<tr><td>Length of stay (excluding leave) from acute Bradgate wards

Target is <=33 days (national benchmark)</td><td><table><tr><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td></tr><tr><td>50.5</td><td>51.4</td><td>44.0</td><td>41.4</td><td>35.2</td><td>33.5</td></tr></table></td><td>Length of stay has reduced every month since July and is now only marginally above the 33-day national benchmark.</td></tr>
<tr><td>Length of stay

Community services

National benchmark is 25 days.</td><td><table><tr><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td></tr><tr><td>18.1</td><td>17.7</td><td>18.5</td><td>19.9</td><td>17.7</td><td>19.9</td></tr></table></td><td>The Trust is below the national benchmark of 25 days.</td></tr>
<tr><td>Delayed Transfers of Care

Target is 3.5%</td><td><table><tr><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td></tr><tr><td>5.3%</td><td>3.7%</td><td>4.6%</td><td>4.1%</td><td>4.4%</td><td>4.6%</td></tr></table></td><td>New specialist DTOC meeting with adult social care will be introduced in January 2020.

Community services DToC is low and delivering the standard.</td></tr>
</table>

<table>
<tr>
<td>Gatekeeping

Target is >=95%</td>
<td>
<table>
<tr><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td></tr>
<tr><td>100.0%</td><td>100.0%</td><td>100.0%</td><td>97.5%</td><td>98.8%</td><td>95.9%</td></tr>
</table>
</td>
<td>The Trust is consistently delivering this standard.</td>
</tr>
<tr>
<td>Care Programme Approach – 7-day follow up (reported 1 month in arrears)

Target is 95%</td>
<td>
<table>
<tr><td>May-19</td><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td></tr>
<tr><td>92.8%</td><td>93.7%</td><td>91.3%</td><td>92.6%</td><td>89.2%</td><td>97.8%</td></tr>
</table>
</td>
<td>The Trust delivered this standard in October.</td>
</tr>
<tr>
<td>Care Programme Approach

12-month standard

Target is 95%</td>
<td>
<table>
<tr><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td></tr>
<tr><td>90.4%</td><td>91.9%</td><td>90.8%</td><td>89.0%</td><td>92.4%</td><td>94.8%</td></tr>
</table>
</td>
<td>The Trust performance has improved against this standard in recent months.</td>
</tr>
</table>

5. Quality and safety measures

A wider set of measures are reported and considered by service directorates, the Trust Executive and Quality Assurance Committee.

<table>
<tr><th>Target</th><th>Trust performance</th><th>RAG/Comments on recovery plan position</th></tr>
<tr><td>C difficile

Full year ceiling is 12.</td><td><table><tr><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td></tr><tr><td>1</td><td>0</td><td>1</td><td>1</td><td>0</td><td>2</td></tr></table></td><td>Trust is below ceiling year to date with 6 cases in 8 months.</td></tr>
<tr><td>Serious incidents</td><td><table><tr><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td></tr><tr><td>14</td><td>15</td><td>2</td><td>26</td><td>3</td><td>17</td></tr></table></td><td>N/A</td></tr>
<tr><td>STEIS - SI action plans implemented within timescales

Target = 100%</td><td><table><tr><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td></tr><tr><td>100.0%</td><td>100.0%</td><td>90.9%</td><td>100.0%</td><td>100.0%</td><td>0.0%</td></tr></table></td><td>None of the three SI action plans were implemented within agreed timescales in November.</td></tr>
<tr><td>Safe staffing
No. of wards not meeting >80% fill rate for RN day shifts

Target 0</td><td><table><tr><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td></tr><tr><td>2</td><td>3</td><td>4</td><td>3</td><td>1</td><td>6</td></tr></table></td><td>There was an increase in the number of wards not meeting the 80% fill rate for day shifts in November.</td></tr>
</table>

Additional quality measures

- Work is underway to define KPIs, set targets and gather performance information to add performance information on a number of quality measures including repeat falls, restraint, seclusion and pressure ulcers.
- The 2020/21 KPI setting process will include KPIs linked to the Quality Account commitments which will then be reported to the Board through the Performance report.

6. Data quality

The following measures are key indicators of the quality of data completeness. These should be read alongside the Mental Health Services Data Standards (MHSDS) set out in section one of this report.

<table>
<tr><th>Target</th><th>Trust performance</th><th>RAG/Comments on recovery plan position</th></tr>
<tr><td>MH Data quality Maturity Index

Target >=95%</td><td>
<table>
<tr><td>Mar-19</td><td>Apr-19</td><td>May-19</td><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td></tr>
<tr><td>86.7%</td><td>84.8%</td><td>84.6%</td><td>90.6%</td><td>88.0%</td><td>91.1%</td></tr>
</table>
</td><td>The Trust is failing to deliver the 95% target. Improvement plan required.</td></tr>
</table>

7. Workforce/HR

<table>
<tr><th>Target</th><th>Trust performance</th><th>RAG/Comments on recovery plan position</th></tr>
<tr><td>% Normalised Workforce Turnover (Rolling previous 12 months)

Target is <=10%</td><td><table><tr><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td></tr><tr><td>9.0%</td><td>8.7%</td><td>8.5%</td><td>8.7%</td><td>8.8%</td><td>8.8%</td></tr></table></td><td>The Trust is below the ceiling set for turnover.</td></tr>
<tr><td>Vacancy rate

Target is <=7%</td><td><table><tr><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td></tr><tr><td>8.1%</td><td>8.6%</td><td>8.9%</td><td>9.6%</td><td>8.8%</td><td>8.6%</td></tr></table></td><td>Performance improved in October and November. A vacancy control process is now in place linked to financial turnaround.</td></tr>
<tr><td>Health and Well-being Sickness Absence (1 month in arrears)

Target is <=4.5%</td><td><table><tr><td>May-19</td><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td></tr><tr><td>4.2%</td><td>4.7%</td><td>4.7%</td><td>4.9%</td><td>5.0%</td><td>5.2%</td></tr></table></td><td>The Trust is not delivering the ceiling set for sickness absence. Subject to a QAC review.</td></tr>
<tr><td>Agency Costs

Target is <=£641,666 (NHSI national target)</td><td><table><tr><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td></tr><tr><td>£918,204</td><td>£876,966</td><td>£813,941</td><td>£926,375</td><td>£867,920</td><td>£864,714</td></tr></table></td><td>Increased controls over agency spend is part of the financial turnaround process.</td></tr>
<tr><td>Mandatory Training Compliance for substantive staff

Target is >=85%</td><td><table><tr><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td></tr><tr><td>92.8%</td><td>92.8%</td><td>92.1%</td><td>92.2%</td><td>92.1%</td><td>93.0%</td></tr></table></td><td>The Trust is consistently delivering this target.</td></tr>
</table>

<table>
<tr>
<td>Culture and leadership
Staff with a Completed Annual Appraisal

Target is >=80%</td>
<td>
<table>
<tr><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td></tr>
<tr><td>91.7%</td><td>92.9%</td><td>93.4%</td><td>93.1%</td><td>93.5%</td><td>93.5%</td></tr>
</table>
</td>
<td>The Trust is consistently delivering this target.</td>
</tr>
<tr>
<td>Equality and diversity - % of staff from a BME background

Target is >= 20%</td>
<td>
<table>
<tr><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td></tr>
<tr><td>22.1%</td><td>22.1%</td><td>22.3%</td><td>22.6%</td><td>22.5%</td><td>22.5%</td></tr>
</table>
</td>
<td>The Trust is consistently delivering this target</td>
</tr>
<tr>
<td>Staff flu vaccination rate (frontline healthcare workers)

Target is >= 80%</td>
<td>
<table>
<tr><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td></tr>
<tr><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>22.0%</td><td>44.9%</td></tr>
</table>
</td>
<td>The Trust has not yet achieved the 80% rate. Significant focus on this measure. Verbal update on progress at the Board meeting.</td>
</tr>
<tr>
<td>% of staff who have undertaken clinical supervision within the last 3 months

Target is 85%</td>
<td>
<table>
<tr><td>Jun-19</td><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td></tr>
<tr><td>81.3%</td><td>81.5%</td><td>80.0%</td><td>84.5%</td><td>86.0%</td><td>86.2%</td></tr>
</table>
</td>
<td>The 85% target is being delivered by the Trust.</td>
</tr>
</table>

8. Directorate performance reviews

The first round of the new service directorate review meetings that form the core of the new Trust Performance Management Framework have been arranged for the following dates in January:

Adult Mental Health – 27 January 2020

Families, Young People, Children and Learning Disabilities – 27 January 2020

Community Services – 27 January 2020

9. Regulatory meetings

The following regulatory meetings have taken place since the last Board report. The key issues are highlighted:

NHS England/Improvement

- December 24 SIAM meeting cancelled
- Next meeting Tuesday 28 January 2020
- Focus of attention for deep dive – Privacy and Dignity - Arrangements for Inpatient Accommodation

Care Quality Commission – Last meeting 17 December 2019

- Undertook short tour of the Agnes Unit
- Reassured by progress with the action plan
- Two CQC Mental Health Act review visits last month on Griffin and Kirby wards

10. Recommendation

The Trust Board is asked to note the performance of the Trust on these key measures and the position in relation to improvement plans for areas that are not being delivered.

The Board is asked to note the improvements that have been made in developing and implementing improvement plans.

Draft version 13

2 January 2020

Paper N

Appendix 1

Harm Assurance Process Update Report for Patients on Waiting Lists in LPT

This appendix is to provide assurance to The Board of our harm assurance processes.

The assurance of this work is through the joint FPC QAC Meeting and last reported in December 2019.

Two key processes have been agreed:

- To use an agreed set of principles, to which all services must adhere to, when entering a patient onto a waiting list and benchmark current practice to develop an assurance dashboard. These have been developed based on NHSI good practice.

- A process to undertake Harm Reviews to monitor and learn about any harms caused to patients whilst on our waiting lists and then act on the learning with a system overview.

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

1. Robust prospective clinical triage in place in each service
2. Weekly reviews of the waiting list by service management and lead clinicians through PTLs (Patient Tracking Lists)
3. Clear process for reprioritisation if clinical presentation changes/is escalated
4. Clear information, including easily accessible formats, is provided to ensure that patients are fully aware and understand:

- their right to have an appointment under the NHS Constitution
- that they have been placed on a waiting list and the likely length of the wait
- what to do if their situation changes/deteriorates
- what to do if their situation becomes a crisis
- what to do if they or their family/carers have any questions
- if appropriate are signposted to supportive resources that could be accessed whilst waiting

Services are benchmarking against these principles and a dashboard of the high risk services and over 52 week waits will be produced and shared with NHSI/E at the January 2020 SIAM meeting.

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

There are established processes to do this within acute hospitals, where waiting lists have been a focus, and a number of policies have been reviewed. There were no established formats to undertake Clinical Harm Review in mental health trusts, and so we are initiating a pilot of harm review questionnaires.

A Task and Finish group has been set up to manage the pilot and the patient demographics and involvement in this is key. From a safety perspective we have moved the implementation by two months to allow time to fully engage with patient representatives and also consider how best to administer the questionnaire as 4 of the areas are psychological therapies and it was vital to do this in a safe way in conjunction with the clinical services.

A second strand of work is the data triangulation and colleagues are currently working on the feasibility of being able to collect data for when a service user on a waiting list attends A+E, contacts crisis services or accesses the Mental Health Triage Car. Recently it appears that this will need to be included in the transfer to SystemOne build design.

The first System Harm Assurance Meeting is being organised and will agree its terms of reference, which will essentially be to have oversight of the process and the subsequent learning.

Dr S Elcock

Medical Director

7 January 2020

Meeting name and date	Trust Board – 14th January 2020
Paper reference	**O**

Name of Report
Performance Management Framework

For approval	X	For assurance		For information	

Presented by	Dani Cecchini Director of Finance, Business and Estates	Author (s)	Dani Cecchini Director of Finance, Business and Estates

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	
Caring		E – Environments	
Responsive	X	P – Patient Involvement	
Well-Led	X	G – Well-Governed	X
		R – Single Patient Record	
		E – Equality, Leadership, Culture	
		A – Access to Services	X
		T – Trust-wide Quality improvement	X
Equality impact (Y/N)		N	

Report previously reviewed by	
Committee / Group	Date
Board report reviewed by private Trust Board	3 December 2019
Strategic Executive Board	6 December 2019
Finance and performance Committee	11 December 2019

Assurance: What assurance does this report provide in respect of the Organisational Risk Register?	**Links to ORR risk numbers**
New Framework supports delivery of good Performance Management	20 – Performance Management.

Recommendations of the report
The Trust Board is asked to approve new Trust Performance Management Framework.

Leicestershire Partnership NHS Trust

Performance management framework

Approved by Finance and Performance Committee on 10 December 2019

Review date – July 2020

1. Contents

2. Scope, purpose and approach

Scope - This performance management framework covers all operational services provided by Leicestershire Partnership NHS Trust.

Purpose - The purpose of this framework is to support the achievement of the Trust's strategic objectives and key performance indicators. The framework clearly set out how performance will be managed in a consistent way across LPT, the KPIs that will be used, the roles and responsibilities of different Boards, Committees and meetings held within the Trust. The framework also sets out expected behaviours which should be consistent with the Step Up to Great programme.

Transparency - The framework seeks to promote transparency within the Trust. The framework seeks to ensure that the information used in reviewing directorate performance is consistent with that used to report and review performance with the Trust Board, Finance and Performance Committee, commissioners and regulators.

Service directorates will receive a performance dashboard which will be used in the performance review meetings and in reporting and discussing performance with the Board, commissioners and regulators. Service directorates will receive copies of papers and reports that relate to their performance and improvement plans. Service directorates will also receive timely feedback from Board and external meetings.

Consistency - The framework introduces a more consistent approach to performance management, reporting, RAG ratings and a rules-based approach to escalation.

Constructive – The interactions set out in this framework need to be constructive to be of value. Challenge of poor performance or a lack of clear recovery plans is appropriate but must seek to drive towards a resolution of issues.

The performance review meetings need to be clear and transparent. They are an opportunity to discuss issues, provide assurance and to ask for support. They are not established to provide a platform for aggressive performance management or for issues to be downplayed, hidden or externalised.

3. Trust strategic objectives – Step Up to Great

The performance management framework is an approach that aims to deliver the strategic objectives of the Trust. The strategy of the Trust focuses on creating high quality, compassionate care and wellbeing for all. Underpinning this strategic vision is the Step Up to Great programme which has nine key themes:

S – High standards

T – Transformation

E – Environments

P – Patient involvement

G – Well governed

R – Single patient record

E – Equality, leadership and culture

A – Access to services

T – Trust-wide quality improvement

The Step Up to Great values define how we will behave towards our patients, partners and each other. Each performance KPI will be linked to one of the strategic objectives.

<u>Annual process</u>

Each year, performance KPIs will be agreed before 1 April, linked to the strategic objectives of the Trust. Performance KPIs will need to be SMART. These KPIs should be agreed by the Finance and Performance Committee on behalf of the Board.

A programme of performance review meetings will be set out prior to the start of the financial year.

4. Roles and responsibilities

The table below sets out the role of each forum within the framework.

Trust Board	The Trust Board has overall collegiate responsibility for the performance of the Trust and setting the organisational strategy. The Trust Board will receive a regular Quality and Performance report with clear narrative setting out areas of concern and whether improvement plans are in place and delivering.
Finance and Performance Committee	The Finance and Performance Committee will review performance in some more depth to seek assurance on behalf of the Trust Board. The Finance and Performance Committee will receive a regular Performance report with clear narrative setting out areas of concern and whether improvement plans are in place and delivering. The Finance and Performance Committee may choose to review an aspect of performance in more depth on behalf of the Board. The Finance and Performance Committee should sign off this framework, any revisions to it and the annual KPIs to be monitored via the framework. The Finance and Performance Committee should receive a review of the effectiveness of this framework once it has been running for six months and on a six-monthly basis thereafter.
Audit Committee	The Audit Committee independently contributes to the Board of Director process for ensuring that an effective internal control system is maintained by providing assurance on internal control activities. The Audit Committee may choose to review processes relating to performance such as the resolution of waiting time issues.
Quality Assurance Committee	The Quality Assurance Committee is established to provide assurance to the Trust Board on issues of quality, safety and patient experience.
Strategic Executive	The Strategic Executive is the senior executive decision-making body of the Trust and is accountable to the Board of Directors for the performance of the Trust. The Strategic Executive will review performance against national, local and internal KPIs and any long wait issues on a monthly basis.

Directorate Performance Review meetings	The primary means by which the Strategic Executive holds the service directorates to account for progress and deliver of agreed performance measures is through regular performance review meetings. These meetings are also an important mechanism through which service directorates can escalate issues to and seek support from the Strategic Executive. Directorate performance review meetings will take place every two months. The frequency of these meetings may increase to monthly if performance issues merit such a change. The meetings will be led by the Finance and Performance Director, alongside the Director of HR and OD and either the Medical Director or the Director of Nurses, Allied Health Professionals and Quality. The Service directorate should be represented by the Service Director, Clinical Director, Business lead and Finance lead. Meetings should be arranged so that the responsible Service Director can attend. The core attendees set out above are expected to attend at least 75% of these meetings each year. An appropriate deputy should be nominated if one of the core attendees is unable to attend. A programme of dates will be sent out for six months ahead. A performance review pack will be circulated at least one week prior to the meeting and will be used in the meeting. The meetings will focus on performance, quality, finance and workforce issues that require escalated discussion. A key output from each review meeting should be a clear narrative to be used in the assurance reports to the Finance and Performance Committee, the Trust Board, with commissioners and regulators. These meetings are the cornerstone of this framework and should be prioritised. Attendees should come prepared to have a constructive open discussion of successes and challenges.
Directorate Management meetings	Each directorate should hold a monthly review of performance. This may be through a focus in one of the regular senior management team meetings or via a bespoke meeting. These should take place ahead of the Directorate Performance Review meetings set out above so that information can be fed into the discussions rather than an upcoming meeting used as a mechanism to defer discussion.

5. Key performance indicators

The following KPIs will be used to monitor, report and discuss performance under the headings:

1. Performance
2. Finance
3. Workforce
4. Quality

<u>Performance</u>

NHSE/I oversight

- EIP – 2-week standard
- Out of area placements
- MH data standards – employment and accommodation
- 18 weeks referral to treatment
- 6-week diagnostic standard

Access – waiting time targets

- CAMHS Eating Disorders – 1 week and 4-week standards
- CYP Access – Urgent and Routine
- Adult CMHT Access – 5 day and 6-week standards
- 52 week waits

Patient flow

- Occupancy
- Length of stay
- DTOC
- Gatekeeping
- CPA 7-day follow up

<u>Finance</u>

- CIP delivery – actual and %
- Income v budget YTD
- Expenditure v budget YTD
- Better Payment Practice Code - % not paid in 30 days

Workforce

- Turnover rate
- Vacancy rate
- Sickness rate
- Cost of sickness absence
- Agency costs
- Bank utilisation
- Mandatory training
- Annual appraisals
- Equality and diversity
- Flu vaccination
- Clinical supervision

Quality

- C difficile
- Serious incidents
- Serious incident action plans not within timescales
- Restraint
- Seclusion
- Falls
- Pressure ulcers
- Quality account targets
- Safe staffing

6. Directorate performance reviews

Purpose - The primary means by which the Strategic Executive holds the service directorates to account for progress and deliver of agreed performance measures is through regular performance review meetings. These meetings are also an important mechanism through which service directorates can escalate issues to and seek support from the Strategic Executive.

Frequency - Directorate performance review meetings will take place every two months. The frequency of these meetings may increase to monthly if performance issues merit such a change.

Attendees - The meetings will be led by the Finance and Performance Director, alongside the Director of HR and OD and either the Medical Director or the Director of Nurses, Allied Health Professionals and Quality.

The Service directorate should be represented by the Service Director, Clinical Director, Business lead and Finance lead. Meetings should be arranged so that the responsible Service Director can attend.

The core attendees set out above are expected to attend at least 75% of these meetings each year. An appropriate deputy should be nominated if one of the core attendees is unable to attend. A programme of dates will be sent out for six months ahead.

Performance packs - A performance review pack will be circulated at least one week prior to the meeting. The meeting will work through the performance review pack and seek to understand whether issues are in hand, whether there is a clear written and funded plan is in place to drive improvement, and, whether it is delivering or not.

Coverage - The meetings will focus on performance, quality, finance and workforce issues. Where a directorate is forecasting or experiencing an adverse variance to plan or to an agreed KPI, the directorate will be responsible for preparing a short clear diagnostic and a written plan to remedy performance. This may include a request for internal or external support. The diagnostic and remedial plan should own the issue and resolution. It should not externalise responsibility.

The focus of the review meetings should be on issues that require escalated discussion. The data in the pack is the data that will be used in the review discussion and will be taken as read prior to the meeting.

Actions - Action notes will be captured and circulated in a timely manner. The actions should be followed up between meetings, to the timeframes agreed. Previous actions should be reviewed at each meeting.

Providing assurance - A key output from each review meeting should be a clear narrative to be used in the assurance reports to the Finance and Performance Committee, the Trust Board, with commissioners and regulators.

Prioritisation - These meetings are the cornerstone of this framework and should be prioritised. Attendees should come prepared to have a constructive open discussion of successes and challenges.

7. Escalation

The frequency of review meetings may be increased to monthly if performance issues merit such a move. Focused meetings on a particular performance issue may also be established.

For the most serious performance concerns a more frequent generation of data, review discussion and assurance narrative may be required.

Reports to the Finance and Performance Committee and Trust Board should identify all performance concerns and be clear as to whether plans are in place to recover and sustain performance, or not.

The Finance and Performance Director may recommend escalation to the CEO, the Finance and Performance Committee or Trust Board.

The Finance and Performance Director and lead Service Director may decide to escalate issues or requests for support to the regulators of the Trust.

The Finance and Performance Director may agree to invite commissioners or STP representatives to the review meetings, if appropriate.

8. Divisional performance reviews

Each directorate should hold a monthly review of performance as part of the rhythm of management meetings. This may be through a focus in one of the regular senior management team meetings or via a bespoke meeting.

These should take place ahead of the Directorate Performance Review meetings set out above so that information can be fed into the discussions rather than an upcoming meeting used as a mechanism to defer discussion.

9. Performance information

A standard directorate performance pack will be produced and shared at least one week before the monthly performance review meetings.

The information used will be consistent in content and format with the information that is used to report and discuss performance with the Trust Board, commissioners and regulators.

A simple RAG rating should be used in all of the interactions and reports referenced in this framework:

- Red – a target that is not being delivered
- Amber – a target that is not being delivered but has an approved recovery plan with trajectory that is being met or there is a query about delivery
- Green – a target that is being delivered

10. Performance reporting

A product of the monthly performance review meetings should be to provide a clear narrative on performance issues to be used in reporting to the Board and to regulators. There should be a flow and consistency of information and narrative. For this to succeed, the performance review meetings need to be clear and transparent.

11. Review

The LPT Performance Framework will be reviewed after six months in June 2020.

END

P

Leicestershire Partnership NHS Trust

CHARITABLE FUNDS COMMITTEE– DATE 17TH DECEMBER 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	Risk Reference
Review of Risk Register	High	The Risk Register has been updated and has one low risk related to funding, with strong controls in place as evidenced by the recent audit. As the charity's risks won't go onto the Trust's Organisational Risk Register, they will be retained on Ulysees.	1911
Review of Raising Health Fundraising Plan 2019 – 2021	High	Discussions were held around each section of the fundraising plan, its vision, its ambition, objectives and its aspirations. It was agreed that Raising Health and the Trust had moved forward significantly since the Fundraising Plan was written, and some amendments were required to reflect this. It was agreed that visibility within the Trust was an area we still needed to focus on, and the updated strategy needed to consider how to address this. It was suggested that presenting the strategy to Trust Board could help with visibility and fundraising idea generation.	1911
Fundraising Manager's Quarterly Report (Q3)	High	An update was provided on current appeals. The dementia garden at the Evington Centre was starting to progress, the new CAMHS unit Beacon appeal had made an excellent start and consideration could be given to increasing the initial target. The fundraising manager would work with the service to progress this. Interserve has confirmed that they have chosen the Beacon appeal as their charity of the year for	1911

Report	Assurance level*	Committee escalation	Risk Reference
Continued…. Fundraising Manager's Quarterly Report (Q3)		2020. Coalville League of Friends will be transferring a legacy from a patient for £55k to Raising Health. This will be spent on a garden space between two wards at Coalville. A procurement exercise would be undertaken.	
Finance Report (Q2)	Medium	An update on the charity financial position was provided. The investment value had increased in the first two quarters with £102k total growth. Income is down £35k on the planned levels year to date, this is due to a fall in donations and only £1k received as legacy so far this year. Expenditure is also lower than planned. The year end cash forecast currently is £27k, which is £11k less than planned. Expenditure commitments for the remainder of the year will be reviewed to ensure the cash forecast was robust. It was highlighted that the cash position won't change in April, so there needs to be a review of the approach to income/legacies for next year.	1911
Allocation of residual ABCD Funds	High	The Residual balance from the ABCD project is £100k. The committee approved the reallocation of £40k to specific existing projects to speed up the delivery: Stewart House Gym, Willows Gym equipment, Bradgate Unit Garden, Evington Centre Dementia Garden and Tai Chi staff training to deliver sessions to Mental Health patients. The remaining £60k was returned to the original funds it was drawn from.	1911
2018/19 Annual Report and Annual Accounts Annual Accounts Management Representation Letter	High	The 2018/19 annual report and annual accounts were approved by the committee. The Annual Accounts Management Representation letter was signed by the chair.	
Review of SFIs and SORD – change in charity procedures	High	The committee approved the proposed amendments in cash handling/carrying procedures which had arisen following the internal audit review of the charity's finances.	
Internal Audit report	High	The 2019/20 internal audit report was reviewed by the committee. There were 4 low risk recommendations which will be implemented by March 2020. The review had given a significant assurance opinion. The finance team was thanked for their contribution.	

Report	Assurance level*	Committee escalation	Risk Reference
New bids approved	High	Bids were approved by the committee: Evington Centre Dementia garden - £16.5k Hawthorn Centre - £3k (approved subject to further clarification of items requested) Hinckley staff room - £5k	
New funds created	High	The creation of new funds were approved: The Beacon Appeal Recovery College Simple Sensory	
Work plan	High	The work plan was reviewed and amendments were agreed to ensure timing of items e.g. budget setting was appropriate.	
Review of risk register	High	It was agreed that a new risk would be created to reflect the worsening cash position.	

Chair	**Cathy Ellis, Trust Chair & Trustee**

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Leicestershire Partnership NHS Trust

TRUST BOARD – 14 January 2020

AUDIT AND ASSURANCE COMMITTEE held 6 DECEMBER 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
Risk Assurance (Chairs of FPC and QAC)	MEDIUM	The new Organisational Risk Register process was now being applied to FPC and QAC and assurance was improving. More time was needed for complete confidence.	All
Internal Audit Progress Report	MEDIUM	The report updated on progress against internal audit plan, and matters of attention for t he committee. There were no concerns raised for completion of 19/20 plan. Possible adjustments to the draft Internal Audit plan 2020-21 were discussed. Internal audit first follow actions completion rate were still at only 60%. Concerns were also raised about the delay beyond a timeline agreed of three reports (the agreed delay was due to significant changes in the functions covered by the internal audit reviews).	1 18
External Auditors Progress report External Auditors Plan 2019-20	HIGH	A summary of KPMG's work since October 2019 was received, with positive progress was reported. Discussion was held around the approaches to the implementation of IFRS 16 (leases) from April 2020.	17

Report	Assurance level*	Committee escalation	ORR Risk Reference
Counter Fraud Progress Report	HIGH	The draft Fraud, Bribery and Corruption Policy was considered for adequacy. Nothing material had changed and it would now have minor corrections before being viewed by FPC in February 2020.	17
Clinical Audit Annual Review	HIGH	The committee was assured that the Clinical Audit team pursue actively quality improvement over assurance. Also that adequate systems and processes had been put in place to develop and approve the Clinical Audit Annual Report 2018-19 and the Clinical Audit Forward Plan for 2019/20. The Clinical Audit annual report was received positively.	1, 31
Annual Accounts process and key considerations for 2019/20	HIGH	The Committee was assured that the annual accounts process was underway, with plans in place for the successful submission of the accounts within key dates, and to include any statutory or Trust changes introduced in 2019/20.	17
Annual Refresh of Standing Financial Instructions (SFIs) including Scheme of Reservation and Delegation (SORD) and Standing Orders (SOs)	MEDIUM	The timing was challenged as being seen post being received at the Trust Board. In addition confirmation of capital spend authorization at Committee level was needed. A revised set of orders would be considered next year that would address the issues raised.	17
Summary of Chief Executive Waivers and Awarded Tenders	High	No issues raised.	17
Internal Audit Follow-Ups	LOW	Focused Work by Associate Director of Corporate Governance had provided capacity to clear many outstanding risk actions. Increased Executive meeting oversight had also improved the situation. However the First Follow-Up agreed management actions completion rate was still not at an acceptable level and not assured for future improvement.	1 18
Deep Dive	HIGH	Discussion led by Freedom To Speak Up Guardian Role considered: • Triangulation process of concerns raised in services to performance delivery • Governance process to escalate concerns • What issues are arising? • Is the process/approach working?	3
Review	MEDIUM	The framework and understanding of the new	All

Report	Assurance level*	Committee escalation	ORR Risk Reference
Organisational Risk Register		risk management approach, and currency of the Organisational Risk Register were improving. However it would need time before full assurance was given.	

Chair	Darren Hickman